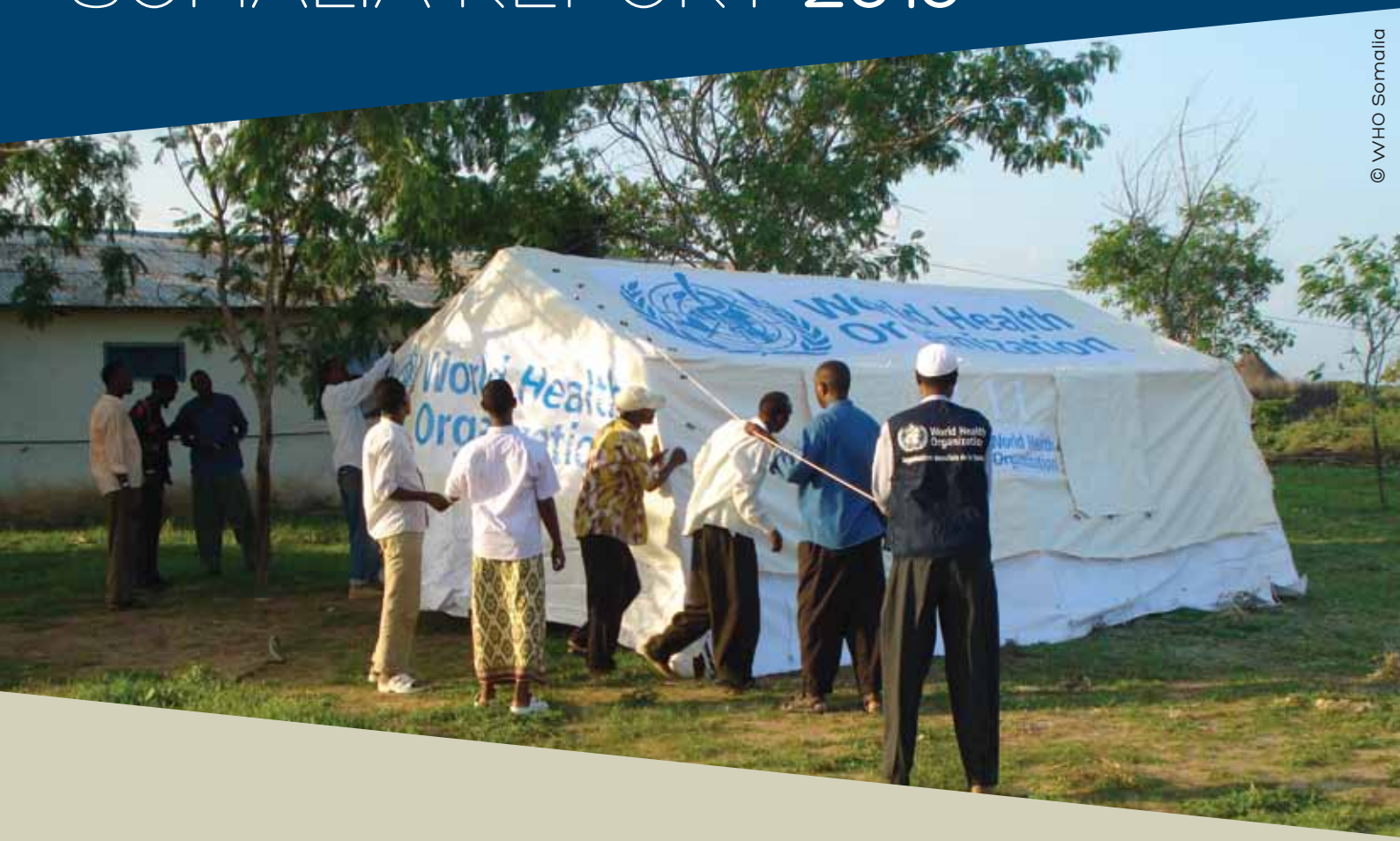
World Health Organization

SOMALIA REPORT 2010



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INTRODUCTION

In 2010, WHO Somalia supported various health programmes resulting in key accomplishments. Somalia remained polio-free, with no new cases reported since March 2007. More than two million children younger than five years of age were vaccinated against polio. The country has now four test kits (Mini-labs®), which screens quality of medicines sampled from various facilities. WHO and Health Cluster partners ensured early detection, timely response and control of 74% of the 89 outbreaks of diseases within the recommended 96 hours of reporting. More than 850 health workers in Somalia were trained on addressing communicable diseases surveillance outbreak detection and control, emergency surgical procedures and trauma management and reproductive health including emergency obstetric care. Over 60 TB centres are functioning in Somalia, treating more than 8 000 TB patients. A significant decrease in the number of malaria cases was reported thanks to prompt treatment and mass distribution of long-lasting insecticidal-treated nets in Somalia. Compared to 2009, voluntary counseling and testing services were increased by 60%.

WHO, as one of the few UN agencies, was able to maintain its presence in all districts of the country, including South Central Somalia. Without the support of donors and health partners, WHO's programmes would not have been able to achieve the successes as well as improving the health of the people of Somalia.

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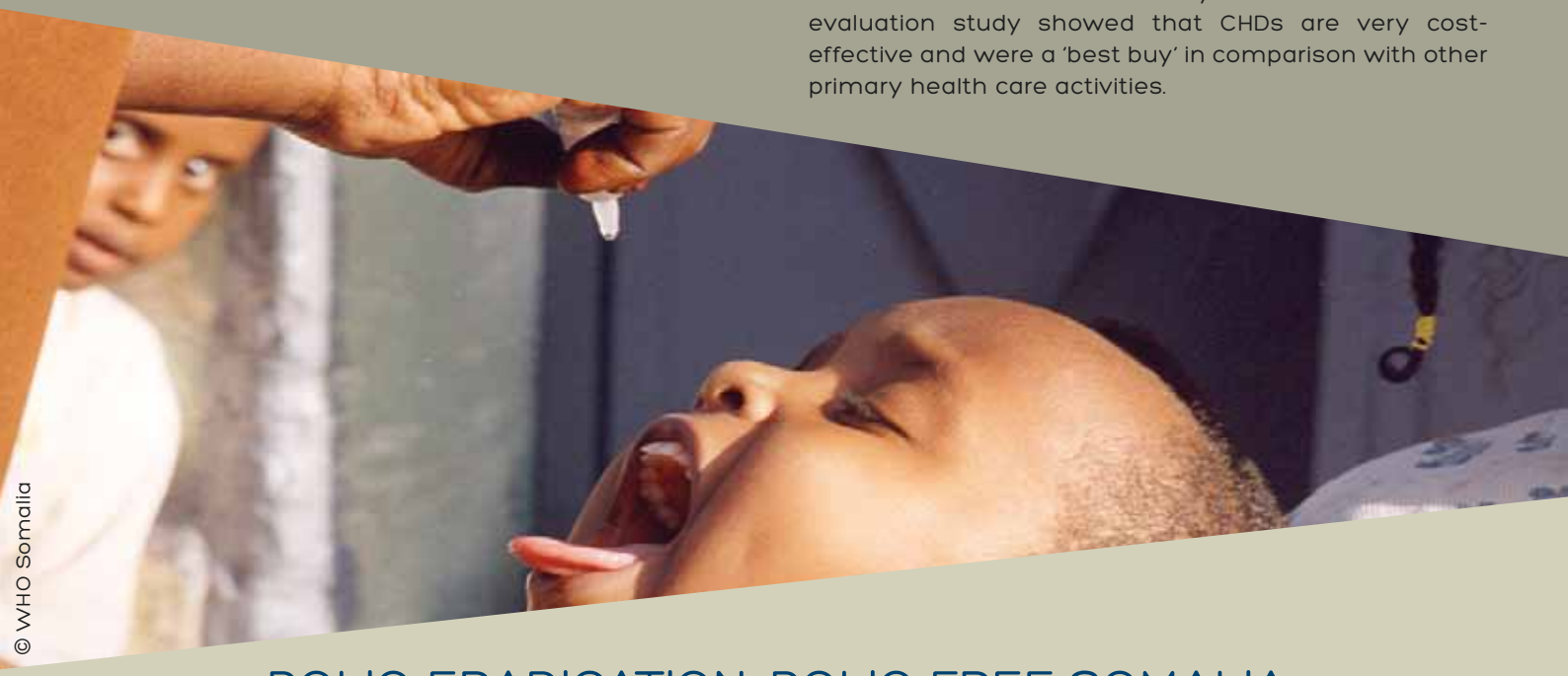
FOCUS - CHILD HEALTH DAYS

Child Health Days (CHDs), a joint WHO and UNICEF initiative, are held twice a year in Somalia reaching out to children under five and women of child-bearing age. The two rounds conducted in 2010 have reached over 1.5 million children with immunization against measles, polio, diphtheria, whooping cough and tetanus. In addition, a package of other essential child health interventions, including de-worming, vitamin A supplementation, oral rehydration salts, water purification tablets and screening of the nutritional status, were provided. About 1.3 million women of child-bearing age were vaccinated against tetanus toxoid. CHDs are implemented both in urban and rural settings, including hard-to-reach areas.

CHDs proved to be very effective to deliver key child survival interventions. Preliminary results of an economic evaluation study showed that CHDs are very cost-effective and were a 'best buy' in comparison with other primary health care activities.



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POLIO ERADICATION: POLIO FREE SOMALIA

For the last three years, Somalia maintained its polio free status (the last case of poliomyelitis was reported in March 2007 in Hobyo, North East Somalia). Two rounds of polio vaccinations were conducted in all accessible districts reaching more than two million children under the age of five. The Acute Flaccid Paralysis (AFP) surveillance key indicators for 2010 were maintained above certification standards. These achievements are attributed to the high acceptance of communities for vaccination activities, continuous support of health authorities, religious and clan leaders, and dedication of local staff and community volunteers.

ROUTINE IMMUNIZATION

Vaccine-preventable diseases remain one of the major causes of death and disability for Somali children. For the first time ever, the coverage of childhood immunization increased to 51% in 2010, compared to around 30% in previous years. A nation-wide vaccination week was conducted in Somalia, including Mogadishu. To improve the coverage of immunized children, the Reaching Every District (RED)-strategy was implemented in 20 districts with very positive outcomes. In support of measles eradication, the measles case-based surveillance was improved in North East and North West Somalia. As a result, a measles outbreak in Hargeisa was successfully controlled in 2010. Laboratory confirmation tests identified that a B3 genotype is circulating in Somalia. Samples of suspected measles cases from across Somalia were collected and confirmed by the laboratory investigation unit in Hargeisa.

TUBERCULOSIS

In 2010, the Somali TB programme detected a total of around 10 500 cases for TB while about 5 800 sputum smear positive cases registered in 2009 were evaluated for treatment outcome. A treatment success rate of 88.5% was maintained based on routine sputum smear investigation of over 5 120 positive cases.

The Somali TB programme conducted a survey on multi-drug resistance TB (MDR-TB). Preliminary results showed that almost 11% of TB-patients have MDR-TB, which is a worrisome outcome. The TB programme obtained approval to provide treatment to an initial 100 MDR-TB patients.

An additional seven new TB centres were opened across the country, bringing the total number of centres to 63. Capacity building activities for staff resulted in a total number of 250 health workers trained on TB case detection and treatment. Three monitoring missions were carried out by Global Drug Facility to estimate needed quantities of TB medicines in the country.

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HIV/AIDS AND SEXUAL TRANSMITTED INFECTIONS (STI)

SCALING UP ACCESS TO SERVICES

The Somali HIV/AIDS/STI programme opened an additional three HIV voluntary counseling and testing sites, bringing the total number to a total of 30 sites. Compared to 2009, voluntary counseling and testing were increased by 60%. By December 2010, 880 patients benefited from antiretroviral therapy.

In 2010, a total of 175 health workers got trained in integrated prevention treatment components. This training course has improved the provision of quality services to patients resulting in an increase of service uptake and patient satisfaction.

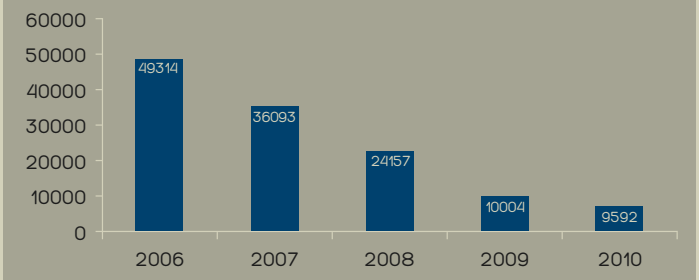
TABLE 2.

	NORTH EAST SOMALIA	NORTH WEST SOMALIA
HIV PREVALENCE AMONG ANTENATAL CARE	1,1%	0,3%
SYPHILIS PREVALENCE	1,4%	1,2%

MALARIA

The Somali malaria control and elimination programme, in collaboration with partners, delivered many activities in line with the national strategic plan. A significant decrease in the number of malaria cases was reported thanks to prompt treatment and mass distribution of long-lasting insecticidal-treated nets in Somalia and indoor residual spray campaigns covering more than 2 800 households. During 2010, the positive trend continued to decrease further (see graph 2). A vector sensitivity study undertaken showed that current treatments are adequate to combat malaria. Around 30 Somali health workers got a malaria microscopy refreshing training course in 2010.

GRAPH 2. SENTINEL REPORTED MALARIA CASES (CONFIRMED AND CLINICAL) SOMALIA 2006-2010



Source: WHO data collected in the field

PRIMARY HEALTH CARE

HEALTH SYSTEM STRENGTHENING - A WINDOW OF OPPORTUNITY

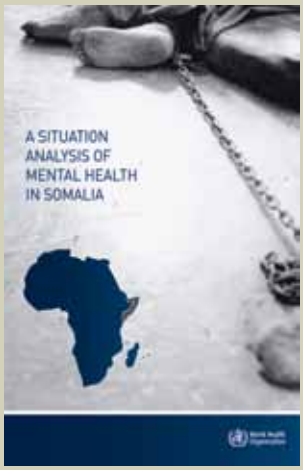
In 2010, WHO Somalia organized two planning missions on strengthening health systems by developing strategic action plans. During the missions meetings were set up with all stakeholders including UN agencies, donors, health authorities and NGOs in North East and North West Somalia to review the context and existing status, to discuss issues and challenges, and to develop consensus on a framework for health system strengthening (HSS).

For the coming five years, the Global Alliance for Vaccine and Immunization (GAVI) and The Global Fund to Fight AIDS, Tuberculosis and Malaria agreed to support HSS in Somalia. It is expected that implementation will start in 2011. The goal of the GAVI-Global Fund support is "Better health of Somalis and progress towards the health related Millennium Development Goals".

MENTAL HEALTH - A NEGLECTED PRIORITY

Prolonged conflict and instability have largely impacted on the mental and psychological well-being of the Somali people. It is estimated that one in three Somali's are affected by some kind of mental illness, a prevalence which is higher than in other low-income and war-torn countries. Many Somali's have experienced beating, torture, rape or have been injured for life. Others witnessed horrific violence against family or friends. Many Somalis with mental illness are socially isolated when becoming violent. The pain of this isolation is felt intensely because Somali culture is traditionally communal and family oriented. These are generally chained or imprisoned. The country has only five health centres (Hargeisa, Berbera, Bosaso, Garowe and Mogadishu) that provide essential mental health care services.

To address this issue, WHO Somalia in collaboration with the local health authorities provided medicines to mental health care services and expanded the Chain Free Initiative. This initiative that addresses the rights of the mentally ill by advocating for chain-free hospitals, chain free homes and chain-free environment is well established in Mogadishu and Hargeisa and will start in Bossaso in 2011. To have a better understanding of the mental health services within the country, WHO Somalia produced a mental health situation analysis. The document groups all crucial information on mental health in Somalia. This report will form the basis of developing a mental health strategy in 2011.



SOCIAL DETERMINANTS OF HEALTH (SDH)

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, and influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries. An orientation and sensitization seminar was held in Entebbe, Uganda, in September 2010 in which Somali health authorities and WHO field staff participated. During the workshop, the participants identified priority social determinants of health and the effect of conflict on those determinants (see table 1). The outcome of the seminar was presented to various stakeholders including UN agencies, donors, international and local NGOs.

COMMUNITY BASED INITIATIVE

During 2010, the plan to revitalize community based initiatives in Somalia was initiated. Three model villages/demonstration sites were identified in Somalia. A training manual for community representatives (CR's) and village development committees (VDC's) was adopted and translated into Somali language, followed by training of 165 CR's and VDC's. The training covered family health, emergencies, environmental health and food safety, communicable and non-communicable diseases and emergency preparedness, response and recovery.

TABLE 1. SDH IDENTIFIED & EFFECTS OF CONFLICT

IDENTIFIED SDH PRIORITIES	EFFECT OF CONFLICT
Political instability and Poor governance	Loss of social cohesion and trust
Population Displacement (internal, external)	Fear and insecurity
Unhealthy lifestyle/harmful practices	Distress, mental disorders. Khat, FGM
Unemployment	Institutional and economic collapse
Weak Health and education systems	Institutional and loss of human captal
Environmental effects	Deforestation, desertification and loss of fauna; illegal fishing and dumping of industrial and nuclear toxic waste with subsequent loss of marine resources
Gender disparities	Increased women vulnerability and increased female-headed households
Food insecurity	Crop failure, limited distribution, etc
Water, sanitation and Hygiene	Limited access to improved sources of water, limited access to sanitary facilities
Urbanization/housing	Overcrowding; unregulated and inexistent town planning; increased and unplanned urbanization
Role of non-state actors	Highly visible, but with limited trust

Tackling SDH and Health Inequities through ISA and HiAP. Cairo 22-24 Sept. 2010.

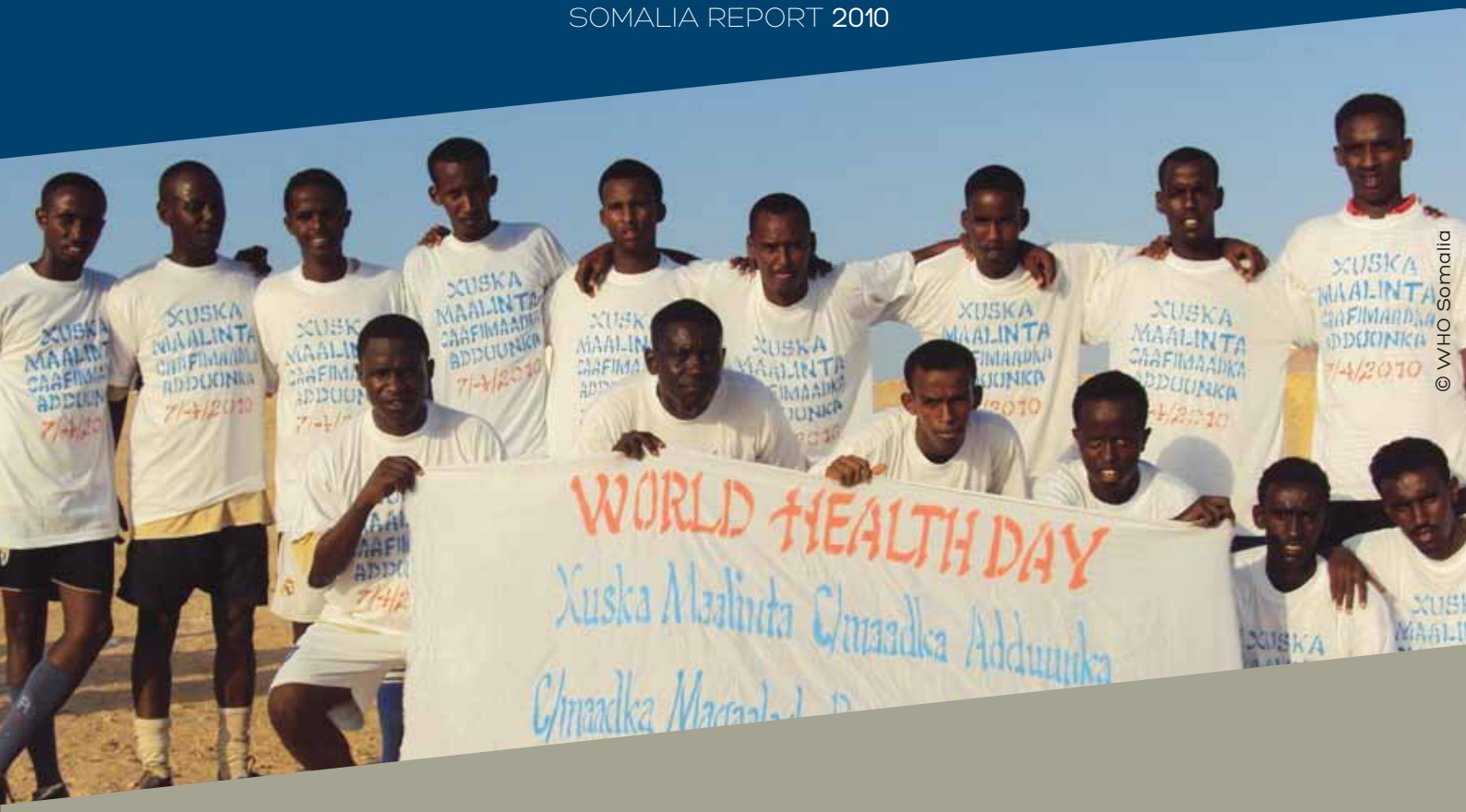
ESSENTIAL MEDICINES

PROMOTING MEDICINES QUALITY CONSCIOUSNESS

In 2010, the Somali Essential Medicines Programme (EMP) provided two Minilabs® (test kits), bringing it to a total of four in the country. EMP trained 12 health workers on the use of the Minilabs® for screening of medicine samples taken from the public as well as the private sector. A three-week training course taught health staff on how to screen antiretroviral, anti-malaria and anti-TB medicines. Following an initial screening of medicines, by using the Minilabs®, medicine samples were sent to the National Quality Control Laboratory in Nairobi, Kenya, for confirmatory quality analysis. All samples were found of assured quality.

A total number of 75 pharmacy and nursing assistants, who are in charge of hospital medicines stores, were trained on effective management of medicines. In addition, EMP produced a brochure for increasing awareness of good dispensing and storage practices of medicines in Somali and English language and was distributed to medicine outlets across the country.

A separate store for keeping inflammable materials and reagents was constructed in the premises of the central medical store/WHO warehouse in Hargeisa. Four hospitals in North West Somalia were identified for rehabilitation of their medicine stores.



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FOCUS - WORLD HEALTH DAY, 7 APRIL 2010

MY CITY, MY HEALTH

Eight cities in Somalia Burao, Berbera, Bosasso, Galkayo, Garowe, Hargeisa, Merka and Mogadishu signed up to the '1000 Cities, 1000 Lives' global campaign. World Health Day (WHD) was celebrated in these cities with a number of activities to promote health including provision of free health check-ups, health forums, cleanup campaigns, tree planting, no-smoking campaign, family walks, and football matches.

Key health messages were disseminated through SMS during the week of WHD with support of three mobile service providers in Somalia: Nationlink, Hormuud and Telesom. An estimated 2.2 million customers received various SMS's during this week. The use of mobile communication showed that in a country like Somalia, key messages in support of health promotion could reach many people. Case studies from health partners, as well as drawings from school children on the theme of urbanization and health were exhibited during an event marking the day in Nairobi.

LABORATORY SERVICES

The Somali laboratory programme has been at the forefront of providing timely and quality results. These results have been used in diagnosis and monitoring with the aim of controlling and eradicating diseases. In 2010, and in collaboration with other programmes, laboratory supplies and equipment have been provided to more than 30 hospitals in Somalia. More than 100 laboratory technicians were trained in different aspects of laboratory analysis for malaria, tuberculosis, HIV and measles. Monitoring progress and performance of laboratory technicians was done in more than 30 hospital laboratories throughout the country, preparing a base for accreditation and scaling up external quality assessment to further expand in 2011.

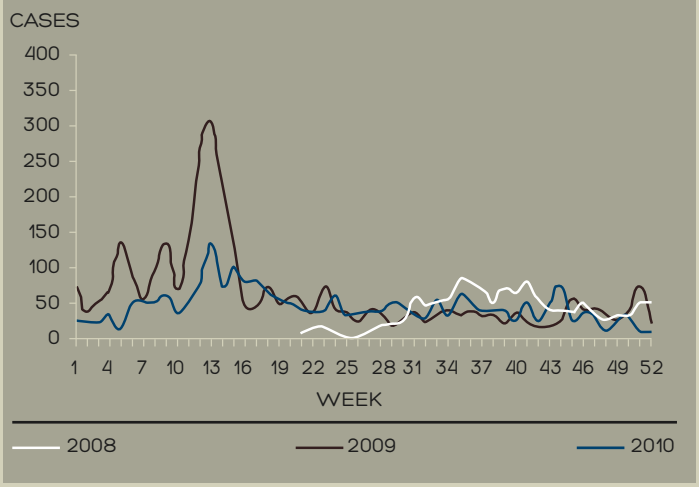
EMERGENCY PREPAREDNESS AND HUMANITARIAN ACTION

Up to two million people in Somalia, including 1.46 million displaced persons, were in need of humanitarian assistance in 2010. South Central Somalia is the area most affected by the ongoing conflict due to increased violence and a looming drought period followed by increased displacements of population. Disruptions of health services combined with the absence of safe drinking water and sanitation facilities represented major threats to the health of vulnerable population.

WHO reported more than 7 500 war-wounded civilians who were admitted to three main hospitals in Mogadishu, one in five being children and one in three women. WHO estimated that since the beginning of 2010 over 500 people have been killed during the fighting in Mogadishu. The exact number of deaths remains unknown due to lack of death registration.

Health workers in South Central Somalia faced increased challenges to provide the much needed care to the people. The challenges ranged from hazardous working environments, lack of proper qualifications and an insufficient number of health workers. The Emergency Preparedness and Humanitarian Action programme (EHA), in collaboration with health partners, conducted training courses and capacity building activities related to emergency health services and the integrated reporting system in support of infectious diseases, surgical care and reproductive and maternal services. In 2010, more than 850 health workers were trained on outbreak investigation and response, trauma and burn management, emergency obstetric care, caesarean section and guidance on risks for mother and child during delivery.

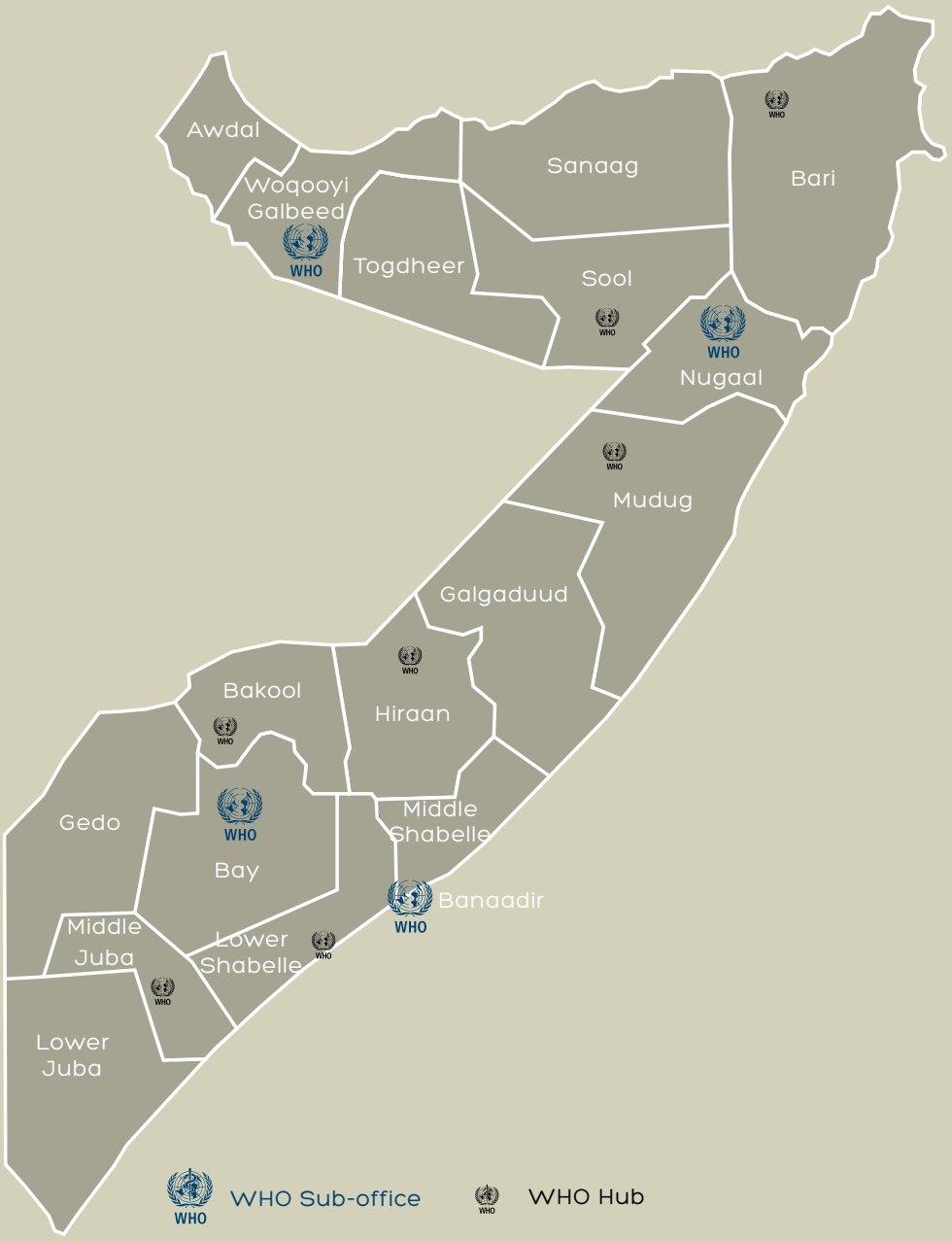
GRAPH 1. LOWER SHABELLE REGION WEEKLY AWD CASES WEEK 21 (2008) - WEEK 52 (2010)



A total of 89 outbreak investigation missions for rumor verification were conducted across Somalia by EHA and health partners. Suspected outbreaks were reported for acute watery diarrhoea/ cholera, whooping cough, measles, pandemic H1N1 and rabies. WHO alerted partners about the high risks of acute watery diarrhoea in Lower Shabelle (see graph 1) and Banadir regions. The continuous presence of EHA staff in strategic locations across Somalia is crucial to promptly respond to emergency health needs.

WHO, as the lead agency of the health cluster, works with 35 health partners on the ground to facilitate the coordination of emergency health interventions, mainly in South Central Somalia. The close cooperation of international agencies with local partners enabled to distribute almost 60 tonnes of emergency medical supplies to partners and health facilities across Somalia reaching out to more than 700 000 people in need of emergency health care.

WHO PRESENCE IN SOMALIA



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