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Somalia



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Foreword

The Government of Somalia and WHO are working together to effectively improve the public health situation in the country with special emphasis on the five key regional priorities:

- health security and prevention and control of communicable diseases;
- noncommunicable diseases, mental health, violence and injuries, and nutrition;
- promoting health through the life-course;
- health systems strengthening; and
- preparedness, surveillance and response.

The strategic directions to address these priorities are broadly in line with WHO's 12th General Programme of Work, the Programme Budget 2016-2017 endorsed in May 2015 by the 68th World Health Assembly and the five strategic areas of work endorsed by the WHO Regional Committee for the Eastern Mediterranean in 2012.

Reliable and timely health information is essential for policy development, proper health management, evidence-based decision-making, rational resource allocation and monitoring and evaluation of the public health situation. While the demand for health information is increasing in terms of quantity, quality and levels of disaggregation, the response to these needs has been hampered because of fragmentation and major gaps and weaknesses in national health information systems.

The strengthening of health information systems is a priority for WHO in the Region. Intensive work with Member States since 2012 has resulted in a clear framework for health information systems and 68 core indicators that focus on three main components: 1) monitoring health determinants and risks; 2) assessing health status, including morbidity and cause-specific mortality; and 3) assessing health system response. In order to successfully achieve this important goal, concerted and aligned action at national and international level are required to address the gaps and challenges in the health information systems of all countries. This will ensure the generation of more effective evidence to monitor improvement in the health situation, nationally, regionally and globally.

This comprehensive health profile is intended to serve as a tool to monitor progress in the health of the population. WHO's collaboration with its Member States will strengthen the national health information systems, and enable the generation of timely and reliable evidence to assess the health situation and trends, and the health system response. Most important, it will provide the information needed by health policy and decision-makers.

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Introduction

The population of the country has increased by 43.2% in the past 25 years, reaching 11.1 million in 2015, and is projected to increase by an additional 48.7% in the next 25 years. It is estimated that 61.8% of the population lives in rural settings (2012), 38.6% of the population is between the ages of 15 and 24 years (2015) and life expectancy at birth is 53 years (2012).

The burden of disease, (2012), attributable to communicable diseases is 69.0%, noncommunicable diseases is 19.1% and injuries 11.9%. The health workforce density is 0.4 physicians and 1.1 nurses and midwives per 10 000 population (2006).

The public health issues facing the country are presented in the following sections: communicable diseases, noncommunicable diseases, promoting health across the life course, health systems strengthening, and preparedness, surveillance and response. Each section focuses on the current situation, opportunities and challenges faced and the way forward. In addition, trends in population dynamics and in selected health indicators are analysed to provide policy-makers with evidence and forecasts for planning.

Communicable diseases

HIV

Tuberculosis

Malaria

Neglected tropical
diseases

Vaccine-preventable
diseases

Communicable diseases

- A national strategic plan on HIV and AIDS was finalized in 2014.
- National authorities have been actively involved in facilitating the work of the tuberculosis programme.
- All areas of the country have national malaria control programmes within their ministries of health to coordinate malaria control activities.
- A plan to improve routine immunization coverage is being implemented.

HIV

The HIV prevalence is low. The most affected population are female sex workers, with an overall HIV prevalence of 5.2% (1). The estimated number of pregnant women living with HIV is 1800 (2) while antiretroviral therapy coverage to prevent mother-to-child transmission is 1.0% (1). Estimated antiretroviral therapy coverage was 3.0% (1). A national strategic plan on HIV and AIDS has been in place since 2014, and additional financing under the Global Fund has been secured. The 2013 WHO recommendations for use of antiretroviral therapy were adopted and implementation is under way. There are 15 antiretroviral therapy sites.

Challenges include: low overall service coverage, even for antiretroviral therapy and prevention of mother-to-child transmission; heavy dependence on Global Fund financing, leaving a need to bring additional funders on board which is still difficult; very limited interventions to date targeting the key populations at risk, such as female sex workers, with difficult cultural sensitivities, even for activities such as bio-behavioural surveillance. The government resource base and contribution to HIV response are very limited.

More strategic information needs to be generated through further surveillance among key populations. HIV testing and counselling need to be expanded and point-of-care diagnostics for HIV, CD4 count and viral load testing need to be introduced. Additional resources need to be mobilized and government and civil society partners sensitized in support of well targeted interventions for key populations at risk, such as sex workers. Furthermore, syndromic management of sexually transmitted infections and linked HIV testing need to be expanded to at least all regional and district hospitals.

Tuberculosis

The tuberculosis-related mortality rate is estimated at 74.0 per 100 000 population (3). A total of 13 306 detected tuberculosis cases were reported in 2013, of which 6538 were new

sputum smear-positive cases (3). The treatment success rate for new and relapsed cases registered in 2012 was 88.0% (3). Drug-resistant tuberculosis is estimated at 5.2% among new cases and 41.0% among previously treated cases (3).

The strength of the tuberculosis programme relies on the willingness of the international community to support the programme and the political will of the national authorities to ensure that the programme operates unhindered despite the continued war in the country. The programme is entirely dependent on the Global Fund for financial resources to manage it. However, the national authorities are actively involved in facilitating the programme activities, and providing infrastructure and staff to the nongovernmental organizations that implement the programme. The programme still faces some challenges. The continuing insecurity has not only hindered expansion of the programme but also makes supervision, monitoring and evaluation of the programme very difficult. The turnover of staff among nongovernmental organizations is high and it is difficult to find qualified staff in the country. The sustainability of the programme also poses a challenge.

More tuberculosis centres need to be opened. Multidrug-resistant tuberculosis is emerging as a public health problem and its management is therefore another important gap that needs urgent attention.

Malaria

The country is considered to be a high burden and high risk country for malaria. Total confirmed malaria cases increased from 7571 in 2003 to 18 842 in 2012 (4). Coverage in targeted areas for households that had at least one long-lasting insecticidal net for malaria prevention has reached 21.0% (4).

Plasmodium falciparum is the main parasite responsible for malarial illness although studies show that *P. vivax* is also present. There are two malaria seasons, following the spring (May–August) and the autumn (December–January) rains. Overall, malaria prevalence has remained very low in the North-West and North-East. In the South and Central area where the malaria burden has traditionally been high, particularly along the Juba and Shabelle rivers, community prevalence surveys show a decline in prevalence. Each of the three zones has established national malaria control programmes within their ministries of health to coordinate malaria control activities. However, all programmes have inadequate human resources, infrastructure and logistics support to carry out their full mandate. There is no allocation for malaria in the national budgets. The malaria programme is entirely dependent on donor support, in particular the Global Fund, for all activities, including human resources in the national malaria control programme and at some service delivery points. The health management information system and communicable disease surveillance system face challenges, in particular in regard to coverage, completeness and timeliness of reporting for malaria data, and provide inadequate support to malaria control activities.

Human resource capacity needs to be strengthened for coordination, quality assurance, surveillance, monitoring and evaluation and a functional mechanism needs to be established in the national malaria control programmes for reporting of malaria information from all levels of the health care system, through the health management information system. Establishing comprehensive malaria surveillance activities that are integrated within the national disease surveillance and response system, while building capacity for and implementing epidemic preparedness and response in three zones are a priority. Other priorities are expansion of quality diagnosis and treatment for uncomplicated malaria to all public health facilities and the private sector, implementation of internal and external quality assurance schemes for rapid diagnostic tests, and development of a multisectoral approach to advocacy and social mobilization.

Neglected tropical diseases

The country was certified free of dracunculiasis in 2013. No autochthonous cases were reported for cutaneous leishmaniasis but visceral leishmaniasis, onchocerciasis and blinding trachoma are still endemic (5). In 2012, 410 cases of reported visceral leishmaniasis and 39 cases of leprosy were reported (5). The number of people treated in 2010 for soil-transmitted helminthiasis was 418, while 10 103 schistosomiasis cases were treated in 2011 and 177 015 onchocerciasis cases were treated in 2013 (5).

The challenges include inadequate human and financial resources, lack of political commitment and absence of a dedicated unit within the Ministry of Health. Most endemic regions in the country are inaccessible and neglected tropical diseases are not a priority for most of the development agencies.

Focus needs to be placed on: establishing a neglected tropical diseases unit within the Ministry of Health to coordinate and plan future interventions; mobilizing political will and resources for these diseases; mapping of neglected tropical diseases; and capacity-building on the One Health approach to address zoonotic diseases.

Vaccine-preventable diseases

Despite recent improvement, immunization coverage continues to be very low in the country. Immunization coverage among 1 year olds improved between 1990 and 2013 for BCG from 31.0% to 33.0%, DTP3 from 19.0% to 42.0%, measles from 30.0% to 46.0% and polio from 18.0% to 47.0% (6). Neonatal tetanus coverage increased during the same period from 49.0% to 64.0% (6). In 2013, hepatitis B vaccine (HepB3) coverage among 1 year olds was 34.0% (6). Pentavalent vaccine was introduced in 2013 with Gavi support. Measles is highly endemic with very frequent outbreaks and neonatal tetanus has not been eliminated. The immunization system in the country is weak, specifically in regard

to routine vaccination coverage. A coverage improvement plan was developed in 2013 and implementation is ongoing. Efforts are under way to improve the expanded programme on immunization (EPI) with EPI units now established in the different zones.

The main constraints and challenges facing the programme include the need to strengthen the national programme at national and subnational levels, dependence on partners for running immunization activities, the inaccessibility of a large proportion of the country to immunization activities and, hence, very low vaccination coverage for all antigens.

Focus needs to be placed on: encouraging ownership of the programme by national authorities; strengthening the newly developed EPI units in the different parts of the country so that the national programme can gradually take over implementation of immunization activities; and ensuring the quality of implementation of child health days and reaching every district approach in order to improve vaccination coverage. The quality of the planned measles supplementary immunization activities needs to be ensured.

Noncommunicable diseases

Noncommunicable diseases

Mental health and substance abuse

Violence and injury

Disabilities and rehabilitation

Nutrition

Noncommunicable diseases

- An essential package of health care services has been developed with noncommunicable diseases as an integral part.
- A number of mental health initiatives, such as the 'chain free' initiative, were introduced and a mental health strategy has been developed.

Noncommunicable diseases

The burden of noncommunicable diseases is rising, causing 19.1% of all deaths. Cardiovascular diseases account for 5.7%, cancers 3.9%, respiratory diseases 1.4% and diabetes mellitus 0.8% of all deaths (7). As a result, 19% of adults aged 30–70 years are expected to die from one of the four main noncommunicable diseases (8). Around 13.0% of youth (13–15 years of age, 11.0% boys, 10.4% girls) have ever smoked cigarettes, while 29.1% report having been affected by passive smoking (9) and per capita consumption of alcohol is 0.5 litres of pure alcohol (10). Raised blood pressure, in adults above 18, affects 31.4% of the population (33.9% male and 29.0% females), while obesity affects 4.8% (3.1% males and 4.8% females) (8). Only eight of the eleven essential medicines for treatment of noncommunicable diseases are available in the public health sector.¹

The main challenge is the lack of data about noncommunicable disease-related morbidity and mortality. This is because noncommunicable diseases are not an integral part of the health information system, there is no civil registration and cause of death registration is weak. However, among the main opportunities is the development of the essential package of health care services in which noncommunicable diseases prevention and management are an integral part.

A national noncommunicable diseases strategy will be developed based on the STEPwise survey that will be conducted in 2015 to identify the risk factors and the situation among the population.

Mental health and substance abuse

Neuropsychiatric disorders are estimated to contribute 4.9% of the burden of diseases (11) and the suicide rate is 12.4 per 100 000 per year (12). Annual prevalence of cannabis use is 2.5% and opiates 0.2%, while estimated prevalence for substance use disorders among adult (15 years and over) males is 0.5% and females 0.2% (13).

¹ WHO Regional Office for the Eastern Mediterranean, unpublished data, 2013.

Mental health is a public health priority in the country. The long years of conflict with high exposure to trauma and violence, the large proportion of displaced population, high stigma and discrimination in the community towards persons with mental disorders, and limited opportunities for education and employment have all contributed to the high mental health needs of the population. One of the main challenges is limited mental health resources to address the total needs of the population. Another is the fact that the humanitarian and development agencies have not prioritized mental health and this lack of awareness has led to complete neglect of the mental health programme with deleterious effect on the health of the community. Several mental health initiatives, such as the 'chain free' initiative, improvement of mental health care facilities, training of human resources, development of private sector mental health care facilities and provision of psychotropic drugs, have been introduced.

A mental health strategy has been developed. The overall goal of the strategy is to strengthen the integrated response of the health sector and other related sectors through the implementation of evidence-based and achievable plans for the promotion of mental health and the prevention, treatment and rehabilitation of mental and neurological disorders, with respect for human rights and social protection.

Violence and injury

The percentage of deaths caused by injuries in 2012 was 11.9%; of this, unintentional injuries accounted for 55.5% (of which 19.7% were due to road traffic injuries and 19.7% as a result of fire, heat and hot substances) while intentional injuries accounted for 44.5% (77.8% collective violence and legal intervention and 11.2% interpersonal violence) (7). In 2010, the estimated road traffic fatality rate was 10.5 per 100 000 population (14).

The main challenges are inadequate financial and human resources, and inadequate reporting and information systems to report related cases and build evidence for planning the interventions needed. Furthermore, there is no programmatic structure in the Ministry of Health for national injury prevention to systematically address this important area. The security situation has its own adverse implications.

There is a need to establish registration and reporting systems for violence and injury in addition to a functional programmatic structure in the Ministry of Health. There is a need also to set up an injury surveillance system for evidence-based planning. Trauma care services need to be integrated in the essential package of hospital services and possible gaps identified and addressed. There is an urgent need to identify resources in this important area of work, particularly in view of the situation in the country.

Disabilities and rehabilitation

The UN Convention on the Rights of Persons with Disabilities was signed in 2007 and ratified in 2011. The High Commission for the Welfare of Persons Disabilities is the national coordination mechanism as of 2007 and is chaired by the Minister of Social Development, with representation of persons with disabilities.

Disabilities must be an integral part of the health information system in order to develop the evidence needed for strategic planning for prevention and control of disabilities and injury prevention.

Nutrition

The estimated prevalence of various conditions due to malnutrition in children under 5 years is summarized in the following indicators: 32.8% underweight, 13.2% wasting, 4.4% severe wasting, 42.1% stunting and 4.7% overweight (15). The estimated prevalence of anaemia in women of reproductive age (15–49 years) is 50.0%² and iodine deficiency affects 98.8% of the population (16). Initiation of breastfeeding within one hour after birth is 26.0% while 9.0% of children under 6 months are exclusively breastfed. Low birth weight is 5.0% (16).

Malnutrition rates remain stubbornly high requiring emergency nutrition supplementation, mainly due to lack of access to clean water, sanitation infrastructure and better hygiene.

A number of guidelines and policy documents to guide nutrition interventions are in place: national nutrition strategy 2011–2013; management of acute malnutrition 2010; infant and young child feeding strategy and plan of action 2012–2016; micronutrient strategy and plan of action 2014–2016; and basic nutrition services package. Technical support is needed in all these areas, through capacity-building and setting up programmes, especially in remote areas and camps for internally displaced persons.

² WHO Regional Office for the Eastern Mediterranean, unpublished data, 2014.

Promoting health across the life course

Reproductive,
maternal, newborn,
child and adolescent
health

Ageing and health

Gender, equity
and human rights
mainstreaming

Social determinants
of health

Health and the
environment

Promoting health across the life course

- In 2012, the first health sector strategic plan (2013–2016) was produced clearly expressing the vision of “a healthy and productive population contributing to the development of the nation”.
- The government endorsed the WHO regional strategy on health and the environment and framework for action 2014–19, and will initiate a national multi-stakeholder process to develop a strategic framework for action in 2015–2016. This will focus on environmental health priorities, including environmental health preparedness and response to emergencies.

Reproductive, maternal, newborn, child and adolescent health

The maternal mortality ratio declined between 1990 and 2015 from 1210 to 732 per 100 000 live births (17) and the under-5 mortality rate decreased from 180 to 137 deaths per 1000 live births (18). The leading causes of under-5 mortality are acute respiratory infection (19.0%), measles (13.0%), diarrhoea (12.0%) and intrapartum-related complications (11.0%) (19). The proportion of women receiving antenatal care coverage (at least one visit) is 31.6% and (at least four visits) 6.3% (16), while contraceptive prevalence rate is 15.0% (19).

The leading causes of maternal mortality are postpartum haemorrhage, eclampsia and sepsis. The key determinants of mortality remain low, including contraceptive use, immunization coverage, antenatal, postnatal and delivery care, and involvement of skilled birth attendants. The main challenges to further reduction of maternal and child mortality are: insecurity and countrywide maldistribution of the limited health sector human resources; inequitable access to care; low quality of interventions; limited capacity in planning, management and evaluation; the cultural and geographic isolation of women; and poor access to improved drinking-water and sanitation.

There is a need to: support delivery of services, build capacities to improve managerial skills and ensure access to lifesaving medicines, commodities and equipment; ensure equitable human resource distribution with community outreach; target evidence-based, cost-effective and community-based interventions promoting community education and mobilization; and encourage supportive supervision, monitoring and evaluation.

Ageing and health

Life expectancy at birth rose by 6 years between 1990 and 2012 (from 47 years to 53 years) (19). In 2010, the ageing population, above 60 years, represented 4.5% of total population (20).

Detailed information on older people is lacking. This makes decision-making difficult, with no evidence on the status of older persons from socioeconomic and health perspectives. The main challenges are: the absence of a policy framework; declining community support for older people; lack of technical expertise and financial support; and absence of and weak health facilities.

Establishing a multisectoral body and national programme for ageing and health will be one of most important first steps towards addressing the existing challenges. The momentum created by the 2015 *World report on ageing and health* and the related global strategy and action plan could help streamline a national strategy and national efforts. Capacity-building is also needed to provide age-friendly services through the primary health care system

Gender, equity and human rights mainstreaming

The country is not ranked in the *Human development report* (21). Female participation in the labour force is 37.2% (21).

In 2012, the first health sector strategic plan (2013–2016) was produced clearly expressing the vision of “a healthy and productive population contributing to the development of the nation”. However, the health system remains far from eliminating health inequity and promoting gender equality and access to sustainable and acceptable health care. Years of conflict have resulted in a population living in poverty and a large internally displaced population, many of whom require humanitarian assistance. Data on key indicators, such as health care coverage and gender equality, are lacking, which impedes evidence-based planning. Vulnerable groups, such as children, lack access to basic health needs, such as nutrition, immunization and safe water. Child health indicators show inequity by geographical area and income quintile. Women, another vulnerable group, particularly widows and internally displaced persons, have limited access to health care services and experience income and geographical inequities. The practice of female genital mutilation remains common. Challenges include a fragmented and under-funded health system with a severe workforce shortage, and limited reach. Political turbulence, coupled with scarce and unpredictable funding, has slowed improvement in health services access and health equity.

There is a need to integrate gender and human-rights approaches in health programmes and actions, including those related to humanitarian efforts. Women and children, particularly the poor and displaced, need special attention given their immense medical needs.

Social determinants of health

The urban population increased between 1990 and 2012 from 29.7% to 38.2% while access of the rural population to improved water sources decreased by 18.1% (61.3% to 50.2%) (22). In 2010, the age group 0–24 years accounted for 66.6% of the total population (20). Adult literacy rates in 2006 were 19.0% (23), while overall unemployment was 7.6% and for youth (15–24 years) 12.7% in 2012 (22).

Challenges include inadequate financial and human resources and the prevailing political and security situation, which impedes coordination and sustainability of efforts.

There is a need to advocate for the social determinants of health to be prioritized in the planning of the health and other sectors, including humanitarian action activities, in order to promote improved performance and effective implementation.

Health and the environment

It is estimated that 49 200 people a year die as a result of environmental factors and the percentage of disability-adjusted life years attributable to the environment is estimated at 31.0% (24). Deaths due to inadequate water, sanitation and hygiene are estimated at over 9500 (2012) per year (25). It is estimated that 95.6% of the population uses solid fuels (biomass for cooking, heating and other usages) (26), resulting in an estimated 11 300 deaths per year as a result of indoor pollution (27).

Due to the continuing complex emergency, these figures are expected to rise. The population still uses solid fuel for cooking. Outdoor air pollution is not monitored. However, evidence indicates high levels of particulate matter in the air.

The government endorsed the WHO regional strategy on health and the environment and framework for action 2014–2019. However, adaptation at the national level needs to be considered within the context of the emergency situation.

Health systems

National health
policies, strategies
and plans

Integrated people-
centred health
services

Access to medicines
and health
technologies

Health systems,
information and
evidence

Health systems

- The three health authorities decided in 2013 to scale up the *marwo caafimaad* (female community health worker) programme which has been recognized as one of the most cost-effective and sustainable interventions to address barriers in access to primary health care.
- Analysis of the health information system, leadership and governance building blocks was completed.
- Education of pharmacists is ongoing at a university in Hargeisa as well as one and two-year training courses for pharmacy technicians at Edna Maternity Hospital in Hargeisa.
- An analysis of the health information system, leadership and governance building blocks was completed.

National health policies, strategies and plans

The country's national health planning cycle is addressed in the national health policy strategy and plan 2013–2016. The current national strategic plan 2013–2016 resulted from the consolidation of three zonal strategic plans. The strategy is based on the six building blocks of the health system according to the needs. It prioritizes governance and leadership, followed by human resources, services delivery, health financing, pharmaceuticals and medical technology, and health intelligence and information systems.

Focus needs to be placed on: developing a national strategic plan as the basis for health system restructuring and strengthening; finalizing a legal framework and developing a public health law; continuing to support the leadership and management capacity-building plan; strengthening the health policy and reform unit in the Ministry of Health; supporting the development of a regional health information management system; continuing to support monitoring and evaluation; developing a strategy on procurement and service contracting capacity; and continuing to support health sector coordination (Health Advisory Board, Health Sector Committee, Technical Consultative Group, Steering Committee meetings).

Integrated people-centred health services

The health workforce density (2006) for physicians is estimated at 0.4 per 10 000 population, nurses and midwives 1.1 per 10 000 population and pharmacists 0.1 per 100 000 population (28). Health service delivery data showed mental hospitals in 2011 averaged 0.12 per 100 000 population (28), while the number of psychiatrists working in the mental health sector (2011) is estimated to be 0.04 per 100 000 population (29).

The majority of the population suffers from limited and inequitable access to basic health care services, especially in the rural areas and nomadic population. In the North-West and the North-East, access to basic health services in densely populated areas seems adequate. In the South and Central area of the country, about 60% of the population have no access to health care, because of the limited number of health facilities, poor quality health care services, high number of internally displaced persons and prevailing insecurity. Service provision is uneven. Most district hospitals are not sufficiently equipped, or do not have qualified human resources, to attend to maternal, newborn and child health and to other essential medical and surgical services. Regional and central hospitals provide reasonable levels of specialist care, although the service demand overwhelmingly exceeds the capacity and the resources that these hospitals require. The public health sector is complemented by a thriving private health sector which has a significant impact on health care-seeking behaviour. The network of public health services in the country is supported through the assistance provided by nongovernmental and international organizations. These organizations guarantee the provision of and access to medical supplies and equipment, as well as the salaries for the health workforce, promoting the retention of qualified professionals and their general support staff. The three health authorities decided in 2013 to scale up the *marwo caafimaad* (female community health worker) programme which has been recognized as one of the most cost-effective and sustainable interventions to address barriers in access to primary health care, improving the continuum of integrated care, delivering results and bridging the gap between health care delivery system and the communities. Each *marwo caafimaad* is responsible for a population of 600–1000 within her community. So far 500 have been recruited across the country. Assuming the availability of funds it is expected that, by 2018, their numbers will reach 8000 to cover the majority of the rural population and urban slums.

The focus should be on intensive and coordinated support from United Nations agencies, donors and international stakeholders to: improve health care coverage through deployment of mobile health teams outreach teams; and overcome the shortage of health workforce through expansion of *marwo caafimaad*; and strengthen the health information system to enable evidence-based planning and identification of gaps for provision of the essential package of health services. The existing health care facilities need to be rehabilitated and properly equipped. Internally displaced persons and refugees need better access to the health care services, medicines, environmental services, food security and nutritional supplementation.

Access to medicines and health technologies

A draft national medicines policy is available. The essential package of health services is defined and some financial support available for implementation. Long-term capacity development plans are available in health governance, leadership and management, with

commitment to improving access to essential medicines. Education of pharmacists is ongoing at a university in Hargeisa as well as one and two-year training courses for pharmacy technicians at Edna Maternity Hospital in Hargeisa.

Challenges include: inadequate financial and human resources, essential medicines and equipment for the public health sector; poor health service infrastructure; fragmented and under-funded health systems functions; unpredictability of external aid to health sector development; low access to health services; loss of human capital; shortage of qualified professionals; an unregulated private sector; the need to put in place national health and medicine policies and health and pharmaceutical sector strategies and to initiate the necessary health reforms; a high level of dependency on external assistance; limited institutional capacities to provide leadership, develop policies, manage programmes and monitor performance; lack of legislation, weak regulatory functions, and weak enforcement; lack of system accountability and limited transparency in decision-making; and insufficient partnership and collaboration among stakeholders and with the private sector.

Focus should be placed on supporting increased stability and maintaining external commitments for reconstruction and development. Focus should also be placed on the potential role of the private sector in health care delivery and increasing the role of community-based organizations in health care provision. The support of major donors (Gavi, Global Fund, Joint Health and Nutrition Programme) is needed to invest in health system strengthening. Agreement is needed on developing one health policy by the health authorities in the three zones. Focus should also be placed on the resilience of the population and the existence of skilled, experienced and motivated members of the Somali diaspora to support health development.

Health systems, information and evidence

A monitoring and evaluation framework has been developed for the health information system. An analysis of the health information system, leadership and governance building blocks was completed and an analysis of service delivery and human resources for health is ongoing. A mapping of health system strengthening activities was conducted and a health system analysis framework was drafted. In addition, a research committee was established in the North-West, North-East and the South and Central area, and a research agenda was produced.

Focus should be placed on developing a health information system that is inclusive of all surveillance systems and other disease-specific information systems.

Preparedness, surveillance and response

Alert and response
capacities

Epidemic and
pandemic-prone
diseases

Emergency risk and
crisis management

Food safety

Poliomyelitis
eradication

Outbreak and crisis
response

Preparedness, surveillance and response

- The government designated a national focal point in 2014 which will advance progress in implementation of the International Health Regulations (IHR 2005).
- The country has initiated actions to scale up emergency preparedness and response in the health sector with an all-hazards approach.
- An emergency action plan, including mapping of hard-to-reach areas and a communications strategy to reach the nomadic population, has been developed.

Alert and response capacities

The government requested a second extension in order to meet the obligations for implementation of the International Health Regulations (IHR) 2005 by June 2016. Very few IHR requirements have been implemented for the capacities of coordination, preparedness, response, risk communication, laboratory and handling food safety and zoonotic events. The government designated a national IHR focal point in 2014. The high turnover of existing human resources, lack of awareness of IHR among policy-makers due to frequent change and consequent lack of targeted funding for implementation, as well as the absence of a national focal point prior to 2014, have all impeded progress.

National capacities for surveillance and response to public health events of different origins need further strengthening, including at points of entry. The country is one of six countries infected with wild poliovirus. The country is not currently exporting the virus but continues to pose an ongoing risk for new wild poliovirus exportations. Thus special attention needs to be placed on enhancing cross-border surveillance and response. Cross-border activities may require ad hoc political, administrative and practical arrangements between Somalia and neighbouring countries, as well as full integration of activities taking place at ground crossings within existing public health services.

Focus should be directed toward supporting the development of event-specific national and zonal preparedness plans and their implementation, as well as the legislation process for the implementation of the IHR, and declaration of and approach to public health threats and other notifiable events. Providing leadership in implementation of the core capacities for IHR is a priority. Capacity-building for surveillance and for data management in health facilities and Ministry of Health and zonal offices; training and equipping health workers for quarantine and case management of suspected and probable cases; procuring

and repositioning outbreak response case management kits and supplies; disseminating epidemiological information to partners and stakeholders for action; and sharing epidemiological information in interagency coordination forums are also areas that should be achieved. There is also need for support to increase access to secondary and surgical care for the war wounded through deployment of doctors and other medical staff and equipping of hospitals; increase access to emergency obstetrics and neonatal care; deploy surgeons, doctors, nurses and anaesthetists; and establish national public health laboratories and blood banks.

Epidemic and pandemic-prone diseases

The country's public health system for detection and response to epidemic diseases remains fragile. A surveillance system remains functional in parts of the country and has shown that outbreaks can be detected and responded to if the system remains responsive and optimally performing. Cholera and diarrhoeal diseases remain the major public health problems in the country.

As the health system recovers, priority should be given to revitalizing the public health system through strengthening the disease surveillance system, enhancing its capacity for timely detection and response and establishing an evidence-informed long-term strategy for control of endemic diseases in the country.

Emergency risk and crisis management

The country is exposed to both man-made and natural disasters. For over two decades, the country has been in protracted crisis, which has naturally contributed to weakening the health system. The country has initiated actions to scale up emergency preparedness and response in the health sector with an all-hazards approach. Institutional initiatives in this regard include the establishment of a coordination unit for emergency preparedness and response within the Ministry of Health. The country has also started a dialogue with stakeholders to develop a longer term national plan for capacity development in disaster management. The main challenge is the ongoing crisis with regard to developing systematic capacity in the country's health sector.

There is a need for a comprehensive assessment of capacities and for vulnerability analysis to generate evidence for development of the health workforce, especially in the area of mass casualty management. Community-based interventions for disaster risk reduction and emergency preparedness are key to developing resilience. Capacity development for emergency preparedness can also be implemented through the collaborative efforts of all humanitarian partners.

Food safety

The food safety system is rudimentary and reflects the general situation in the country. Officers from the three administrative zones have been brought together to prepare for the creation of a Codex Alimentarius National Committee once conditions are conducive. At present, it is not realistic to refer to an actual national food safety system although there are a few initiatives on the development of individual components.

Focus should be given to: strengthening the food safety system; building national capacity to better monitor and track food safety at different levels; and developing a national food safety strategy and policy.

Poliomyelitis eradication

Polio eradication activities were initiated in 1997. Following the start of acute flaccid paralysis surveillance in 1998, an outbreak was detected in Mogadishu in 2000 and wild poliovirus cases were reported until 2002. In July 2005, a wild poliovirus outbreak secondary to an importation was detected and resulted in 228 cases (the last case was reported in March 2007). The country has had sustained circulation of vaccine-derived polioviruses since 2009 due to low routine immunization coverage rates and lack of supplementary immunization activities in insecure areas. A third outbreak started in April 2013 after an importation from Nigeria resulting in 199 cases reported in 2013 through 2014. More than 10 vaccination campaigns were conducted in 2014 with the support of WHO and other partners, to build immunity levels, to stop the outbreak and to prevent spread of the virus to other countries. Moreover, 360 checkpoint teams are deployed at strategic locations to vaccinate children moving from/to insecure areas. An emergency action plan, including mapping of hard-to-reach areas and a communications strategy to reach nomadic populations, has been developed. Religious leaders have been involved in advocacy to help reach and vaccinate children in insecure areas and the country's strong work has borne fruit. No wild polio cases have been detected since August 2014 and 38.0% of children living in insecure areas have been reached.

Inaccessibility of children due to insecurity and hard-to-reach areas remains a challenge; 0.2 million children are still inaccessible, routine vaccination is very low and the nomadic population remains at risk.

Stakeholders should continue their support to the country to maintain the achievements. There is a need to fully implement the emergency action plan and to reach all children everywhere in the country in order to sustain the achievements so far and keep the country polio-free.

Outbreak and crisis response

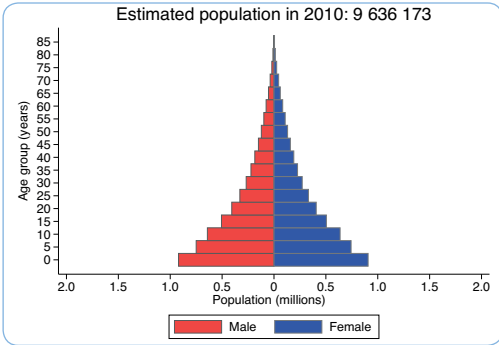
Humanitarian needs have increased dramatically following severe drought, food price rises and continuing conflict. Millions of Somalis, particularly in the south, are facing acute levels of hunger. Across the country, up to four million people, or 53.0% of the population, are in crisis, including 1.5 million who are displaced. The South and Central parts of the country are the areas most affected by conflict and the resultant displacements of population, disruptions of health services and restrictions on movement.

Health service delivery is hampered by a weak public health system with a lack of infrastructure, health facilities (including supplies, equipment and amenities) and skilled health workers. Combined with the absence of safe drinking-water and sanitation, and the low level of immunization coverage, the risk of communicable disease outbreaks is high. The interruption of basic essential health services continues to increase the health risks of the Somali population. In late 2014, the government began scaling up its preparedness for Ebola virus disease by assessing and measuring their level of preparedness and readiness for using the WHO assessment checklist and accordingly identifying critical gaps for improvement.

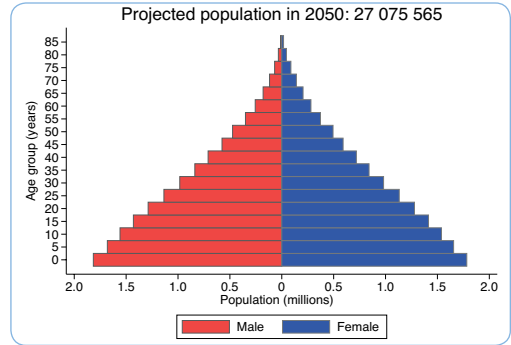
The low capacity of the local health system and low coverage of essential health services means that innovative approaches are required, particularly for the most affected populations, such as children. Key priorities include maintaining the country's polio-free status, conducting nationwide immunization campaign for measles by mid-2015, strengthening the national health information system, and establishing a national emergency preparedness and response unit within the Ministry of Health.

Demographic profile

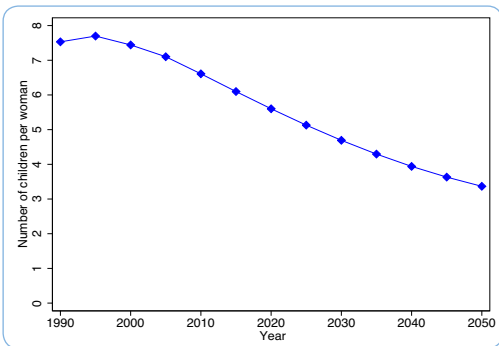
Population pyramid 2010



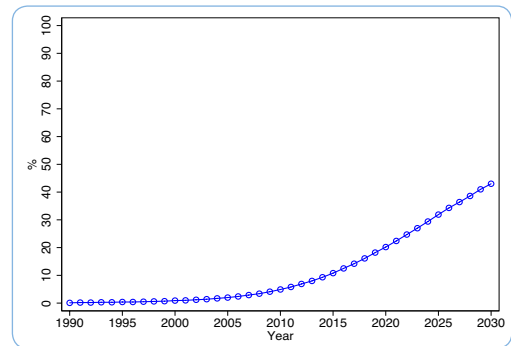
Population pyramid 2050



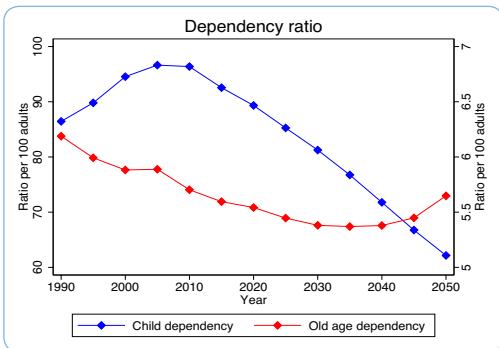
Total fertility rate



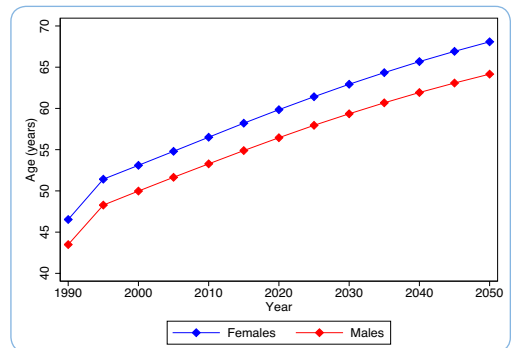
Need for family planning satisfied



Dependency ratio



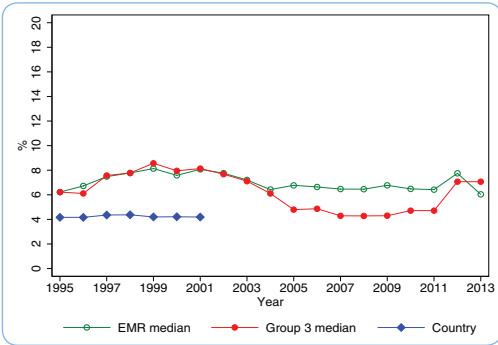
Life expectancy at birth



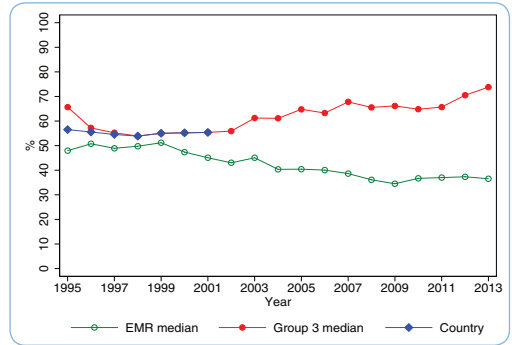
Source for all graphs: (20)

Analysis of selected indicators

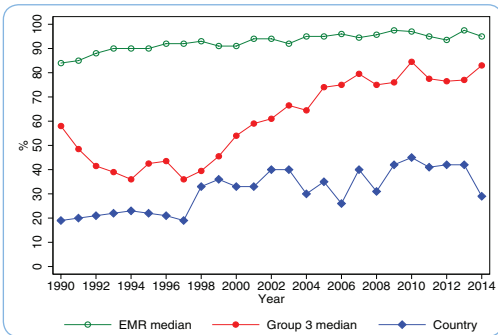
General government expenditure on health as % of general government expenditure (30)



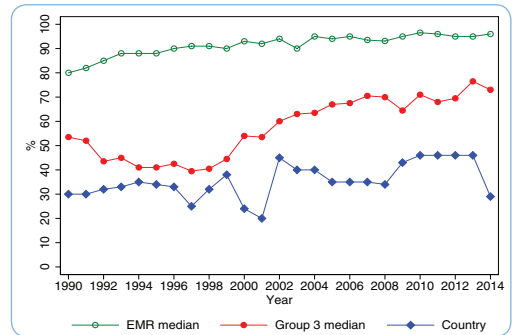
Out-of-pocket expenditure as % of total health expenditure (30)



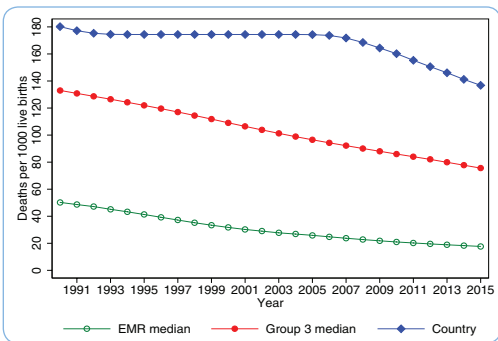
DPT3/pentavalent coverage among children under 1 year of age (%) (6)



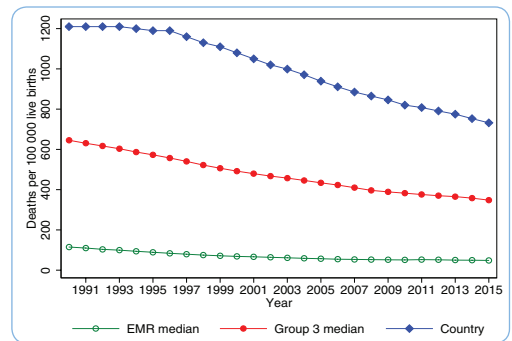
Measles immunization coverage (%) (6)



Under-5 mortality (per 1000 live births) (18)



Maternal mortality ratio (per 100 000 live births) (17)



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