

Somalia health cluster coordination in 2010: joint response of health cluster partners

At a glance

Current number of people of humanitarian concern: 3.64 million

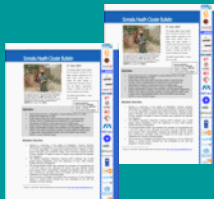
Number of displaced people: 1.55 million

Total CAP requirements for 2010 in health: USD \$46.4 million

Number of health cluster projects in CAP 2010: 36

Number of health cluster partners in 2010: 18 who contributed to the CAP; over 30 active partners in coordination

The health cluster produces a regular bulletin of partners' activities



Visit the health cluster's webpage at

www.emro.who.int/somalia/healthcluster.htm



cluster@nbo.emro.who.int

Context

The health cluster approach was launched in Somalia in April 2006 to address identified gaps in **response** (e.g. predictability, timeliness and effectiveness); facilitate joint strategic **planning, resource mobilization, monitoring and reporting**; and enhance the quality of humanitarian action by strengthening **leadership, partnership, accountability, and local capacity**.

Currently the health cluster consists of a group of more than **30 active partners** (5 UN agencies, 25 international and local NGOs, and in addition the International Red Cross and Red Crescent Movement and MSF as observers) **and other stakeholders** working together in humanitarian health response. The expansion of partnership and networks linked with local capacity building is an integral part of the health cluster strategy for response to the deteriorating humanitarian situation in 2010. For instance, over 20 local agencies have expressed their interest in health cluster partnership for next year, and their profiles are currently being reviewed by the health cluster.



The deteriorating humanitarian situation in Somalia in 2009 calls for strengthened and coordinated health response in 2010

WHO as the lead agency of the health cluster at both global and country level facilitates the coordination of health interventions in the different regions of Somalia. The international NGO **Merlin co-chairs the health cluster in Somalia** and together with WHO is in charge of cluster coordination and emergency preparedness in Puntland. **Save the Children UK** partners with WHO in the coordination of humanitarian health interventions and emergency preparedness in Somaliland. At the regional

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level within Somalia, different partners have been appointed as **health cluster focal agencies**. The commitment for the respective agencies is currently being confirmed for the coming year.

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

The linkage between field level and Nairobi-based coordination (e.g. tele-conferencing; field visits; joint trainings) aims to enhance the efficiency of emergency response by avoiding duplication of activities, emphasizing the potential of local capacity, joint monitoring, and facilitating inter-agency support and partnerships.

Health cluster partners meet on a monthly basis in Nairobi to share information and updates concerning current health situation (e.g. conflict, population movement and displacement, natural disasters) in different regions of the country; completed, ongoing and planned health interventions; disease outbreaks; and other issues relevant to the health situation and coordination in Somalia.



The health cluster Flood Contingency Plan captures the need for supplies, training of health workers for disease control and operational support in case of outbreaks, and access to health services.

Health cluster meetings are also attended by representatives of the water/sanitation/hygiene (WASH) and nutrition clusters. The close **tri-cluster coordination, cooperation** and **information sharing** facilitates more effective interventions and response to meet humanitarian needs of health.

Information is shared on a wider basis through the **monthly health cluster bulletin** which aims to provide an overview of the health activities ongoing in Somalia. Partners contribute updates, technical guidelines, reports, pictures and any other health-related information relevant to the generic **health cluster email** at cluster@nbo.emro.who.int.

Reports, updates, reference documents such as standards, guidelines and other tools, as well as the bulletin and other information relevant for health cluster activities and coordination are available and archived

on the **health cluster website** at www.emro.who.int/somalia/healthcluster. Based on the information provided by partners, regularly updated and verified, the health cluster has also developed a **3W (Who/What/Where)-Matrix** in order to monitor which agency is providing which service in which location in Somalia, and to ensure gaps are identified and addressed.

The health cluster also facilitates joint strategic planning (e.g. Consolidated Appeal Process) and supports partner agencies in **advocacy** and **emergency resource mobilization** (e.g. HRF). The preparation for the Consolidated Appeals Process (CAP) was conducted in close inter-cluster coordination between health, WASH and nutrition clusters, and interactive consultation with health partners.

Health cluster achievements in 2009

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

- **Emergency health response for internally displaced people (IDPs)** in Greater

LIST OF INFORMATION SHARING & COORDINATION TOOLS

- monthly bulletin & meetings
- website & generic email
- 3W matrix
- regional/zonal focal agencies
- Tri-Cluster coordination
- AWD preparedness matrix

Mogadishu and the Afgooye Corridor. Through joint efforts, partners are providing basic health services with utilization rates of up to 3 visits per person per year.

- The health cluster developed a **flood contingency plan** which has been incorporated within overall preparedness activities for communicable diseases. Partners contributed to the development of an **AWD preparedness matrix** which includes information about available stocks of AWD supplies and levels of preparedness of health partners in several locations.
- Health cluster partners have been able to ensure **early detection, timely response to and control** of more than 60 outbreaks throughout Somalia within 96 hours of reporting of rumors by timely information-sharing and coordination of response activities. Outbreak interventions include social mobilization activities, case management training, and chlorination activities in coordination with the WASH cluster. As of the end of November, cholera has been laboratory confirmed in 43 out of 135 tested samples collected in Lower Jubba, Lower Shabelle (including the Afgooye Corridor), Bay, and Mudug regions and



Joint planning and implementation of health activities in 2009 facilitated coverage of health services for the vulnerable population in Afgooye Corridor to within 1.2km from their settlements.

from Mogadishu. Due to improved quality and timeliness of case management, good coordination of different partners and beyond different clusters and training of health care providers as well as the provision of standardized emergency medical supplies, the overall case fatality rate (CFR) of acute watery diarrhoea was steadily reduced since 2007. The Early Warning and Alert Response System (EWARS) has been reporting from 36 health facilities in Lower Shabelle covering key populations of humanitarian concern.

- Health cluster partners **trained over 280 health workers** throughout Somalia addressing AWD/cholera prevention, preparedness, response and control; case definitions, data collection and reporting for early detection, alert and response to communicable diseases including diarrhoeal diseases; malaria prevention and treatment; tuberculosis treatment standards; cold chain management; and emergency services such as first aid, trauma, and obstetric care.
- With CERF funding, between September and November 2009, WHO was able to procure and distribute 10 inter-agency emergency health kits, 8 complete trauma kits, 20 diarrhoeal disease kits, 6 surgical instrument kits, 6 surgical supply kits, 6 anaesthetic kits, 100 health post kits, and 40 cholera diagnostic kits. While UNICEF is regularly providing Mother and Child



Information-sharing, joint monitoring and quality control will be integral elements of the coordinated health cluster approach in 2010

Health Centres with **medical supplies**, WHO provides emergency and trauma supplies. As of end of October, in 2009 WHO, UNICEF and health cluster partners distributed **essential supplies for AWD/ cholera management** including over 30 cholera and 30 rapid diagnostic kits, 75 sample transport media sets, more than 5,000 litres of ringer lactate, over 13,000 sachets of ORS (oral rehydration salts), over 1 million aquatabs and chlorine powder; other medical supplies such as trauma and inter-agency emergency health kits and more than 23 cartons of emergency medical supplies; as well as over 7,000 litres of diesel fuel and 90kg of oil for generators of Banadir, Baido and Merka hospitals.

- In order to be able to provide basic primary and secondary health care, health partners **rehabilitated 8 health facilities** including 2 hospitals, in Bay and Bakool, Lower Jubba, Middle Shabelle, and Galgaduud since the beginning of 2009.

Planned health response in 2010

In 2010, WHO as the lead agency together with Merlin in Puntland and Save the Children UK in Somaliland, as well as health cluster partners will enhance the coordination efforts of the health response for vulnerable populations affected by conflict and/or natural disaster in Somalia using the following strategy:

- Decentralizing health cluster coordination at regional level in all three zones; including the confirmation of health cluster focal agencies and strengthening of their roles at regional level (e.g. cluster meetings for coordination of activities and joint efforts; updates and information-sharing amongst partners at all levels and in inter-cluster collaboration).
- Strengthening the capacity of local partners in health emergency mitigation, preparedness and response planning and implementation, including for health risks caused by natural disasters.
- Establishing and strengthening the network of health cluster partners at field level with support from Nairobi. Strong partnerships between international and

local agencies and joint interventions will ensure access for implementation of activities and services as well as wider scope of advocacy and resource mobilization.

- Conducting regular assessments of health and health services, and developing regional health profiles, including joint monitoring and evaluation of humanitarian health interventions.



WHO as the health cluster lead agency will conduct and coordinate joint assessments of the health situation and services

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

- The performance of the health cluster relies upon the **continuity of available and dedicated** staff in the cluster lead agency. Currently, WHO is providing three staff members one of which is fully dedicated to tasks related to the health cluster; Merlin is supporting the necessary efforts with one staff member; and OCHA has assigned a cluster support officer. The demanding workload related to the effective functioning of the health cluster requires a dedicated health cluster coordinator and support staff. **WHO is currently in the process of recruiting a suitable candidate for this position.**
- The lack of a central government, and the presence of 3 different health authorities with different levels of development in the zones of Somalia contribute to the complexity of coordination. Specifically, the lack of oversight mechanisms leads to unequal distribution of health service cover-

age throughout Somalia. Zonal and regional health cluster focal agencies in line with decentralization of coordination will enable health cluster partners to adapt to and address specific health needs at the regional level.

- Highly fluctuating **operational presence** within Somalia results from the fast-changing security environments. This situation leads to limited access for the humanitarian community that jeopardizes the continuity and sustainability of health service provision. Strengthened partnerships and joint interventions will improve the planning and implementation process in 2010.
- During the preparation of the CAP 2009, **monitoring and supervision** were proposed through remote control mechanisms as a temporary solution to limited access and presence of the humanitarian community in Somalia. However, this approach did not prove reliable due to limitations in

the availability of information and the ability to verify it, WHO and health cluster partners are planning to increase their presence and capacity of national staff on the ground.

- Low capacity of local agencies and workforce implementing health activities can compromise the quality of services and requires more monitoring and quality control, which may be difficult due to limited access and security. However, health cluster partners have agreed to reinforce local capacity through on-the-job training, adhoc training during outbreak response, and support to local partners in the form of guidelines and supervision.
- Limited access due to gaps in the infrastructure, in addition with localized security constraints, lead to increased operational costs such as logistics and security measures. These additional requirements must be accounted for, at the outset within both the planning and budgeting of activities.

Joint response health cluster partners: 2010 budget (as in CAP 2010)

	Save the Children UK	WHO	Merlin	TOTAL
Personnel costs	107,000	205,000	93,600	405,600
Direct project inputs	312,000	550,000	48,000	910,000
Operations support costs	75,000	180,000	26,000	281,000
Transportation and storage	35,000	125,000	36,000	196,000
Programme support costs	79,350	74,200	14,252	167,802
totals	608,350	1,134,200	217,852	1,960,402