

Somalia

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THE PRESENT CONTEXT

The health status of Somalia's estimated 8.2 million people is severely affected by a civil war which has claimed up to half a million lives and left the country with some of the worst health indicators in the world. Close to 450 000 have sought refuge in neighbouring countries and up to 1 million are internally displaced. Ongoing violence continues to trigger fresh waves of displacement. Poverty, disease and limited educational and employment opportunities take a severe toll on the health and welfare of the population. As agriculture is affected by social disruption, environmental destruction and drought, food insecurity is a constant concern.

The self-declared republic of Somaliland (1991) and the self-autonomous region of Puntland (1998) are experiencing political development, economic recovery and relative stability, while the Central and South Zone remain unstable and violent.

The Transitional Federal Government (TFG), formed in June 2005, has so far failed to produce effective governance. The Union of Islamic Courts took control of the capital and much of the centre and south until January 2007 when they were driven out; the fighting created up to new 400 000 IDPs. Insecurity and violence remain major concerns for health and development.

Included in the CAP 2007

Crisis involving part of the population

MAIN PUBLIC HEALTH ISSUES AND CONCERNS

Health Status

- Maternal health is among the poorest in the world with very low indicators when any are available. Malnutrition and anaemia among women are high and the practice of genital mutilation is almost universal. Rising incidence of HIV and sexual violence and a low contraception rate of 12% are all additional concerns.
- Communicable disease remains a major cause of preventable mortality. An estimated 87% of the population is at risk for malaria and TB while upper respiratory illnesses are common. Cholera, measles and meningitis outbreaks claim the lives of many Somalis. Cholera is endemic in Mogadishu and there are seasonal outbreaks from November to May.
- With only 26% of the population having access to safe drinking water, diarrhoeal diseases are a major threat to health. During the first part of 2007, 36 275 cases of acute watery diarrhoea were reported from central south Somalia, including 1102 related-deaths. The majority of health clinics and posts have no water supply. Similarly, schools do not have water and sanitation systems.
- The overall HIV prevalence is 0.9% with regional variations ranging from 0.9 in central south, 1% in Puntland to 1.4% in Somaliland. A 2004 survey indicated that HIV prevalence among pregnant women nationally was 0.6%, with the highest infections levels in the capital (0.9%). STIs are highly prevalent and the context features multiple vulnerability factors which might facilitate a rapid escalation.

Main indicators¹

Total population in million (2005) ²	8.2
% under 15 ²	...
% of urban population (2005) ²	35
Life expectancy at birth m/f (2005)	45/45
Infant mortality ‰ (2005)	133
Under-five mortality ‰ (2005)	225
% population with sustainable access to an improved water source (2004) ²	29
% population with sustainable access to improved sanitation (2004) ²	26
Total adult literacy rate, m/f (2002)	19 25/13
Human Poverty Index rank out of 102 countries ²	...
Gross National Income (GNI) per capita (US\$) (2005) ³	130
% population living with less than US\$ 1 a day	...
Total public and private expenditure on health as % of GDP	...
Total per capita health expenditure (US\$)	...
Nurses/midwives rate /1000 (1997)	0.19/...
Physicians rate /1000 (1997)	0.04
Malaria rate /1000 (2003)	2.36
TB prevalence /100 000 (2005)	286
TB mortality /100 000 (2005)	40
Adult HIV/AIDS prevalence /100 000 (2005)	870
Reported # of people receiving ARTs (2006)	49
Total fertility rate (2000-2005) ²	6.4
% antenatal care coverage (2002)	47
% birth attended by skilled personnel (2002)	23
Maternal mortality /100 000 (2000) ^{1,2}	1100/1600

Sources:

¹ WHO unless indicated otherwise

² UNDP Report 2006

³ UNICEF

- Malnutrition rates are high; significant regional differences exist, with Global Acute Malnutrition (GAM) ranging from 19.5% in Jilib in the Middle Juba region, to 31% in Dusomareb in the Galgadud region and 37% in Bulahawa in the Gedo region.

Health System

- Access to health services is very precarious due to insecurity, lack of trained staff in many health facilities or inability to meet the costs (out of pocket expenditure constituted 55% of all health care spending in 2001). This applies particularly to women and children and to the central and southern regions.
- Primary coverage in 2003 was reported at 72% overall, 95% and 61% urban and rural respectively. However, these figures are likely a gross overestimate because they do not account for the significant social disruption in the intervening years.
- During the last 15 years, the collapse of national institutions has compelled WHO and its partners to take over vital public health functions usually carried out by the MoH and implement wide-ranging programmes. UN Agencies and NGOs support a variety of health services: curative care, immunization, antenatal care, nutritional rehabilitation, family planning and rehabilitation of disabled people. Donor health funding is in the order of US\$ 5 per capita.
- Efforts are ongoing to re-establish central institutions, but at present central authorities have minimal managerial, technical, implementing or enforcing capacity.
- The health network can be summarized as follow: 84 hospitals, 199 mother and child health/outpatient departments, 525 health posts, 91 private clinics, 51 school clinics, 3,949 hospital beds, 53 cold chains and 451 polio surveillance sites. Health facilities do not cover large pockets of the territory, especially in the south. In Somaliland and Puntland, war-damaged hospitals and clinics have been rebuilt and qualified health professionals are returning to their practices.
- The private health sector, which has begun filling the gaps of the collapsed public health system particularly in the area of curative services, is in need of urgent regulation and policies. Private health clinics and private pharmacies have proliferated all over the country, especially in the main towns.
- Human resources for health remain scarce. As a result of the civil war, Somalia has lost at least one generation of trained health professionals. Few professionals have the skills and experience needed for reconstruction or public health management background. Low salaries in the public sector force professionals to devote considerable part of their working hours to the private-for-profit curative sector.

MAIN SECTOR PRIORITIES

Nationwide, health facilities, services and personnel should be standardized and rationalized, taking into account a balance that should be created between curative and preventive services, urban and rural settings, rural and nomadic areas and standard salaries and incentives to operate in remote, disadvantaged areas.

The availability of basic services, such water, health and sanitation facilities, in South and Central Somalia will encourage the return of refugees to these areas.

In the Somalia CAP 2007, the main objectives are to:

- Increase access to essential health services of adequate quality by the most vulnerable population groups, especially IDP women and children;
- Scale up reproductive health services, focusing on emergency medical obstetric care and family planning;
- Increase the coverage of the public health programme, especially of the Expanded Programme of Immunization (EPI) and vitamin A distribution;
- Support health services providers through training and capacity building;
- Strengthen existing surveillance systems, supporting their integration with the health information systems;
- Strengthen coordination of health activities and stakeholders at all levels with special emphasis on emergency preparedness, response, gap filling, early recovery and capacity building;
- Increase the availability of mental health services to communities.

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More information can be obtained from the [CE-DAT](#), a database on the human impact of complex emergencies part of the SMART initiative launched in June 2002 by a consortium of UN agencies, NGOs and academic institutions.