Somalia Health Cluster Strategy – for the period through to the end of 2018

Section 1: Population health status and health needs

Somalia is in its second year of widespread drought. Conditions in 2017 continued to deteriorate following poor and below normal Gu rains. It is estimated that only 35% of water sources have been replenished. Livestock losses have been reported across the country and overall crop production has been significantly affected. For the period through to the end of 2017, the total population of nearly 3.5 million people living in declared Emergency (IPC Phase 4) and Crisis (IPC Phase 3) areas remains undiminished.

The combination of malnutrition, cholera and measles disease outbreaks has resulted in widespread suffering as well as death. It has affected a population with pre-existing poor health status and in a country where the health system markedly underperforms. WHO reporting in 2016 on core indicators for Somalia’s health situation and health system performance details that even prior to the onset of the current drought, amongst children under the age of 5 years, 42% were stunted whilst 13.2% were wasted. Both the under 5 mortality rate of 137/1000 as well as maternal mortality ratio of 732/100,000 live births are the highest in the region. Data on health service delivery indicators is limited however in 2015 DTP3 coverage was 44% and measles coverage of 41% was reported.

According to the revised 2017 Humanitarian Response Plan, an estimated 2.2 million people are in need of nutritional interventions, out of which approximately 50% are targeted under the Nutrition Cluster strategy. This includes 350,000 severely malnourished children and more than 500,000 moderately malnourished children. Since the beginning of the year, there have been substantial increases in new admissions of acutely malnourished children to treatment and feeding centers reported through the Nutrition Cluster, rising from 29,000

1 The drafting of this strategy began in late July/early August 2017 and therefore data sources are up to this point in time.
3 http://applications.emro.who.int/dsaf/EMROPUB_2016_EN_19169.pdf?ua=1&ua=1
in January 2017 to 100,000 in May 2017.

2017 has seen two major communicable disease outbreaks across the whole of Somalia – measles and cholera. For the period through to the end of July, more than 75,000 cases of cholera/AWD and 14,000 cases of measles have been reported.

The cholera outbreak has affected the entire country with Togdher, Bay, Gedo and Lower Shabelle regions seriously affected. Caseloads between 5,000 and 15,000 have been reported for each of these districts. The epidemic has resulted in at least 1,155 deaths attributable to cholera with average case fatality rate (CFR) across the outbreak of 1.5%. The total numbers of cholera cases has been in decline since week 22 of 2017 whilst numbers being reported at the end of August suggest that the outbreak is now finally coming under control. The onset of October rains has the potential to reverse the current decline in cases.

More than 14,379 suspected cases of measles have been reported year-to-date to 30 July 2017, out of which children aged up to ten years comprise approximately 83%. Suspected measles cases have been reported from all regions of Somalia, except Bakool region. This may be explained by more limited surveillance in areas of insecurity surveillance. The measles epidemic is attributed to low measles vaccination coverage rates, compounded by drought-related mass displacement and overcrowding. The targeted measles vaccinations by WHO, UNICEF & partners in early 2017 did not prevent spread of disease to other areas of the country. A nationwide measles campaign is planned for Nov/Dec 2017.

Multiple analyses highlight the very high levels of vulnerability amongst IDPs. Across the country, some 766,467 people have been displaced due to drought in 2017 with the majority now living in settlements in Baidoa and Mogadishu. Additionally, nearly 1.1 million people remain in protracted displacement countrywide.

Section 2: Availability of health services

A preliminary health service mapping exercise was completed through the Health Cluster in March 2017, based upon Service Availability and Readiness Assessment (SARA) data (2016) and supplemented by additional information from Health Cluster partners. The mapping exercise highlights very significant regional inequities in service delivery availability, exacerbated by complete closure or inaccessibility of facilities across areas of the country.

Out of 1,075 facilities in Somalia, 801 (74.5%) health facilities are functioning whilst out of the of the remaining 274 facilities, 105 (9.8%) are closed and 169 (15.7%) are inaccessible. The SARA study determined that, nationally, there is less than 1 health facility per 10,000 population (0.76 facilities per 10,000 population), which indicates the country is 38% of the way towards achieving the facility density target of two health facilities per 10,000

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5 This dataset is being updated and reviewed as a contribution to the preparation of the 2017 Humanitarian Needs Overview
### Table: Health Facility Accessibility in Somalia

<table>
<thead>
<tr>
<th>State/Zone</th>
<th># Population</th>
<th># OPEN HFs</th>
<th># CLOSED HFs</th>
<th># INACCESSIBLE HFs</th>
<th>Ratio of HF/population</th>
</tr>
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<tbody>
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<td>Galmadug</td>
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<td>23</td>
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</tr>
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<td>128</td>
<td>7</td>
<td>36</td>
<td>1/37,394</td>
</tr>
</tbody>
</table>

population. However even these figures hide the very significant inequalities in health service availability across different areas of the country\(^6\). The 2016 SARA study, which preceded the onset of drought, included point in time Information on access, use, performance and functioning of health services analysis.

“Results from the health workforce domain show that nationally there are 4.28 core health workers per 10,000 population indicating that the country is 19% of the way towards achieving the health workforce density target of 23 core health workers per 10,000 population. In looking at the domain of health service utilization, indicators demonstrate poor availability and access to health services in Somalia. Nationally, Somalia is 5% of the way towards achieving the outpatients visit target and 8% of the way toward achieving the hospital discharge target (10 per 100 population per year). When examining the areas of infrastructure, health workforce, and service utilization together, the overall General Service Availability index shows that on average, the country is only 18% of the way towards achieving the General Service Availability target”\(^7\).

The rapid onset and progression of disease outbreaks in combination with rising numbers of cases of severely malnourished children has demanded a rapid scale-up in capacity to treat cholera and malnutrition. To date this year, during the course of the response, a combined total of 100 cholera treatment units and centres have been opened to deal with the patient caseload. Beyond a focus on scale-up of access to services, during the response a DFID-funded remote monitoring programme has been implemented by WHO, UNICEF and the

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\(^7\) SARA 2016 report, WHO
NGO Consortium\textsuperscript{8}. It has served two purposes. Firstly, to monitor functioning and outcomes of cholera treatment centres and nutrition stabilisation centres being supported by MOH and partners. Secondly, to report trends in priority conditions and events, including mortality, from health facilities. This function has also included clinical decision support and end to end monitoring of supply chain.

\textbf{Section 3: Priority health problems, foreseeable risks and recommendations}

The focus on control of cholera has placed significant stress on limited pre-existing services. Beyond this, barriers to accessing healthcare remain critical and are attributable to gaps in geographical coverage, access barriers for specific vulnerable populations and gaps in sub-sector provision e.g. GBV service provision.

The situation at the beginning of 2017 have been compared to the drought conditions in 2010/11, which led to a famine in Somalia in July 2011 when approximately 750 000 people entered the IPC V (famine) phase, 260 000 people lost their lives and massive displacement across the region occurred\textsuperscript{9}.

During 2017, malnutrition, measles and cholera constituted the priority health problems arising as the immediate consequence of drought and crop failure. Population displacement with movement into areas where services are either not available or not accessible for a range of reasons, including insecurity, absence of or pressure placed upon existing services, perpetuates vulnerability. All this is occurring amongst a population already affected by poor health and facing an under-resourced and under-performing health system.

The risks to individual and population health from malnutrition and measles, and the possibility of a resurgence of cholera as a consequence of October rains, remain as the major foreseeable risks through to the end of 2017. This is beyond excess avoidable morbidity and mortality occurring as a consequence of major gaps in health service availability, accessible and utilization. FSNAU data foresees little improvement in drought related circumstances through to the end of 2017\textsuperscript{10} whilst seasonal rains in October threaten the progress made to date in controlling cholera outbreaks.

November 2017 will see the launch of the nationwide measles vaccination campaign which will place significant demands upon institutions, systems and services but is essential if control of measles is to be achieved.

Based upon experience to date, clear principles for the strategy guiding the humanitarian health response through to the end of the year include:

\begin{itemize}
\item \textsuperscript{9} https://ec.europa.eu/echo/sites/echo-site/files/hip_hoa_v3.pdf
\item \textsuperscript{10} http://fsnau.org/in-focus/quarterly-brief-june-2017-focus-post-gu-season-early-warning
\end{itemize}
1. **Clarity:** over the goal and objectives of the health response, also the role to be played by the Cluster is essential for a joint and coordinated response.

2. **Linkages:** ensure that humanitarian operations and longer-term efforts to scale-up service provision are effectively linked at levels of planning and programming.

3. **Needs and prioritization:** given the scarcity of financing, resources and capacity, there is a very real imperative to prioritize how limited resources are allocated to address emergency humanitarian needs and using clear criteria.

4. **Access:** the Cluster needs to better understand “access” issues, to develop measures for better describing whether lack of access is due to insecurity or lack of resourcing and to engage within and beyond the Health Cluster to work towards solutions.

5. **Health systems:** Supply chain strengthening, in principle through a unified supply chain for commodities, is required. Limited preparedness due to pre-existing poor health systems performance constitutes a major challenge. This demands attention if a “durable” solution is to be found.

6. **Integrated approaches:** there is a clear need to ensure that planning and delivery of humanitarian assistance is provided through integrated packages, especially comprising health, WASH and nutrition assistance.

7. **What is working:** where there is existing experience of delivering integrated responses, including through Integrated Emergency Response Teams (IERTs), review of their efficiency and effectiveness is required. A wider evaluation of Cluster performance is also required.

8. **Capacity building:** there is a need to factor capacity building into all aspects of strategy and programming, ensure sufficient financing to support these objectives and ensure sufficient national capacity especially within institutions, principally the MoH.

9. **DRR:** in a country prone to natural disasters (including disease outbreaks, drought and flooding), there is an urgent need to mitigate risks. Increased investments in DRR activities will reduce the number and severity of emergencies.

**Section 4: Context analysis**

The 2016/2017 Somalia drought has resulted in a major humanitarian crisis. Significant resources have been diverted towards running cholera/measles prevention and control programme. The response to cholera necessitated the establishment of over 100 CTUs/CTCs. The major focus has been upon supply-side initiatives, especially the scale-up of service delivery, although an important programme of remote monitoring has also figured within the Cluster response strategy. The response has been hampered by a lack of preparedness. Cholera prevention activities, including integrated Health-WASH programming, have largely been undertaken by WASH Cluster partners. Supply-side efforts have predominated during the response. Lesser emphasis has been placed upon demand-side initiatives which would also address barriers preventing access to health services. Lack of access to populations, poor availability and use of information hampering decision making and systemic weaknesses e.g. in the supply chain have made for a challenging response. Quality of care has been addressed as part of the response strategy to date, through the use remote monitoring tools including electronic tablets, whilst the potential
exists to institutionalize the approach in order to impact on quality of health care for the longer term.

The response strategy for the remainder of 2017 needs to begin to address the issue of how to sustain established response capacity in the face of diminishing sources of health financing. Supply chains, disease surveillance, health information systems and other elements of response capacity will need to be integrated within pre-existing elements of the health system. The 2016 SARA report provides in-depth and definitive information on pre-existing system capacities and gaps.
**Goal, Outputs and sub-outputs**

**Goal:** To reduce avoidable mortality, morbidity and disability, and restore the delivery of, and equitable access to, preventive and curative basic health services as quickly as possible and in a sustainable a manner as possible.

**Outputs**

- **Output 1:** Strengthen leadership, planning and co-ordination of emergency health responses.
- **Output 2:** Provision of and scaling up of essential lifesaving health and nutrition services.
- **Output 3:** Strengthen disease outbreak surveillance, response and improve monitoring and performance of humanitarian health services.
- **Output 4:** Support linkage of emergency, resilience and development health programming, including a strong focus on DRR.
- **Output 5:** Ensure integrated approach of health, nutrition and WASH lifesaving interventions
- **Output 6:** Strengthen health action advocacy and resources mobilization efforts

Capacity building is a cross-cutting objective

**Sub-outputs**

- **Output 1:** Ensure leadership, planning and co-ordination of the health cluster/sector response in Somalia.
  - Sub-output 1.1: Strengthen health cluster/sector coordination at national and subnational level to effectively respond to the Somalia humanitarian health crisis
  - Sub-output 1.2: Provision of strategic and technical support to health cluster partners through regular TAC/sub-cluster WG forums
  - Sub-output 1.3: Contribute HNO/HRP development and ensure alignment with national policies, plans and strategies.
  - Sub-output 1.4: Production of regular and timely information products.

- **Output 2:** Provision of and scaling up of essential lifesaving health and nutrition services.
  - Sub-output 2.1: Define priority populations – through an analysis based on geography, (hard to reach, IDP and mobile communities), conflict, additional measures of vulnerability.
  - Sub-output 2.2: Support roll out and scaling up of EPHS implementation (Essential package of health services).
  - Sub-output 2.3: Design approaches to implementation specific to service delivery setting e.g. newly displaced populations, IDPs in protracted
displacement settings, migrant populations, populations exposed to ongoing conflict.

- **Output 3**: Strengthen disease outbreak surveillance, response and improve monitoring and performance of humanitarian health services.
  - Sub-output 3.1: Strengthen and expand disease surveillance and early warning system
  - Sub-output 3.2: Ensure regular measure and communication of health resource availability and health services coverage
  - Sub-output 3.3: Support improvements in the quality of care and clinical outcomes through regular monitoring of health facility functioning (building upon current remote monitoring of cholera treatment centers, nutrition stabilization centers)

- **Output 4**: Support linkage of emergency, resilience and development health programming in Somalia, including a strong focus on DRR.
  - Sub-output 4.1: Contribute towards wider, ongoing and longer-term efforts to strengthen the health system resilience.
  - Sub-output 4.2: Ensure alignment of humanitarian health projects with sector-wide policies, strategies and plans (HSSP II, HRP etc)
  - Sub-output 4.3: Strengthen health sector preparedness and response capacities for emergencies, including through a regularly updated contingency plan for key risks, including disease
  - Sub-output 4.4: Ensure that these capacities are maintained and sustained through appropriate and adequate resourcing (financial, technical, human) and are linked to national systems

- **Output 5**: Ensure integrated approach of health, nutrition and WASH lifesaving interventions.
  - Sub-output 5.1: Joint health, nutrition and WASH needs assessments, design and planning wherever possible.
  - Sub-output 5.2: Scaling up of recently initiated Integrated emergency response interventions (Health, nutrition and WASH)

- **Output 6**: Strengthen health action advocacy and resources mobilization efforts Sub-output.
  - Sub-output 6.1: Production and sharing of regular health cluster information products.
  - Sub-output 6.2: Enhance resources mobilization efforts to increase health cluster funding level

Capacity building is a cross-cutting objective