WHO SOMALIA

Biennial Report 2008 - 2009

World Health Organization

WHO SOMALIA
Biennial Report
2008 - 2009

Table of contents

Foreword ...iii

1. Introduction ... 1

2. Partnerships in health development ... 2

3. Health programmes in Somalia ... 3

Polio-free Somalia ... 4

Routine immunization ... 6

HIV and AIDS treatment and care ... 9

Tuberculosis control ... 11

Malaria control and elimination ... 13

Primary health care ... 16

Essential medicines ... 23

Laboratory services and blood safety ... 25

Emergency preparedness and humanitarian action ... 27

4. WHO presence in Somalia ... 35

Foreword

We are pleased to share with you the biennial report of WHO Somalia for the period of 2008-2009. We hope that the report provides an update of the health programmes in Somalia in which WHO is involved to address the pressing health needs of the Somali population.

Looking back at the biennium 2008-2009, this period included my arrival as the new WHO Representative for Somalia in May 2008 and represented a dynamic and challenging working environment with successes and remarkable achievements but also setbacks due to security and access issues in Somalia.

The worsening humanitarian situation in mainly Central and Southern regions of Somalia and the bombing in Hargeisa in October 2008 with the withdrawal of international staff of multilateral and international organizations from all regions, were matters of great concern to humanitarian organizations. During 2008 and 2009, the Somali population, especially vulnerable groups such as women, children and the elderly, suffered immensely from displacement due to the ongoing crisis, armed conflicts, drought and floods. Solutions had to be found to assist almost half of the Somali population in their basic needs.

The global financial crisis had its effect on the funding of activities of both health cluster and sector, especially in areas of emergency response and early recovery, and health system development. The consequence was that some of the health partners on the ground had to scale back their humanitarian health activities and others to cease their operations.

Despite these challenges, WHO maintained its presence in Somalia with over 300 national staff working in health or disease control programmes. In collaboration with almost 30 health cluster partners, WHO established and strengthened primary and secondary emergency health care services in Central and Southern regions. Rehabilitation of several hospitals was successfully concluded in collaboration with UNOPS and health partners on the ground. WHO continued to provide medical supplies and equipment for adequate emergency response to health cluster partners. During the biennium, WHO trained newly graduated medical doctors in basic surgical interventions and trauma care, and provided supportive supervision where possible.

Somalia remained polio-free during 2008 and 2009 despite new cases of polio detected in neighboring countries in 2009. This is due to the unconditional dedication and commitment of the polio staff in Somalia. The implementation of Child Health Days, which is a component of the joint WHO/UNICEF/UNFPA Accelerated Young Child Survival Initiative, was based on the polio staff and infrastructure. By the end of 2009, after two rounds of Child Health Days, the routine immunization coverage was 51% in Somalia which was a remarkable success in the history of Somali public health where routine coverage was on average 30%.

WHO strengthened its disease surveillance activities for polio and measles case detection but also for other infectious diseases, such as acute watery and bloody diarrhoea, cholera, meningitis, pneumonia and H1N1. In 2009, activities were initiated for an integrated disease surveillance and response system in order to avoid "vertical" approaches in information collection and response and to start working towards zonal public health laboratories for verification and confirmation of infectious disease cases.

During 2008 and 2009, other disease control programmes such as HIV/AIDS, tuberculosis and malaria, made remarkable progress in activities related to case detection, lab confirmation, and the provision of adequate patient treatment and care. Health workers benefited from regular in-service training, technical support and supportive supervision. Accreditation of various cadres in the provision of quality care and services indicated commitment and professional interest of newly trained health staff.

During the biennium, together with health partners, a HIV proposal with a health system strengthening (HSS) component was submitted to the Global Fund to fight AIDS, TB and Malaria, GFATM, and approved by the GFATM Board in 2009. In addition, a HSS proposal was submitted to the Global Alliance for Vaccines and Immunization, GAVI Alliance, to complement the GFATM HSS component, especially at the district health level.

WHO continued its efforts in capacity building of staff from health authorities and health care workers in primary health care services, especially in blindness prevention, leprosy elinination, mental health, maternal and newborn health, access to essential medicines, and laboratory services and blood safety. Community-based initiatives were revived to allow communities to take charge of their public health-related problems.

A situational analysis of reproductive health was undertaken followed by drafting a national strategy. Both documents were endorsed and published in 2009. In August 2009, an outline was prepared for a Somali nutrition strategy based on the current (mal) nutrition situation and information provided by FSNAU and UNICEF. The final publication is expected in 2010 as well as publications on the Somali child health situation and related strategy. These publications are in support of the various health-related Millennium Development Goals.

The Country Cooperation Strategy (CCS) was drafted with the involvement of the Somali health authorities, donors and partners. This document was endorsed as the interim Somali Health Sector Strategy. Based on the CCS, the work plans of the priority health programmes for the biennium 2010-2011 were developed in collaboration with the Joint Programme Review Mission and the Somali health authorities, and presented to health partners and donors in August 2009.

In the last month of the biennium, on 3 December 2009, the Minister of Health of the Transitional Federal Government, Dr Qamr Aden Ali, was killed by a suicide bomb attack during a graduation ceremony of medical students of Banadir University in Mogadishu. Newly graduated medical doctors also lost their lives as a result of the hideous act. Dr Ali strongly believed that equitable access to health services was an entry point for lasting peace in Somalia.

It is our hope that this report provides an update of health programmes in Somalia and reflects the impact, opportunities but also the challenges WHO Somalia faced in 2008 and 2009 to meet the health needs of the Somali population.

On behalf of all staff of WHO Somalia,

Dr Marthe M. Everard
WHO Representative for Somalia

1. Introduction

This biennial report highlights the operations undertaken by the WHO Country Office for Somalia during the biennium 2008-2009. In this report the WHO contributions to the health programmes in Somalia are summarized. They are in line with the WHO Medium Term Strategic Plan 2008-2013, and reflecting the 11 technical strategic objectives of WHO. The report also highlights aim and objectives, main achievements, and lessons learnt in 2008-2009, and the strategic directions for each of the health programmes for the biennium 2010-2011.

The progress made in the health programmes in Somalia was with the support of a dedicated country team of 350 staff working at the WHO Liaison Office in Nairobi and at WHO sub-offices in Baidoa, Garowe, Hargeisa, and Mogadishu, and at various WHO hubs in the country. The country team received technical back-stopping from colleagues at the Eastern Mediterranean Regional Office in Cairo and at WHO headquarters in Geneva.

The report should not be seen as an exhaustive account of WHO inputs in Somalia, but rather provides the major activities that have shaped health development in Somalia, in line with the WHO Somalia biennial work plan for 2008-2009 which was negotiated with the three health authorities.

The report has four sections, starting with a Foreword of the WHO Representative for Somalia, and followed by section 1 Introduction, section 2 Partnerships in health development, section 3 Health programmes in Somalia, and section 4 WHO presence in Somalia.

2. Partnerships in health development

WHO Somalia maintained close collaboration with health authorities and worked in partnership with the various departments of the health authorities. Progress achieved was based on the commitment of the health authorities in all three zones in Somalia.

Partnerships were reinforced or established with other UN agencies and both the local and international non-governmental organizations for the implementation of health activities, especially the provision of essential life-saving health interventions to vulnerable groups, such as women, children and the elderly in South Central Somalia.

Humanitarian health assistance to Somalia benefited from the generous support of the donor community. Also financial support was provided to health sector development in Somalia.
WHO Somalia received contributions from the Arab League, Centers for Disease Control and Prevention/Atlanta, UK Department for International Development, the European Union, Bill & Melinda Gates Foundation, the Global Fund to Fight AIDS, TB and Malaria, Global TB Drug Facility, the Italian Cooperation, Measles Partnership, the Patient Help Fund Kuwait, Rotary International, SIDA, UNAIDS, UNDP, UNFPA, UNICEF, USAID/OFDA, the World Bank and Governments of Australia, Belgium, China and Germany.

We take this opportunity to thank our donors and health partners for their trust and support during the biennium 2008-2009 and we look forward to collaborate and work closely together to improve the health and well-being of the people of Somalia.

3. Health programmes in Somalia

Polio-free Somalia

> "Over 1.8 million children in Somalia have been immunized against polio during 2008-2009. WHO and partners have been able to achieve more than two years of polio-free status since March 2007. With at least one polio officer present in every district, the polio network also forms a backbone of the humanitarian response in times of disease outbreaks and response."

Polio situation in Somalia

Somalia is characterized by low coverage of children immunized routinely and the inability to conduct adequate and timely vaccination activities especially in some regions of South Central zone due to inaccessibility and insecurity. Somalia marked over two years of polio-free status in December 2009. The last wild poliovirus case from a four-year old female child was reported on 25 March 2007 from Hobyo district, Mudug region in Northeast zone of Somalia. In 2009, seven cases of circulating vaccine-derived polio virus (cVDPV) were detected in children in Somalia's central regions. Most of these children received more than three doses of trivalent oral polio vaccine (*Somalia has been using this vaccine since 2008*).

Since 2000, Somalia has exceeded the WHO-established minimum acute flaccid paralysis (AFP) reporting rate of 2 non-polio AFP cases per 100 000 children aged <15 years, which indicates a highly AFP sensitive surveillance system. In 2009, the non-polio AFP rate was 3.4. Somalia has also maintained more than 80% stool specimen collection rate first achieved in 2003.

Aim and objectives in 2008-2009

The overall aim of the programme was to keep Somalia polio free. Specific objectives were to:

- Maintain a highly sensitive AFP surveillance system (with all key indicators above certification standards) and provide evidence of absence of wild polio virus circulation for certification;
- Boost the immunity of all children below five years of age and protect them against poliomyelitis through routine and supplementary immunization activities, and Child Health Days.

Main achievements of the programme in 2008-2009

- Polio free status maintained: no wild polio virus case reported since 25 March 2007;
- All six rounds of supplementary immunization activities recommended by the Horn of Africa Technical Advisory Group on polio eradication were successfully implemented, four national immunization days in 2008 and another two in 2009 with coverage above 95%;
- High oral polio vaccine coverage achieved during supplementary immunization days and Child Health Days: oral polio vaccine is highly accepted by the Somali community yielding to coverage above 90% in each round of national immunization days, which targeted over 1.8 million children below 5 years of age;

- Presence of the polio network in all districts, regions and zones of Somalia continued to act as the backbone of the AFP surveillance system. The 200 national staff conducted regular active AFP site visits and reported from over 400 AFP surveillance sites, which include hospitals, mother and child health centres, out-patient departments, private clinics, traditional healers and pharmacies to ensure that no AFP cases were missed. They conducted AFP case investigation soon after reporting, collected samples and sent them to the KEMRI laboratory in Nairobi for analysis. This has enabled Somalia to maintain a highly sensitive AFP surveillance system with all key indicators above the certification standards;
- Strong coordination and collaboration was maintained among polio eradication partners—health authorities, UNICEF and non-governmental organizations. The continued support of donors enabled Somalia to implement all supplementary immunization activities. The new joint WHO/UNICEF initiative of Child Health Days, the first initiative of its kind in Somalia, was successfully implemented and over 1 million children under five years and women of child bearing age reached with a package of life-saving health interventions. Oral polio vaccine included in the Child Health Days package provided additional protection to children against polio (see page 8).

Lessons learnt in 2008-2009

- Whilst implementing large-scale interventions like the supplementary immunization activities and Child Health Days, a level of flexibility is required on the ground despite access restrictions due to security concerns. The collaboration with partners is a major benefit to reaching children with life-saving health interventions.
- Presence of polio staff in every district remained vital in the successful implementation of polio programme activities especially in the regions of South and Central Somalia.
- Resource mobilization is essential for sustainability of polio eradication and other immunization activities in Somalia.

Strategic directions for 2010-2011

The priority for WHO will be to maintain the polio free status in Somalia through improving the immunity profile of children under five years of age by the scheduled supplementary immunization activities, Child Health Days and routine immunization. A highly sensitive AFP surveillance system will be maintained at all levels and vaccine-preventable disease surveillance and child survival initiatives will be supported. Partnerships will be maintained and expanded where possible to support polio eradication and child survival activities in the country.

Routine immunization

> The expanded programme of immunization has seen remarkable improvement in routine immunization coverage. With the introduction of the Reach-Every-District strategy and the implementation of Child Health Days, immunization was boosted . As a result, the routine coverage increased from 36% in 2008 to 51% in December 2009. This is the highest ever routine immunization coverage reached in Somalia.

Routine immunization coverage in Somalia

Vaccine-preventable diseases remain the major causes of disability and death among Somali children in spite of the availability of cost-effective immunization interventions. By the end of 2009, the coverage of childhood immunization was 51% in Somalia. With only five years to go before the millennium development goals (MDGs) target year of 2015, this remains a key concern for Somalia to meet MDG 4 of reducing child death by two-thirds.

Aim and objectives in 2008-2009

The aim of the programme was to improve survival and health of children in Somalia by decreasing death and disability from vaccine preventable diseases through provision of the six primary antigens to all eligible target groups in the Somali population.

Specific objectives were to:

- Increase immunization coverage of children of less than one year old to over 80% in two years;
- Improve immunization service management at regional and zonal levels in Somalia by establishing and strengthening expanded programme of immunization (EPI) units with health authorities;
- Strengthen vaccine preventable disease surveillance in the three zones of Somalia.

Main achievements of the programme in 2008-2009

WHO scaled up its efforts to improve the health of children in Somalia through initiating the Reaching Every District strategy in order to improve coverage of immunized children;

Measles follow-up campaigns were conducted in all zones of Somalia in 2008 and 2009 along with other interventions as part of the new Child Health Days Initiative;

Measles case-based surveillance was initiated in Northeast and Northwest zones of Somalia. This surveillance system was also initiated in South and Central zone;

Despite the security and accessibility challenges, Child Health Days have been conducted all over Somalia (except one region in Central Somalia). The Reach-Every-District strategy was implemented

in relatively stable areas in Northeast and Northwest zones. WHO's presence in every district in Somalia and the collaboration with the health authorities, UNICEF and other health partners has contributed immensely to the successful implementation of immunization activities.

Other achievements of the programme during the biennium:

- More than a million children have been vaccinated against childhood diseases through rounds of Child Health Days during 2009;
- Measles outbreaks reported in Northeast zone and Afgooye district in South Central zone were detected and controlled.
- In Northeast and Northwest zones, two EPI units were set up. With the technical and financial support of WHO, these units made zonal assessments on the status of immunization. They prepared a plan of action, the first of its kind for the health ministries that included the training of more than 200 health workers, and coordination of EPI activities;
- Disease monitoring activities were implemented;
- Supported EPI service delivery at health facilities;
- The distribution of 60 refrigerators.

Lessons learnt in 2008-2009

- There was high demand for childhood vaccines among the vast majority of Somali communities. Only few communities refused vaccination which needed to be addressed.
- Strong partnership with the health ministries, UNICEF and other UN agencies and non-governmental organizations was vital in Somalia, where there is no central functioning government.
- Polio infrastructure was also used to strengthen other public health activities.
- Measles vaccination campaigns have served as the foundation for delivering other child health interventions in an integrated approach.

Strategic directions for 2010-2011

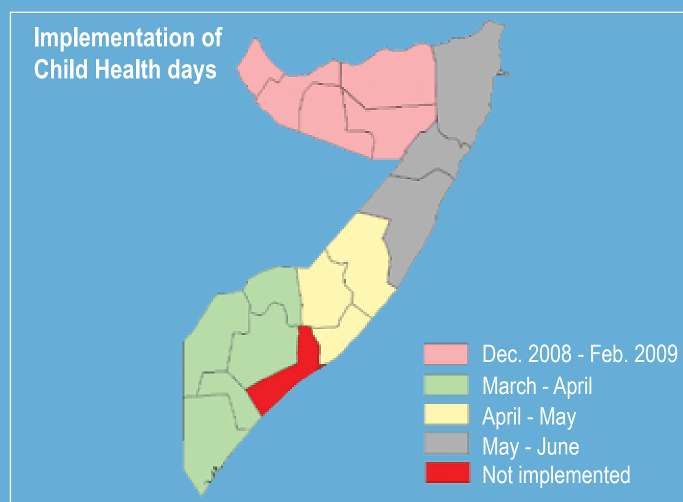
WHO will strengthen routine and supplementary immunization activities to increase immunization coverage up to 60% through coordinated efforts with partners. Improvement of service utilization will be initiated through effective behavioural change, communication and reduction of drop-out rates. Integrated disease surveillance and response system will be initiated to monitor the trends of epidemic-prone diseases, early detection of outbreaks, appropriate case management and response in the country. Hepatitis vaccine will be introduced in 2010 in Northwest zone of Somalia.

Focus: Child health days

In response to the low routine immunization coverage in Somalia, WHO and UNICEF embarked on a joint initiative called Child Health Days (CHDs) to address the high level of death and disability in children under the age of 5 years in Somalia. CHDs is a delivery strategy of multiple life-saving interventions which include **measles, DPT, oral polio vaccine, de-worming tabs, Vitamin-A supplementation, oral-rehydration salts, aqua tabs, nutritional screening and tetanus toxoid** for mothers of child bearing age. These high-impact child survival interventions are delivered through CHDs that are conducted through regular campaigns. CHDs are implemented both in urban and rural areas, including hard-to-reach areas through the use of around 30 000 community volunteers, conducted in a phased manner.

During the biennium, the CHDs campaigns reached 1.2 million children and 900,000 women which was more than 80% of the targeted population.

Figure 1: Geographical areas in Somalia reached through CHDs in 2008 and 2009

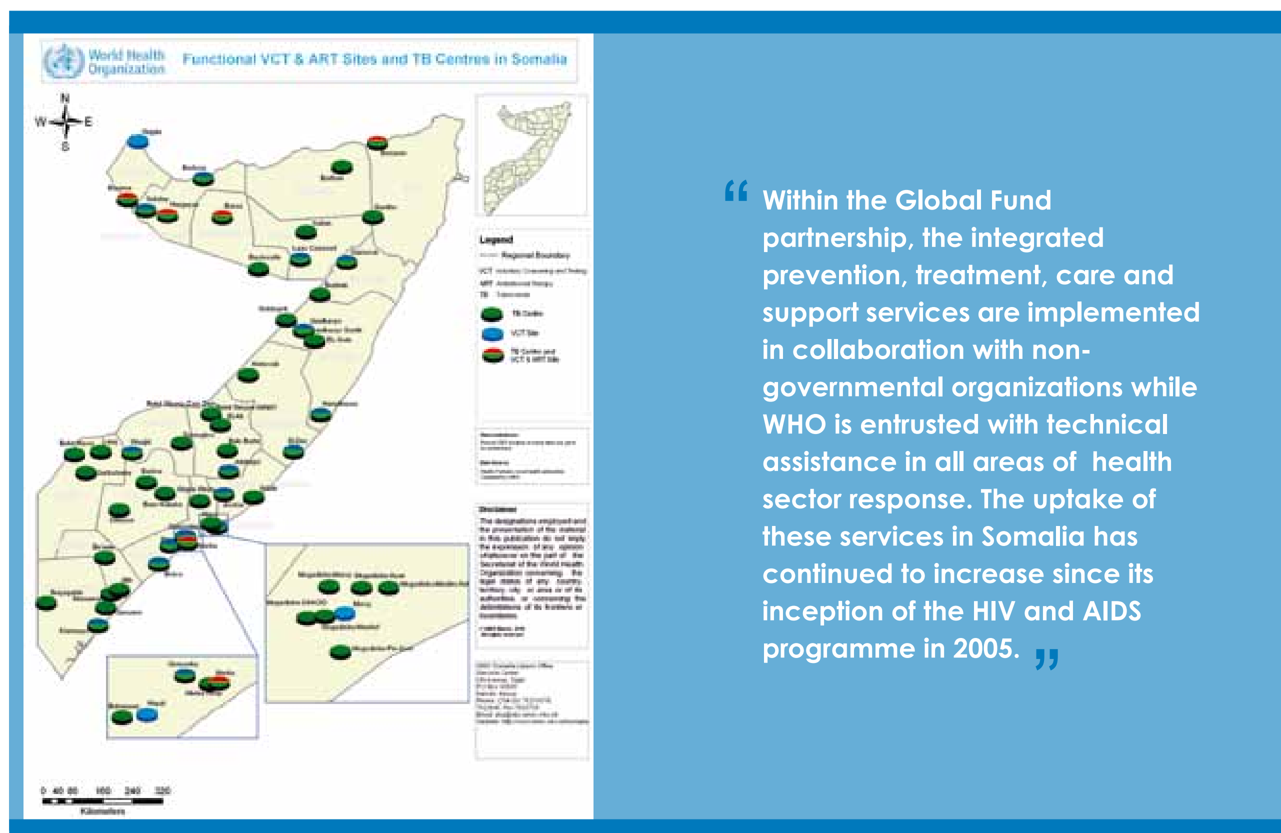


The implementation of CHDs in 2008-2009 saw:

- Scaling up of child health through multiple health interventions;
- Integrated interventions are more cost-effective compared to single interventions whether during campaigns or routine mode of service delivery;
- Improved routine immunization;
- High community acceptance of integrated interventions;
- Utilization of the already existing polio network (the presence of WHO polio staff in every district in Somalia).

Child health days have provided an innovative way of reaching a high number of children in support of weak routine immunization services. These health interventions also allowed women of child-bearing age to receive tetanus toxoid vaccination.

HIV and AIDS treatment and care



> " Within the Global Fund partnership, the integrated prevention, treatment, care and support services are implemented in collaboration with non-governmental organizations while WHO is entrusted with technical assistance in all areas of health sector response. The uptake of these services in Somalia has continued to increase since its inception of the HIV and AIDS programme in 2005. "

Situation of HIV and AIDS in Somalia

Survey data available indicate that Somalia has multiple HIV epidemics. In the Northwest zone, the features of HIV prevalence is more generalized with HIV among women attending antenatal care being 1.4% and 1.3% for 2004 and 2007 respectively. HIV infections among transactional sex workers is 5.2%. In Northeast and South Central zones there is concentrated or low level epidemic. HIV among antenatal care attendants is 0.5% in the Northeast regions while in south and central the rate is 0.5%. There has been an increase in the uptake of HIV integrated prevention, treatment, care and support services in Somalia as a result of building the capacity of service providers despite security concerns in the country. These services were initially established at out-patient departments in major hospitals and cross-border towns. Expansion of the services is also targeting areas where there is strong evidence of vulnerabilities to contracting HIV associated with high-risk behaviors. Community-based and household support to the anti-retroviral treatment programme remains a key concern.

Aim of the programme in 2008-2009

The HIV and AIDS programme aimed to:

- Provide technical support to health workers to strengthen their capacity in expanded delivery of prevention, treatment and care interventions for HIV, AIDS and sexually transmitted infections;
- Establish integrated prevention services for internally displaced persons;
- Carry out HIV/STI surveillance to monitor coverage of essential prevention and treatment services in accordance to WHO/UNAIDS recommendations;
- Establish HIV/TB collaborative activities.

Biennium Highlights

More than 3000 health workers were trained on delivering anti-retroviral therapy to strengthen integrated prevention, treatment, care and support services.

More than 25 000 patients received treatment for sexually transmitted infections.

Main achievements of the programme in 2008-2009

- By the end of 2009, 578 people living with HIV/AIDS received anti-retroviral therapy, 24 284 were tested for HIV and received counseling at voluntary counseling and testing centres and among them 9.6% (2343) tested positive. About 25 047 were provided with syndromic case management;
- Integrated prevention, treatment, care and support (IPTCS) services were implemented after partners agreed on a basic minimum package. The introduction of TB/HIV collaborative activities in 2009, and services targeting cross border and mobile populations helped expand the IPTCS services;
- In 2009, a project targeting cross border mobile populations was initiated in Northeast zone. Of the 679 people tested and received counseling, only one case tested HIV positive (0.1%);
- HIV/STI sero-prevalence surveillance studies among antenatal care attendants in Northeast and Northwest zones of Somalia started in December 2009 with sampling collection, to assess HIV trends in Somalia. This activity will be completed in April 2010.

Lessons learnt in 2008-2009

- Strong partnership with authorities from the three zones of Somalia, the AIDS commissions, UN agencies and non-governmental organizations has been vital in the implementation of the HIV and AIDS programme and in better monitoring of the health response.
- Deteriorating security has limited access to most of the regions in South Central Somalia even for national staff, and this affected the implementation of planned HIV and AIDS activities. However, training of national health workers has allowed vital interventions to be conducted even in the absence of international staff.
- Strengthening the national capacity including the managerial structures and promoting ownership of the HIV and AIDS programme improved service delivery and ensured its sustainability.

Strategic directions for 2010-2011

WHO will undertaken more surveillance studies with focus on identifying the risks of HIV in the country. Integrated biological and behavioral studies and population size estimates for the most-at-risk populations will be conducted to provide and expand the IPTCS services the country. Border areas where there is high mobility among the population will be targeted. The anti-retroviral therapy programme will be closely linked to community and household support to alleviate some of the social and economic impact on people living with HIV and in dealing with stigma. TB/HIV collaborative activities will be strengthened with focus on collection of TB/HIV data that is critical to the advancement of universal access. A joint programme monitoring and evaluation framework will be developed by partners. Capacity building of health workers in the management of medicine supply and rational prescribing and use will continue.

Tuberculosis control

> “WHO worked with partners to strengthen detection and treatment of over 23 000 tuberculosis cases as well as provided support to health authorities to develop national strategies and guidelines. The tuberculosis (TB) programme has made remarkable progress to achieve the millennium development goal to combat the disease in Somalia by 2015. Contributing factors are that both public and private health sectors were incorporated into the national TB control programme. The practical approach to improve lung health was to accelerate TB case detection in Somalia by trained health workers.”

Situation of tuberculosis in Somalia

The national TB programme in Somalia was established in 1995 and has steadily improved TB detection notwithstanding the complex emergency situation within which it has been operating. DOTS, the basic treatment package that underpins the Stop TB Strategy is implemented at the TB centres. The TB prevalence in Somalia is estimated to be 290 per 100 000 population for all forms of TB, based on data collected in 2008 and 2009 and the outcome of 160 per 100 000 for sputum smear TB positive cases. WHO takes the lead in the management of the national TB programme by coordinating with the health authorities and local and international NGOs with financial support from the Global Fund.

Aim and objectives in 2008-2009

The overall aim of the TB programme in Somalia is to reduce the burden of TB and improve the quality of life of the Somali people in support of the millennium development goal 6 and achieving Stop TB Partnership targets. In 2008-2009, the programme provided DOTS at 50 TB centres countrywide with at least one TB centre in each of the 18 regions and in major district localities.

Specific objectives of the programme were to:

- Pursue high-quality DOTS expansion and enhancement;
- Address TB-HIV co-infection and multi-drug resistance TB, and to meet the needs of poor and vulnerable population;
- Empower people with TB, and communities through partnership and engagement strategies;
- Enable and promote the TB research agenda;
- Contribute to health systems strengthening with focus on primary health care services.

Biennium Highlights

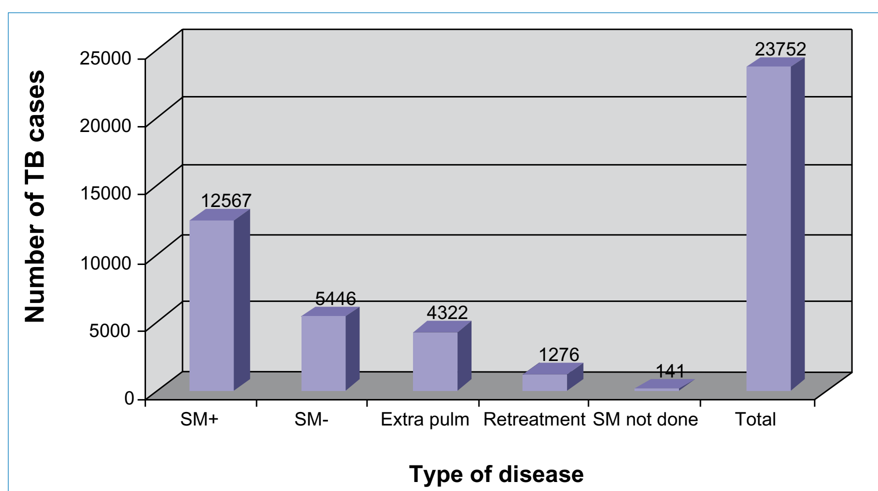
A total of 625 health workers were trained during the biennium of whom 211 laboratory technicians and 414 health workers.

TB medicines were provided by the Global Drug Facility and Kuwait Helping Fund Society strengthening coverage of approximately 26 000 people.

Main achievements of the programme in 2008-2009

- TB case detection and treatment improved: a total of 23 752 TB cases were diagnosed across Somalia with 12 567 (52.9%) confirmed by sputum smear testing. The TB cases that were detected but without bacilli were 5446 (22.9%) while 4322 (18.2%) patients had other forms of TB other than lung TB (see graph 1). About 1276 (5.4%) TB cases were treated for a second time after not completing their initial treatment (defaulter) or become re-infected after successful treatment (relapse). The introduction of a new recording and reporting system will facilitate more detailed information collected for better case detection. Treatment success in 2008 was 89.1%, death rate 3.0% defaulter rate 3.6%, failure rate 2.0% and transfer-out rate was 2.3%. The treatment success rate improved during 2009;
- Microscopy: a system for sputum microscopy external quality control and assurance was established by WHO and partners;
- Multi-drug resistance: TB medicine resistant survey was initiated in 2009 but will be completed in 2010;
- Strategic plan: The national TB strategic plan was developed including a workplan for advocacy, communication and social mobilization.

Graph 1. Number of TB cases diagnosed in the biennium according to the disease type



Lessons learnt in 2008-2009

- Capacity-building of both laboratory staff and local health workers was key to successful implementation of the TB programme and its continuity in situations where international technical staff were not able to work.
- Additionally, the effective coordination and commitment among partners and the involvement of health authorities was critical for the proper planning and implementation of the programme.

Strategic directions for 2010-2011

WHO will support partners to establish six new TB centres in the three zones of Somalia. Based on the survey results, health partners will address the disconcerting issue of multi-drug resistant TB in Somalia. WHO will also support partners to develop and roll out a system for external quality control and assurance of TB laboratory services.

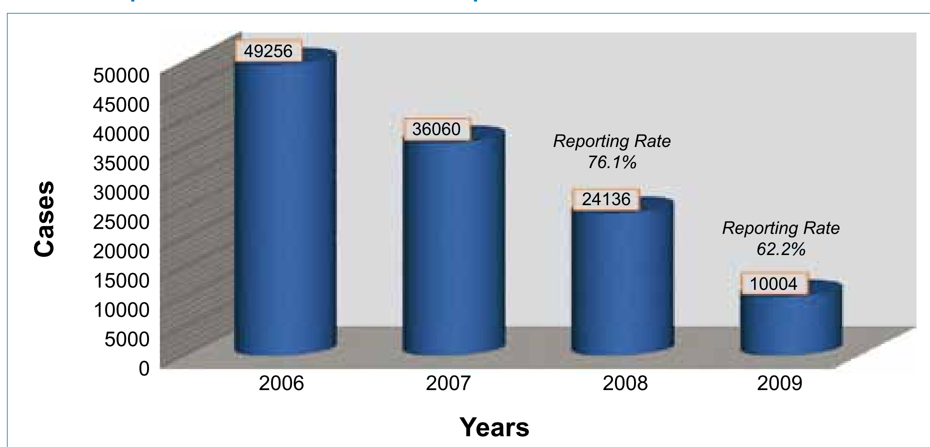
Malaria control and elimination

> Partnership played a key role in taking preventive measures and the control of malaria in Somalia. Reported cases and deaths significantly reduced as a result of collaborative initiatives by various partners to combat malaria. Somalia achieved to halt malaria cases and began to reverse the number of malaria cases by 50%.

Situation of malaria in Somalia

Malaria is still a major health concern in Somalia, particularly affecting pregnant women and children under five years of age. However in recent years, progress has been made in provision of key interventions to combat malaria such as effective treatment and mass distribution of long-lasting insecticidal-treated nets throughout Somalia. In 2008-2009, more than 34 000 malaria cases (confirmed and clinical) were reported, a significant decrease as compared to the previous biennium of 2006-2007 (see graph 2). With the support of health partners, WHO implemented the artemesinin-based combination therapy at mother and child health centres. Microscopical diagnosis was strengthened and there was expansion in rapid diagnostic testing at health facilities. Vector control was stepped-up with treated bed nets distributed in malaria-prone areas.

Graph 2. Number of malaria cases reported from sentinel sites in Somalia



Aim and objectives in 2008-2009

The aim of the programme was to eliminate malaria as a public health problem and obstacle to socio-economic development in Somalia, through sustained efforts by local authorities in collaboration with national and international partners. Specific objectives during the biennium included to:

- Reduce under five, maternal and adult mortality due to malaria by 50%;
- Strengthen health authorities capacity in close collaboration with national and international non-governmental organizations and partners.

Biennium Highlights

Partners have distributed over 400 000 long-lasting insecticidal nets across Somalia.

About 120 national staff were trained in the different aspects of malaria prevention and case detection, and programme management.

Main achievements of the programme in 2008-2009

Activities were undertaken to prevent and ensure early diagnosis and prompt treatment of malaria. Sentinel sites reported a 60% reduction in reported cases across Somalia, with 34 000 cases and 48 deaths during 2008-2009 with a case fatality rate (CFR) of 0.0014 as compared to 85 000 cases and 91 deaths with CFR 0.1 during the previous biennium of 2006-2007.

WHO and health partners (UNICEF, PSI, FSNAU, CCM/Italy, Merlin, Health Unlimited, Havoyoco, and PHF/Kuwait) achieved the following:

- UNICEF and PSI distributed more than 400 000 treated nets. The current estimated bed net utilisation rate is 47%. Distribution of the insecticidal nets in targeted districts in Central South Somalia increased from 20% in 2006 to 75% in 2009;
- Human resource development: 80 microscopists were trained across the three zones. In addition, 27 health workers were trained to undertake household surveys and net distribution through the support of Kuwait Helping Fund and UNICEF. Eight health staff were enrolled in a masters programme in entomology. Other training provided were in areas of surveillance and case management;
- Supplies and equipment were provided to 80 peripheral laboratories, in mother and child health centres and hospitals. Two quality control centres in Hargeisa and Garowe were established in 2009. Medicines for the treatment of severe malaria cases were distributed and indoor-residual spray equipment were made available in all zones;
- Partnership development: Coordination mechanisms were established, malaria review meetings organized and working groups met at regular intervals;
- World Malaria Day marked on 25 April focused on malaria awareness raising activities;
- Operational research: Five malaria vector suitability studies were conducted in all three zones. Findings indicated that the malaria vector is still sensitive to the insecticides used in indoor residual spraying exercises with 100% mortality rate;
- Monitoring and evaluation: Health information management system at sentinel sites was strengthened.

Lessons learnt in 2008-2009

- Extended efforts of human resources development will ensure sustainability of the national malaria programme.
- More funding is needed to maintain progress made in achieving the millennium development goal to combat malaria in Somalia.

Strategic directions for 2010-2011

WHO will work together with health authorities to develop a National Malaria Strategy 2011-2015 and a Monitoring and Evaluation Plan in collaboration with UNICEF. WHO will also strengthen the malaria control programme at all levels to enable delivery of reliable and effective malaria preventive interventions, early diagnosis and prompt treatment. WHO will coordinate the integration of the malaria surveillance system into the integrated disease surveillance and response system.

Focus: Using the community in the fight against malaria

Considering the need to enhance community ownership in health programmes, WHO, through its community-based initiative and roll back malaria programme in Somalia provided a 3-day training course in Merka in September 2009, on community involvement in preventing malaria transmission through the use of long-lasting insecticidal-treated nets in 15 villages in Lower Shabelle region. Participants were trained to advocate within their communities, to provide health education on how to prevent malaria, as well as to help implementing bed net distribution.

Of these 15 villages, 27 health volunteers attended the training to understand better the prevention and treatment of malaria, and to conduct a household survey to register the eligible families. In the second phase of the project about 5000 nets were distributed by village representatives and health volunteers. This intervention targeted about 15 000 people comprising of about 2500 households that received 2 nets per family. This project was supported by the Patient Helping Fund/Kuwait and by Mabarah Assayer Society.

Making use of community-based initiatives, so far WHO has distributed bed nets to 2500 households in 2009.

Primary health care

> " Primary health care starts with people. "
>
> *Dr. Margaret Chan,*
> *WHO Director General*

Situation of primary health care in Somalia

In 2008-2009, WHO identified human resource development as one of the important building blocks of strengthening health systems. Health workers in Somalia were trained on the various aspects in primary and secondary health care service delivery. In 2009, with the support of GAVI and Global Fund, WHO successfully developed health system strengthening proposals in consultation with partners and endorsed by the health sector committee and authorities. Community involvement in health awareness campaigns played a key role in improving access to critical life-saving health interventions. WHO distributed medicines in support of control of non-communicable diseases like mental health, a forgotten priority in Somalia. Health initiatives were undertaken towards primary health care delivery in Somalia although implementation of some of the programmes is faced with very limited financial resources.

Human resource for health

Lack of skilled health workers is a major constraint in scaling up the delivery of health services in Somalia. During the long-standing conflict there has been massive brain drain of skilled health workers. Only until recently formal pre-service training was introduced through the re-opening of some nursing institutions in the country. The average health work force ratios are very low in Somalia: 3 physicians per 100 000 and 11 nurses per 100 000. The shortage is particularly acute for midwives with a total of 282 midwives, a ratio of 3 midwives per 100 000.

WHO carried out national training activities for health workers in Somalia. About 20 midwifery teachers from medical schools in Hargeisa, Bossaso, Boroma, Burao and Mogadishu received training to meet the health needs of the population. Fellowships were provided to medical students at the various training institutions abroad.

WHO established a post basic nurse-midwifery training programme in the three nursing institutes: in Mogadishu and Bossaso, the programme is at preparatory stage, while at the Hargeisa Nursing School, the curriculum was finalized. The skills of practicing midwives in all zones have been enhanced through the technical assistance provided by WHO. Support has been provided to the tutors through technical workshops, provision of medical literature, teaching aids and laboratory equipment. In addition, technical support was provided to developing various curricula. Teaching guidance and incentives were provided to the tutors at the six health science and nursing institutions in Somalia.

Nutritional situation in Somalia

The rate of malnutrition in Somalia is ranked amongst the worst in the world. Data in 2009 provided by the Food, Security and Nutrition Analysis Unit-Somalia, showed worsening levels of malnutrition with 1 in every 6 children being acutely malnourished. However, in South and Central Somalia the rates are higher with 1 in 5 children acutely malnourished. Malnutrition is common in Somalia due to a number of factors including food insecurity, low purchasing power, poor feeding and breast feeding practices and lack of access to safe water and sanitation facilities. In 2009, around 3.6 million people were in need of emergency livelihood and life-saving assistance which accounts for approximately half of the population. The analysis unit estimated that 285 000 children under 5 years of age were acutely malnourished, of which 70 000 were severely malnourished and were at an increased risk of death without the appropriate therapeutic feeding interventions and care.

To address malnutrition in a comprehensive way, WHO in collaboration with UNICEF, FSNAU, FAO, WFP, NGOs and health authorities initiated the development of a Somali Nutrition Strategy. The strategy aims to improve the nutritional status of the Somali population through:

- Improved access to and utilization of quality nutrition treatment services;
- Improved availability and coverage of micronutrients through food fortification and de-worming interventions to the population;
- Improved capacity for health staff to deliver essential nutritional services;
- Increased knowledge, attitudes and practices on infant, young child and maternal nutrition and feeding practices.

Nutritional interventions like administering of Vitamin A supplementation and de-worming of children were carried out during Child Health Days, a child survival initiative in partnership with UNICEF, partners and health authorities (see page 8).

Community based-initiatives

Basic development needs (BDN) programme was implemented in 71 villages in Somalia, with a population coverage of over 100 000. In addition, 13 villages received BDN management support from partners and Somali Red Crescent Society. In 2008-2009, advocacy of the BDN concept was initiated at the various levels. The implementation of the BDN programme required further WHO technical guidance and adequate funding to benefit more villages.

Another initiative, the Healthy City programme, focused on improving the quality of life of the population through education and promotion of healthy lifestyles. By the end of 2009, the programme was fully implemented in Hargeisa. There is high commitment to this initiative expressed by the municipalities of major cities across Somalia. In order to ensure the sustainability of the Healthy City programme and

their operational capacity, WHO provided supplies and equipment. A technical team comprising of ministries of Education, Health and Family Welfare, and municipality staff adopted WHO's Healthy City guidelines which were translated into Somali, and household questionnaires as well.

During 2008, a comprehensive review of the community-based initiatives in all three zones of Somalia was conducted to identify ways of strengthening communities. WHO conducted training for village development committees on improving coordination among BDN villages. In addition, the training manual was translated into Somali and distributed to community representative and health volunteers for reference.

In 2009, in collaboration with the malaria programme, the BDN programme received support from Patient Helping Fund/Kuwait to procure 5000 insecticide-treated nets. The bed nets were distributed to about 15 000 beneficiaries living in 2500 households in 15 villages. This is an initial component of a larger community-based malaria vector control plan, through the use of treated nets to benefit at least 42 000 people (7000 households).

Maternal and newborn health

According to WHO and UNICEF, it has been estimated that only 47% of pregnant women are attended to by professional healthcare personnel. The vast majority (80%) of childbirths in Somalia takes place at home with the help of family members and traditional birth attendants (TBA). The maternal mortality rate for Somalia is estimated between 1044-1400 per 100 000 live births. Complications such as hemorrhage, prolonged labor, obstructed labor, infections, and eclampsia are the major cause of death at child birth. Many of those who do not die from complications continue to suffer from chronic anemia, chronic and acute infections and fistula. Female genital mutilation has impacted negatively on maternal health, despite advocating for behavioural change. In addition, poor quality antenatal, delivery, and postpartum care and the absence of emergency obstetric referral system further contribute to high rates of death and disability.

To improve maternal health in Somalia, WHO supported capacity-building for over 200 health workers which included clinical aspects of maternal and newborn care and 170 traditional birth attendants were trained on data collection, reporting and infection control; 30 midwives and nurses on the management and care of newborn babies; and 22 midwives on tutorship for midwifery. Other training courses provided were on family planning and on strengthening of reproductive health monitoring and evaluation. Additionally, TBA kits, provided by WHO's key reproductive health partner UNFPA, were distributed to health facilities.

In 2009, WHO conducted a comprehensive situation analysis of Reproductive Health (RH) in Somalia. Based on the identified needs, a National Reproductive Health Strategy for Somalia was developed in close collaboration with UNFPA, UNICEF and health authorities. The strategy aims to reduce maternal mortality through improved availability, accessibility and quality of essential RH services;

increasing the coverage of safe deliveries by skilled attendants; promoting healthy families through family planning and addressing harmful practices.

Prevention of blindness

Avoidable blindness is a major health problem in Somalia. The estimated blindness prevalence rate is 1.2%, and there are more than 100 000 blind people in Somalia. Cataract remains the major cause of blindness. Other major causes of blindness are corneal opacity, refractive errors and glaucoma. The cataract surgical rate was 254 per million population in 2006. The national programme for prevention of blindness is still in its initial stage. Primary eye care is not yet integrated within primary health care. WHO supports human resource development for eye care by facilitating training of Somali doctors, provision of cataract kits, diagnostic and surgical equipment, and technical support.

In an effort to prevent blindness in Somalia, WHO and Manhal International embarked on:

- Implementing free cataract surgery for affected people;
- Establishing eye clinics in collaboration with the health authorities in Northeast and South Central Somalia;
- Developing a national comprehensive plan for eye-care in line with Vision 2020 and capacity building in eye-care;
- Implementing a school screening programme for Somalia.

In September 2008, WHO established the National Eye Centre in Mogadishu in collaboration with Manhal and the Ministry of Health. The cataract surgical rate has improved from 254 in 2006 to 855 per one million people by the end of 2009. During the biennium, several eye camps were conducted with nearly 70 000 patients benefiting in 2009. More than 12 000 affected by blindness were treated including 5070 cataract surgeries carried out in 18 eye camps throughout the country in 2009.

Additionally, 3000 cataract kits, diagnostic and surgical equipment were supplied by WHO to eye care centres in the country.

Skills of health workers in diagnosis and treatment of eye diseases were improved. Somali doctors were sponsored to undertake further studies in ophthalmology. In-service training were offered to local eye-care providers at Manhal Specialty Hospital in Hargeisa.

Mental Health

The impact of decades of conflict in Somalia resulted in large-scale civilian injury, death and destruction, the collapse of social and economic systems, and high internal displacement of the population. This has greatly affected the psychological well-being of the Somali people. Further, the effects of chewing Khat by Somali men is a growing social problem. The prevalence of psychological trauma and stress is generally reported to be widespread. The lack of a mental health care policy and the practice of keeping the mentally ill patients in chains hampered mental health care delivery in Somalia. Mental health services in Somalia face a serious lack of qualified health care personnel and under funding of the programme is a major challenge to provide these services. There are four mental health centres, in Hargeisa, Berbera, Bossaso and in Mogadishu, providing care to people suffering from mental health conditions.

The Chain-Free Initiative (CFI) is making human rights a reality for people living with mental disorders in Somalia. Already implemented at the Habeeb Hospital in Mogadishu, the initiative aims to foster chain-free hospitals, chain-free homes and a chain-free environment to ensure the dignity of people with mental health disorders. CFI is also fully implemented in Northwest zone with preparations for its expansion to Northeast zone of Somalia.

©GRT

Continuous support was provided to mental health care service delivery in all zones. WHO provided mental health medicines and supplies for mental health care to the four mental health facilities (Hargeisa, Berbera, Bossaso and Mogadishu) as well as supportive supervision and monitoring rational use of mental health medicines. During the biennium, about 6640 people with mental health disorders were admitted to these mental health facilities.

Addressing the challenges faced by the national mental health programme, a highlight was the 3-month training course organised by WHO from October to December 2009, on the integration of mental health in primary health care. In this course, 33 health workers from the three zones were trained.

In 2009, a mental health focal point was nominated for South Central zone.

A comprehensive mental health situation analysis was initiated in 2009, based on a survey on mental health facilities, a mapping exercise, and review of existing reports. A national strategy will be developed based on the collected information.

Leprosy elimination

© World Concern

Somalia is one of the five countries in the Eastern Mediterranean region that has a high burden of leprosy. Leprosy is a public health concern in the riverine areas of Somalia. Contributory factors to transmission of leprosy include over-crowding, population movement from riverine areas of the South to urban areas. Since 2004, untreated leprosy accounted for about 2500 cases. Prior to the longstanding conflict in Somalia, health facilities treating leprosy cases were functional in Mogadishu, in Banadir region and in Jilib district of Middle Jubba region. The Forlanini Hospital, which was the leprosy centre in the Mogadishu area, was destroyed during the conflict thus affecting leprosy treatment services. The incidence of the leprosy is estimated to be 18 per 100 000 with an estimated prevalence rate of 403 per 100 000 cases in 2008. The programme target is to reduce the occurrence of the disease by 50% by 2015 and to halve the leprosy disability cases and death rates, currently at 11 per 100 000 in 2008.

The leprosy elimination programme in Somalia received support from donors and community-based organizations, enabling health facilities in Labadaad, Mdoa and Chovae villages in Lower and Middle Jubba region to provide communities affected by leprosy access to health care services. WHO Somalia in collaboration with World Concern, local communities and health authorities, re-established the programme, implementing leprosy elimination activities in Somalia.

In 2008, WHO signed a memorandum of understanding with World Concern to implement the following strategic interventions:

- Capacity building of health workers in leprosy treatment and management;
- Access to multi-drug therapy (MDT) and prednisolone for patients throughout Somalia;
- Prevention and management of disabilities with focus on distributing translated material on self-care for the leprosy patients and their communities, especially in areas where there is limited access to health facilities;
- Awareness campaigns for communities to tackle issues of stigma associated with leprosy.

To deliver the much needed services, a total of 230 health workers were trained during 2008-2009. Training focused on leprosy management and self-care practices including providing nutritional interventions like the administering of deworming tablets to children in the Southern regions of Somalia.

In Lower Shabelle and Middle Jubba regions, 125 leprosy cases were reported and treated in 2008-2009. The programme extended to cover internally displaced persons who were screened for leprosy. Awareness campaigns were initiated through distribution of information, education and communication materials, in order to tackle the issue of stigmatization among the community.

Focus: New country cooperation strategy for 2010-2014

In mid-2009, WHO, health authorities and health stakeholders came together to develop the Country Cooperation Strategy (CCS) which for the first time, brought together the three zonal health authorities.

The new CCS sets out a health sector strategy for Somalia, where 18 years of war, armed conflict and insecurity have had a devastating effect on the health sector. The situation is at worst level since 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 for the most part 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 the health system, vast numbers of internally displaced people, poor security conditions and a scattered nomadic population that struggles to survive in the face of repeated droughts, floods and food insecurity.

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.

Focus: Forging partnerships to improve maternal health

Somalia has one of the highest maternal mortality rates in the world. Women have a 1 in 10 lifetime risk of dying as a result of pregnancy or childbirth-related complications. In 2009, WHO, UNFPA and UNICEF, with the support of DfID and the EU, led the development of the National Reproductive Health Strategy. The strategy is meant for both humanitarian response and development activities within reproductive health over the coming period.

In 2010-2011, partners will be looking for support and developing new partnerships for the implementation of the new strategy.

To download a copy of the strategy, please visit www.emro.who.int/somalia

Essential medicines

> WHO's activities strengthened the capacity of health workers in prescribing and managing medicines as well as initiated plans to improve quality assurance systems. Through these efforts, WHO is working to improve both the availability and quality consciousness of the general public and in health services across Somalia.

Situation of essential medicines in Somalia

For almost two decades, the provision of pharmaceutical supplies to public health facilities in Somalia has been heavily dependent on international aid through WHO, UNICEF and non-governmental organisations. The public sector has been unable to adequately meet the needs of the population. The lack of capability among the private pharmaceutical sector, who has been the main provider, is a key concern to provision of quality medicines in Somalia. The quality of medicines imported into the country is not assured owing to the lack of drug quality control and assurance systems for testing the quality of medicines entering the country and a drug administration regulating the pharmaceutical sector.

Aim and objectives in 2008-2009

The overall aim of the programme is to ensure access to essential medicines and vaccines in adequate quantities; and develop mechanisms for quality assurance, well-functioning supply system and the rational prescribing and use of medicines.

During the biennium, the objectives of the programme were to:

- Support health authorities in developing proper medicine policies and a regulatory system to ensure affordable medicines of assured quality;
- Strengthen the medicine supply system;
- Build the capacity of health workers who are dealing with medicines and other health commodities in both the public and private sectors in the area of selection, quality, procurement, management, distribution and use;
- Provide essential medicines for health services to conflict-affected communities and areas where supply gaps exist.

Biennium Highlights

Over 200 health workers were trained in medicine supply management and in rational use of medicines.

The second edition of the Somalia National Standard Treatment Guidelines was published and widely distributed to health workers in Somalia.

Main achievements of the programme in 2008-2009

Through close collaboration with health authorities and with the support of donors like the European Commission the following was achieved:

- The Somalia National Standard Treatment Guidelines and an Essential Medicines List for Primary Health Care facilities were published and distributed to health workers and partners. The treatment guidelines have been translated into Somali;
- In collaboration with the National Quality Control Laboratory, Kenya, 10 health workers in both the public and private sectors including pharmacists, mid-level pharmacy personnel and medical laboratory technicians were trained, in the use mobile laboratories "Minilab" for screening of medicine samples of public health importance;
- A Drugs and Therapeutic Committee was established at the Hargeisa Group Hospital, the main referral hospital in Northwest zone of Somalia. The committee produced a draft essential medicines list for the hospital, based on the WHO Model List of Essential Medicines;
- Equipment was provided to the central medical store in Hargeisa and the Pharmaceutical Association of Somaliland to enhance their activities;
- Technical support was provided to the main warehouses in Hargeisa, Garowe, Bossaso, Mogadishu, Wajid, Merka and Jamaame, that distribute medicines and medical supplies to disease control programmes and health partners;
- The health authorities' main warehouses in Hargeisa and in Garowe were refurbished.

Lessons learnt in 2008-2009

- The availability of qualified and experienced technical counterparts at health authorities is a critical factor to ensure sustainability of the programme.
- More funding and capacity building is essential to maximise the impact of the programme, especially in the area of quality of medicines.

Strategic directions for 2010-2011

WHO will continue to work to improve the policies of supply of medicines through human resource development and better interagency coordination. Health partners will promote quality consciousness and the rational prescribing and use of medicines. In terms of governance, WHO will strengthen health authorities in medicine policy, regulation and supply management.

Laboratory services and blood safety

> "Laboratory services and blood transfusion are required for all types of health services. During 2008-2009, WHO has conducted a range of activities to improve the availability and quality of laboratories and blood banks in Somalia. Through capacity-building, provision of essential supplies and equipment, technical assistance, supervision and quality control, WHO has worked with health authorities to improve the delivery of these life-saving support services."

Situation of laboratory services in Somalia

Laboratory services are essential for the effective functioning of health services. The current laboratory network in Somalia experienced serious limitations in terms of both the availability and quality of services, and hampering of service delivery. The laboratory network in the country consists of 51 tuberculosis (TB) sputum centres. There are 96 malaria microscopy centers of which 60 are located in mother and child health centres to benefit the rural communities. Currently there are 36 hospital blood banks. Banadir hospital, Hargeisa Group hospital and Bossaso hospital provide communicable disease and cholera testing services although with limited diagnostic capacity. WHO takes a leading role in these support services, working in partnership with a range of health partners.

Aim and objectives in 2008-2009

The aim of the programme was to improve the availability and quality of laboratory services and blood banks in Somalia. Objectives of the programme during the biennium were to:

- Improve capacity of health workers through on-the-job training in TB sputum and malaria microscopy;
- Improve monitoring and evaluation of laboratory activities through supervision of staff and quality control of services;
- Provide essential laboratory supplies, reagents, and equipment where needed;
- Coordinate activities of health partners within laboratory services;
- Provide technical and operational support to TB multi-drug resistance survey and HIV/sexually transmitted diseases sero-prevalence surveillance studies.

Main achievements of the programme in 2008-2009

Through the active partnership with health authorities and partners, WHO was able to achieve the following:

- Three reference laboratories, 16 laboratories and 16 blood banks were upgraded with essential equipment;
- 61 laboratory technicians were trained in HIV testing techniques;

- 13 laboratory technicians were trained in measles/rubella testing techniques and the establishment of testing facilities in Hargeisa and Garowe;
- 113 laboratory technicians were trained in malaria and TB sputum microscopy;
- 32 laboratory technicians received basic training in blood safety techniques including for HIV, HBV, HCV, syphilis and blood grouping or cross-matching techniques;
- Four laboratory technicians from Hargeisa Hospital Reference Laboratory were trained in bacteriological culture techniques;
- Technical support was provided to the procurement of laboratory supplies, reagents for TB, HIV, malaria and disease outbreaks like diarrhea to laboratories, and blood screening kits to all 36 blood banks;
- Nearly 4000 blood samples were collected as part of HIV/STI sero-prevalence surveillance studies in Northeast and Northwest zones.

The laboratory services programme was supported by other WHO health programmes. Blood safety supplies were financially supported by UNDP.

Biennium Highlights

More than 200 staff working in anti-retroviral therapy/voluntary counseling and testing centres, TB centres and hospital-based clinical laboratories received training. This also includes health workers providing blood transfusion services.

Upgrading of over 30 laboratory facilities and providing laboratory supplies to over 35 health facilities.

Lessons learnt in 2008-2009

Implementation of activities throughout the biennium have highlighted the need for:

- The establishment of public health laboratories in the three zones of Somalia;
- Continuing efforts to develop national capacity in laboratory services;
- Establishment of external quality assessment programme for blood safety, TB sputum and malaria microscopy;
- Additional financial support needed to sustain achievements.

Strategic directions for 2010-2011

WHO will strengthen and expand quality laboratory services to support disease control programmes and assist in early confirmation of epidemic-prone diseases to ensure appropriate and prompt response in all the three zones of Somalia. This will be in support of the integrated disease surveillance and response (IDSR) system (see page 33). Through its programming, WHO will continue to promote safe blood transfusion practices in all laboratories by ensuring the universal screening of blood and its products and safe blood storage at all blood banks.

Emergency preparedness and humanitarian action

> "The number of people in need of humanitarian assistance rose to 3.6 million people, roughly half the population. With a specific focus on South Central Somalia, WHO as both agency and health cluster lead has carried out a range of activities to meet the pressing health needs of the internally displaced persons and vulnerable communities."

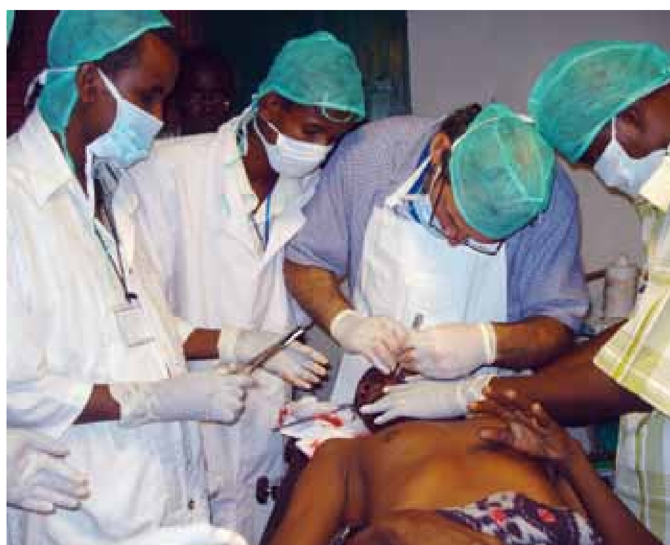
Humanitarian situation in Somalia

The humanitarian situation in Somalia was at its worst level in 18 years. The year 2008 was marked by public health emergencies due to civil conflict, drought and floods. During 2009, humanitarian needs increased dramatically following the onset of heavy fighting in Mogadishu and other parts of South Central Somalia resulting in widespread population movement. By the end of 2009, over 3.2 million people were in need of humanitarian assistance with 1.4 million displaced across the country, most of whom were located in South Central Somalia. Escalating conflict, new displacement, shrinking humanitarian access and limited implementing capacity of the service provider network were posing specific risks to the health of the Somali population of humanitarian concern. These risks to health originated from a lack of access to safe drinking water, appropriate sanitation facilities and to life-saving health services. These factors heightened the risk of outbreaks of communicable diseases as well as preventable death and disability amongst the vulnerable population such as women and children including obstetric complications and physical and mental trauma. The situation was further aggravated by greater weapon-related injuries and deaths.

Aim and objectives in 2008-2009

The aim of the programme is to meet the health needs of vulnerable communities in Somalia. The programme for emergency preparedness and humanitarian response focused on the following aspects of health care provision:

- Extending essential health services to vulnerable people especially internally displaced populations;
- Outbreak investigation and response;
- Coordination of emergency health response.

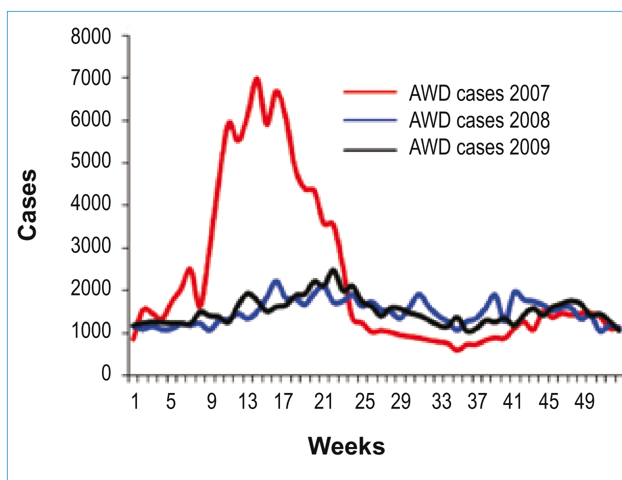


Main achievements of the programme in 2008-2009

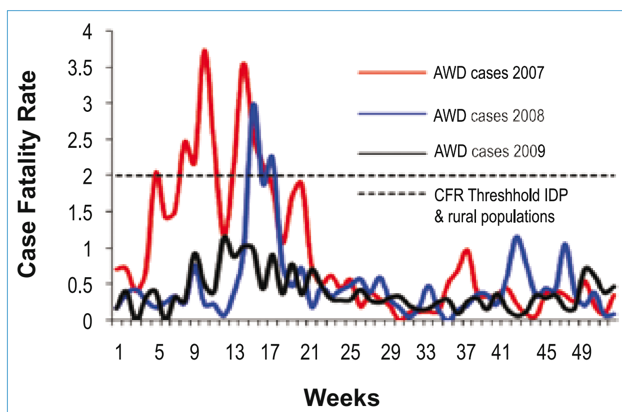
Major needs in health services have been covered through the provision of emergency health supplies, training of key health workers, monitoring and supportive supervision:

- Over 350 health staff were trained by WHO to deliver lifesaving services. Topics covered were trauma management, safe delivery and emergency care, infection control, acute watery diarrhoea (AWD) prevention and case management, outbreak response, surveillance and reporting. Over 140 health staff trained in pandemic influenza (H1N1) preparedness and response;
- Rumors of acute watery diarrhoea were responded to within 96 hours by using the existing monitoring and response mechanisms in place. In 2008-2009, more than 130 outbreak investigations were carried out. Over 60% of these investigations were undertaken in collaboration with health partners on the ground. On health events, about 172 sentinel sites in Somalia reported on a weekly basis. In Lower Shabelle region and Banadir Hospital, 36 health facilities undertook routine surveillance to monitor trends of communicable diseases and conducted response activities;
- WHO and partners managed to maintain a low incidence of acute watery diarrhoea in Somalia in 2008 and 2009 compared to 2007. A total of 118 187 acute watery diarrhea cases with 1776 deaths were reported with a case fatality rate of 1.5 reported in 2007, whereas 78 583 cases with 432 deaths; case fatality rate of 0.5 were reported in 2008. A similar trend was observed in 2009 with 78 378 cases including 324 deaths with a case fatality rate of 0.4. Compared to 2007, a 33.5% decrease in reported incidences and a 66.7% decrease in case fatality rate were observed in 2008. In 2009, the trend in reported incidences was maintained and a further decrease of 20% in case fatality rate was achieved as compared to 2008 (see graphs 3 and 4).

Graph 3. Acute watery diarrhoea cases reported in Somalia



Graph 4. AWD crude fatality rates among reported cases



Biennium Highlights

WHO provided operational support through provision of essential medicines, supplies and fuel to key hospitals across South Central Somalia.

Over 40 interagency emergency health kits, 30 diarrhoeal response kits, 15 trauma kits and other essential medical supplies were distributed to partners involved in health services to conflict-affected communities.

- WHO carried out rehabilitation of health facilities in regions of Somalia. The first phase of Baidoa and Wajid hospitals was completed and the rehabilitation of the Galkayo Hospital's X-ray department. In 2009, WHO extended secondary and surgical services to conflict-affected communities in Lower Jubba region by setting up of a field hospital.

Lessons learnt in 2008-2009

- Remote control operations posed a significant challenge when coordinating the humanitarian response regarding the efficiency and effectiveness of humanitarian health interventions.
- The challenges faced by the delivery of hospital services were wide-ranging requiring comprehensive and sustained financial support for making any impact on emergency health services.

Strategic directions for 2010-2011

In response to the need to overcome access difficulties, WHO will decentralize emergency health response and build local capacity to respond timely and adequately to the needs of vulnerable populations. WHO and partners will improve health infrastructure through the rehabilitation of health facilities in Mogadishu including major existing hospitals and mother and child health centres in the regions of South Central Somalia. Capacity building of newly graduated medical doctors in emergency surgical care and trauma management will be continued and where possible expanded.

Focus: Somalia health cluster

WHO as the health cluster lead agency has been coordinating health interventions in Somalia since the introduction of the cluster approach in 2006. Coordination of interventions is particularly important in South Central Somalia where access to several areas is limited for the humanitarian community. The close cooperation of international agencies with local partners enables implementation even in challenging environments and ensures local capacity building.

Health cluster focal agencies in Somalia

Regional/Zone	Agency
Northwest	Save the Children
Northeast	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)

Awareness of the coordinated approach by partners increased substantially over the years, as has the active participation and contribution to the overall information sharing. While the average number of contributing partners increased by 27% from 2008 to 2009, the contribution of information into the health cluster bulletin and other information sharing tools increased by over 250% from an average of 14 to 50 contributions per month in the same period.

As part of the efforts to decentralize coordination and strengthen leadership in preparedness and joint response to emergencies in Somalia, the health cluster nominated focal agencies at zonal level for Northeast and Northwest and at regional level in all regions of South Central Somalia.

In line with the coordination efforts towards joint interventions and partnerships, WHO as the health cluster lead agency facilitated joint projects and fund-raising efforts. In 2009, WHO conducted more than 70 outbreak investigations, of which at least 60% were carried out in collaboration with health partners on the ground. WHO worked directly with partner agencies such as Merlin (outbreak response), Muslim Aid (provision of primary health care services), UNICEF (life-saving health services, water, sanitation and hygiene-WASH and child health days), Merlin and Save the Children (coordination).

Other health cluster interventions included emergency health response for internally displaced people in Greater Mogadishu and the Afgooye Corridor; a flood contingency plan was developed and incorporated within overall preparedness activities for communicable diseases; over 280 health workers were trained addressing communicable diseases and emergency health care services and; 8 health facilities were rehabilitated. All this was achieved despite the worsening humanitarian situation and lack of funding to sustain the provision of the much needed basic health services in Somalia. Other challenges that require to be addressed is the limited capacity of local agencies and health workforce involved in implementing basic and emergency health activities.

©SOYDA

Focus: Extension of surgical services to conflict-affected communities in Lower and Middle Jubba

Hostilities in Lower Jubba region in South Central Somalia continued to result in deaths and casualties during 2008-2009. As of early November 2009, the total number of casualties reported by Kismayo General Hospital and surrounding health facilities was over 400. In October, hostilities broke out in the Afmadow and Hagar districts of Lower Jubba region which, as well as resulting in casualties, led to the displacement of the community, including health workers. Bu'aale district is a location that allows key health workers from the region to attend training away from the current insecurity. Furthermore, there has been an almost near lack of secondary health care services for these communities since the onset of the civil war in 1991.

To extend surgical services to conflict-affected communities in Lower Jubba region, the capacity of Bu'aale mother and child health centre was extended with tents, equipment and essential medical supplies to act as a field hospital providing an additional 12 beds, operating theatre and hospital pharmacy. Through the installation of the field hospital in November 2009, in conjunction with WFP and World Vision, WHO was able to conduct on-the-job training for key health workers on emergency surgery, basic emergency obstetric care and trauma management. Thirty six health workers were trained, including all qualified nurses working in health facilities in the region of Lower Jubba, the Head of Primary Health Care in Lower and Middle Jubba regions and medical doctors and community volunteers. The training combined both theoretical and practical aspects of trauma management and surgical techniques.

From 11 to 15 November 2009, over 240 patients were screened, with 145 patients receiving a full medical examination and 25 patients undergoing surgical operations for a range of medical complaints. Patients received post-operative care and were followed up by the WHO trauma surgeon.

Focus: Emergency health care for internally displaced communities in Afgooye

Renewed hostilities in Mogadishu since May 2009 led to new population displacements in Somalia. Over half a million internally displaced people (IDPs) took refuge in the Afgooye Corridor outside Mogadishu. These displaced communities faced health risks from overcrowding, lack of drinking water and sanitation facilities and disrupted access to health services. Women and children were particularly vulnerable.

In response, WHO and Muslim Aid partnership extended health services including an additional three clinics along the Afgooye Corridor and on Bal'ad Road in North Mogadishu, bringing the total number to eight health facilities. This was to improve the general health of the internally displaced persons and other communities and thus reduce the risk of communicable disease outbreaks. These clinics served nearly 200 000 people however they struggled to cope in the face of ever-increasing numbers of IDPs. The corridor was densely populated with the newly displaced.

Muslim Aid distributed ready-to-use therapeutic food in a number of sites to combat high levels of anaemia among the displaced persons, particularly children and pregnant women. Other main health conditions diagnosed among the internally displaced persons were acute respiratory infections, anaemia, acute watery diarrhoea and parasitic infections. Health staff in the clinics took advantage of displaced persons visits to raise awareness of communicable diseases and health, and hygiene measures.

Focus: Expanding the integrated disease surveillance and response system to conflict-affected communities

Early detection for prompt and effective response to outbreaks of communicable diseases

Health events under surveillance	2008		2009	
	Total cases	% under 5 years	Total cases	% under 5 years
Acute watery diarrhoea	77 962	77.55	78 378	75.22
Bloody diarrhoea	16 255	59.74	16 545	60.44
Meningitis	294	81.63	325	83.69
Measles	560	67.68	2 305	79.31
Malaria	27 567	47.61	27 306	51.24
Whooping cough	706	82.58	831	72.32
Neonatal tetanus	266	32.33	53	100.00

Key achievements in 2008-2009

- Outbreak preparedness: WHO led the development of the acute watery diarrhoea preparedness plan including the developing of matrix which sets out the available response supplies in the country in the case of outbreaks
- Reporting through early warning alert and response system (EWARS): Through 36 sites, the early warning alert and response system, has been functioning throughout Lower Shabelle region providing a means for regular monitoring of trends and early detection of and response to outbreaks. Over 150 health workers from 125 health facilities, including 11 hospitals and over 60 mother and child health clinics in Northeast zone, Bakool, Banadir and Middle Shabelle regions have been trained in disease reporting in 2009.
- Outbreak response and rumour verification: WHO and partners responded to over 70 rumoured outbreaks in 2009, all within 96 hours of initial reporting. WHO is the only agency that collects and transports outbreak related samples from Somalia for confirmation to Nairobi as there is no referral laboratory facility within Somalia.
- Effective case management: In 2009, WHO has trained over 70 health care workers delivering health services in how to effectively managing patients with acute watery diarrhoea.

Strategic directions for 2010-2011

Integrated disease surveillance and response system (IDSR) is a comprehensive strategy for improving communicable disease surveillance and response whilst linking the community, health facility, district and national levels in the country. It provides for the rational use of resources for disease control and prevention. Currently, many health intervention programmes within WHO have their own disease monitoring systems. Experiences from the polio eradication programme show that disease control and prevention can be successful when resources are dedicated to improving the ability of health workers to detect the targeted diseases, obtain laboratory confirmation of outbreaks, and use action threshold at the district level. Based on these experiences, this system proposes multi-disease surveillance on selected priority disease or conditions in an integrated approach.

WHO will expand IDSR to conflict-affected communities; continue outbreak investigation and response activities; strengthen laboratory confirmation systems; support effective case management and environmental health interventions including monitoring the quality of drinking water.

Focus: Mission to Somaliland by WHO Assistant Director-General of the health action in crises

Dr Eric Laroche, WHO's Assistant Director-General for Health Action in Crises and Dr Marthe Everard, WHO Representative for Somalia visited Hargeisa, Somaliland on 22 November 2009. The mission met with the President, the Minister of Health and Labor, and the Minister of Planning of Somaliland.

The mission visited Hargeisa Group Hospital especially the Mental Health Ward and spoke to patients, and health workers participating in mental health training course. Dr Laroche and Dr Marthe Everard were able to see the current challenges of the hospital in meeting the needs of people with mental health disorders in Somaliland. After adequate medication, these patients could be cared for without chains.

The mission had the opportunity to visit services for people with mental health disorders. Chronic conflict and insecurity, amongst other factors, contribute to the high burden of mental health disorders in Somalia. In 2009, WHO and partners assessed the situation to understand the full burden and the status of health services for people with mental health disorders. A mental health strategy will be developed in 2010.

4. WHO presence in Somalia

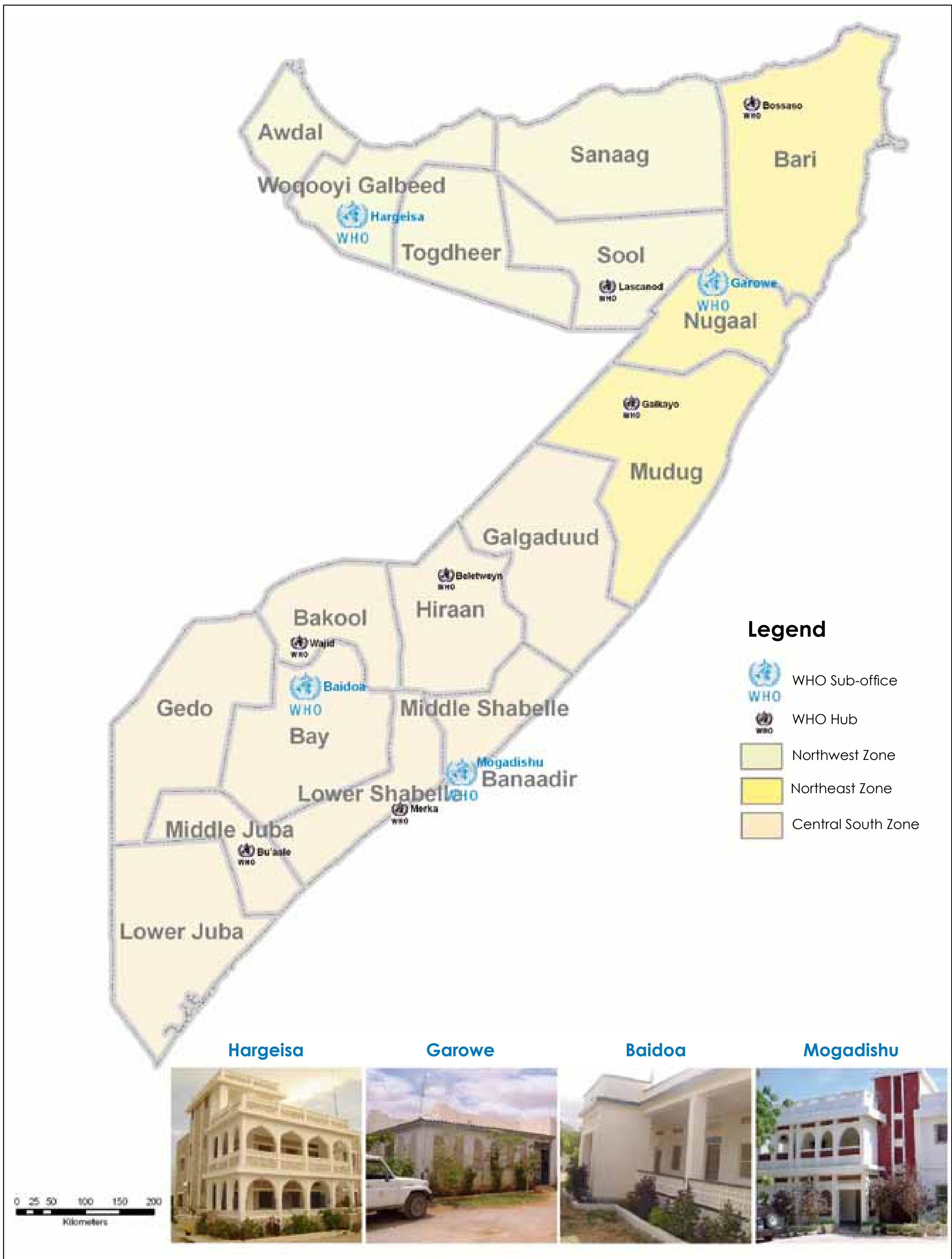


Photo credits: ©WHO/Somalia, or indicated otherwise
Design and Layout: Catherine K. Kimeu/UNON
Printing: Publishing Services Section, UNON, Nairobi-Kenya, ISO 14001:2004 certified.

WHO Somali Liaison Office
Warwick Centre, UN Avenue, Gigiri
P.O. Box 63565-00619, Nairobi, Kenya

Tel: +254 20 7623197/8, 7622840
Fax: +254 20 7623725
E-mail: wroffice@nbo.emro.who.int
http://www.emro.who.int/somalia