EMRO

HEALTH SYSTEM PROFILE

SOMALIA

Regional Health Systems Observatory
World Health Organization

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FOREWORD

Health systems are undergoing rapid change and the requirements for conforming to the new challenges of changing demographics, disease patterns, emerging and re emerging diseases coupled with rising costs of health care delivery have forced a comprehensive review of health systems and their functioning. As the countries examine their health systems in greater depth to adjust to new demands, the number and complexities of problems identified increases. Some health systems fail to provide the essential services and some are creaking under the strain of inefficient provision of services. A number of issues including governance in health, financing of health care, human resource imbalances, access and quality of health services, along with the impacts of reforms in other areas of the economies significantly affect the ability of health systems to deliver.

Decision-makers at all levels need to appraise the variation in health system performance, identify factors that influence it and articulate policies that will achieve better results in a variety of settings. Meaningful, comparable information on health system performance, and on key factors that explain performance variation, can strengthen the scientific foundations of health policy at international and national levels. Comparison of performance across countries and over time can provide important insights into policies that improve performance and those that do not.

The WHO regional office for Eastern Mediterranean has taken an initiative to develop a Regional Health Systems Observatory, whose main purpose is to contribute to the improvement of health system performance and outcomes in the countries of the EM region, in terms of better health, fair financing and responsiveness of health systems. This will be achieved through the following closely inter-related functions: (i) *Descriptive function* that provides for an easily accessible database, that is constantly updated; (ii) *Analytical function* that draws lessons from success and failures and that can assist policy makers in the formulation of strategies; (iii) *Prescriptive function* that brings forward recommendations to policy makers; (iv) *Monitoring function* that focuses on aspects that can be improved; and (v) *Capacity building function* that aims to develop partnerships and share knowledge across the region.

One of the principal instruments for achieving the above objective is the development of health system profile of each of the member states. The EMRO Health Systems Profiles are country-based reports that provide a description and analysis of the health system and of reform initiatives in the respective countries. The profiles seek to provide comparative information to support policy-makers and analysts in the development of health systems in EMR. The profiles can be used to learn about various approaches to the organization, financing and delivery of health services; describe the process, content, and implementation of health care reform programs; highlight challenges and areas that require more in-depth analysis; and provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policy-makers and analysts in different countries. These profiles have been produced by country public health experts in collaboration with the Division of Health Systems & Services Development, WHO, EMRO based on standardized templates, comprehensive guidelines and a glossary of terms developed to help compile the profiles.

A real challenge in the development of these health system profiles has been the wide variation in the availability of data on all aspects of health systems. The profiles are

based on the most authentic sources of information available, which have been cited for ease of reference. For maintaining consistency and comparability in the sources of information, efforts have been made to use as a first source, the information published and available from a national source such as Ministries of Health, Finance, Labor, Welfare; National Statistics Organizations or reports of national surveys. In case information is not available from these sources then unpublished information from official sources or information published in unofficial sources are used. As a last resort, country-specific information published by international agencies and research papers published in international and local journals are used. Since health systems are dynamic and ever changing, any additional information is welcome, which after proper verification, can be put up on the website of the Regional Observatory as this is an ongoing initiative and these profiles will be updated on regular intervals. The profiles along with summaries, template, guidelines and glossary of terms are available on the EMRO HSO website at www.who.int.healthobservatory

It is hoped the member states, international agencies, academia and other stakeholders would use the information available in these profiles and actively participate to make this initiative a success. I would like to acknowledge the efforts undertaken by the Division of Health Systems and Services Development in this regard that shall has the potential to improve the performance of health systems in the Eastern Mediterranean Region.

Regional Director

Eastern Mediterranean Region

World Health Organization

1 EXECUTIVE SUMMARY

Somalia, formerly known as the Somali Democratic Republic, is a coastal nation in East Africa. Continentally, it is entirely surrounded by Ethiopia and Djibouti on the north and mid-west, and Kenya on its south-west; with the Gulf of Aden on its east. It currently exists solely in a de jure capacity. Somalis form the vast majority of the population, whose ethnicity is defined by a shared language, a pastoral economy, and adherence to Islam and a clan-based social and political system.

The population of Somalia is around 8,591,000. However, estimates are very difficult because of the continuing situation. The last census was in 1975. About 60% of all Somalis are nomadic or semi-nomadic pastoralists who raise cattle, camels, sheep, and goats. About 25% of the population is settled farmers who live mainly in the fertile agricultural region between the Juba and Shebelle rivers in southern Somalia. The remainder of the population (15%-20%) is urban.

After almost a decade of war, chaos and disorder in the country, a transitional national government was elected in October 2000, with a president to lead the government. The bitter years of war witnessed the formation of two major administrations- 'Somaliland' in the Northwest and 'Puntland' in the Northeast both of which attempted to re-establish peace and stability in their zones of administration. The central and southern parts of the country have been operating autonomously, with incessant contradictions over the leadership of the capital city of Mogadishu.

Despite the designation of an elected transitional national assembly and government, there are still parts of Somalia that have not accepted the legitimacy of the transitional national government (TNG). ‘Puntland’ and ‘Somaliland’, with their respective forms of government, and parts of the central and south of Somalia have not accepted the existence of the transitional national government, thus making the political situation even more difficult.

Somalia, classified as a Least Developed Country (LDC), is one of the poorest countries in the world, with an annual per capita income of less than $ 200. The vast majority of the population live way below the poverty line and Somalia has the lowest GNP and adult literacy rate and the highest infant mortality rate in the Horn of Africa. The country’s economy traditionally and largely depends on the exploitation of natural resources, mainly livestock and agriculture. After the failure of the centrally-planned economic policies of the Barre regime in the 70’s and 80’s, the Somali economy plunged into a prolonged recession which was further depressed by the collapse of the state in 1991 accompanied by the disintegration of public economic infrastructure and regulatory mechanisms as well as of vital services such as recognized banking systems, telecommunications, provision of inputs, access to international markets.

In general terms, livestock remains the basic economic activity; the precarious foreign exchange earnings rely almost entirely upon exports of livestock and livestock products, as well as on the regular and massive influx of remittances (estimated to total US$ 300-400 million annually) from the diaspora, which has a cushioning effect for many of the poorest households as well as fuelling certain economic sub-sectors such as trade and construction. The overall economic aspirations are set against a bleak background of poor public sector management and an almost complete lack of economic and monetary policies and regulation. This poor management, combined with a resounding lack of institutional support, continues to have a crippling effect on

Somalia's economy and its few unguarded natural resources.

After ten years of civil conflict and state collapse, human development in Somalia is unacceptably poor. Hundreds of thousands of Somalis live in destitution, vulnerable to the vicissitudes of political violence, global markets and climate. At the same time, some people have benefited economically and over the past decade and there have been significant developments in communications technology and economic infrastructure. Cultural changes are also apparent in the enhanced role of traditional institutions in governance, the greater economic role of women, and the influence of Islamicists in social, economic and political life. Key human development indicators point towards one of the worst situations in the world. One out of five children die before the age of five; only one out of six children are enrolled in primary school; one out of eight women are literate; and only one out of four families have access to clean drinking water. Somalia was ranked 161 amongst 163 countries by the Human Development Report (UNDP, 2001).

The current data indicates that the trends in human development are mixed. While there have been very modest improvements in some of the human development indicators over the past three years, such as primary school enrolment and per capita income, Somalia's Human Development Index (HDI), which is calculated at 0.284, places the country near the bottom of world rankings in human development. These improvements are primarily due to reduced levels of armed conflict and population displacement in comparison to the early and mid 1990s.iv In 1986/87 average life expectancy was recorded as 47 years (45.7 for males, 47.6 for females). Between 1990 and 1995 life expectancy is estimated to have dropped to as low as 30-35 years, due to war, famine and economic crisis. Life expectancy is estimated to have returned to pre-war levels of 47 years or even higher.

Education and formal classroom learning opportunities are virtually non-existent in Somalia. There have been substantial increases in the number of operational schools and in enrolment rates, but considerable disparities in the quality of and access to primary education are still problematic in parts of the country because of the socio-economic, cultural and political realities. Most existing schools are concentrated in and around urban areas and are mainly financed by fees or other forms of support from parents and communities, with some input from external agencies. Somalia has one of the lowest primary school enrolment rates in the world.

The Survey of Primary Schools in Somalia for 2003-2004 provides valuable insights According to the survey report, there are 1,172 operating schools with a total enrolment of over 285,574 children representing 19.9 per cent gross enrolment ratio (GER). This places Somalia among the lowest enrolment rates in the world. Gender-related disparities remain an area of major concern. The survey results revealed that only slightly over one third, or 37 per cent, of pupils are girls at the lower primary school levels. Since the 2003/4 survey, there has been very little progress toward reducing the gender disparity, which increases rapidly in higher grades. Results of previous school surveys reflect the same pattern. The low enrolment and high drop-out rates of girls in most areas are due to a combination of traditional attitudes, timing of classes and economic considerations. Female teachers are under-represented, making up only about 13 per cent of the total number of all teachers. The sector suffers from severe managerial, technical and financial resource limitations, and a lack of consistency in standards.

After 15 years of conflict, the health care system remains underdeveloped, poorly resourced, inequitable and unbalanced. It struggles to provide services to a limited number of Somalis, against crushing constraints: inadequate resources and capacity, insecurity, lack of motivation and vision, uncertainty about the future political and administrative settings, and financial and operational fragmentation. The collapse of the pre-war public health system has encouraged the emergence of a variety of relief and vertical programs, run by NGOs and UN agencies. In addition, hundreds of private practitioners are operating in clinics, hospitals, pharmacies and shops, in a totally deregulated system, and in a policy and strategic vacuum. The quality of basic health services has substantially deteriorated, while access to health care is heavily conditioned by the limited ability to pay of the majority of patients.

The health infrastructure is small, concentrated in secure areas, mainly in towns, and dilapidated, because of war destructions or lack of maintenance. There are currently 144 Mother Child Health (MCHs) clinics, 23 hospitals, 26 TB centers, 14 Out-patient departments (OPDs), 35 MCH/ OPDs, 13 mobile units, 350 health posts and 43 Malaria Microscopy centers. Almost all health facilities are supported by NGOs. WHO plays a key role in providing technical support to most of the facilities. The health workforce is small, under-skilled and ageing, often engaged in dual - public and private - practice, forced to work in an insecure and demotivating environment.

Public health expenditure is low, although increasing. In aggregate terms, at USD 5 per head external financing looks modest, while private spending is not quantified, but considered to be substantial. Health information is fragmented, unreliable and under-used. Although impossible to quantify, inefficiencies seem severe and pervasive. Only a sustained, long-term and well-resourced effort can correct this somber picture.

In the absence of a functioning health surveillance system, accurate data on mortality and morbidity is difficult to obtain in Somalia. There is a consensus, however, that Somalia has some of the worst health indicators in the world, with life expectancy of 47 years, infant mortality of 132 per 1,000 live births, under-five mortality of 224 per 1,000 live births and maternal mortality of 1,600 per 100,000 live births. Vaccination rates are dismally low, with only 10.6% of all children less than one year and 27% of children less than five years fully immunized against all the childhood diseases, with considerable variations between urban, rural settled and nomadic populations71. There has been no Yellow Fever vaccination for a decade. Despite the investments made in health services by international agencies and the private sector over the past decade, there appears to be little improvement in these indicators.

Infant, child and maternal mortality rates in Somalia are among the highest in the world. Diarrhoeal disease-related dehydration, respiratory infections and malaria are the main killers of infants and young children, together accounting for more than half of all child deaths. Cholera is endemic in Somalia, with outbreaks occurring annually from December to June. The major underlying causes of diarrhea are the lack of access to safe water and poor food and domestic hygiene. In the 2000 multiple indicator cluster survey, it was found that almost 24 per cent of children under five years of age had diarrhoea in the two weeks preceding the survey.

Though data is lacking, Somalia remains among countries with the highest incidence of tuberculosis in the world. Overcrowded camps and lack of treatment facilities, unsystematic and poor quality drugs and high rates of malnutrition keep tuberculosis as one of the main killer diseases in the country. Diarrhoeal disease-related dehydration, respiratory infections and malaria are the main killers of infants and young children in Somalia, together accounting for more than half of all child deaths. Neonatal tetanus

and other birth-related problems contribute significantly to infant mortality, while measles and its complications result in widespread illness and numerous child deaths when outbreaks occur. Susceptibility to measles is compounded by poor nutritional status, and transmission is rapid in crowded living conditions such as congested urban/peri-urban areas and camps for displaced people. Immunization coverage is not yet sufficient to prevent measles outbreaks.

Reproductive health is a major problem in Somalia, with a maternal mortality rate of 1,600 per 100,000 placing Somali women among the most high-risk groups in the world. The high maternal mortality dismally reflects how years of conflict have resulted in virtually all basic facilities – such as referral hospitals, maternal and child health (MCH) facilities and services – being damaged or totally destroyed. Hemorrhage, prolonged and obstructed labour, infections and eclampsia (toxemia that may occur in late pregnancy) are the major causes of death at childbirth. Anemia and female genital mutilation (infibulation) have a direct impact on, and aggravate these conditions. Poor antenatal, delivery and postnatal care, with an almost complete lack of emergency obstetric referral care for birth complications, further contribute to these high rates of mortality and disability.

Immunization coverage, despite being generally low for all antigens is reaching an increased number of children and mothers through the Expanded Program on Immunization (EPI). There has been a steady drop in polio cases since 2000, when an outbreak of 46 cases was reported. By 2002, circulation of the virus had reduced so that only three cases in and around Mogadishu were reported. No wild virus cases have been reported so far in 2003.

Malnutrition is a chronic problem in all areas of Somalia and appears in acute form in areas of drought, flood or localized conflict. Poor availability and accessibility of food (primarily due to successive drought and conflict), quality of diet, infant feeding practices and inadequate home management practice (keeping food in safe, sterile conditions, the proper storage of water, etc.) contribute to the poor nutritional status of children. Considerable variations exist between different areas and population groups, with the central and southern areas being the worst affected. Micronutrient deficiencies including iron-deficiency anemia, vitamin A deficiency and iodine deficiency are serious health issues facing the population. Anemia is suspected to be high among women and adolescents, and iodine deficiency is a public health concern as access to iodized salt is extremely low. In addition, sub-clinical vitamin A deficiency is most likely a contributing factor in morbidity (frequent sicknesses within families and disease) and mortality (death).

HIV/AIDS prevalence in Somalia is regarded as low despite the high prevalence of HIV/AIDS in the surrounding countries of Djibouti, Ethiopia and Kenya. Somalia has a high prevalence of Sexually Transmitted Infections (STIs) and low awareness on HIV transmission. Combined with high levels of stigma and discrimination, these factors could quickly evolve into a serious problem unless there is rapid and adequate support for carefully designed HIV/AIDS prevention and control across Somalia. Recent studies suggest violence, abuse, exploitation and discrimination against children continue on a wide scale. Low education levels, poor access to safe water and sanitation, and inadequate health and nutrition services demonstrate a prevailing lack of human rights accountability within Somalia, for which children remain the foremost victims.

Access to safe water is a significant problem in Somalia, aggravated by the destruction and looting of water supply installations during the civil war, the continuing conflict, and a general lack of maintenance. This situation is compounded by erratic rainfall

patterns that produce both drought and flooding. It is estimated that 65 per cent of the population does not have reliable access to safe water throughout the year. Less than 50 per cent of Somalis live in households with sanitary means of disposing excreta. Lack of clean water significantly contributes to the high rates of illness and death in Somalia.

The impact of poor environmental sanitation is particularly felt in the cities, towns and large villages, or other places where people live in close proximity to each other. Defecation is generally close to dwellings and water resources and lack of garbage collection and the proliferation of plastic bags affect the urban environment and water sources. Poor hygiene and environmental sanitation are major causes of diseases such as cholera among children and women. Cholera is endemic and claims hundreds of lives annually, particularly in densely populated areas. Access to clean water is essential for prevention of diarrhoea diseases and cholera.

Before the collapse of its state in early 1991, Somalia had a public health system – though rudimentary but reasonable by African standards – which had painstakingly been built over the previous 30 years by both civilian and military administrations. With the onslaught of the devastating civil war, the modest health infrastructure of the country was destroyed or seriously damaged; most of its premises were looted, vandalized or taken over by poor squatters, internally displaced people and at times armed tribal militias. There is a functional the Ministry of Health in Puntland which has a policy and strategy framework. However, resources available to the Ministry are limited and its role has been primarily to coordinate the activities of international agencies and NGOs as well as local NGOs who support health services and responsibilities that were previously handled by the Ministry of Health during the pre-war period.

The Somali private health sector has grown considerably in the absence of an effective public sector. The private provision of health services is unregulated and, as such, can be a risk rather than a solution to health problems. In 1997, it was estimated that 90% of all curative care was being provided by the private sector, with up to 75% of the population in some areas utilizing private health facilities. This trend is encouraged by declining external finances, a lack of resources or commitment by administrations to support a public health service, and a lack of qualified personnel.

With the absence of a national political entity agreed upon by all representatives of the Somali population, and the fragility of existing governance structures, Somalia has none of the detailed government policies, nor a National Development Plan or a poverty reduction strategy. However, each of the three political entities (TG, local administrations of Somaliland and Puntland) has its own agendas and plans regarding the future of the country or for the part they control. By and large, most of these plans focus on the very local level and mostly on the large cities and are prepared solely by the administrations. In the absence of unified and credible national counterparts, the international community has developed its own mechanisms not only for ensuring coordination of aid interventions through the Somalia Aid Coordination Body (SACB – created in 1994), but also, in the conduct of consultation between donors and implementing partners on the one hand, and local administrations and communities on the other, for developing comprehensive sector strategies focusing on the role of the community, the level of ownership, and the need for long-term sustainability.

Financial, as well as human, resources are inadequate, and Somalia depends almost entirely on external sources for health financing. The Somaliland and Puntland administrations currently allocate some public money to the health sector. In 2000,

however, this amounted to as little as 2.9% and 2.5% respectively of Somaliland's and Puntland's recurrent budgets, and was mostly allocated to salaries. Elsewhere, these services are heavily subsidized by communities, international aid agencies or Islamic foundations.

After the onslaught of the devastating civil war in 1991, the severest blow to country's health system was the departure of the overwhelming majority of the limited number of qualified doctors, nurses, technicians and other medical professionals either for lack of security, work facilities or to find better opportunities abroad. With an estimated 0.4 qualified doctors and 2.0 qualified nurses per 100,000 people, there is a chronic lack of qualified health professionals. Most qualified professionals have migrated overseas and those that remain work in the urban centers. With no newly qualified young people coming in to replace them, the health system will face a major crisis in the next ten years.

Most of Somalia's public health facilities have fallen into disrepair since the collapse of the state in 1991. Today, nearly all remaining Somali doctors live in urban areas. For over a decade, there has been no formal training of health staff, although some international partners have provided technical refresher courses. While there is widespread agreement that the rehabilitation and development of district health systems, strong community participation and enhanced referral facilities are desperately needed to improve services to rural areas, major shortcomings persist in funding, management, training and expertise. The need for regulation in this sector and for building the managerial capacity of emerging health authorities remains a huge challenge for Somalia. Furthermore, due to the conflicts, it is widely perceived that no governmental or institutional infrastructure exists in the country capable of supporting the development of expansion of primary health care.

Essential drugs program in Somalia ceased with the collapse of central government and the infrastructure of the Ministry of Health in 1991. Access to essential drugs, particularly through public health services, is low and variable depending on the local presence of donor supported programs. Lack of access to essential drugs of good quality is making a large number of Somali people compromise their health and lives.

2 SOCIO ECONOMIC GEOPOLITICAL MAPPING

2.1 Socio-cultural Factors

Table 2-1 Socio-cultural indicators

Indicators	1990	1995	2000	2002	2003
Human Development Index:**	0.200	0.246	-	0.284	-
Literacy Total:	-	24*	35.4	37.8*	-
Female Literacy:	-	-	25.8	-	-
Women % of Workforce*	39**	43	43	-	43.4
Primary School enrollment**	18	11.5	-	13.6	-
% Female Primary school pupils	-	-	-	-	-
% Urban Population	23.5(87)	25 (97)	-	-	35

Source: http://www.emro.who.int/somalia/countryprofile.htm#demographic
UNDP Human development report 2000, 2002, 2003, CIA fact book 2005
*http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/AFRICAEXT/SOMALIAEXTN/0,,menuPK:367691~pagePK:141132~piPK:141109~theSitePK:367665,00.html
Human development report 2001
**Somalia Human development report 2001

Aggregate human development indicators for Somalia disguise significant economic disparities. Levels of human development are generally higher in Somaliland and Puntland than in much of southern and central Somalia, with better food security, an absence of armed conflict and higher household income. Urban populations generally fare better than rural ones, due to the higher concentration of social services in urban centers. Families with access to overseas remittances enjoy privileged access to social services and have better food security than households without.

Somalia has seen a steady decline in the standard and provision of formal education services. The effects of such deterioration are manifested in one of the worst adult literacy rates in the world: 36% of men over 15, and 14% of women. Between 1980 and 1999, the number of primary schools in Somalia plummeted from 1,407 to 651, the number of primary pupils from 271,000 to 148,000. In the past few years, there has been a limited recovery with various local and international efforts resulting in new educational institutions and initiatives. In the North, local communities and administrations are collaborating with donors in the rehabilitation of primary education while ten secondary schools have also been reopened. However, the estimated 1998/99 primary enrolment ratio of 9% for boys and 6% for girls indicates the scale of the challenges ahead. Adult education and training are also seeing renewed expansion, with more primary schools being used for adult education and youth activities. One recent study found 39% of urban youths, aged 14-18, enrolling in some kind of vocational or private training (primarily in English, secretarial and technical skills).

Somalia today is a country where schooling is available to very few children. A child of primary school age has only about a one in five chance of attending school. As a result of the collapse of the central government in 1991 and the ensuing long years of conflict

schools were destroyed, looted and abandoned. Only now is rehabilitation of the damaged buildings beginning to take place and currently there are only 1,192 schools operational in the country, the majority concentrated around and in urban areas. Most schools are financed from fees or other forms of support from parents and communities; with some input from external agencies. The total enrolment figure is some 286,808 students, placing Somalia firmly among the countries with the lowest enrolment rates in the world.

For a girl child in Somalia the prospects of attending school are even poorer: the Survey of Primary Schools in Somalia for 2002-2003 showed that only slightly over one third, or 36 per cent, of pupils are girls at the lower primary school levels. Since the 2002/3 survey, there has been very little progress toward reducing the gender disparity, which increases rapidly in higher grades. Results of previous school surveys reflect the same pattern. The low enrolment and high drop-out rates of girls in most areas are due to a combination of traditional attitudes, timing of classes and economic considerations.

There have been modest gains in education, with enrolment in primary schools reaching levels similar to those pre-war, and numbers of secondary schools increasing since 1998. However, with overall adult literacy of only 17.1% and a gross primary school enrolment of 13.6%, levels of educational attainment remain amongst the lowest in the world.

Many children and youth have suffered displacement and have observed, experienced and sometimes participated in violence. A majority have never experienced normal, stable social relationships and systems of governance. Since the deterioration of the educational system during the conflict period many youth in the teenage age range have never been to school, and are illiterate or only semi-literate. Lack of optimism about the possibilities the future holds for them is common among this group. There are growing categories of vulnerable children who are in need of special care and protection including:

- Those who have been displaced within the country, such as people driven from their homes by conflict, drought, floods, or other factors;
- Children from minority groups, the very poor, orphans, disabled children, working children;
- Children living on the streets, militia children and children in conflict with the law. vii

2.2 Economy

Overview: One of the world's poorest and least developed countries, Somalia has few resources. Moreover, much of the economy has been devastated by the civil war. Agriculture is the most important sector, with livestock accounting for about 40% of GDP and about 65% of export earnings. Nomads and seminomads, who are dependent upon livestock for their livelihood, make up a large portion of the population. Crop production generates only 10% of GDP and employs about 20% of the work force. The main export crop is bananas; sugar, sorghum, and corn are grown for the domestic market. The small industrial sector is based on the processing of agricultural products and accounts for less than 10% of GDP; most facilities have been shut down because of the civil strife. The greatly increased political turmoil of 1991-93 resulted in a substantial drop in agricultural output, with widespread famine. In 1994 economic

conditions stabilized in the countryside, followed in 1995 by slight improvements. However, ongoing civil strife in Mogadishu and outlying areas is interfering with any substantial recovery[i].

Somalia has a market economy. It has long been one of the world's poorest and least developed countries and has relatively few natural resources. Somalia's poverty was even further aggravated by the hostilities of the civil war started in 1991. Agriculture is the most important sector, with livestock accounting for about 40% of GDP and about 65% of export earnings. Nomads and semi-nomads, who are dependent upon livestock for their livelihood, make up a large portion of the population. After livestock, bananas are the principal export; sugar, sorghum, maize, and fish are products for the domestic market. The small industrial sector, based on the processing of agricultural products, accounts for 10% of GDP. Somalia continues to have one of the highest child mortality rates in the world, with 10% of children dying at birth and 25% of those surviving birth dying before age five. Medecins Sans Frontieres has further stated that the level of daily violence due to the lack of legitimate security structures is "catastrophic."

Infrastructure, such as roads are as numerous as those in neighboring countries but of much lower quality. A World Bank report states that the private sector has found it too hard to build roads due to high transaction costs and the fact that those who pay road fees are not the only ones using the road (see free rider problem), presenting a problem with recuperation of investment. The telecommunications is private, offering wireless service and internet cafés. Competing phone companies have agreed on interconnection standards, which were brokered by the United Nations funded Somali Telecom Association. Electricity is furnished by entrepreneurs, who have purchased generators and divided cities into manageable sectors. In 1989, before the collapse of the government, the national airline had only one airplane. Now there are approximately 15 airlines, over 60 aircraft, 6 international destinations, and more domestic routes. The private sector also supplies drinking water. However, a statistic from 2000 indicated that only 21% of the population had access to safe drinking water at that time.

With the collapse of the central government, the education system is now private. A World Bank study reports "modest gains in education." As last measured in 2001, primary school enrollment, which stood at 17%, was nearly at pre-war levels, and secondary school enrollment had been increasing since 1998. However, "adult literacy is estimated to have declined from the already low level of 24% in 1989 to 17.1% in 2001." A more recent 2003 study reported that the literacy rate had risen to 19%. In comparison, literacy is at 49% in wealthier West Africa and 35% among its neighbors. Higher education ended completely in the civil war of 1991, but Mogadishu University reopened in 1998 and its first class graduated in 2001. Other universities have opened in other cities. In addition to customer fees, much of the funding for the education system comes from international Islamic charities such as Al-Islah.

The main problem affecting economic growth is the lack of stability. An example of this is that in Mogadishu, some businessmen would prefer to pay taxes to a government to maintain security rather than to pay warlords for protection from bandits. Remittance services have become a large industry in Somalia. Successful people from the world-wide diaspora who fled because of the war contribute to the economy around $2 billion annually. Wireless communications has also become a giant economic force in Somalia. Because of the war, nobody really knows the size of the economy or how much it is growing.[ii]

GDP (purchasing power parity):	$4.825 billion (2005 est.)
GDP - real growth rate:	2.4% (2005 est.)
GDP - per capita:	Purchasing power parity - $600 (2005 est.)
GDP - composition by sector:	*Agriculture:* 65% *industry:* 10% *services:* 25% (2000 est.)
Labor force:	3.7 million (very few are skilled laborers)
Labor force - by occupation:	agriculture (mostly pastoral nomadism) 71%, industry and services 29%
Agriculture - products:	cattle, sheep, goats; bananas, sorghum, corn, coconuts, rice, sugarcane, mangoes, sesame seeds, beans; fish
Industries:	a few light industries, including sugar refining, textiles, wireless communication
Debt - external:	$3 billion (2001 est.)
Economic aid - recipient:	$60 million (1999 est.) iii

Table 2-2 Economic Indicators

Indicators	1990	1995	2000	2003
GNI per Capita (US$)*	380	360	290	320
GNI per capita(PPP) Current International	-	-	-	-
GDP per Capita: constant 95$	-	-	-	600
GDP annual growth %	-2.2**	-	-	-
Unemployment %	-	-	-	-
External Debt	-	-	$3 B (01)	-

Source: *World Development Indicators database, April 2004
**UNDP Human development report 1991

Table 2-3 Major Imports and Exports

Major Exports:	Livestock, bananas, hides, fish, charcoal, scrap metal
Major Imports	Manufactures, petroleum products, foodstuffs, construction materials, qat

Source: http://en.wikipedia.org/wiki/Somalia

Key economic trends, policies and reforms

Somalia's economic fortunes are driven by its deep political divisions. The northwestern area has declared its independence as the "Republic of Somaliland"; the northeastern region of Puntland is a semi-autonomous state; and the remaining southern portion is

riddled with the struggles of rival factions. Economic life continues, in part because much activity is local and relatively easily protected. Agriculture is the most important sector, with livestock normally accounting for about 40% of GDP and about 65% of export earnings, but Saudi Arabia's recent ban on Somali livestock, because of Rift Valley Fever concerns, has severely hampered the sector. Nomads and semi-nomads, who are dependent upon livestock for their livelihood, make up a large portion of the population. Livestock, hides, fish, charcoal, and bananas are Somalia's principal exports, while sugar, sorghum, corn, qat, and machined goods are the principal imports. Somalia's small industrial sector, based on the processing of agricultural products, has largely been looted and sold as scrap metal. Despite the seeming anarchy, Somalia's service sector has managed to survive and grow. Telecommunication firms provide wireless services in most major cities and offer the lowest international call rates on the continent. In the absence of a formal banking sector, money exchange services have sprouted throughout the country, handling between $500 million and $1 billion in remittances annually. Mogadishu's main market offers a variety of goods from food to the newest electronic gadgets. Hotels continue to operate, and militias provide security. The ongoing civil disturbances and clan rivalries, however, have interfered with any broad-based economic development and international aid arrangements. In 2004 and 2005 Somalia's overdue financial obligations to the IMF continued to grow. Statistics on Somalia's GDP, growth, per capita income, and inflation should be viewed skeptically. In late December 2004, a major tsunami took an estimated 150 lives and caused destruction of prosperity in coastal areas. [iii]

Although Somalia was without a single central government throughout the 1990s, politics, economics and development did not stand still. The early 1990s were a period of state fragmentation and a localization of political authority in which varied structures of governance and authority emerged at community, district, and regional levels to fill the vacuum of central government. Since 1998, the process of state fragmentation and factional politics that characterized the early 1990s has given way to a process of consolidation and an evolution of broader political alliances based on more institutionalized and less violent forms of authority.

Polities have been established since 1991 in the northwest ‘Republic of Somaliland’ and since 1998 in the northeast ‘Puntland State of Somalia’, with public administrations that fulfill some basic functions of government1. Since 1999, the Rahanweyn Resistance Army (RRA) has begun to establish an administration in the two southern regions of Bay and Bakol that have been chronically insecure for most of the past decade. The most significant political development since 2000 has been the establishment of a ‘Transitional National Government’ (TNG), based in Mogadishu. The product of a lengthy national peace process, the TNG holds the potential for resolving the protracted conflict that has plagued southern Somalia for over a decade. The TNG’s acceptance in the UN General Assembly, the Arab League, and the former Organization of African Unity has given Somalia formal representation in these international bodies for the first time in a decade.

The political and economic decentralization that has taken place in Somalia over the last decade is unlikely to be totally reversed and the political entities are still fragile and evolving. Nevertheless, there are economic and social forces in Somalia that appear to demand greater regulation and order. The development of governmental forms of political authority in regional administrations and the growth of urban centres such as Hargeisa, Garowe, Bosasso, and Baidoa, point to a process of consolidation. Coupled with a decrease in humanitarian needs since 1999, due to improved security conditions

and a respite from climatic stress, these trends herald the potential for a period of positive change in Somalia. [iv]

Somalia lacks natural resources and faces major development challenges, and recent economic reverses have left its people increasingly dependent on remittances from abroad. Its economy is pastoral and agricultural, with livestock--principally camels, cattle, sheep, and goats--representing the main form of wealth. Livestock exports in recent years have been severely reduced by periodic bans, ostensibly for concerns of animal health, by Arabian Peninsula states. Drought has also impaired agricultural and livestock production. Because rainfall is scanty and irregular, farming generally is limited to certain coastal districts, areas near Hargeisa, and the Juba and Shabelle River valleys. The agricultural sector of the economy consists mainly of banana plantations located in the south, which has used modern irrigation systems and up-to-date farm machinery.

A small fishing industry has begun in the north where tuna, shark, and other warm-water fish are caught, although fishing production is seriously affected by poaching and the lack of ability to grant concessions because of the absence of a functioning central government. Aromatic woods--frankincense and myrrh--from a small and diminishing forest also contribute to the country's exports. Minerals, including uranium and likely deposits of petroleum and natural gas, are found throughout the country, but have not been exploited commercially. Petroleum exploration efforts, at one time under way, have ceased due to insecurity and instability. Illegal production in the south of charcoal for export has led to widespread deforestation. With the help of foreign aid, small industries such as textiles, handicrafts, meat processing, and printing are being established. The absence of central government authority, as well as profiteering from counterfeiting, has rapidly debased Somalia’s currency. By the spring of 2002, the Somali shilling had fallen to over 30,000 shillings to the U.S. dollar. The self-declared Republic of Somaliland issues its own currency, the Somaliland shilling, which is not accepted outside of the self-declared republic.

There are no railways in Somalia; internal transportation is by truck and bus. The national road system nominally comprises 22,100 kilometers of roads that include about 2,600 kilometers of all-weather roads, although most roads have received little maintenance for years and have seriously deteriorated. Air transportation is provided by small air charter firms and craft used by drug smugglers. A number of airlines operate from Hargeisa. Some private airlines serve several domestic locations as well as Djibouti and the United Arab Emirates. The UN and other NGOs operate air service for their missions.

Remittances have long been a critical part of Somalia’s economy. Currently, with very low levels of agricultural production and manufacturing, remittances from the large Somali diaspora enable the country to run a balance of trade deficit and to enjoy higher levels of food security and access to private social services than would otherwise be the case. Future trends in remittances will be a key factor in sustaining human development.

Privatization is shaping human development in Somalia. The protracted collapse of the central government and low levels of international rehabilitation and development assistance means that Somali households must procure their social welfare needs from the private sector. In some places, the private sector has responded reasonably well. Elsewhere, market failures have left welfare needs unmet and the introduction of user fees for health or educational services invariably excludes the poorest.

The economy has been in recession since the outbreak of the civil war, with large mounts of capital, labor and agricultural land unutilized. In some sectors, however, there have been modest levels of growth. A demand in the Arabian Peninsula for dried limes and sesame, for example, are generating new opportunities for smallholder export crops in southern Somalia, partially offsetting the collapse of banana exports. In Hargeisa, Mogadishu, and Bosasso, investments in light manufacturing have expanded, indicating local investor confidence in the economy and local security.

The service sector is the most dynamic part of the economy. Money transfer companies and telecommunication companies have expanded throughout Somalia and increased the range of financial services, facilitating the flow of remittances from the diaspora and commercial transactions. These companies, which did not exist a decade ago, are amongst the most powerful businesses in Somalia today. Likewise, the transportation sector continues to expand, with several Somali-owned airlines operating international services. Private education and health care services, hotels and restaurants, and utility companies such as electricity and water, are also providing new income generating and employment opportunities. Progress in the service sector is hindered, however, by the lack of regulation and the incompatibility of some utilities such as telecommunications. Commerce has expanded in recent years. Despite the embargo on livestock exports by Gulf States, domestic demand, funded largely by remittances, provides a modest market for foodstuffs, fuel, clothing, and other basic commodities. The main growth in commercial activity has been in the transit trade, with Somalia acting as an entrepõt for goods traveling to markets in the Horn and East Africa. The Berbera corridor handles increasing amounts of container cargo destined for Ethiopia, while in the south a robust transit trade moves consumer goods from Mogadishu's beach ports into Kenya. The absence of credible banking services that can provide a letter of credit remains a severe constraint to trade.

The lack of an accountable and responsible authority to execute monetary policy is a threat to economic development and livelihoods. In 2000 and 2001, the import of counterfeit Somali shillings by Somali businessmen triggered hyperinflation. This has severely reduced the purchasing power of the poor, while wealthier Somalis, who operate mainly in a dollarised economy, have been less affected. There is a stark contrast between northern and southern parts of Somalia in the state of the infrastructure. In Puntland and Somaliland investment in road and port rehabilitation has been possible, facilitating the flow of commerce. By contrast, the road, seaport, and airport infrastructure of the south is in a state of rapid deterioration, adding to the costs of transport and merchandise.

Key Economic Trends

- Long-term recession
- Privatization of economic and social services and formally public goods
- Economic differentiation between regions, between urban and rural areas, and between and within social groups
- Declining terms of trade in the primary industries of livestock and agriculture
- Increasing levels of interstate, transborder and transhipment trade and a growing role as an entrepôt economy
- Heavy reliance on Diaspora remittances
- Growth in the service sector

2.3 Geography and Climate

Somalia is located on the east coast of Africa on and north of the Equator between the Gulf of Aden on the north and Indian Ocean on the east. Together with Ethiopia and Djibouti it is often referred to as the Horn of Africa. It borders Djibouti on the northwest, Ethiopia on the west, and Kenya on southwest. Somalia comprises Italy's former Trust Territory of Somalia and the former British Protectorate of Somaliland (now seeking recognition as an independent state). The coastline extends 2,720 kilometers-- the longest coastline in Africa. The northern part of the country is hilly, and in many places the altitude ranges between 900 and 2,100 metres (3,000 ft.-7,000 ft.) above sea level. The central and southern areas are flat, with an average altitude of less than 180 metres (600 ft.). The Juba and the Shebelle Rivers rise in Ethiopia and flow south across the country towards the Indian Ocean. The Shebelle, however, does not reach the sea except during seasons of high rain. Major climatic factors are a year-round hot climate, seasonal monsoon winds, and irregular rainfall with recurring droughts. Mean daily maximum temperatures range from 30°C to 40°C (85° F-105°F), except at higher elevations and along the east coast. Mean daily minimums usually vary from about 15°C to 30°C (60°F-85°F). The southwest monsoon, a sea breeze, makes the period from about May to October the mildest season at Mogadishu. The December-February period of the northeast monsoon is also relatively mild, although prevailing climatic conditions in Mogadishu are rarely pleasant. The "tangambili" periods that intervene between the two monsoons (October-November and March-May) are hot and humid.[v]

Map of Somalia

2.4 Political/ Administrative Structure

The independence of Somaliland from Britain was proclaimed on June 26, 1960, and on July 1, 1960, unification of the British and ex-Italian Somali protectorates took place. The government formed with Abdullahi Isse, Aden Abdullah Osman Daar was appointed President and Abdirashid Ali Shermarke as Prime Minister. Later, during 1967, Mohammed Ibrahim Egal became Prime Minister in Aden Abdullahi Osman (nicknamed Aden Adde)'s government. Egal was later chosen as President of a self-declared Somaliland. He died in a hospital in Pretoria on May 3, 2002.

In late 1969, a military government assumed power following the assassination of Shermarke, who had been chosen, and served as, President from 1967–1969. Mohamed Siad Barre, a General in the armed forces who was an ally of and helped protect Aden Abullahi Osman's government, became the President in 1969 following a coup d'état. The revolutionary army leaders, headed by Barre, established large-scale public works programs. They also successfully implemented an urban and rural literacy campaign, in which they helped to dramatically increase the literacy rate from a mere 5% to 55% by the mid-1980s.

Intermittent civil war has been a fact of life in Somalia since 1977. In 1991, insurgent forces led by Mohammed Farah Aidid, leader of the United Somali Congress (USC), ousted Siad Barre's government. Somalia has had no effective national government since 1991. In the northwest, there is the breakaway republic of Somaliland. In the rest of the country there are various warlords, cf. Puntland and Southwestern Somalia. In 2000, the international community recognized the Transitional National Government, originally headed by Abdulkassim Salat Hassan, as the government for the entire country. Currently however it controls only part of the capital, Mogadishu.

On October 14, 2004 Somali MPs elected warlord Abdullahi Yusuf, previously president of Puntland, to be the next president. Because of the chaotic situation in Mogadishu, the election was held in a sports centre in Nairobi, Kenya. Yusuf was elected transitional President by Somalia's transitional parliament. He won 189 of the 275 votes from members of parliament. The session of Parliament was also held in neighboring Kenya. His government is recognized by most western nations as the country's legitimate rulers, though his actual authority is extremely questionable. Many other small political organizations exist, some clan-based, others seeking a Somalia free from clan-based politics (such as the United Somali Front). Many of them have come into existence since the new president was chosen. v

Although the interim government was created in 2004 other governing bodies continue to exist and control various cities and regions of the country, including the self-declared Republic of Somaliland, and traditional clan and faction strongholds.

Administrative divisions (As of the official demarcation of 1986): 18 regions (gobolka); Awdal, Bakool, Banadir, Bari, Bay, Galgaduud, Gedo, Hiiraan, Jubbada Dhexe (Middle Juba), Jubbada Hoose (Lower Juba), Mudug, Nugaal, Sanaag, Shabeellaha Dhexe (Middle Shabelle), Shabeellaha Hoose (Lower Shabelle), Sool, Togdheer, Woqooyi Galbeed.

Independence: British Somaliland Protectorate gained independence on 26 June 1960 – 'United Nations Trusteeship of Southern Somalia' (administered by Italy) gained independence on 1 July 1960. Both territories united to form the Somali Republic.

Constitution: 25 August 1979, presidential approval 23 September 1979. i

3 HEALTH STATUS AND DEMOGRAPHICS

Somalia – one of the harshest places on the planet, an extreme environment that presents huge challenges to its people just in terms of simple survival. The combination of a hostile, predominantly arid environment, difficult terrain with settlements scattered over vast distances, the legacy of a nomadic way of life and a civil conflict that has shattered social structures and exacerbated poverty add up to mean that a Somali child's chances of surviving to adulthood are among the lowest of children anywhere in the world. Add to this the fact that the odds of the child's mother dying during pregnancy or in childbirth are also extremely high. These high death rates stem from the interaction of a number of causes set within a complex socio-political context, but are largely attributable to disease, dehydration, malnutrition, lack of safe water, and poor sanitation.

The 2000, UNDP's Human Development Report ranked Somalia lowest in all health indicators except life expectancy. In the latest HDR the country is not even ranked, due to the lack of reliable data. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2005). Extreme poverty in Somalia is estimated to be 43% with large disparities noted between the urban population at 23% and the rural and nomadic populations at 53% (UNICEF, 2001). The MDG health-related indicators in Somalia are among the very worst of the world. The infant mortality rate was estimated at 132 per 1,000 live births in 1999, with the rate of under-five mortality at 224. Maternal mortality was estimated as high as 1,600 per 100,000 live births in 1999 (WB, 2005). Achieving the MDG 5 target -i.e. reducing the 1990 rate by three quarters- would imply to lower the rate to 400/100,000 by 2015, which seems very unlikely when one takes into account the available human resources, the emergency obstetric care (EOC) infrastructure and the services and the range of interventions that would be required to obtain such a dramatic improvement. The most recent survey (UNDP 2004) confirms that 80% of deliveries occur at home in all regions of Somalia. According to a survey of nine regions conducted by UNDP, only 28% of deliveries were attended by qualified personnel. Life-time risk for maternal death has been estimated in 1 in 10 women (WHO, 2005). Other estimates, however, returned lower figures. The proportion of under-five children who are underweight is 26%. The immunization coverage (1 year-old children fully immunized) was only 36% in 2000. Measles is reckoned to be responsible for most deaths resulting from vaccine-preventable diseases in children under-5 years (WHO, 2005).

The epidemiological profile of the country is characterized by common communicable diseases, which could be controlled with simple and relatively cheap measures. Malnutrition, another important cause of mortality, especially among children, is discussed in a separate chapter of the cluster report. Malaria is a major health problem, affecting all strata of the population and representing the leading cause of death in under-five children. The burden of malaria is highest along the rivers and settlements with artificial water reservoirs where there is all year round transmission. TB is one of the leading causes of morbidity and mortality especially among adult men. Somalia has one of the highest incidence rates estimated in the world -372 per 100,000 population- with 1 in every 270 people infected and an average of 25,000 expected cases every year. Overall, there has been an increase in the number of TB cases detected. Malnutrition is also common among TB patients and the HIV/AIDS co-infection is expected to increase. Since 1994 cholera has shown an endemicity trend with seasonal

outbreaks coinciding with the dry season especially in the Central and Southern zones. Outbreaks of acute cholera have continued to occur in various parts of the country since 1994. Leishmaniasis is an old disease with outbreaks reported in 1930 in Jowhar in the Middle Shabelle, and in Darbuluk in the North-West Region in 1950. The most recent detected outbreak occurred in 2000 in the southern Somalia, Bakool, Gedo and Bay regions. Potential vector breeding sites are numerous and scattered in Central and Southern zones of Somalia[vi].

While Somalia is one of the most sparsely populated countries in the world (seven persons/square mile), with a relatively small population, war, clan politics and nature's vagaries have led to a large, and continually expanding, population of internally displaced persons (IDPs). This 'push' factor is leading to rapid urbanization, with most cities and towns having a number of IDP settlements. With high levels of unemployment, women have entered the workforce at the bottom end of the informal labor market and there are a large number of women headed households. Diarrhoeal disease-related dehydration, respiratory infections and malaria are the main killers of infants and young children, together accounting for more than half of all child deaths. Cholera is endemic in Somalia, with the threat of outbreaks recurring annually during the "season" from December to May, when in many crowded communities the pre-conditions are set as a result of critical water shortage. The major underlying causes of diarrhoea are the lack of access to safe water, and poor food and domestic hygiene. In a survey carried out in 2000, it was found that almost a quarter of children aged under five years had diarrhoea in the two weeks preceding the survey—a very high rate. Malnutrition is a chronic problem in all areas, and becomes acute when areas are struck by drought or flood, or where localized conflict flares up, scattering populations. A persistent shortage of food (mainly due to successive droughts and conflicts), low quality diet, poor feeding practices and inadequate home management practices contribute to many children being inadequately nourished. Neonatal tetanus and other birth-related problems are a further cause of many infant deaths, while measles and its complications result in widespread illness. Immunization coverage is not yet sufficient to prevent measles outbreaks. Susceptibility to measles is compounded by poor nutrition and transmission is rapid where living conditions are crowded, resulting in a high death rate.[vii]

3.1 Health Status Indicators

Table 3-1 Indicators of Health status

Indicators	1995	2000	2002	2003
Life Expectancy at Birth:***	44 (99)	46.2	46.9	47.3
HALE:	-	-	36.8	-
Infant Mortality Rate:	152 (90)	132**	122***	113*
Probability of dying before 5th birthday/1000:	225***	224**	225***	187*
Maternal Mortality Rate	-	1100"	-	1600
Percent Normal birth weight babies:+	84	0.3	-	-
Prevalence of low-weight for age	-	15.8**	-	26

Source: World health report 2005
*'World Population Prospects: The 2004 Revision', New York, United Nations, 2005
** http://www.emro.who.int/somalia/countryprofile
*** CIA World Factbook 2000, UNDP Human Development Report 2001, UNDP Human Development Report 2002, UNDP Human Development
" Maternal mortality in 2000, Estimates developed by WHO, UNICEF, UNFPA
+Somalia Human development report 2001
UNICEF http://www.unicef.org/infobycountry/somalia_statistics.html

Health indicators suggest there has been no improvement in the health of the population over the past three years. Indeed, indicators show a slight increase in levels of infant and under-five mortality and pockets of chronic malnutrition persist in southern Somalia. Health facilities are concentrated in urban centers so that rural populations have limited access to health services. There are very few newly qualified medical personnel taking up work. Drug importation is unregulated with the consequence that the privatized health services are supplied with expired and poor quality medical drugs.

Table 3-2 Indicators of Health status by Gender and by urban rural - 2003

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	43	45
HALE:	-	-	36.1	37.5
Infant Mortality Rate*: (99)	129	144	134	130
Probability of dying before 5th birthday/1000:	218	244	222	228
Maternal Mortality Rate:	-	-		
Percent Normal birth weight babies:	-	-	-	-
Prevalence of low-weight for age	-	-	-	-

Source: World health report 2005
*Somalia Human development report 2001

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality	Morbidity
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Rank	Mortality	Morbidity
10.		

Source:

Table: Key Indicators for Somalia based on Multiple Indicator Cluster Survey (MICS) 2000, UNICEF

Indicator	Somalia		Central and Southern zone	North East zone	North West zone
Infant mortality rate	132		137	133	113
Under-five mortality rate	224		231	225	188
Percentage of the population with access to safe drinking water	23.1		17.8	25.9	31.3
Percentage of the population with access to safe sanitation	48.5		50.8	41.5	47.4
Percentage of under-five children with acute global malnutrition	17.2		21.2	14.8	10.1
Gross enrolment ratio for primary school age children (Primary School Survey 2001/2)	17				
Percentage of children aged 12-23 months currently vaccinated against childhood diseases	BCG	69.3			
	DPT3	32.6			
	OPV3	36.9			
	Measles	15.6			
	All	10.6			

A baseline KABP survey on Reproductive Health and Family Planning in Somaliland and Puntland was carried out by WHO Somalia in October 1999. The main findings include:

- Fertility rate of around 7.9
- NMR, IMR and CMR, which are estimated to be 28,113 and 328 respectively.
- FGM Prevalence of 99%
- 18% of married underage (<18) girls

Several studies showed that Maternal Mortality Rate (MMR) is exceptionally as high as 1600/100 000. The high Maternal Mortality ratio is primarily related to limited access of pregnant women to trained midwives and non-availability or limited accessibility of referral services. The midwifery profession was one among those professions that has suffered the biggest attrition in terms of number. Many of them have left the country after the civil war and those who were left behind are getting old, thus the number of midwives decreased dramatically in Somalia.

Certain underlying causes of this high MMR are:

- Post FGM related complications

- In adequate maternal health services
- Unskilled birth attendants
- Low level of education
- Malnutrition with anaemia during pregnancy
- Poor and delayed referral system.

Ten women between the ages of 15-45 die every day in Somalia (including Somaliland) as a result of pregnancy related complications, so in every year up to 110 000 pregnancies result in severe complications, illnesses or permanent disability of the mother and Child. Over ¼ of all under-five deaths occur in the first week of life due to complications during pregnancy and/or delivery. So to reduce neonatal deaths it is an utmost importance to reduce maternal complications in its various forms.

Major health problems documented in the literature review

a. Sexually transmitted diseases including *HIV/AIDS*.

It has been claimed that the prevalence of HIV/AIDS in the country is relatively low <1% *(UNICEF, 1999)* While among study TB cases the Prevalence of HIV/AIDS was up to 8.8% in Some regions(WHO, 2000). The prevalence of other sexually transmitted disease was as high as 30% *(Gillian Duffy, 1999)*. There is a danger of deterioration of the situation of HIV/AIDS in the country and this high prevalence of STIs can be a good indicator of this possible threat, in addition to the neighboring countries in which the disease is hyper-endemic. The widespread practices of harmful traditional surgical operations, which are usually performed during the childhood, are increasing the danger of HIV/AIDS in the country, since un-sterilized sharpened materials are used in all these operations. The knowledge and awareness of STIs among 975 youth interviewed in a study was very poor; most of them even refused to respond the questions on the topic *(UNICEF/MOHL, 1999)*.

b. Neonatal mortality rate (NMR), Infant mortality rate (IMR) and Child Mortality rates (CMR)

It is not possible to list all possible contributors of the children's mortality and morbidity, following health problems affecting children highlighted:

- **Immunization coverage against the six childhood illnesses is very low** through out the country, and estimated to be less than 20% (*Unicef, May 1998*). Apparently the lowest immunization coverage is found in the Nomadic settlements, followed by Rural and Urban. Only 9.3% of children had immunization cards (*Unicef Somalia 2001)* but it is found that 69% of children aged 12-23 months received BCG vaccination, whereas only 35% of children had 3rd dose of DPT. Recurrent outbreaks of measles in almost all the regions of the country is a good indicator of low immunization coverage, and the situation is more severe in the Nomadic and rural areas.
- According to the Muti-indicator Cluster survey (MICS) conducted by Unicef in the year 2000, Only 39% of children aged 6-59 months received the high dose **Vitamin A supplement** and this could lead, theoretically, high prevalence of Vitamin A deficiency disorders, although such deficiencies are not reported in the health settings.

- **Breast feeding practices are not satisfactory:** as mentioned in the Multi-indicator cluster survey (MICS) of the 2000 conducted Jointly by UNICEF & MOH&L, only 20% of children aged less than 4 months were exclusively breast-fed.
- **Unavailable safe drinking water in more than 70% of Households** (UNICEF/MOHL, 2000). Sufficient and safe drinking water is the main cornerstone of health for every person in general, and children in particular; water scarcity usually results in poor sanitation and hygiene measures and thus probable out-breaks of certain communicable diseases. Water shortage is a common phenomenon in the Somaliland, by the fact that the highest annual rainfall ever recorded was 836mm in 1986 and the lowest was 156mm in 1965 *(Hargeisa water agency, 1996).* Availability of water in the urban settlements is also very low. It is estimated that the capital city of Hargeisa gets ¼ of its daily water requirements (*ibid, 1996*). In this situation of scarce safe and clean water, it is no wonder that diarrhoeal diseases ranked number One among the endemic and epidemic communicable diseases, including Cholera.
- **Female genital mutilation (FGM)** is widely practiced in the country with severe subsequent complications for young girls and women from the day the operation took place to the rest of their lives. 99% of the girls were circumcised and 94% of them had the worst type, which is the pharonic circumcision *(WHO, 1999)*. Girls as young as 3 years of age were found to be circumcised, but most of the girls were circumcised between the ages of 5-10 years. The most common complications reported are: Severe hemorrhage during the operation, infection including septicaemia that sometimes results in death of the young girls, urinary and menstruation retention. Later there is a severe complication during the child delivering that mostly endangers (and sometimes kills) either the mother or the child or both *(WHO,1999)* . According to the surveys conducted by WHO and Unicef, most of the people, wrongly, believe that the practice has religious basis, so they are against eradicating this harmful tradition; However, nowadays many people accepted to change the typology of the circumcision from pharonic to Sunne type.
- **Lack of child spacing:** The fertility rate of women in Somaliland is as high as 7.9 (WHO, 1999). Given that there is no family planning and the low percentage of breast feeding mothers after 4 months of delivery, it is clear that there is no child spacing procedures and this will have negative health impact both to the concerned mothers and their children.
- **Early marriage:** Some studies show that 18% of women interviewed told that they give their first child before the age of 18 years *(Unicef 2000)*. Early marriage usually results in adverse effects on the young mothers and their new- born, especially during delivery. Complicated and obstructed labor is very common among the young girls. Early age also predisposes some genetic disorders to the offspring such as Down's syndrome.

The most prevalent diseases that are responsible both the high morbidity and mortality rates are:

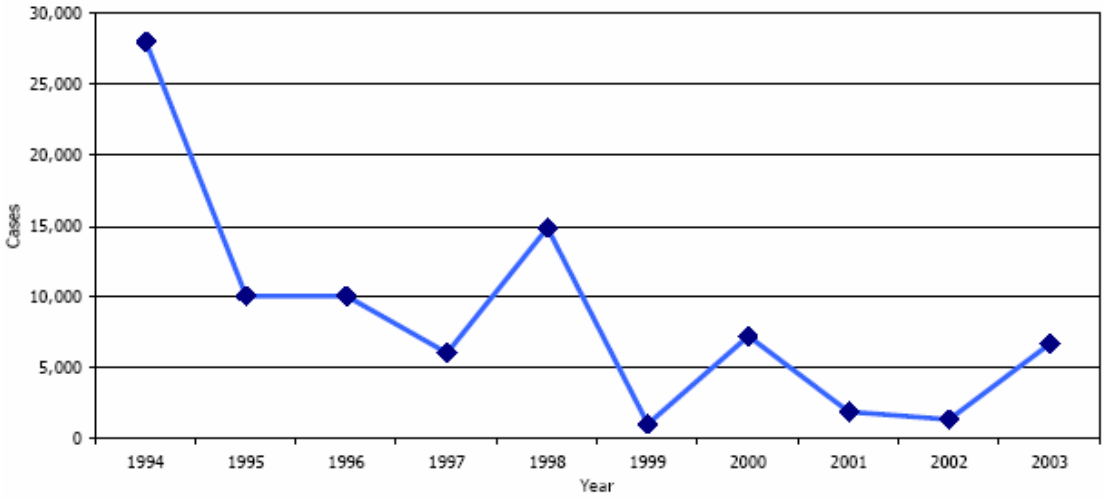
1. **Diarrhoeal diseases:** Like all other developing countries in General and the least developed of the under developed countries in particular, Children's diarrhoeal diseases remains one of the leading killer diseases. In the multi-indicator survey conducted in Somaliland in the 2000, **17%** of children have had diarrhea two weeks prior to the survey. In this MICS only **31%** of household have been identified having safe drinking water, so the main underlying cause of high

prevalence of Diarrhea could be due to poor sanitation and unsafe drinking water. Intestinal parasites are also very common causative agents of diarrhea in children. Giardiasis, Entrobmius Vermicularis and Ascaris Lumbricoides are the most common intestinal parasites among the children although reliable and recorded statistics are not available.

2. **Tuberculosis:** Tuberculosis is a major public health problem in Somalia and is one of the leading causes of morbidity and mortality, especially among productive age groups. Somalia has one of the highest estimated incidence rates of TB in the world (374 per 100,000 population) with around 22,000 cases of TB expected every year. It is estimated that around 10,000 new cases of pulmonary TB occurred in 2002, out of which 46% (4501) were detected and treated in supervised DOTS programs. The rest of the patients are most likely approaching the private sector or not receiving any type of cure.[viii] Twice the number of males to females affected. The number of cases of all forms being detected and put on treatment each year grew from 2,504 in 1995 to 5,662 in 2000.

3. **Cholera:** Prior to the war, cholera outbreaks were recorded only in 1970 and 1985. Since 1994 cholera has become endemic with annual outbreaks. Between 1994 and 1998, there were 70,250 cases recorded, and between 1994 and 199611 there were 1,867 recorded deaths. Relatively low fatality rates (1.9% - 4.6%) are attributed to a well-coordinated and funded cholera prevention and response programme. Cholera outbreaks have been most frequent in southern Somalia, and fatality rates have been higher in rural villages and small towns where there are lower levels of preparedness and fewer treatment facilities.

Figure: Number of Cholera cases since 1994



Source: WHO Somalia annual report, 2003

4. **Measles.** Measles epidemics recur every two years in Somalia, due to low levels of immunization, with 3,965 cases reported in 2000. It is assumed to be an important contributor to under-five child mortality Generally, 7% of Childhood deaths in the developing countries is due to Measles, In Somaliland the low immunization coverage, less than 17% among the 12 months age groups *(UNICEF, 2000)*, epidemics of measles are reported now and then, not only in the nomadic and rural areas where lowest coverage are expected, but also in some urban cities. It

worthies-to- mention that the high mortality and morbidity rates of this childhood illness is well known.

5. **Malaria:** Malaria is one of leading diseases as far as morbidity and mortality is concerned. In year 2003 a total of 30,920 malaria cases reported out of which only 7571 were laboratory confirmed.viii The disease is hypo- endemic in the country, but epidemics are very common and all the regions and districts of the country are considered as epidemic prone areas. Children and Pregnant women are usually the highest risk groups of Malaria, especially plasmodium falciparum that is the causative agent of more than 90% of all malaria cases in Somaliland. 9% of children experience an episode of malaria in Somaliland according the cluster survey. *(Unicef,MoHL, 2000)*. Anti-malarial programmes all but collapsed prior to the war, with the government allocating only US $6,000 for malarial control. A Roll Back Malaria strategy is only just being initiated in Somalia.
6. **Acute respiratory tract infections (ARI):** In the developing countries 19% of child mortality is due to ARI. Pneumonia (plus other acute respiratory tract infections) is considered to be next to Diarrheal diseases as far as morbidity and mortality are concerned. In one survey 2% of children interviewed reported that they have had an episode of ARI two weeks prior to the survey (Unicef, MoHL, 2000)
7. **Malnutrition:** Although actual figures are not available at national level, UNICEF supported household survey show relatively good nutritional status among Somaliland children with severe Malnutrition of 3% and moderate malnutrition of 9%, mainly in the urban areas *(UNICEF, MOHL,1999)* [ix]
8. **Anemia:** High levels of anemia amongst women due to iron deficiencies and repeated malaria episodes are a contributor to maternal death. The high prevalence reported in the 1980s is probably unchanged, but there is no recent data to confirm this.
9. **Yellow Fever:** Due to the collapse of health services, there has been no vaccination against Yellow Fever in the past decade13. An outbreak could be catastrophic for Somalia and neighbouring countries.
10. **Rift Valley Fever (RVF):** RVF vectors exist in southern Somalia and can be stimulated by heavy rains in semi-arid areas. Cases of RVF occurred during the 1997 floods, causing minor loss of human life, and resulted in an embargo by Saudi Arabia on livestock imports from Somalia in 1998. Fatalities from RVF in Saudi Arabia in 2000 led to the imposition of a comprehensive ban on livestock imports into the Gulf States from the Horn of Africa.
11. **Kala Azar:** Kala Azar was sporadically reported prior to the war, mainly in the Middle and Lower Shabelle Regions. Cases have been reported since the mid-1990s and since July 2000 an outbreak was recorded on both sides of the Kenya-Somalia border. The complex epidemiology, high cost of treatment and high mortality without treatment make this a significant health risk for Somali populations.

Key health trends

- No improvement in basic health indicators since 1998
- Increasing incidence of TB and malaria
- Low HIV/ AIDs prevalence

- Increase in preventative services
- Unregulated curative services
- Diminishing numbers of qualified medical personnel

3.2 Demography

Somalia has a population of around 8,591,000. However, estimates are very difficult because of the continuing situation. The last census was in 1975. Most outside analysts use this estimate but Somalia is one of the fastest growing countries in Africa and the world. Some estimates range between 6 and 15 million.

Because of the war, Somalia has a large diaspora. Ethnic Somalis have lived for centuries in large areas of what is now Ethiopia and Kenya. They are also a majority in Djibouti, where they share area with the Afars. There are over a million Somalis (including the minorities) outside Africa. Somalia now has one of the largest diaspora communities of the whole continent. All of these factors and the mostly nomadic nature of the Somalis has made proper estimates very difficult. ii

Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2002	2003
Crude Birth Rate:	46^	45.5** (97)	-	-	46.4”
Crude Death Rate:	22^	18.3** (97)	-	-	17.6”
Population Growth Rate”:	2.5	2.5	2.9	3.4	3.4
Dependency Ratio:	101***	88.5** (97)	116**	-	102
%population <15 years*	45.4	-	44	44.7	44.7
Total Fertility Rate:	6.8^	-	6.8**	-	6.3+

Source: World health report 2005
“ CIA world fact book
*'World Population Prospects: The 2004 Revision', New York, United Nations, 2005
**http://www.emro.who.int/somalia/countryprofile.htm#demographic
*** Somalia Human development Report 2001
^http://www.unicef.org/infobycountry/somalia_statistics.html

Demographic patterns and trends

As early as the seventh century, indigenous Cushitic peoples began to mingle with Arab and Persian traders who had settled along the coast. Interaction over the centuries led to the emergence of a Somali culture bound by common traditions, a single language, and the Islamic faith.

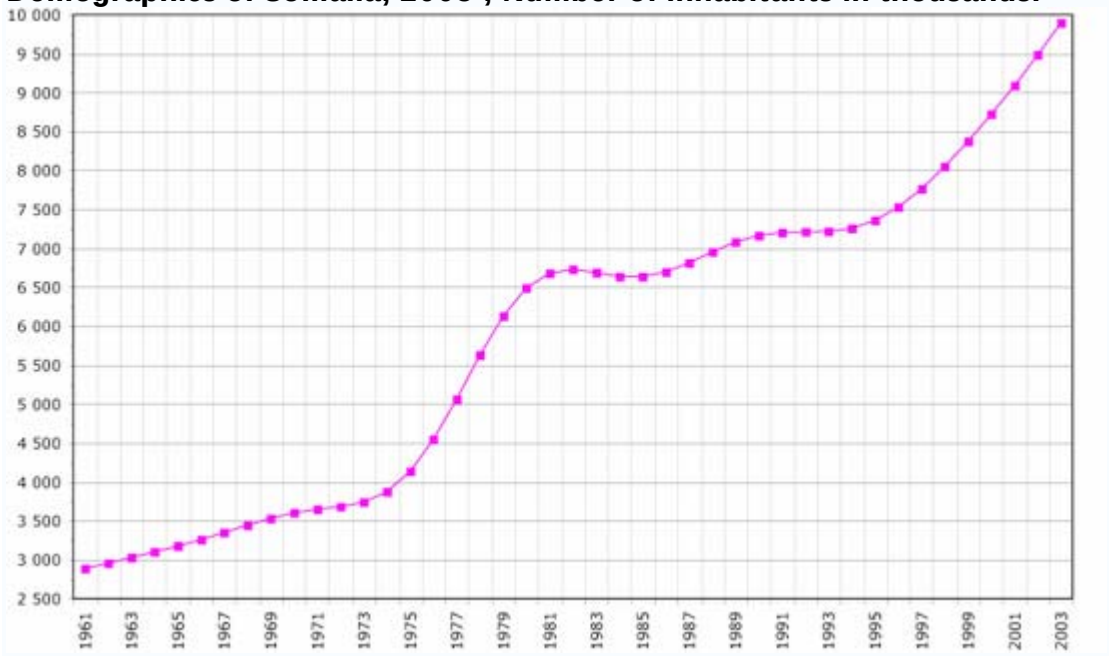
Today, about 60% of all Somalis are nomadic or semi-nomadic pastoralists who raise cattle, camels, sheep, and goats. About 25% of the population are settled farmers who live mainly in the fertile agricultural region between the Juba and Shebelle rivers in southern Somalia. The remainder of the population (15%-20%) is urban.

Sizable ethnic groups in the country include Bantu agricultural workers, several thousand Arabs and some hundreds of Indians and Pakistanis. Apart from the Brava people who speak a language similar to Swahili, nearly all inhabitants speak the Somali language. A population of Italian descent, which dated back to Somalia's colonial era,

began to emigrate following independence and by the outbreak of war most Italian Somalis had left the country.

The language remained unwritten until October 1973, when the Supreme Revolutionary Council (SRC) proclaimed it the nation's official language and decreed an orthography using Latin letters. Somali is now the language of instruction in schools, which are few. Arabic, English, and Italian also are used extensively.

Demographics of Somalia, 2005 ; Number of inhabitants in thousands.



Source: http://en.wikipedia.org/wiki/Somalia

Population:	8,591,629 N*ote:* this estimate was derived from an official census taken in 1975 by the Somali Government; population counting in Somalia is complicated by the large number of nomads and by refugee movements in response to famine and clan warfare (July 2005 est.)
Age structure:	*0-14 years:* 44.5% (male 1,918,209/female 1,905,974) *15-64 years:* 52.9% (male 2,278,406/female 2,263,602) *65 years and over:* 2.6% (male 96,256/female 129,182) (2005 est.)
Median age:	*Total:* 17.59 years *male:* 17.53 years *female:* 17.65 years (2005 est.)
Population growth rate:	3.38% (2005 est.)
Birth rate:	45.62 births/1,000 population (2005 est.)

Death rate:	16.97 deaths/1,000 population (2005 est.)
Net migration rate:	5.19 migrant(s)/1,000 population (2005 est.)
Sex ratio:	*At birth:* 1.03 male(s)/female *under 15 years:* 1.01 male(s)/female *15-64 years:* 1.01 male(s)/female *65 years and over:* 0.74 male(s)/female *total population:* 1 male(s)/female (2005 est.)
Life expectancy at birth:	*Total population:* 48.09 years *male:* 46.36 years *female:* 49.87 years (2005 est.)
Total fertility rate:	6.84 children born/woman (2005 est.)
HIV/AIDS - adult prevalence rate:	1% (2001 est.)
HIV/AIDS - people living with HIV/AIDS:	43,000 (2001 est.)
Literacy:	*Definition:* age 15 and over can read and write *total population:* 37.8% *male:* 49.7% *female:* 25.8% (2001 est.) http://www.cia.gov/cia/publications/factbook/geos/so.html

There are some favorable demographic trends. The numbers of refugees and internally displaced persons have declined over the past three years, indicating an improved security environment. However, migration to strong economic centers, such as Mogadishu, Hargeisa, Bosasso, Burco, Galkaiyo, and Baidoa, is creating new human development challenges in the provision of services and employment that are typical of rapid urbanisation. The most vulnerable people are the internally displaced, returning refugees, the urban poor, destitute pastoralists, and southern riverine farming communities.iv

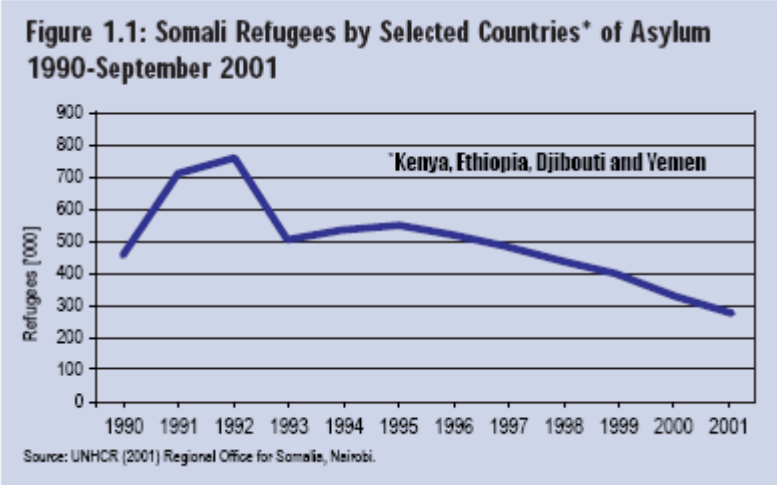
Urban Migration

Although the population of Somalia is predominantly rural, there are strong patterns of urban migration. In the 1980s, Somalia's rate of urban migration was one of the highest in Africa, estimated to be 6.5%33. For a time during the war this process was reversed as people fled the main towns and moved to areas that their clans came from. Consequently, the populations of previously small regional towns such as Beletweyne, Galkaiyo, Qardo or Baidoa, and rural villages such as Jeriban, rose dramatically34. The population of Bosasso is estimated to have increased from 10,000 to 60,000 since 1991, as people fled fighting in Mogadishu, the Lower Juba and the inter-riverine areas. Rapid urban migration has become a particular issue in Hargeisa, where some 62 per cent of Somali refugees returning from Region 5 of Ethiopia have chosen to settle. The concentration of businesses and aid programmes in the administrative capitals serves to attract the rural population, Somalis returning from the diaspora and economic migrants from Bay and Bakol regions. Smaller towns are experiencing similar trends, which present a challenge for urban planning. The

concentration of aid agencies in urban centers such as Hargeisa, and a lack of clear policies by the administrations on investment in rural areas, exacerbate this trend. It is reminiscent of prewar Somalia and indicates that development policies have changed very little.

Refugees and refugee returnees

Prior to 1991, Somalia hosted one of the largest refugee populations in Africa, from the Ethiopian Ogaden. In 1987, one in six persons resident in Somalia was registered as a refugee35. The civil war reversed this situation. In 1988 when war erupted in the northwest, over 600,000 people fled to Ethiopia in one of the fastest and largest forced population movements ever recorded in Africa36. During 1989, a significant number of Somalis sought refuge in Kenya from fighting in southern Somalia. The mass flight of Somalis, however, took place from early 1991 when over one million are estimated to have fled to countries in the region and outside Africa. People continued to leave southern Somalia in large numbers up until 1995. Since then there has been a decline in refugee flows from Somalia and a gradual process of repatriation and reintegration

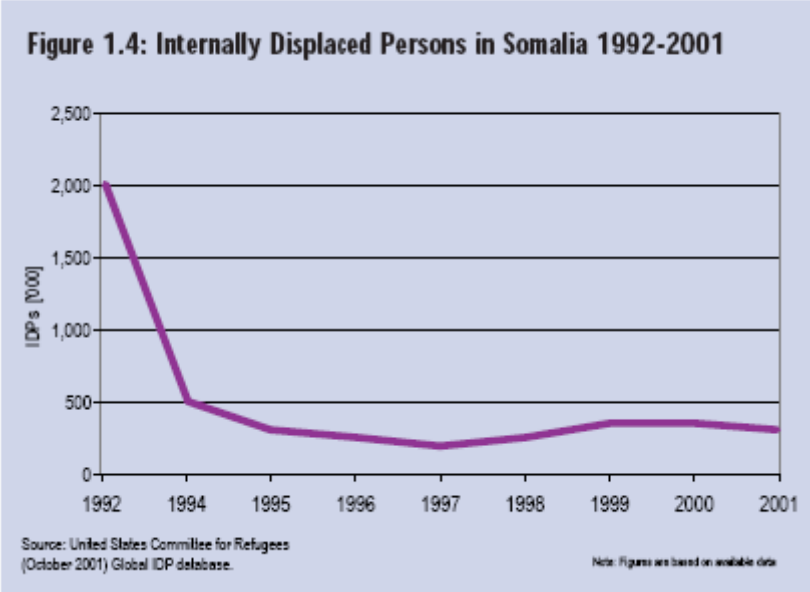


Many have returned to Somalia, while others have obtained permanent residence rights in countries of asylum. Some 400,000 refugees in Ethiopia spontaneously returned to Somaliland in 1991 after the fall of the government, although 90,000 fled again in 1994 when civil war erupted in Hargeisa and Burco. Voluntary repatriation from Region 5 in Ethiopia restarted in December 1998 and after a decade in exile the last refugees from Somaliland resident in Ethiopia and Djibouti are expected to repatriate in 200137. The decline in Somali refugee numbers is, in part, due to improved security inside Somalia, the difficult and unwelcoming environments in refugee camps, and the tighter asylum policies in the West.

Internally Displaced Persons

Another demographic trend is the leveling off of numbers of internally displaced persons (IDPs) in Somalia. Internal displacement as a result of conflict has a long history in Somalia, although the numbers of displaced were never recorded prior to 1991. The largest war-related displacements from central and southern Somalia took place between 1991 and 1993. Prior to May 1992 the main cause of displacement was fighting and drought, and after May 1992 it was mainly food scarcity. In September 1992 there were estimated to be between 556,000 and 636,000 ‘visible’ displaced people in static camps, 50% of whom were living in Mogadishu. In addition there were ‘invisible’ displaced who were supported by kinfolk. Some estimates numbered the

displaced at that time to be over 1.6 million. Since then there have been smaller displacements caused by fighting in the Juba valley (1993), in Bay and Bakol (1995-1999), and in Somaliland (1994- 1996). In late 1997 and early 1998, extensive flooding displaced people from central and southern Somalia. In 2001, some 10,000 people were temporarily displaced from Gedo region into Kenya as a result of armed clashes. It would appear that the overall trend since 1993, however, has been one of diminishing internal displacement, as the war subsided and people either returned to their homes or 'resettled' in different regions of Somalia. Over the years, there has been a clear pattern of people from northern clans moving to the northern regions from the south, which has radically altered the demography of those regions.



As violent conflict has declined and food deliveries have been reduced, displaced camps have also diminished. Climatic stress and economic hardship are now the main causes of population movement. In 2001, there were estimated to be 300,000 internally displaced, including 40-50,000 newly displaced. These figures should be treated with some caution, as there has been no comprehensive study of IDPs since UNOSOM withdrew from Somalia. There is little information on Mogadishu, which is thought to have the biggest concentration of IDPs. IDPs today constitute over 60% of those Somalis considered to be food insecure. The majority is from the poorest rural families or minority groups and lives on the peripheries of the urban centers. Bereft of assets and with limited access to stable employment, their access to education, health and other services is restricted by an inability to pay user fees.

Among IDP populations malnutrition rates as high as 25% have been recorded in the last two years43, compared to a global malnutrition rate for Somalia of 17%, and 10% among more affluent populations. The declining incidents and scale of internal displacement is a positive trend. However, few of the existing displaced seems to be returning to their original homes. For some who were displaced from rural areas such as Bay and Bakol, there is little economic incentive to do so. For others who were originally residents of Mogadishu, a significant proportion does not feel it is safe or viable to return there. This is a potential obstacle to future reconciliation. First, because it reflects the continuing instability of several regions, and second because it reflects a

consolidation of population realignments and the violent transfer of property, such as land, that occurred during the war.

The Somali diaspora

An important, but largely unstudied demographic phenomenon, is the large population of former Somali nationals now settled outside Somalia – the so-called diaspora44. Some estimates put the number of Somalis living abroad today to be over one million45. The diaspora are an extremely important force in the Somali economy and in Somali politics. Several ministers in the TNG, the Somaliland administration, as well as the faction leaders and their family members hold non-Somali passports, for example. The remittances from the diaspora are a key part of the economy and critical to people's livelihoods. The large diaspora means that the Somali 'nation' is no longer confined within territorial borders, but has been globalised, and the diaspora links Somalia into global economic networks. Somalis returning from the diaspora have brought new businesses, restaurants, ideas, and technologies. While many in the diaspora express a desire to return to Somalia, insecurity and poor social services and employment opportunities mean that that there are few inducements to do so. In 2000, for example, airline companies estimated that as many as 15,000 Somalis from the diaspora returned to Somaliland during the European summer school holidays. However, few remained.

4 HEALTH SYSTEM ORGANIZATION

4.1 Brief History of the Health Care System

Until the collapse of the national government in 1991, the organization and administration of health services were the responsibility of the Ministry of Health, although regional medical officers had some authority. The Siad Barre regime had ended private medical practice in 1972, but in the late 1980s private practice returned as Somalis became dissatisfied with the quality of government health care.

From 1973 to 1978, there was a substantial increase in the number of physicians, and a far greater proportion of them were Somalis. Of 198 physicians in 1978, a total of 118 were Somalis, whereas only 37 of 96 had been Somalis in 1973.

In the 1970s, an effort was made to increase the number of other health personnel and to foster the construction of health facilities. To that end, two nursing schools opened and several other health-related educational programs were instituted. Of equal importance was the countrywide distribution of medical personnel and facilities. In the early 1970s, most personnel and facilities were concentrated in Mogadishu and a few other towns. The situation had improved somewhat by the late 1970s, but the distribution of health care remained unsatisfactory. [x]

The Somali health system was already in disarray at the time of Siad Barre, with wide inequalities in access to health services between Mogadishu and the rest of the country. According to the policy adopted at the time, health and education were free of charge. The capacity of transforming policies into action was, however, limited, and so were the resources, largely provided by the international assistance (94% of the health budget in 1989). As a result, an indigenous, coherent health system never took off. No sector-wide adoption of the PHC approach took place in those years.

Government spending for health progressively declined, from 4-5% of total spending in the 70s and beginning of 80s to only 2% in the second half of the 80s. Access to health care further diminished, with only Mogadishu and areas supported by the international community providing some health services. By the early 90s, an estimated 80% of the population had no access to basic health care. As expected, the impact of 15 years of conflict on the health system has been profound, affecting all its components: human resources, infrastructure, management, service delivery and support systems.

International agencies and the private sector have struggled to fill some of the widening gaps affecting public health services. However, in the absence of effective coordination, security, adequate incentives and regulation, inequality in access to basic health services has grown worse, with urban and secure areas benefiting the most from NGOs and private providers. Most externally-financed programs are emergency and/or vertical programs, such as nutrition, polio eradication, EPI, HIV/AIDS, tuberculosis and malaria control. It is well known that these modalities of service delivery lead to both vertical and horizontal fragmentation of interventions and, therefore, to low efficiency in the use of already scarce resources.

4.2 Public Health Care System

Before the collapse of its state in early 1991, Somalia had a public health system – though rudimentary but reasonable by African standards – which had painstakingly been built over the previous 30 years by both civilian and military administrations. The country had a good number of general hospitals (though they were mainly concentrated in big urban areas, like Mogadishu), some regional hospitals, clinics, child and mother health (CMH) centers and out-patient dispensaries. Starting from the early 1970s, for instance, the number of physicians increased significantly, the greater proportion of them being native Somalis. For example, out of about 200 medical doctors in the entire country in 1978, around 120 were Somalis, whereas only 37 out of 96 physicians had been Somalis in 1973. Besides, in the 1970s and 1980s, great efforts were made to increase the number and quality of other health personnel and to enhance the construction of medical facilities. For this purpose, two new nursing schools were set up and several other health educational programs were established.

The opening of the faculty (department) of medicine of the country's single university, i.e., Somali National University (SNU), Mogadishu, was a very important step in this direction. Another important step was the countrywide distribution, as much as possible, of medical personnel and facilities. Nonetheless, the overall situation of the country's public health remained unsatisfactory. This is testified by the fact that, prior to the civil war, Somalia's health sub-sector was significantly under-funded. Less than 2% of the government's recurrent budget was allocated to health; the average in Sub-Saharan Africa was 6%. The reason for this serious under-funding was obvious, as Siad Barre's military/socialist regime was devoting most of its resources and energy to security and defense, particularly after the commencement of the anti-government rebel movements by 1979. When these armed opposition forces became victorious and the state collapsed, Somalia's public health – which was essentially funded by the government – collapsed with it.

Before this tragic collapse, the organization and administration of health services were in the hands of the Ministry of Health, headquartered in Mogadishu, the capital, with some authority delegated to the regional medical officers. One major function that the ministry used to perform was to regulate both medical and pharmaceutical practices in the country – an extremely important role. On the other hand, medical services were practically free for all citizens; but at times you had to buy the prescribed medication, particularly if it was not available at the government hospitals or public health centers. As such, most Somalis, especially the poor and people with a very limited income could get a reasonable degree of health care, free of charge. Another positive feature of this public health, when the country had a functioning national government, was that Somalia had arrangements with some friendly foreign countries, like Italy, Germany or Egypt, to treat Somali patients or perform surgical operations for them if the required facilities were not available at home. Around 1972, at the start of the application of the "Scientific Socialism" in the country, Siad Barre's regime had banned private medical practice to oblige the small core of physicians in the country to devote all their time and energy to serving their needy people and not to run after personal gains. However, by the late 1980s, the ban on private practice of health care was lifted, after the regime realized that the quality of government health care was unsatisfactory; this started initially by allowing the doctors to practice in their private clinics in the evening, after finishing their official work in government hospitals.

With the onslaught of the devastating civil war in 1991, the modest health infrastructure of the country was destroyed or seriously damaged; most of its premises

were looted, vandalized or taken over by poor squatters, internally displaced people and at times armed tribal militias. One of the favorite ways of vandalizing these hospitals, clinics and health centers, it was reported, was to take away their wooden doors, windows, marbles (if any) and the plumbing and electric fixtures – after looting the medical equipment- to sell them or to be used for building the looters' own houses or shacks. The famous Mogadishu General Hospital, which used to be one of the most comprehensive and well equipped hospitals in the Horn of Africa – is now occupied by some destitute families. Besides, the well known Medina Police Hospital and Banadir Mother and Child Hospital, all situated in Mogadishu, have been closed down until very recently. These important hospitals were built with funding from the European Union, Italy and China; now some local merchants want to reopen the last two hospitals. But the severest blow that has befallen the country's health system was the departure of the overwhelming majority of the limited number of qualified doctors, nurses, technicians and other medical professionals either for lack of security, work facilities or to find greener pastures abroad; some of them were also murdered during the civil war. Again, as the faculty of medicine of the national university and other educational facilities for training the required medical personnel were either destroyed, vandalized or closed down, no meaningful number of these badly needed staff have been produced in the past 15 years. The numerous yearly scholarships which foreign governments used to offer Somalia to train its future physicians and other medical personnel were also lost during this period as there was no a functioning central government to deal with.

Current Status of the Health System

Presently, health standards in Somalia are reported to be among the worst in Sub-Saharan African because of widespread poverty, frequent famines and civil strife that has been going on in the past 15 years. According to the World Bank data-base, life expectancy, for instance, is only 47 years in Somalia (in Saudi Arabia, the figure is 73 years); infant mortality (per 1,000 babies): 133; under 5-year old mortality rate (per 1,000 kids): 225; child malnutrition (% of under 5 years): 26; and child immunization, for measles, (% of under 12 months): 40% only. If we compare these figures with those obtaining in neighboring Kenya, for example, we find that although the life expectancy figures are very close in the two countries, the situation in Kenya is much better with regard to all the other categories, i.e., infant mortality, malnutrition and child immunization, etc.

However, there were some positive developments in the recent years, especially in regions where relative peace and security prevailed. For instance, about 30 hospitals, 73 mother and child health centers (MCH) and 132 health posts were opened with the help of foreign donors and Non-governmental Organizations (NGOs), such as *Medicins Sans Frontieres* (of France). Moreover, out-patient dispensaries, and health posts (in rural and nomadic areas) also exist in some regions. Still, most childbirth (88%) is reported to take place without adequate medical facilities (in neighboring Kenya, the figure is 41%). And in Somalia's rural and nomadic areas, the situation is even worse; no nurses or even midwives (except traditional ones) are said to be available there. Another complicating factor is the severe shortage of proper sanitation, as safe drinking water is generally unavailable, and half of the population in Somalia has no access to toilets. Besides, uncollected garbage constitutes a major environmental as well as health hazard in big urban areas, like Mogadishu, since proper municipality functions do not exist anymore.

Some Recent Positive Developments

An important positive development was that with the initiative of the few medical professionals who remained in the country in collaboration with some businessmen, some good health care facilities, albeit much smaller than what the country currently needs, have been established. These include general hospitals like Al-Hayat, Arafat and SOS for Children, all situated in Mogadishu. Several health facilities have also been set up in Self-declared Somaliland Republic, chief among them being the modern and well equipped Maternity Hospital which was constructed in Hargeisa at the personal initiative of Mrs. Edna Ismail (Somaliland's current Foreign Minister). Also, in the cities of Bossaso and Galcaio (in the autonomous region of Puntland), some new general hospitals and other health facilities were established through the help of the local government, businessmen as well as individual doctors who relocated to their regions. In the case of Galcaio, for instance, these new or rehabilitated health facilities serve not only the inhabitants of Mudug region – where it is the capital - but also those of neighboring regions, like Galgudud Nugal and Sol, and even patients from the eastern Somali Region of Ethiopia. On the other hand, the new universities of Amoud, East Africa (Bossaso), Hargeisa and Mogadishu, are also reported to have started to open faculties of medicine within their premises, or plan to do so in future. This would undoubtedly go a long way in addressing the serious shortage of qualified human resources in health delivery and management due to brain drain and lack of training facilities, as alluded to earlier.

Periodic immunization campaigns, against polio and other infectious diseases, have been conducted whenever security permits with the help of the specialized UN agencies and donor-funded NGOs. Malnutrition is also reported to have declined, but is still a serious problem in a county ravaged by civil strife and where low rainfall and frequent famines are the order of the day. This malnutrition which, of course, makes its victims more susceptible to more serious illnesses, is said to be prevalent in children between 5 and 13 years old.

Notwithstanding the fact that these new medical facilities have been filling in the wide gap that has been created by the collapse of Somalia's public health service, the problems facing the citizens in this regard are huge. For one thing, since these medical services are essentially being offered by the private sector, there is no free or cheap health care in Somalia at all. Everybody, no matter how poor he or she might be, has to pay for it dearly, by local standard. Today, a medical visit costs about So. Sh. 50,000 or around 3 US dollars. This is in a country where nearly 45% of its population in urban areas currently lives in extreme poverty, i.e., less than $1 per day (the situation in rural and nomadic areas is even worse). On top of that, the patient has to undergo medical tests, such as x-rays, laboratory tests, etc., some of which might be unnecessary and which could cost him/her hundreds of thousands of Shillings. In a very poor, war-torn country like Somalia, where avenues for gainful employment are extremely limited, only a minority of its citizens who get regular remittances from their relatives in the Diaspora, can afford this kind of medical fees. Those who are lucky enough or have the means also seek better health facilities in neighboring cities like Dubai, Nairobi, Jeddah or Addis Ababa.

Most private hospitals and clinics, everywhere, generate the greater part of their revenues from the above-cited medical tests. It is, therefore, natural that their doctors would often ask people to undergo some superfluous tests, to augment their income. Apart from that, they could prescribe more medicines than are required – some of it could also be available only in a certain pharmacy that is in collusion with the

prescribing physician. But in the opinion of some experts, one of the most serious problems currently facing Somalia's health care system is that there is no governmental authority to regulate this crucial sector. Consequently, in a country whose economy is in shambles, where very few job opportunities exist, where law and order seriously lack, anybody – irrespective of his educational qualifications and work experience – could engage in this lucrative sector. He can then sell his products/services at the highest price possible. Some pseudo-doctors, unqualified pharmacists (or petty traders in medicine) or ignorant traditional healers could also advise you to take quite inappropriate medicines, which could have serious side effects on your health – and some of which may have already expired.[xi]

There is a functional the Ministry of Health in Puntland which has a policy and strategy framework. However, resources available to the Ministry are limited and its role has been primarily to coordinate the activities of international agencies and NGOs as well as local NGOs who support health services and responsibilities that were previously handled by the Ministry of Health during the pre-war period. Improving the health of the population of Puntland through increased access to health services is the goal of the Ministry of Health. In order to improve health services in urban areas that have higher population densities, the International and local NGOs have constructed MCHs and health posts. CHWs and TBAs have also been trained on basic health services.xiii

In the public sector in **Somaliland**, the functioning health facilities in the country are divided into three main categories such as:

1. **Health posts:**

   There are 135 health posts (HPs) evenly distributed in all the regions of the country. These health facilities are available at village level. Ideally there should be at least one Traditional Birth attendant (TBA) and one community health worker (CHW) in every health post *(MOHL, 2001).*

   Major problems Identified:

   - Many HPs are not functioning for one reason or another.
   - Drug supplies are irregular and insufficient.
   - Only UNICEF provides drugs for all the Health posts
   - Motivation of TBAs and CHWs is usually low since they depend on community support only for their needs that is not mostly covered.
   - Insufficient training of CHWs in general and towards children in particular.

2. **Health centers:**

   There are around 53 health centers throughout the six regions of the country *(MOHL, 1999).* Health centers (previously known as mother and child health care centers) are mostly located at the district capitals, some main villages and sections in the main cities.

   They are staffed with:

   - Qualified nurses (usually 1-3)
   - Auxiliary nurses (1-2)
   - Cleaner
   - Watchman

- Rarely one midwife.

The major units of health centre are:

- Under fives clinic
- Antenatal care unit
- Immunization unit
- Growth monitoring unit
- Adult OPD

Health centers are the most important health facilities providing health services to the children. Both immunization and Growth monitoring units are exclusive for children (except the TT for pregnant women). Some basic essential drugs are available for children. Vaccination, treatment of some endemic diseases and management of minor injuries are the most important health services children receive at health centers where they are available.

Major problem identified in this area:

- In adequate number of health centers, so that there is no health centre services in many rural and Nomadic settlements.
- Irregular supplies in most of the health centers that are not supported by an INGO.
- Total dependency to Unicef as far as supplies are concerned.
- Lack of information channel between the health centers, the regions and Ministry of Health and Labor.
- Poor staff motivation
- Under utilization of people even in those well functioning Health centers.

3. Hospitals:

According to the official documents from the ministry of Health and Labor there are nine functioning Hospitals in the region, which are:

- One National Referral Hospital in Hargeisa
- Five regional Hospitals
- One district Hospital
- One TB Hospital
- One Mental Hospital

National and regional Hospitals have various Departments such as:

- Surgical Department
- Medical Department
- Pediatric (not in all hospitals)
- Gyn/Obstetric Department
- Mental Department in most of the Hospital
- TB sections in most of the Hospitals

- Other specialties (in the national Hospital)

Staff categories of the hospitals include: Doctors, Qualified nurses, Auxiliary Nurses, Lab. Technician assistants, Mid-wives and other sub-ordinate staff.

Hospitals are the highest level of health services provision in the country and therefore, they should provide all medical and surgical services that children need in any given time. Children are treated in the Hospitals and some minor operations for children also took place in the hospital, but how what qualities of services are provided? How many beds are available for children in the hospitals? These questions and others cannot be answered easily and not well documented.

Major problems identified in this area include:

- There are no specialists (pediatricians) in the hospitals. All the doctors working in the pediatric department are practitioners without special skills for child illnesses and their management.
- There are also no pediatric nurses
- Most pediatric equipment are very scarce in the hospital, even emergency materials are hard to get.
- Staff motivation and thus patient care is very poor in almost all the hospitals
- No disease preventive measures are available at the hospitals except BCG Vaccination at the maternity wards. ix

4.3 Private Health Care System

The Somali private health sector has grown considerably in the absence of an effective public sector. This means that the most vulnerable are completely excluded from the new services. Of the 20% of the population who get any care at all, about two thirds of them get it from the private health sector. The growth has thrown up a range of problems. Over-the-counter drug prescriptions, the dispensing of expired drugs, and inadequately trained staff can lead to misdiagnosis and drug resistance (for example to anti-TB drugs, antimalarials or antibiotics). Moreover, private health care is characterised by high charges for services - pricing the poor out of health.xv

The private provision of health services is unregulated and, as such, can be a risk rather than a solution to health problems. For example, the importation of cheap uncertified drugs and self-medication risks developing drug resistance that constitutes a health threat for Somalia and the entire region. Efforts are being made by the administrations in Somaliland and Puntland with international support to tackle this problem.

Overall, curative care provision has been ensured by an expanding private sub-sector, while the coverage and quality of public-health services has suffered, despite the support given by international agencies and special programs. The curative orientation of many health workers has compounded the problem. Access to certain basic services, like maternal health, or tuberculosis and malaria control, has remained extremely limited.

Modern, for-profit

The private sector stepped into the vacuum left by government to run social services, such as education, health care, and veterinary services. The Somaliland administration provides a modest public financing for education and health services, but as elsewhere, these services are heavily subsidized by communities, international aid agencies or Islamic foundations. The privatization of social services began prior to the war, when a lack of investment resulted in their virtual collapse. To compensate for this, the government began to decentralize responsibility for public sector financing to regional and district levels, and users were encouraged to contribute directly to the financing of these services. International donors responded with substantial resources to re-establish essential social services in the early 1990s, but from 1995 onwards, as donor financing declined and in the absence of competent public administrations, aid policy reverted to encouraging greater self-financing of services.

Private health care services are concentrated in a few major urban areas, where physicians and nurses run private clinics or attach themselves to a local pharmacy. Despite the low fees charged for a consultation (typically around US $0.50), doctors complain that people still attempt self-diagnosis, running the risk of misuse of antibiotics and other medicines that are readily available in local pharmacies. Pharmacies themselves are often run by business people with no training in medicine.

Private sector consists of several facilities that provide health and these include:

1. **Pharmacies:**

   There are out-numbered pharmacies available in almost all sections of main cities, small town and even some villages; most of them are just drug sellers (Asha Hashi, 1997). They sell drugs of all types, and to every body. There is no quality control of the drugs they sell; there are no regulations and control of any sort. In most of them the persons running the pharmacy is unqualified and may even have no Health background.

2. **Clinics:**

   These are some facilities in which there are inpatients, they are found in the main cities, and mostly run by Doctors. The premises usually consists very few rooms. Almost all of them are in appropriate to admit any patient because of their low standard of sanitation measures, unqualified personnel and unavailability of basic medical supplies. Children are admitted in some of these so- called clinics.

3. **Hospitals:**

   There is only one private Hospital throughout the country and that is Mrs. Edna Aden maternity Hospital. In this hospital Neonates and mothers receive an international standard of health care services.

4. **Consultation rooms:**

   These are the facilities in which doctors work to receive patients, they usually deal with outpatients for drug prescriptions and some investigations.

It has been proved that 83% of the clients of the private sector are women and children *(Asha Hashi, 1997),* but the qualities of services they receive are very questionable. The cost is also very high that most of the families cannot afford to pay for their sick children. In fact some children may get some helpful health services in the private sector, but also there is many who suffer from malpractices, harmful interventions, and inappropriate and/or ineffective drugs.

No document, which tells something about the magnitude of the problem of traditional harmful practices, is available; and the whole area is so far obscure.

The major problems that exist in this sector can be summarized in the following points:

- Poor quality of drugs.
- Lack of rules, regulations and control
- Untrained staff involved
- Unclean and unhygienic premises
- Inappropriate and insufficient medical equipment,
- Profit seeking, rather than patient's interests. ix

Availability of private health services: 2003

(No.)

Selected towns and hospitals	X-Ray technicians	Beds	Doctors	Nurses	Midwives	Laboratory technologists
Hargeisa						
Edna maternity hospital	0	45	4	3	20	2
Ugbaad maternity hospital	0	6	1	0	3	1
Ghalib hospital	1	15	5	10	4	1
Kaah hospital	0	16	3	0	3	1
Borama						
Allale hospital	1	25	3	3	3	2
Total	2	107	16	16	33	7

Source: Ministry of Health and Labour [15]

There are currently 62 private health facilities in Mogadishu. The quality of services varies from fair to very poor. Of the existing 62 health facilities, 33 are run by qualified doctors and nurses, but the remaining 29 are run by people with little or no medical training. Clinics offer health services ranging from normal checkups to major surgery. There are no controls in place to regulate these facilities. xvii

Modern, not-for-profit

As a complement to the emerging regional government structures, is the large presence of local and international NGOs throughout Somalia, with organizations in the North West zone tending to be more development oriented then in the other zones.

There is both coordination and competition between these organizations as well as competition between agencies and local authorities in the North West and North East zones for resources and institutional space. The capacity, competency and commitment of organizations vary within the NGO sector within Somalia. A large proportion is donor driven, and many organizations are essentially program contractors and creations of international aid availability. In many cases, the NGO sector has provided the only institutional vehicle for delivery of social services in the absence of government systems. However, the multiplicity of organizations has resulted in a multiplicity of developmental methodologies and approaches, based on the varying mandates and motivations of the organizations.

Somali NGOs Consortiums

Over the years, Somali NGOs/CSOs have shown varying levels of credibility and capability. Recently, a number of capable and committed NGOs/CSOs have emerged with a strong commitment to community development needs. Recognizing their own limited capacities and the need for information sharing, NGOs/CSOs have formed umbrella organizations to disseminate information on community development needs or human rights to strengthen their combined knowledge and skills base. Among others, these include:

The Consortium of Somaliland Non-Governmental Organizations, COSONGO, was founded in 1998. COSONGO believes that NGOs can build their capacities by pooling resources and sharing information. COSONGO aims to ‘give local NGOs a stronger voice to disseminate information about development, to improve the capacity of its members, and to continue advocating for local NGOs in Somaliland.’ The Network for Somali NGOs, NETSON was launched in southern Somalia in 1999. NETSON members implement relief and development projects in a diverse number of locations, but aim to maintain mutual relations and co-operation since they all have common goals. NETSON's goals are to establish a public information centre on socio-economic indicators for Somalia, to provide training to NGOs/CSOs to improve their capacities, and to assist member NGOs to develop technically sound proposals and secure funding. The Talawadag Network of NGOs in Puntland was founded in 2000. It aims to strengthen the capacity of local NGOs, improve their project implementation skills, initiate contact and dialogue with local and international stakeholders.

Traditional

1. **Traditional operations sites:**

   Such facilities are operational in almost every corner of a city, town and village. Traditional surgical Practitioners run these sites; they usually deal with children and carryout all the traditional surgical operations such as: Tonsillectomy, uvulectomy, teeth-extractions, nose bleeding and other harmful practices.

   There are no sanitation measures available in these sites and children usually suffer from such practices. Apart from the psychological trauma that children experience from these practices it has a direct and indirect health problem such as: Severe hemorrhages, infections, nerve damages and many other complications. Unknown number of children dies due to such complications every day. Unfortunately there is no specific study carried out on this matter.

2. **Traditional healers and herbalists:**

   These traditional healers use different methods of treatment. Some of them claim that they inherited the skill from their father and grandfathers. They mostly use

various herbs and chemicals of unknown origin. The side effects of such drugs are unknown and there are no fixed dosages. Problems that result from such chemicals are very common among the population.

3. **Tibi practitioners:**

   These claim that they treat their patients with some religious based practices in very different ways from reciting of Quran to using plants as medicines.

4. **Spiritual healers:**

   These are very common individuals who claim that the treat their patients through spiritual and supra-natural actions. Their actions are other superstitious or psychological. Some of them claim that “Satan” or “evil “affects their patients; and that they know how to fight against such unnatural elements. ix

4.4 Overall Health Care System

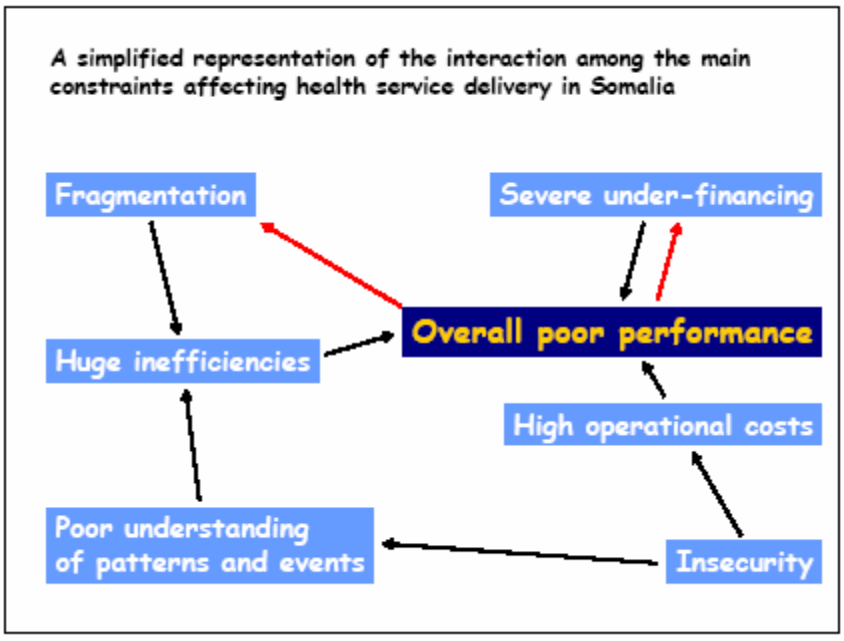
Prior to the war, the provision of public health services was heavily subsidized by foreign aid. In 1989, over 95% of the Ministry of Health’s budget was funded by donors, with the government allocating only 2% of its recurrent budget to health. An urban bias and uneven access to health services, poor quality of care due to inadequate training of health care providers, mismanagement and poor knowledge and practice, contributed to generally poor health indicators. Foreign aid continues to subsidize public health services. The Somaliland and Puntland administrations currently allocate some public money to the health sector. In 2000, however, this amounted to as little as 2.9% and 2.5% respectively of Somaliland's and Puntland’s recurrent budgets, and was mostly allocated to salaries. Over the past decade, however, private health provision has grown significantly. In 1997, for example, it was estimated that 90% of all curative care was being provided by the private sector, with up to 75% of the population in some areas utilizing private health facilities. This trend is encouraged by declining external finances, a lack of resources or commitment by administrations to support a public health service, and a lack of qualified personnel. In this context, community self-financing of minimal services is considered the only option for sustaining health services. This policy has several consequences. First, privatization and the introduction of user fees limit poor people’s access to health services.

Second, there are probably more health facilities in Somalia now than before the civil war, and the distribution of health facilities and health professionals has changed to the advantage of some areas like Puntland. Nevertheless, there is still a bias towards urban areas. Although difficult to measure, it has been estimated that only 15% of rural people have access to health services, compared to 50% of the urban people. In Puntland, for example, 49% of health personnel are in Bosasso while the whole of eastern Sanag has only one doctor. Third, the focus of international assistance is mainly on Primary Health Care (PHC), preventative and life saving health care. Consequently, there has been an increase in community-based health posts since the war, with community health workers and traditional birth attendants providing basic preventative and curative care, but a decline in referral services. Before the war each district, on paper, had a hospital with a qualified doctor. In reality, few of them functioned. A rationalization of the health system in the 1990s has seen the closure of many hospitals. For example, Baidoa has the only hospital for the whole of Bay region, and this has not provided an adequate standard of service for several years. Fourth, with an estimated 0.4 qualified doctors and 2.0 qualified nurses per 100,000 people, there is a chronic lack of qualified health professionals. Most qualified professionals

have migrated overseas and those that remain work in the urban centers. With no newly qualified young people coming in to replace them, the health system will face a major crisis in the next ten years. This requires long-term public investment in basic education and training and a creative strategy to attract professionals to return from the diaspora. Currently the only nurse training facilities are in Bosasso and Hargeisa. Fifth, the private provision of health service is unregulated and, as such, can be a risk rather than a solution to health problems. For example, the importation of cheap uncertified drugs and self-medication risks developing drug resistance that constitutes a health threat for Somalia and the entire region. Efforts are being made by the administrations in Somaliland and Puntland with international support to tackle this problem. Finally, certain health interventions, such as HIV/AIDS prevention, require a wider structure of public support beyond a community-based system. In the absence of a central government authority, attempts have been made in some regions to foster a broader health structure through district and regional health boards.

Summing up, the Somali health sector is trapped in a combination of factors that reinforce each other, resulting in an appallingly poor systemic performance. Crushing constraints, to be tackled in a balanced, phased and coherent way, with adequate resources and within a medium-long term horizon, are displayed in a simplified way in the picture:

- Insecurity,
- Severely inadequate resources and skills, both in health management and clinical care,
- Skepticism, or lack of motivation and vision by politicians and managers,
- International neglect,
- Unclear future political and administrative settings, which encourage piecemeal, short-term initiatives,
- Financial and operational fragmentation,
- Imbalances in the supply of services,
- Low standards of health care,
- Inadequate information.



Source: Joint Needs Assessment- Somalia. 2006

5 GOVERNANCE/OVERSIGHT

5.1 Process of Policy, Planning and management

With the absence of a national political entity agreed upon by all representatives of the Somali population, and the fragility of existing governance structures, Somalia has none of the detailed government policies that exist within normal developing countries, nor a National Development Plan or a poverty reduction strategy. However, each of the three political entities (TG, local administrations of Somaliland and Puntland) has its own agendas and plans regarding the future of the country or for the part they control. By and large, most of these plans focus on the very local level, and mostly on the large cities (Mogadishu, Hargeisa, Berbera, Garowe and Bosaso) and are prepared solely by the administrations. They are constructed on the premise of combating the common threat of insecurity, and pay inadequate attention to the foundations of sustainable services delivery and the productive sector.

In the absence of unified and credible national counterparts, the international community has developed its own mechanisms not only for ensuring coordination of aid interventions through the Somalia Aid Coordination Body (SACB – created in 1994), but also, in the conduct of consultation between donors and implementing partners on the one hand, and local administrations and communities on the other, for developing comprehensive technical sector strategies focusing on the role of the community, the level of ownership, and the need for long-term sustainability.

A process is currently evolving through which existing administrations in Somalia are beginning to develop policies and strategies of their own. This is particularly true in Somaliland and Puntland, where government budgets are published and limited resources are being channeled to the social sectors. Unfortunately, governance institutions remain extremely weak, with poor institutional and organizational capacities, a low skill base, limited economic policies, and a lack of managerial transparency. The process of political patronage and the need to maintain clanic balances make this situation particularly difficult to counter.[xii]

Through the encouraging of local health authorities to first recognize the importance of health and second to assume some responsibility over public health in their areas of influence, the UN agencies and international NGOs in coordination with the Somalia Aid Coordination Body (SACB) are attempting to work with and strengthen local health authorities in the following:

1. To attempt to formally examine alternative approaches to health system development in Somalia. Two alternatives of principal interest are the greater recognition of and support to the private health sector in Somalia and the value of BDN concepts and strategies in helping communities meet their own needs in a sustainable manner. Efforts to expand BDN villages have been successful in North West Somalia and partially successful in Lower Shabelle (due to deteriorating security conditions)
2. With regard to food supply and nutrition steps are taken in areas where security exists to either remove barriers or improve access
3. To foster the construction of safe water harvesting and storage mechanisms

4. To support the development of standardized manuals and training modules for training of health personnel with special emphasis on mid-level and private health workers
5. To continue to approach donors for additional funds needed for health development programs
6. To continue to train local national staff to upgrade their managerial capabilities
7. To increase national professional capacity to prepare for and respond to emergencies through the establishment of disease surveillance and epidemic preparedness and response system
8. To assist and guide women's groups
9. Eradication of poliomyelitis
10. To improve the utilization of immunization outlets
11. To continue to develop plans for control of Tuberculosis in the Horn of Africa under the auspices of IGAD/ HATCI/ HOAI
12. To support and develop plans for scaling up the control of Malaria under the global Roll Back Malaria (RBM) initiative
13. To support and develop plans for the prevention and control of priority communicable diseases, including the strengthening and expansion of the health laboratory network

There is a functional the Ministry of Health in Puntland which has a policy and strategy framework. However, resources available to the Ministry are limited and its role has been primarily to coordinate the activities of international agencies and NGOs as well as local NGOs who support health services and responsibilities that were previously handled by the Ministry of Health during the pre-war period. Improving the health of the population of Puntland through increased access to health services is the goal of the Ministry of Health. In order to improve health services in urban areas that have higher population densities, the International and local NGOs have constructed MCHs and health posts. CHWs and TBAs have also been trained on basic health services.[xiii]

5.2 Decentralization: Key characteristics of principal types

5.3 Health Information Systems

Data for Somalia is very scarce. This is particularly the case for quantitative and qualitative socio-economic data and information. Where data is available, it is often incomplete. In addition to the general lack of information, what is available is often outdated. This is primarily because the situation in Somalia changes frequently and substantially. Difficulties often arise when collecting new data because the information is not accessible. In emergency situation, information systems and data collection is given low priority in most of Somalia.

Health information is fragmented and, thus, not easily accessible to planners and decision makers. The quality of the information depends on the strength of each vertical program. As for facility-based activity statistics, information is recorded and compiled in Health Registers at Health Posts and Maternal And Child Health (MCH) facilities and, on that basis, monthly summaries are produced. In addition monthly summaries are produced for nutrition, EPI and morbidity. Nutrition summaries are sent to the Food Security Unit, EPI data to UNICEF zonal offices and, less consistently morbidity data to UNICEF. The reporting rates achieved to date are approximately 80% for nutrition and EPI. In 2003 improvements were made in compiling and analyzing the EPI data which fed into the UNICEF-WHO Joint Reporting Form for 2003 and 2004. Data related to hospitals are incomplete and unreliable.

Conducting household surveys implies overcoming severe constraints: lack of sampling frames, uncertain security and substantive logistic costs. Most recent, national or sub-national surveys include: MICS 2000 and the Socio-Economic Survey 2002, KAP study on HIV/AIDS, STIs in Somaliland 1998. In addition, several anthropometric surveys and few, localized mortality studies have been carried out. Another MICS is to be conducted in mid-2006.

5.4 Health Systems Research

5.5 Accountability Mechanisms

6 HEALTH CARE FINANCE AND EXPENDITURE

6.1 Health Expenditure Data and Trends

Table 6-1 Health Expenditure

Indicators	1990	1995	2000	2003
Total health expenditure/capita,	-	15 (98)	13	13 (01)
MoH expenditure per capita	-	7 (98)	6	6 (01)
Total health expenditure as % of GDP	-	2.7 (98)	2.6	2.6 (01)
Investment Expenditure on Health	-	-	-	-
Public sector % of total health expenditure	-	46.1 (98)	44.8	44.6 (01)

Source: WHO estimates 2005 http://www.who.int/nha/country/SOM.xls

Table 6-2 Sources of finance, by percent

Source	1990	1995	2000	2002	2003
General Government	-	-			-
Central	-	-	-	-	-
State/Provincial	-	-	-	-	-
Local	-	-	-	-	-
Social Security	-	0	0	0	-
Private					
Private Social Insurance	-	-	-	-	-
Other Private Insurance	-	-	-	-	-
Out of Pocket	-	100	100	100	-
Non profit Institutions	-	-	-	-	-
Private firms and corporations	-	-	-	-	-
External sources	**-**	5.3 (98)	9	9.3 (01)	**-**

Source: WHO estimates 2005 http://www.who.int/nha/country/SOM.xls

There is no consolidated estimate of the resources allocated to health care provision in Somalia from public and private sources. Given prevailing political and security uncertainties, available assessments of macroeconomic perspectives are cautious and vague. However, most analyses reach the conclusion that Somalia will remain poor for long, even with peace and stability. It could even get poorer, if the flow of diaspora remittances dries out, as anticipated by some observers. There are, however, indications that in some regions public funding is increasing substantially: in Somaliland, for example, funding for the MoH has grown from 1,607 million Somali

Shillings in 2000 to a budgeted total of 4,573 million for 2004, with a proportion of the total health budget growing from 2.3% to 3.2% for the same period. In Puntland, spending on health doubled as a percentage of overall spending, albeit to a still low level of 1.8% in 2004, which was the pre-war level. Total expenditures amount to around 4,754 million Somali Shillings (WB, 2005).

Private financing is considered important by all informants, and its growing role is reflected by the flourishing private sector, whose expansion can be seen also as an encouraging sign of trust and stability. Given large income disparities between rural and nomadic communities, and recipients or not of remittances from abroad, private contributions (and consequently access to paid-for health care) are likely to be very uneven. Better-off patients rely frequently on health services provided in foreign countries.

It is impossible to quantify private spending. According to the UN Transition Plan for 2005, private spending might represent up to 80% of all health financing. The WHO Statistical Information System puts private expenditure at 55% of total expenditure on health in 2001. Both estimates are mere guesses. Given the prevailing widespread poverty, it seems reasonable to assume that remittances from the diaspora represent an important source for private health expenditure. Somalis living abroad have also financed investments in health facilities, some of which are offering high-tech services. Local businesses represent an additional not quantified source of private financing.

The total resource envelope allocated to health care in Somalia is likely to remain tight, in the order of US$ 8-10 per head, if the political and security situation remains dire. With improving conditions, donor increased support and a better economic performance may lead to funding levels of US$ 12-15 per head. In any case, no reconstruction bonanza is to be anticipated. The future health sector must be designed with this tight resource constraint firmly in mind.

Given the small size of the health sector, regional partition, and weak or absent governance, operational fragmentation, general under-resourcing, lack of public budget systems and of banks, the absorption of the expanded financial allocations spurred by peace and recovery is likely to be poor. Poor systemic absorption is made worse by the tiedness of much financing, controlled by projects, vertical programs and private donors and operators. No fungible funds are available to fill gaps, remove bottlenecks and invest in sector-wide systems. vi

Trends in financing sources:

Financial, as well as human, resources are inadequate, and Somalia depends almost entirely on external sources for health financing. In 1989, the Ministry of Health was allocated 2.95% of the government's regular budget. While 67% of the total health budget came from external aid in 1984, 95% of the utilized budget came from this source during 1990. In 1990, over 79% of the Ministry of Health's financial resources were allocated to Mogadishu, the capital, alone. Many health programs suffered serious setbacks due to lack of funds and rising costs. The implementation rate of health projects was as low as 35.3%.[xiv]

Prior to the war, the provision of public health services was heavily subsidized by foreign aid. In 1989, over 95% of the Ministry of Health's budget was funded by donors, with the government allocating only 2% of its recurrent budget to health. An urban bias and uneven access to health services, poor quality of care due to inadequate training of health care providers, mismanagement and poor knowledge and practice, contributed to generally poor health indicators. Foreign aid continues to

subsidize public health services. The Somaliland and Puntland administrations currently allocate some public money to the health sector. In 2000, however, this amounted to as little as 2.9% and 2.5% respectively of Somaliland's and Puntland's recurrent budgets, and was mostly allocated to salaries. Over the past decade, however, private health provision has grown significantly. In 1997, for example, it was estimated that 90% of all curative care was being provided by the private sector, with up to 75% of the population in some areas utilizing private health facilities. This trend is encouraged by declining external finances, a lack of resources or commitment by administrations to support a public health service, and a lack of qualified personnel. In this context, community self-financing of minimal services is considered the only option for sustaining health services.

Health expenditures by category

Table 6-3 Health Expenditures by Category in Ministry of Health

Expenditures	1995	2000	2002	2003
Total expenditure: (specify if only public)	-	-	-	-
% development expenditure	-	-	-	-
% recurrent expenditure	-	-	-	-
% by type of service	-	-	-	-
Curative Care	-	-	-	-
Rehabilitative Care	-	-	-	-
Preventive Care	-	-	-	-
Primary/MCH	-	-	-	-
Family Planning	-	-	-	-
Administration	-	-	-	-
% by item	-	-	-	-
Staff costs	-	-	-	-
Supplies and materials	-	-	-	-
Services	-	-	-	-
Other	-	-	-	-

6.2 Tax-based Financing

6.3 Insurance

Table 6-4 Population coverage by source

Source of Coverage	1990	1995	2000	2002	2003
Social Insurance	-	-	-	-	-
Other Private Insurance	-	-	-	-	-
Out of Pocket		-	-	-	
Private firms and corporations	-	-	-	-	-
Government		-	-	-	-
Uninsured/Uncovered	-	-	-	-	-

6.4 Out-of-Pocket Payments

Cost Sharing

Cost-sharing schemes have been established across the health sector, under donor pressure or as a response to severe funding shortages. In the absence of a dominant model, a variety of modalities can be recognized. Many schemes (particularly hospital-based ones) have passed the test of time, and now look as consolidated. No attempt at studying this wealth of experience has been done since 1997. In the prevailing unregulated environment, attempts at disciplining user charges seem desirable. Given the financial constraints to be faced in the future by the emerging government, reliance on cost-sharing revenues looks as inescapable as development takes off (unless donor generosity attains unprecedented levels), but it should kept to a level that does not prevent access to health services of the poor. The approach provides opportunities for higher involvement of the community in the management of the facilities, hence increased ownership.

6.5 External Sources of Finance

Most public financing to health care is provided by the international community. Donor funding levels have consistently increased since 1993, when they plunged in the aftermath of the collapse of the peacekeeping operation. Transaction costs are likely to be high. Interruptions in funding flows are reportedly commonplace.

According to the SACB database, the EC, Britain, the Polio Eradication Program and the Global Fund stood out as the largest funding sources in 2003. At least other 15 donors were financing health care provision in Somalia. Important funding sources, like the Arab League, have so far not been captured by SACB records. The contributions of Islamic charities are largely unknown, but their magnitude might be considerable.

By all accounts, external financing looks modest in aggregate terms. According to the SACB Donor Report 2003 (the most reliable and comprehensive source), and after adjusting for allocations spanning several years, external contributions were below US$ 5 per head, an absolutely low level for health services provided in a protracted crisis,

even more so once the substantial logistic, security and overhead costs incurred have been considered. This reflects the marginal role occupied by Somalia on the international agenda, and the reluctance of donors to engage in political as well as in financial terms with this country. vi

Foreign aid to Somalia has fallen significantly since before the war and since the early 1990s. Since 1998 humanitarian assistance has declined while rehabilitation assistance has increased as a proportion of overall aid, reflecting an improved security environment and change in donor aid policy. Pre-war Somalia was considered a classic case of an aid-dependent state, a perception reinforced during the time of UNOSOM. From the 1960s to the 1980s Somalia was one of the highest per capita recipients of foreign aid in the world. Successive governments relied on foreign aid grants for development projects and faced few problems in attracting them during the Cold War. By the mid-1980s, 100% of Somalia's development budget was externally funded and 50% of its recurrent budget was dependent on international loans and grants. The adoption of structural adjustment and liberal economic policies in the 1980s, as elsewhere in the world, heralded a reversal of policies that for decades had supported the state as the engine of development. Somalia's adoption of these policies coincided with a decline in development aid to the government, growing support for non-governmental civil society organizations, and the intensification of the civil war. As aid declined, the struggle for control of the state was redirected to other resources such as land. As aid was cut off, government institutions collapsed. The international response to the war and famine in Somalia temporarily reversed this trend with a massive infusion of assistance. In 1993, the annual budget of UNOSOM II alone was US $1.5 billion.

Since 1995 foreign assistance to Somalia has fallen significantly. Gauging the volume and importance of international aid to Somalia is difficult. The UN Consolidated Appeals (CAP) for Somalia and periodic reports of the SACB are the main public records of international aid to Somalia. These, however, provide only a partial analysis. They do not include assistance provided by the UN and NGOs from their own resources or assistance from non-traditional donor sources such as the Arab States or Islamic institutions. Similarly, there are no records of non-developmental financial or military aid to Somalia. A number of trends in external assistance are worth noting, however. First, since 1995 international aid to Somalia has fallen to below pre-war levels and the UNOSOM period. As figure 1.15 illustrates, between 1993 and 2000 assistance raised through the CAP fell from US $200 million to less than US $50 million. Since 1993, the CAP has raised less than one third of the funding requirements of UN agencies. Although the total assistance to Somalia from SACB donor members for the year 2000 was reported to be US $115,487,100, this still represents a significant decline from the early 1990s.

There are several reasons for this decline in aid. Reduced aid flows to Somalia reflect global declines in foreign aid. During the period of UNOSOM, Somalia received an inflated amount of foreign assistance so that a drop-off in assistance was inevitable. After 1994, donors prioritized humanitarian crises in Rwanda and the Balkans. A long history of failed aid projects in Somalia has also contributed to a certain level of donor fatigue and wariness. And, finally, the objectives of the international engagement in Somalia have changed.

A second trend worth noting since 1998 is a decline in humanitarian assistance as a proportion of overall aid, although it continues to be more readily available than rehabilitation and development funding. This trend reflects both an improved security

environment in Somalia and a change in donor aid policy. Rehabilitation assistance is itself changing in nature, with greater emphasis on technical support and capacity building as opposed to material assistance, and a greater insistence on cost-recovery measures in social services. Third, since donors adopted a so-called 'peace dividend' approach in Somalia in the late 1990s and made aid conditional on security and good governance, the policy has been to invest in the more politically stable northern areas of the country.

In 1998, the UN stated that 'the most important work of the UN is to invest in the rehabilitation and development of the social and economic fabric of relatively peaceful areas'. Of the US $115.4 million disbursed in 2000, 42% was spent in the north compared to 31% in the south, with 27% on countrywide programs. The difficult operational environment in the south and the northwards drift of resources has seen international NGOs either withdraw or move to the north. The 'wait and see approach' to the TNG in Mogadishu adopted by western donors also reflects this position.

Finally, the channels through which aid is disbursed have changed. Since 1993, only 36% of total humanitarian assistance has been channeled through the UN, with most channeled through the ICRC and NGOs. One lesson of the past decade, therefore, is that the Somali state can no longer rely on foreign aid. The education sector, for example, was almost 100% funded pre-war by foreign. In 2000, donor funding for education was estimated to be only US $10.9 million.

Furthermore, a study of food aid illustrates that, with the exception of 1991- 1993, food aid to Somalia throughout the 1980s (excluding food for refugees) was significantly higher than it is today. Bilateral aid, when or if it is restored, is unlikely to reach pre-war levels. The US $115 million in aid in 2000 represents a small contribution to Somalia's economy, when compared to the value of trade or estimates of annual remittances of up to some US $500 million. As a proportion of the aid is spent on logistics operations and offices in Nairobi, and on foreign personnel, the amount that actually enters the Somali economy is much smaller. The ability of international aid to influence the direction of development in Somalia is, therefore, more limited than in the past. More importantly, as international aid resources decline, responsibility for meeting welfare services is being passed on to Somali households through policies of participation, cost-recovery, and privatization. While rationalized in terms of sustainability, Somali ownership, or good governance, it still needs to be proven that Somali populations are able to sustain welfare services better now than they were before the war. An inability to meet such costs should not be confused with an unwillingness to do so or 'dependency'. However, for the foreseeable future, social welfare provision will continue to be reliant on international subsidies.

7 HUMAN RESOURCES

7.1 Human resources availability and creation

After the onslaught of the devastating civil war in 1991, the severest blow that has befallen the country's health system was the departure of the overwhelming majority of the limited number of qualified doctors, nurses, technicians and other medical professionals either for lack of security, work facilities or to find greener pastures abroad; some of them were also murdered during the civil war. Again, as the faculty of medicine of the national university and other educational facilities for training the required medical personnel were either destroyed, vandalized or closed down, no meaningful number of these badly needed staff have been produced in the past 15 years. The numerous yearly scholarships which foreign governments used to offer Somalia to train its future physicians and other medical personnel were also lost during this period as there was no a functioning central government to deal with.xi

MSF has estimated that the country has less than 15 qualified doctors per million people. Trained healthcare professionals fled the country to safety during the 1990s. The only nurse training facilities are in Bosasso and Hargeisa - and the few health workers that remain tend to be based in the more secure urban centres. The whole of eastern Sanag, for instance, had only one doctor in 2001.[xv]

The health workforce is small, under-skilled and dilapidated. No reliable counts are available for Central - Southern Somalia. Skilled cadres in Puntland are fewer than 200, while in Somaliland may be around 400. The number of workers operating private outlets is unknown. Overall, health workers are counted in the few thousands. The proportion of workers lacking formal training, but providing health care is considered to be significant.

Hospital-oriented staff, like doctors and nurses, dominate the workforce. No equivalent of the PHC professional cadres established in many African countries has been introduced in Somalia. Reportedly, the experience gained elsewhere in delivering PHC has failed to be absorbed by health professionals.

No training program for health managers has been offered so far. Management positions remain the sole remit of medical doctors, despite their overall lack of related skills. The ranks of laboratory technicians, pharmacists and midwives are also diminutive. The workforce has aged, due to the protracted stop of training activities, which has prevented an adequate replacement of retiring cadres. Non-standard and faked qualifications abound (Burns, 2004).

Poor educational levels compound the picture. The proportion of staff not susceptible of retraining, due to poor education and professional background, as well as to advanced age, is likely to be substantial. Male workers constitute the majority of the workforce. Political / clan considerations influence heavily the recruitment of cadres, distorting the terms of employment and limiting their deployment.

Health professionals are concentrated in urban centers, where overstaffing of facilities is reportedly frequent. Somaliland and Puntland have benefited from staff moving northwards, away from conflict. Ratios of skilled health workers to population are reckoned more favorable in the Northern Regions than in Central-Southern Somalia, where staff cluster in Mogadishu and within relatively secure areas.

A variety of contracting and employment modalities, with large salary differentials, is applied across Somalia. NGOs and special programs contract staff, or complement their salaries with substantive top-ups. Informal arrangements abound. In Somaliland and Puntland, old civil service provisions might be reintroduced in an effort to re-establish state functions. Both health authorities are encouraging emerging professional associations to take regulatory responsibilities for the cadres belonging to them.

The performance of health workers is considered poor on most accounts: technical capacity, productivity and commitment. Reportedly, inadequate skills combine with commercial incentives, to encourage unacceptable, even fraudulent behaviors. The boundaries between public and private employers are blurred. Mixed arrangements prevail. Health workers complement their meager or absent public salary with formal or informal private practice. Bogus -i.e. unqualified- doctors freely provide health care of worrisome quality, while untrained street vendors market drugs in the open (Burns, 2004).

The proliferation of training outlets, mostly of university level, is the likely outcome, if health training is left to market forces. Given present under-resourcing, poor standards are to be expected. Without a pro-active review of training contents, traditional training models, centered on high-tech curative care, will continue dominating training institutions, in turn biasing the health sector towards hospitals and urban areas.

For years to come, health sector development will depend on the import from abroad of qualified cadres, to fill key positions as managers, trainers and health care providers. The diaspora will provide some of these qualified cadres, but its contribution is likely to fall short of expectations (at least in relation to the public sector), as witnessed in other post-conflict health sectors. vi

Table 7-1 Health care personnel

Personnel per 100,000 population	1990	1995	2000	2004
Physicians	0.6*	4 (97)		4
Dentists		0.19 (97)		
Pharmacists		0.103 (97)		
Nurses and midwives	4*	19 (97)		
Paramedical staff	-	-	-	-
Community Health Workers	-	-	-	-
Others	-	-	-	-

Source: Global atlas for the health workforce, WHO
http://www.who.int/globalatlas/dataQuery/reportData.asp?rptType=2
* http://www.emro.who.int/mnh/whd/CountryProfile-SOM.htm

Availability of health personnel in Puntland 2003

Description	Bari	Nugaal	Sool	Sanaag	Mudug	Cayn	Total
Doctor	28	7	7	0	19	1	62
Pharmacist	3	3	4	2	1	0	13
Post bas nurse	1	0	1	0	0	0	2
Midwives	18	2	2	3	3	5	33
Nurses	25	42	35	16	17	5	140
Lab. Tech	6	1	3	4	5	1	20
Asst. lab. Tech	28	18	10	3	21	1	81
Sanitation	14	1	10	0	1	0	26
CHWS	72	120	19	20	60	4	295
TBAs	72	119	19	20	44	4	278
Total	**267**	**313**	**110**	**68**	**171**	**21**	**950**

Source: Ministry of Health

In 1990, Somalia had a reported ratio of 0.6 physicians per 10 000 population and four nurses per 10 000 population.

Health personnel in Somaliland, 2003

Availability of health service personnel: 2003

(No.)

Selected indicators	Awdal	N/West	Tog-dheer	Sool	Sana-ag	Sahil	Total
Doctors	10	46	9	3	3	4	75
Asst. Doctors	0	0	0	0	0	0	0
Nurses	43	84	47	0	28	14	216
Midwives	2	13	3	0	0	0	18
Auxiliary Staff	30	70	42	12	29	45	228

Source: Ministry of Health and Labour

Trends in skill mix, turnover and distribution and key current human resource issues and concerns

Somalia health human resources have been severely affected by the 12 years of conflict. As expected, there has been a dramatic loss of qualified health professionals in many different ways; many highly qualified health professional left the country during the war. In addition, human resources development activities were disrupted. Over the past years, NGOs and UN Agencies undertook the training of health workers to meet the emergency needs of the population, many of the nursing returnees worked in the refugee camps during the conflict period. At present, there is a shortage of qualified health professionals in the country, especially nurses and midwives including allied health personnel such as laboratory technicians, pharmacists, radiography and environmental health officers, resulting the community to seek health care services from the traditional and the private sectors managed by the private sector without regulation procedures in place. Many of available health personnel involved the public health systems are close to retirement.

Several public and private training institutions have started operations in recent years, offering medical and nursing programs. No standard training programs have been developed. A few hundred students are now enrolled in courses based in Hargeisa, Boroma, Bosasso and Mogadishu. Due to lack of resources and capacity, all training institutions struggle to attain acceptable quality standards. A shortage of competent teachers is likely to constrain the development of training programs, even if adequate funding becomes available, for the coming years. The present outputs of the training network are certainly inadequate to restructure the workforce.

During 2002, technical support was provided by WHO to re-open the Institute of Health Sciences (IHS) after being closed for 12 years in Hargeisa, the rehabilitation was done by UNHCR. So far 85 students were accepted into the general nursing programmed in May 2003. The IHS in Hargeisa is expected to prepare nurses and allied health personnel. In addition to the (IHS) in Hargeisa, Edna Maternity Hospital, which is a non-profit making maternity hospital, established a general nurse-training program in July 2000. Also, there are two schools in Mogadishu, one private and one public, one nursing school in Bosasso and one in Puntland.

The physical status of the schools is poor, and there is a lack of prepared faculty, teaching learning resources, equipment and materials, and financial resources to remunerate the teaching staff.

Table 7-2 Human Resource Training Institutions for Health - 2004

Type of Institution	Current		Planned		
	Number of Institutions	Capacity	Number of Institutions	Capacity	Target Year
Medical Schools	-	-	-	-	-
Postgraduate training Institutions	-	-	-	-	-
Schools of Dentistry	-	-	-	-	-
Schools of Pharmacy	-	-	-	-	-
Nursing Schools	-	-	-	-	-
Midwifery Schools	-	-	-	-	-

Type of Institution	Current		Planned		
	Number of Institutions	Capacity	Number of Institutions	Capacity	Target Year
Paramedical Training Institutes	-	-	-	-	-
Schools of Public Health	-	-	-	-	-

Capacity is the annual number of graduates from these institutions.

7.2 Human resources policy and reforms over last 10 years

7.3 Planned reforms

8 HEALTH SERVICE DELIVERY

8.1 Service Delivery Data for Health services

Table 8-1 Service Delivery Data and Trends

TOTAL (percentages)	1990	1995**	2000	2004
Population with access to health services	28***	-	27 (98)	-
Married women (15-49) using contraceptives	-	-	12**	1
Pregnant women attended by trained personnel	-	-	32**	32
Deliveries attended by skilled personnel	-	-	34.2*	25
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	31***	60	69	50
Infants immunized with DPT3		40	33	30
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	30***	45	35	40
Infants immunized with OPV3	-	40	37	30
Population with access to safe drinking water	29***	-	23**	29
Population with adequate excreta disposal facilities	18***	-	49**	25

Source: Official country estimates
http://www.who.int/immunization_monitoring/en/globalsummary/countryprofileresult.cfm?C='som'
*UNICEF. Multiple Indicator Cluster Survey 2000 Somalia. 2000
** 98 http://www.emro.who.int/somalia/countryprofile
*** Somalia Human development report 2001

URBAN (percentages)	1990	1995	2000	2004
Population with access to health services	-	50	54 (98)	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-	-	-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel	-	-	-	-
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-

Population with access to safe drinking water	-	-	31.3	-
Population with adequate excreta disposal facilities	-	-	-	47 (02)

Source: Somalia Human development report 2001
http://www.unicef.org/infobycountry/somalia_statistics.html

RURAL (percentages)	**1990**	**1995**	**2000**	**2004**
Population with access to health services		15	18 (98)	-
Married women (15-49) using contraceptives	-	-	-	-
Pregnant women attended by trained personnel	-	-		-
Deliveries attended by trained personnel	-	-	-	-
Infants attended by trained personnel				
Infants immunized with BCG	-	-	-	-
Infants immunized with DPT3	-	-	-	-
Infants immunized with Hepatitis B3	-	-	-	-
Infants fully immunized (measles)	-	-	-	-
Population with access to safe drinking water	-	-	18.6	-
Population with adequate excreta disposal facilities	-	-		14 (02)

Source: Somalia Human development report 2001
http://www.unicef.org/infobycountry/somalia_statistics.html

Access and coverage

Overall, the public health care network is small, concentrated in the main towns, and where security conditions allow. In Somaliland and Puntland, access to basic health services in densely populated areas seems adequate. In Central and Southern Somalia, large portions of the population (in the 2-3 million range) have no access to health care, because of nomadic behavior, destruction and looting of health facilities, and prevailing insecurity. Unevenness and instability of service provision are the rule. Lack of census data, associated to nomadic habits, limits the utility of ratios of facility to served population, as planning instruments. Resettlements induced by improvements in security conditions will further alter the already unclear demography of Somalia.

The district health centre, which is staffed by one senior physician among others, is responsible for four primary health care units and covers from 40 000 to 60 000 persons. The regional health centre is in effect the district health centre of the regional capital. Governmental health curative services were offered at district and regional hospitals. Until recently, the primary health care program was working in nine regions, with an additional seven regions receiving partial coverage. Because of security-related deteriorations in various regions and the subsequent withdrawal of various donor agencies during early 1990, primary health care coverage only partially existed in nine regions. Now, with the total collapse of all government structures as a result of recent conflicts, renewed effort will have to be made to assist in the establishment of government institutions.

Access to health services is low and uneven, particularly once the needs of the significant nomadic population and the extremely low population density, probably the lowest in Africa, are taken into account. Economic, cultural and gender barriers play certainly an important role, which must be better understood if adequate solutions have to be found.

Distance to health facilities is not the only impediment to access services, in particular for the most vulnerable groups. Given the lack of good transport and communication systems, the regular supply of drugs, supervision and surveillance activities are also limited. As a geographic split of service coverage among regions is not available, gauging the meaning of average figures is difficult.

Lack of access to safe water is a striking feature in almost all parts of Somalia. Probably less than 1 in every 5 households has reliable access to safe water throughout the year. A result of erratic rainfall patterns which are responsible for droughts and floods, this climatic causation has been compounded by the destruction and looting of water supply installations during the civil war, by depredation during continuing conflicts, and through the general lack of maintenance of existing infrastructure.

The MICS 2000 survey found that overall only 23% of the population has access to safe drinking water. Slightly more than 31% of households in the North West zone have access to clean drinking water which is the same coverage found in the 1996 MICS for the North West zone. The proportion of households with clean drinking water is 26% in the North East zone, which shows an improvement from the 19% zonal access in the 1997 MICS. The 2000 survey found an access rate of 18% in Central and Southern zone. The Situation Analysis in 1998 also estimated the access to clean water in the Central and Southern zone to be less than 20%.[xvi]

Less than 50 per cent of the population of Somalia lives in households with sanitary means of excreta disposal. Poor hygiene and environmental sanitation are major causes of diseases such as cholera among children and women. The impact of poor environmental sanitation is particularly felt in the cities, towns, large villages, and other places where people are living in close proximity to each other with waste disposal adjacent to dwellings. Lack of garbage collection facilities is another factor affecting the urban environment and polluting water sources, along with the proliferation of plastic refuse bags. Some dynamic progress has however been made in the field of health. In the last two years, Somalia has stepped up its polio eradication drive as part of the global polio eradication effort. No cases of the wild polio virus have been reported since October 2002 and there is hope that in the next two years Somalia may be certified polio free if no more cases are reported. vii

8.2 Package of Services for Health Care

The public health network is fragmented along vertical lines, created by special programs and aid agencies. The package of services provided by health facilities is conditioned by the external support received by them. Attempts at designing basic packages of services have had a limited impact on service provision.

Despite the widely recognized need to provide PHC services to nomadic populations, which represent a substantial share of Somalis, different obstacles have discouraged the introduction of new models of service delivery for these communities, such as mobile health units, the training of nomadic community health workers, etc. Such constraints include the prevailing insecurity, the political precedence accorded to urban

constituencies, the low funding and the lack of a consensus on effective and affordable ways of providing services in the particular environment in which nomads live.

8.3 Primary Health Care

Most of Somalia's public health facilities have fallen into disrepair since the collapse of the state in 1991. No standard layouts, nor building guidelines, have ever been elaborated. Existing health facilities follow a variety of models and standards. Many facilities offer inadequate working conditions. No delivery model has explicitly addressed the issue of providing health services to nomadic communities.

Today, nearly all remaining Somali doctors live in urban areas, where they can supplement their meager incomes with private practices, though mostly unregulated and often of doubtful quality. For over a decade, there has been no formal training of health staff, although some international partners have provided technical refresher courses. While there is widespread agreement that the rehabilitation and development of district health systems, strong community participation and enhanced referral facilities are desperately needed to improve services to rural areas, major shortcomings persist in funding, management, training and expertise. The need for regulation in this sector and for building the managerial capacity of emerging health authorities remains a huge challenge for Somalia.

Resource distribution was becoming more inequitable and human resources shortages were becoming more severe. Apart from security problems and the almost total absence of government-provided compensation to Ministry of Health employees, weaknesses in the national logistic, transport and communication networks were probably the main obstacles to the implementation of primary health care in Somalia. Moreover, the Ministry of Health's coordination of individual agencies implementing primary health care activities and the coordination between agencies was inadequate.

Furthermore, due to the recent conflicts in Somalia, it is widely perceived that no governmental or institutional infrastructure exists in the country capable of supporting the development of expansion of primary health care. Additionally, the very fabric of society, as well as social and family relationships, have suffered serious damage as a result of these conflicts and the resulting deprivations. xiv

Infrastructure for Primary Health Care

Health Facilities in Somalia: provisional summary data[2]

	SOMALILAND	PUNTLAND	CENTRE AND SOUTH	TOTAL
Hospitals	23	19	47	**86**
Specialised Centres	3	1	1	**6**
MCH / OPD	69	31	99	**199**
Health Posts	157	48	320	**525**
TOTAL	252	99	467	**818**

Source: Joint Needs Assessment- Somalia. 2006

Knowledge on health infrastructure is also limited. Most health facilities were seriously damaged and looted during the civil war, and only few were completely rehabilitated. Recent inventories report eighty-six hospitals, around 200 health/MCH centers and 500 health posts, but the functioning status of many health facilities is unknown and we can assume that several ghost health units are included in available lists of health facilities. In 2005, WHO has started assembling a database of health facilities, which has to be updated, strengthened and expanded to become a reliable planning tool. The information collected so far must be validated during field visits and through the scrutiny of knowledgeable people. Additional key variables must be added. Once considered reliable, the database must be disseminated among potential users.

Availability of health facilities in Puntland 2002 by region

Region/District	Hospital	Beds	MCH	Health post
Nugaal/Garowe	3	99	1	10
Mudug/Galkacyo	5	156	10	5
Bari/Bosasso	5	200	2	6
Sool/Las Anod	3	100	3	4
Total	**16**	**555**	**16**	**25**

Source: Ministry of Health

Availability of health facilities and beds in Somaliland

Number of available health service facilities: 2003

Selected indicators	Aw-dal	N/west	Tog-dheer	Sool	San-aag	Sahil	Total
Hospitals	2	4	2	1	1	2	12
Beds	320	568	320	100	100	178	1,586
MCH Centres	11	18	10	6	6	3	54

Source: Ministry of Health and Labour

8.4 Non personal Services: Preventive/Promotive Care

Environmental health

Somalia faces some serious environmental challenges. Uncontrolled cutting of acacia and juniper forests for charcoal exports and timber is causing lasting damage to the rangelands, Somalia's most precious resource. Similarly, Somalia's marine resources are being depleted through unsustainable fishing practices, mostly by foreign trawlers.

Current issues:

Famine; use of contaminated water contributes to human health problems; deforestation; overgrazing; soil erosion; desertification

Environment - international agreements: Party to: Endangered Species, Law of the Sea, Ozone Layer Protection

Table O - Environmental Profile	Indicator		
	1985-90 [base]	Latest data	Year
Land area ('000 km²)	638	–	n/a
Population density (per km²)	--	10[1]	1999
Rangeland (% of total)	45[2]	–	1988
Arable land (% of total)	13[2]	–	1988
Forest and woodland (% of total)	14[2]	–	1988
Unclassified (% of total)	28[2]	–	1990
Livestock per capita	5.35[3]	6.7[4]	1999
Production of fuelwood (annual % increase)	3.6[5]	–	1985
Annual internal renewable water resources (1,000 cubic metres per capita)	980[5]	750[6]	1999
Annual fresh water withdrawals as % of water resources	5.1[7]	–	1989
Annual fresh water withdrawals per capita (cubic metre)	99[7]	–	1989
Average annual rate of deforestation (%)	0.1[8]	–	1989

[1] Based on the population estimates from Vaidyanathan, K.E. (1997, December) *Report of the UNFPA Consultant on Population Statistics of Somalia*. Nairobi: UNDOS.
[2] *Somali Yearbook of Agricultural Statistics* (1988).
[3] UNDP (1991) *Human Development Report*. New York: OAU. Table 22. p.163.
[4] Ministry of Livestock, Forestry and Range, Department of Planning and Statistics, Mogadishu, Somalia, July 1990. The national total of cattle includes animals brought in by refugees from Ethiopia in 1987.
[5] UNDP (1991) *Human Development Report*. New York: OAU. Table 22. p.163.
[6] Chris,P. (1999) *Paradigms and Process: rainfall environment and water resource development in Somaliland and the Sahel*. MSc thesis. London: Imperial College.
[7] FAO (1995) Aquastat Factsheet: Statistics on Somalia.
[8] UNDP (1995) *Human Development Report*. New York: OAU. Table 17. p.189.

Source: Somalia Human development report 2001

Environmental Trends

The social and economic well-being of the Somali people is intrinsically linked to the status of the country's natural resources. Many of the regulations for governing the use and protection of natural resources have not been enforced since the government collapsed. Economic necessity has resulted in the unplanned overuse of some natural resources by some groups, while others have opportunistically exploited them for economic gain. There has been no comprehensive study of environmental change over the past decade, or a program for monitoring the environment. Various studies, however, point to problems of rangeland degradation, deforestation, coastal desertification and sand dune encroachment, depletion of wildlife, marine pollution and

the depletion of marine life through excessive fishing, and lack of sanitation and waste management facilities.

Key Environmental Trends

- Rangeland degradation
- Deforestation
- Depletion of renewable fresh water
- Depletion of wildlife
- Marine pollution
- Depletion of marine life
- Revival of customary rules (*xeer*) for community-based management

Environmental pollution

Environmental problems also arise from the lack of systems for solid waste disposal. Garbage collection systems in most urban centers are inadequate or nonexistent, and only 52% of the population have sanitary means of excreta disposal. There are also frequent reports of toxic waste dumping by foreign vessels along Somalia's coastline, although the material evidence for this has not been produced.

Environmental protection

There is considerable awareness among the administrations and communities of critical environmental issues. Some Somali communities are taking action in response to some of these problems, reviving traditional laws (xeer) or drawing up new ones to protect the environment. The Somaliland and Puntland administrations have also drawn up environmental policies to conserve and protect the environment. Recognizing the magnitude of the charcoal problem, the Puntland administration in early 2000165, and the TNG more recently, have banned charcoal exportation. However, the trade continues. Such ecological resources are a regional concern and therefore international and regional action is needed to promote the sustainable management of Somalia's natural resources.

8.5 Secondary/Tertiary Care

Hospitals are on average small (50-100 beds), providing in most cases sub-standard services. No fully-fledged tertiary hospitals exist within Somalia. In total, few thousands beds are available. Occupancy rates are low in most cases. Poor quality of care leads to inadequate utilization, which is common. Kant (2004) provides a vivid description of the extreme dereliction of the hospital network in Puntland, due more to under-financing, neglect and mismanagement than to war destruction.

Since 1988, there has been a marked increase in the urbanization of health care in Somalia-there has been a reported increase in human resources and facilities in urban areas resulting in a more severe inequity between urban and rural areas. Regional hospitals varied in size, from 50-to 200-bed capacity. Each of the 18 regions had one regional hospital and there were two public hospitals in the Banadir Region. The specialized hospitals numbered 17, comprising 10 tuberculosis hospitals, three mental hospitals, two leprosy hospitals and one paediatric and obstetric hospital. The district hospitals followed more or less the administrative map of the country. The usual

capacity ranged from 10 to 20 beds. In 1988, the total number of beds reported was 5857. As a result of the current (1990-91) conflict in Somalia, few of the urban hospitals are now functioning and virtually none of the rural ones is operational. In addition to hospitals, there were 411 primary health care posts, 50 primary health care units and 94 maternal and child health centres reported at the end of 1990.

Before the civil war, Mogadishu had four major hospitals, all in the south of the city—the Chinese-built Benadir Hospital, for women and children; the European Union-built Digfer Teaching Hospital; the Russian-built Military Hospital; and the Madina Police Hospital. There were also numerous small clinics. All health facilities were government owned before 1990. Before the war, tuberculosis patients were treated and isolated in Lazareti in north Mogadishu and De Martini hospital in the south. A hospital and an SOS children's village was established before the civil war, by the Austrian-based international organization.

After fighting broke out in 1991, and sub-clan militia divided and laid waste the city, all the hospitals and clinics were either looted, destroyed or occupied by internally displaced people (IDPs). There was one exception: Madina Hospital was saved by its staff, and later rehabilitated by the International Committee of the Red Cross (ICRC). There are 55 beds in the hospital, and a laboratory. Supplied and renovated by the ICRC, it runs on a cost-sharing basis. Patients pay about Somali shillings 400,000 (US $40) for major surgery and 15,000 (US $1.50) for a bed in a ward. This patient cost recovery program was set up in September, and covers only about 7 percent of the total cost of the hospital. The ICRC pays 80 percent of the running costs. The business community in Mogadishu has contributed $17,000 in the past six months towards upgrading and supplying the hospital. [xvii]

Table 8-2 Inpatient use and performance

	1990	1995	2000	2004
Hospital Beds/1,000 pop	-	-	-	-
Total Beds	-	-	-	-
Discharges	-	-	-	-
Average LOS (days)	-	-	-	-
Occupancy Rate (%)	-	-	-	-

Source:

8.6 Pharmaceuticals

Essential drugs program in Somalia ceased with the collapse of central government and the infrastructure of the Ministry of Health in 1991. Access to essential drugs, particularly through public health services, is low and variable depending on the local presence of donor supported programs. Lack of access to essential drugs of good quality is making a large number of Somali people compromise their health and lives.

National drug policies based on essential drugs are not well developed. Non-qualified and often inappropriate sale of medicines in the informal private sector has expanded without any control. Quality of drug imported into the country is very doubtful. There is no functioning regulatory system of quality control for drugs in the country. This is particularly serious in view of the widespread and thus currently uncontrolled

importation of medicines of undeterminable quality. Although in the Northwest and northeast steps have been initiated to regulate pharmaceutical sector in their respective zones. However, neither of the zonal authorities have the capacity to enforce the regulations developed.

Pharmaceutical supply to public heath institutions is totally dependent on international aid. Different agencies and the remnants of the health facilities have been using drugs which are not always appropriate for the prevailing health priorities and which may be unnecessarily expensive. Today, drugs are brought to the country, mainly through international aid organizations and the private sectors. Public financing for drug purchasing is largely provided by Western donors, and Western and Islamic charities, but no quantification is available, mainly of the latter sources. Private financing is substantial, as suggested by the proliferation of drug selling outlets. Many channels supply private health care providers. No large-scale private scheme is said to be in place.

Since 14 years, UNICEF ensures the supply of PHC kits to about 300 facilities, mainly MCH clinics, across the whole of Somalia. Since two years, UNICEF has introduced a complementing system, supplying additional basic drugs according to requests from facilities. UNICEF / WHO / GFATM support the supply of drugs needed by disease-control programs, like malaria or tuberculosis. Many NGOs supply the hospitals they support with drugs acquired through their own channels. No supply system shared by many partners is in place, which results in diseconomies of scale.

In Somaliland, drugs are taxed at the entry port, which could provide a way to estimate their value. Many of the drugs imported into Somalia might be exported to neighboring countries thereafter. In 2001, very poor standards of storage and distribution were reported. Drugs are stored in small amounts at multiple points, which makes their proper handling difficult. Most staff managing drugs lack professional skills. The WHO database lists 14 warehouses.

Private suppliers are handling drugs without the care required to ensure the activity and safety of the products. Sporadic quality controls have given worrisome results. The substantial drug expenses incurred by Somali people are therefore likely to translate into the purchase of ineffective and dangerous preparations.

Absolute deregulation and commoditization prevails in Central / Southern Somalia. The health authorities of Puntland and Somaliland have issued regulatory provisions, which remain to be enforced. Overall, drug selling outlets are now counted in the thousands, representing an important source of income. Some agencies rely on Kenyan laboratories, considered as reliable, to submit the drugs they use to test.

No pre-service pharmacy training program is provided within Somalia. Skills have been acquired on the job, or not at all. No information about the number of cadres active in the pharmaceutical area has been found. Both pre-service and in-service training programs are needed to improve the performance of drug handlers. The design of these programs must address the demands generated by the advanced privatization of health care delivery.

An assessment of drug utilization in Somaliland and Puntland, carried out in 2001, showed worryingly poor standards of practice, equally shared by private and public prescribers. Reportedly, over-prescription of drugs is commonplace. Self-prescription habits are strong and may account for much drug consumption. An Essential Drugs' List, a National Formulary and Standard Treatment Guidelines have been formulated in 2005, but remains to be finalized and introduced into practice. vi

9 HEALTH SYSTEM REFORMS

UNICEF assistance for decentralizing health management structures has included supporting regional workshops focused on improving the staff management and coordination skills. Cost recovery to bring funds back into the health sector has been introduced in 39 out of 48 maternal and child health centers in the region, with the remainder following shortly. The funds generated will mostly be used for infrastructure maintenance and staff incentives. The reform process in the Northeast area has been negatively affected by the internal constitutional crisis and when these activities will be resumed depends largely on achieving peace and stability in the region. [xviii]

REGIONAL PERSPECTIVES

SOMALILAND

Information in the health sector is incomplete and reliable. Many agencies collect data: WHO, UNICEF, FSAU, UNDP, ICD. There is therefore the need to integrate and harmonize the existing information after agreeing upon on a number of well-thought health and management indicators. A basic agreement among international agencies and Somaliland health authorities must be reached on demographic figures.

Health facilities: The approximate 1.5 Million population of Somaliland is served by 23 hospitals, 69 Health Centers and 157 Health Posts. A map of health facilities, their functioning, number of qualified staff both in the public and private sector and the kind and quality of services delivered is not available.

Health Facilities in Somaliland

Health facility	Awdal	Hargeisa	Sahil	Togdher	Sool	Sanag	Total
Hospitals	3	10	2	2	2	4	**23**
Specialised Centres	0	3	0	0	0	0	**3**
MCH/OPD	13	20	4	14	8	10	**69**
Health Posts	31	26	11	30	30	29	**157**
Total	47	59	17	46	40	43	**252**

The health network presents numerous imbalances in terms of access (urban vs. rural and nomadic areas); content of care, coverage, quality. Numerous flaws affect the utilization of the existing public health network: (i) lack of confidence towards public institutions; (ii) absence of information, awareness and knowledge towards diseases and pharmaceuticals, (iii) very high levels of illiteracy (90%); (iv) widespread self-medication, (v) inability to enforce the rule of law, and the regulations and guidelines issued by health authorities.

Human Resources: The skills of the public and private health staff are poor and fragmented. The average age of doctors, nurses, midwives, is approximately 45 years. Part of the staff will retire soon leaving vacancies to be filled by a new generation of professionals. Only 422 cadres have a health qualification. The ratio 1 qualified to more than 2 unskilled is the reverse of what is internationally considered as satisfactory.

Doctors	Nurses	Midwives	Technicians	Auxiliaries	TBA/CHW	Support staff	Total staff
82	215	35	90	216	447	392	**1477**

The training needs of the health staff are considered massive, but a thorough learning need assessment has never been conducted. Existing training institutions are de-regulated and uncoordinated. Quality of training is uncertain. Basic training for medical and paramedical staff is provided through one nursing school and two universities,

funded by the diaspora, businessmen and Islamic organizations (i.e. Hargeysa and Boroma - Amuud School). These institutions have initiated two courses for medical doctors. The process of selection of students, the development of common and standardized curricula, teaching methodologies, the quality of training tools and the qualifications and capacities of the trainers must be assessed. In few years, the existing privately funded training institutions will graduate scores of new medical and paramedical staff, who will have received training courses of uneven and doubtful quality. Existing medical and pharmaceutical associations reportedly pursue the interests of their members, rather than sector priorities.

INGOs and UN agencies have been providing a great number of training courses to the public health work force. These courses suffer from flaws commonly found elsewhere: (i) training courses are too numerous and teach often inappropriate skills; (ii) they keep away key health staff from their duties for long periods. (iii) training programmes are agency-driven, un-coordinated and not standardized; (iv) the quality of teaching and teaching methods are sometimes doubtful; (v) proper follow-up is rarely carried out as part of supportive supervision. The benefits of such courses are therefore limited.

Private sector: The majority of the doctors employed in the public health facilities operate as private practitioners (75% of the medical doctors operate in the main towns especially in Hargeysa). The private sector manages a conspicuous network of hospitals, clinics (approx. 80) and pharmacies (approximately 400, of which 200 in Hargeysa). The private health network is totally de-regulated, certification norms for public and private practitioners are not existing and/or implemented as well as assessment methods of the knowledge and skills of the workforce are not in place.

Pharmaceuticals: A widely-endorsed essential drugs list for PHC facilities has been formulated with WHO support during the past few years. A list for hospitals is available but has still to be endorsed. Multiple networks of drugs procurement exist in the public and private sub-sectors. Drugs are imported without any quality control and sold at a variety of prices. The dynamics of the existing, de-regulated market network must be understood. Rather unorthodox, innovative approaches might be demanded to improve the picture.

Organization and structure: The institution governing the health sector is the Ministry of Health and Labor. A structure and an organogram have been elaborated but not yet translated into practice. The MOHL has been developing since 1999 a Strategic Health Plan with the objective of pursuing Health Sector Reforms. The Ministry will be in charge of the re-organization, regulation, monitoring and evaluation of both public and private practices. Full operational and financial decentralization to Regions and Districts is foreseen to take place.

Regional / District Health Boards and Regional/ District Health Management Teams, in charge of financing and delivering health services to populations, are partly in place. The National Health Policy still has to be endorsed by the two chambers of the Parliament. The Health Sector Reforms Secretariat is in charge of the reform process and it has developed a number of relevant strategic and policy documents that should be amply reviewed. The effort made by the MOHL to proceed with the envisioned Health Sector Reform has to be recognized. Nonetheless major weaknesses prevail; the lack of capacities and funding for implementation should be urgently addressed.

Health financing is fragmented and poorly documented. Financial data from existing cost sharing mechanisms, the financial contribution of the diaspora and the funding provided by Islamic organizations are missing. Salaries for hundreds of staff and basic

running costs are financed by external organizations in un-harmonized manner. Public spending for the health sector increased from 1998 to 2004. However the percentage of the National Budget allocated to the health sector has decreased from 4.2% to 2.9%. The support provided by the international community to the health sector was 3.7 Million USD in 2004. Total funding (MOHL + International community) to the health sector in 2004 was in the order of 3 USD / per capita / Year. This financing level may under-estimate total financial resources allocated to health in Somaliland, as donor funds made available to the whole of Somalia might have escaped recording. If confirmed, the figure of USD 3 would imply that Somaliland receives half donor inputs than the national average.

PUNTLAND

Population estimates in Puntland diverge dramatically. The MOH reports in 2004 that the Puntland population amounts to 2.5 millions inhabitants (including Sool and Sanag). The Polio Program projects the population (3 regions without Sool – 149,000 population - and Sanag –`191,000 population -) at 535,000. Demographic data, in the absence of a census in Somalia ever since, raises constant controversies. Nonetheless the Polio Program, which targets all Somali population including scattered pastoralists and small, remote settlements, provides a useful guidance that, in the absence of more accurate figures, should be considered as a useful reference. Therefore all JNA sectors will harmonize demographic data as soon as they will be available and agreed upon.

Facilities: The total number of staff is 1123; 641 (57%) is not qualified (auxiliary nurses, CHWs and TBAs). Hospitals total approximately 600 beds. The total number of doctors is 72, of whom 42 operate as private practitioners. Some of the doctors who work in public hospitals have their own private clinic. The majority operate in Bosaso and Galkayo, where hundreds of private shops and pharmacies sell drugs of doubtful quality. There are imbalances between major urban centres and rural areas as in the other parts of Somalia. The conditions of the health infrastructures are appalling: lack of basic sanitation needs, lack of maintenance, absence of basic equipment may lead to a total collapse of the major curative facilities in Puntland (Kant, 2004).

Health facility	Nugal	Sool	Bari / Kakar	Ayn	Mudug	East Sanag	Total
Hospitals	5	1	9	1	2	1	**19**
Specialized Centers	0	0	0	0	1	0	**1**
MCH/OPD	9	0	8	1	9	4	**31**
Health Posts	12	5	27	0	4	0	**48**
Total	26	6	44	2	16	5	**99**

Health Staff (Public and Private Facilities): The total number of staff is 1123; 641 (57%) is not qualified (auxiliary nurses, CHWs and TBAs). Hospitals total approximately 600 beds. The total number of doctors is 72, of whom 42 operate as private practitioners. Some of the doctors who work in public hospitals own a private clinic. The majority operate in Bosaso and Galkayo, where hundreds of private shops and pharmacies sell drugs of doubtful quality. There are imbalances between major urban

centres and rural areas, as in the other parts of Somalia. The conditions of the health infrastructures are appalling: lack of basic sanitation needs, lack of maintenance, absence of basic equipment may lead to a total collapse of the major curative facilities in Puntland (Kant, 2004).

	Doctors	Nurses	Midwives	Lab Technicians	X-Ray Technicians	Auxiliaries	TBA	CHW	Total staff
Public	30	128	29	13	14				
Private	42	208	18	NA	NA				
Total	72	336	47	13	14	159	287	195	1123

The private health sector:
is de-regulated and concentrated in the major towns. It provides mainly curative health care. A mapping of the existing facilities and human resources is needed. Since a number of years, in Galkayo North, Mudug region a privately-funded certification mechanism for public and private practitioners, has been setup, with the long-term aim of becoming a medical association. A number of requests for technical support and longer term funding have been forwarded to the international community with little response so far.

Medical and paramedical training: Puntland has one nursing school (training also midwives) in Bosaso, mainly funded by Islamic charities and institutions and one private medical school in Galkayo. The Galkayo University has initiated in 2006 the first year of basic training for Assistant Physicians (3 years). They represent a new category, equivalent to the Clinical Officers operating in many African countries, meant to be deployed to rural and remote areas. The results of this teaching experience must be studied (admission requirements of students, qualifications of the teachers, teaching methods and curricula, skills acquired by trainees). The experience gained in the Galkayo Medical School may provide useful lessons for other parts of Somalia.

Organization and structure: The MOH is incipient. Lack of capacity, funds and human resources makes the MOH in Puntland unable, under the present circumstances, to play a relevant role.

Health Care Financing: is inadequate to cover even basic expenses.

CENTRAL AND SOUTHERN REGION

General: Central and Southern Somalia, with 5.4 million people, is the part of the country most affected by 15 years of civil war. However, a vibrant private sector has developed in the capital Mogadishu (approx. 1.5 millions). The population living in the Central and Southern region is vulnerable to continuous natural and man made hazards (epidemics, floods, drought, looting and banditry). Mogadishu accounts for the highest number of displaced people: approx. 250,000. Only few urban centres have relatively functioning social public and private facilities, while in rural and pastoral areas instability and insecurity have hampered access to health and education services.

Facilities, where still existing, remain closed for most of the time: no salaries, no supplies, no supervision, no training or guidance. In Bay, Bakool, Middle and Lower Juba regions, health and education services practically absent, due to the fact that the poorly functioning pre-war facilities have been abandoned and / or destroyed (i.e.).

Therefore, at least half of the Central and Southern population benefits from extremely limited health services, or has no access at all. The only health services provided in some regions are related to the polio eradication program and more recently measles elimination. The largest public hospitals of Somalia (Forlanini, Martini, Benaadir, Madina, Kesseney) are concentrated in Mogadishu.

Health facility	Bakool	Banadir	Bay	Galgaduud	Gedo	Hiran	Lower Juba	Lower Shabelle	Middle Juba	Middle Shabelle	Total
Hospitals	1	25	2	2	5	2	2	3	0	5	**47**
Specialised Centres	0	1	0	0	0	0	0	0	0	0	**1**
MCH/OPD	6	16	9	7	12	7	11	14	7	10	**99**
Health Posts	68	0	72	9	53	30	39	15	34	0	**320**
Total	75	42	83	18	70	39	52	32	41	15	**467**

Human Resources	Central and Southern Zone
Doctors	146
Pharmacists Assistants	50
Midwives	200
Nurses	414
Lab Technicians	82
Assistant Lab Technicians	184
Sanitarians	432
CHWs	291
TBAs	467
Total	**2,383**

Out of the 2,383 staff available, 58% are unskilled. The remaining professional staff does not receive proper in-service training since a long time. The majority of the doctors posted to urban public health facilities operate as private practitioners as well. A number of doctors and health professionals have come back to Mogadishu to initiate their own private clinics funded in many cases by Islamic charities and institutions.

Mogadishu remains violence-affected. Nonetheless, several examples of successful public health interventions, like the SOS Kinderdorf missionary hospital and nursing school, the ICRC supported Keseney and Madina war-surgery specialized hospitals must be taken into consideration. In Galgaduud and Mudug, the El-Der and Harardere PHC programmes have been successful, until the international community has stopped providing technical and financial support. The same holds for the PHC programme in

the Lower Shabelle region. In Gelalaxy, Bulo-Burti, Abudwack and Jowhar, modest success has been registered, in spite of international assistance:. In Mogadishu, Baidowa and Kisimayu, some small-scale emergency interventions have not been substituted by rehabilitation/reconstruction operations, due to progressively increasing insecurity. The health services in Gedo region have been supported in 5 of the 7 districts since 2001. Chronic insecurity has always hampered the consolidation of a well-conceived bottom up regional health programme. In Middle and Lower Juba, Bay and Bakol, Dussamareb and Hobbio in Galagaduud and Mudug regions, Beltweyne in Hiraan region, sporadic health operations have been abandoned from the beginning of the nineties and never resumed.

Private sector: A detailed mapping of the number and the quality of the services provided by private operators in Mogadishu is not available. Private providers manage a large number of hospitals, clinics and pharmacies, concentrated in Mogadishu. Private health practices in the other towns such as Marka, Baidowa, Kisymayu are less important, given the relatively small population living in these urban centres.
Beyond insecurity, other factors intervene to limit the access and the utilization of services: (i) fragmented, externally-funded, weak public health programmes; (ii) absence of roads and long distances; (iii) neglect for minority groups, especially along the two main rivers (Shabelle and Juba); (iv) the poverty of most displaced people, who can not afford to pay transport and health care costs. Therefore reliance on traditional medicine and self medication represent the most frequent health practice.

Organization and structure: The TFG/MOH is grappling with enormous difficulties to establish itself. The MOH has produced a preliminary Health Policy document that has to be discussed extensively to understand its operational implications and how best implementing its prescriptions.

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The Regional Health Systems Observatory is an undertaking of the WHO Regional Office for the Eastern Mediterranean. The Observatory supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in the EMR. Its primary goal is to contribute to the improvement of health system performance and outcomes, in terms of better health, fair financing and responsiveness of health systems. The aim of this initiative is to provide relevant comparative information to support policy-makers and analysts in the development of health systems and to serve as repository of information on health systems.

This document is part of a series of in-depth health systems profiles, produced and updated by the Observatory using standardized approach that allows comparison across countries. They provide facts, figures and analysis and highlight reform initiatives in progress.

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