

Needs Assessment of Obstetric Fistula in Selected Zones in Somalia

Final Report

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Inclusive travel dates: 13 – 26 March 2005 Places: Nairobi and Somalia	Main Purposes of the Mission: Needs assessment for Emergency Obstetric Care and Obstetric Fistula – Capacity building for maternal mortality and morbidity reduction
Objectives of the Mission: 1/ Visit reproductive health-related structures and institutions wherever possible in the country 2/ Conduct a preliminary rapid needs assessment for EmOC and Obstetric Fistula in Somalia 3/ Identify gaps and priorities for UNFPA interventions in the areas of EmOC and OF 4/ Assess the capacity of local institutions and implementing partners to organise a complete NA in the future	

Table of Contents

1. Abbreviations
2. Executive Summary
3. General Background Information
4. Obstetric Fistula
5. Rationale, Terms of Reference, Methodology for the Rapid Needs Assessment
6. Situation Analysis
7. Issues and Challenges
8. Recommendations and Critical Needs
9. Fact Sheets on facilities visited
10. Fact Sheets on meetings with NGO/GOs
11. Key Contacts

References & Notes

1. Abbreviations

AIDS.....Acquired Immune Deficiency Syndrome	MOHL.....Ministry of Health and Labour
AMREF.....African Medical Research Foundation	MSF.....Médécins Sans Frontières
ANC.....Antenatal Care	MVA.....Manual Vacuum Aspiration
ART.....Anti Retroviral Therapy	NA.....Needs Assessment
CARE.....Cooperatives for Assistance and Relief Everywhere	NGO.....Non Governmental Organisations
CISP.....Comitato Internazionale per lo Sviluppo del Popoli	NPO.....National Program Officer
COMSED..Cooperation for Medical Services and Development	NWZ.....North West Zone
COOPI.....Cooperazione Internazionale	OB.GYN....Obstetrics & Gyneacology
C-section....Caesarian section	OF.....Obstetric Fistula
D&C.....Dilatation & Curettage	OPD.....Outpatient Department
EMOC.....Emergency Obstetric Care	RH.....Reproductive Health
FGM.....Female Genital Mutilation	RHO.....Regional Health Office
FP.....Family Planning	RVF.....Recto Vaginal Fistula
FSAU.....Food Security Analysis Unit	SACB.....Somalia Aid Coordination Body
GO.....Governmental Organization	SM.....Safe Motherhood
HMIS.....Health Management Information System	SRCS.....Somalia Red Crescent Society
HIS.....Health Information System	STD.....Sexually Transmitted Disease
HIV.....Human immune deficiency Virus	STI.....Sexually Transmitted Infections
ICRC.....International Committee of Red Cross	TB.....Tuberculosis
IDP.....Internally Displaced People	TBA.....Traditional Birth Attendant
IFRC..... International Federation of Red Cross	TFG.....Transitional Federal Government (of Somalia)
IM..... intramuscular	TFR.....Total Fertility Rate
IMC..... International Medical Corps	TOR.....Terms of Reference
IMPAC..... Integrated Management of Pregnancy and Childbirth	UN.....United Nations
IRHP.....Integrated Reproductive Health Project	UNDP.....United Nations Development Program
IUD.....Intrauterine Device	UNFPA...United Nations Population Fund
IUFD.....Intrauterine Fetal Death	UNHCR....United Nations High Commissioner for Refugees
IV.....intravenous	UNICEF...United Nations Children's Fund
JHPIEGO...Johns Hopkins University affiliated health organization	UNSECOORD United Nations Security Coordination
MCH.....Maternal and Child Health (clinic)	USAID.....United States Agency for International Development
MMR.....Maternal Mortality Rate	USD.....United States Dollars
MOH.....Ministry of Health	VCT.....Voluntary Counselling and Testing
	VVF.....Vesico Vaginal Fistula
	WHO.....World Health Organisation
	WV.....World Vision

2. Executive Summary

Introduction

Since 1991, Somalia has never had a central government. The country remains divided into three political zones of Somaliland, Puntland, and South Central. While political stability varies among the zones, health infrastructure and health training institutions have significantly deteriorated throughout Somalia. In recent years, the quality of life for Somalis has plummeted to global record lows. As drought and famine continue to plague the country, particularly the Lower Juba Valley, the average life expectancy has dropped to 46 years. Further, the country has a large number of refugees, internally displaced people, and nomads, all without adequate access to healthcare.

In Somalia, the maternal mortality rate is one of the highest in the world, estimated at 1600 maternal deaths per 100,000 live births. Most of these deaths are due to lack of access and delivery of quality health services, including emergency obstetric care (EmOC). It is estimated that 95% (rural areas) and over 82% (urban) of the deliveries take place at home, attended by family members or traditional birth attendants. An additional factor that increases the vulnerability of Somali women to maternal mortality and morbidity is the high fertility rate: a Somali woman can expect to have an average of 7.7 children over her lifetime.

In 2005, UNFPA Somalia country office and UNFPA Headquarters designed a rapid needs assessment to assist the country in formulating a detailed plan of action for future activities on EmOC in Somalia. The purpose of the mission was to assess the capacity of the referral health infrastructures; the status and conditions of the basic and essential equipment; and how effectively these facilities were operated and maintained. In order to best design the appropriate range of interventions to reduce the incidence of obstetric fistula (OF) and improve maternal health, the Needs Assessment also considered what facilities exist, how they operate and whether they are accessible to the population in need, as well as the status of the human resources for health. The assessment included a consideration of the capacity of the potential implementing partners (NGOs) in selected regions, in order to advise the best implementation arrangements to be followed by the Somalia Country Office.

The Assessment included site visits to five health centres, including hospitals, in Somaliland, and two facilities in Puntland. The final report of the assessment recommends practical steps that UNFPA take in order to assist the local health authorities in the area of capacity-building for sustainable EmOC and OF management. It also seeks to devise an appropriate course of action for UNFPA's envisaged priority interventions in a phased timeframe. Both qualitative and quantitative methods were used to elicit the relevant information from the facilities.

Findings and Challenges

While there is awareness at all levels that obstetric fistula is a major complication of childbirth, no plan or program exists for organized prevention, treatment or rehabilitation.

Further, for a number of reasons, it was difficult to establish the exact magnitude of the problem of OF in the country.

The conflict in Somalia adds an additional layer of complexity to the context. A large number of patients of all categories migrate from Central South Zone and insecure parts of Puntland and from Ethiopia in order to get access to health services in Somaliland (the health infrastructure situation in the zone of Puntland and South Central Zone is worse than in Somaliland, but could not be assessed sufficiently due to lack of time and security). However, OF patients are typically unable able to undertake long journeys and reach health facilities.

While the specific experience with fistula varied in the facilities visited, a number of common challenges emerged surrounding EmOC and OF, namely:

- Severe lack of qualified human resources and hospital facilities to address OF. In a number of the facilities visited, more cases had been seen than could be repaired. Only few surgeons engage in fistula repair sporadically. In Puntland, one expatriate carries out OF repairs in the Galkayo hospital, where the poorest of working conditions of all visited hospitals were observed. Otherwise, there is no fistula surgery in public hospitals in Puntland except for Bossaso.
- Most facilities, apart from the private Edna Adan hospital in Somaliland, did not meet basic or comprehensive EmOC standards. While UNFPA and UNHCR as well as other agencies had worked to refurbish some hospitals, in general, they were dilapidated. Unreliable water and electricity was a challenge at some facilities, and in most hospitals including the public hospital in Hargeysa, there was no anaesthesia. Economic issues arose in a number of sites as well, where fistula repair would not be affordable for the typical fistula patient.
- The local and international NGOs engaged in reproductive health programs including EmOC have not streamlined their efforts together with the local ministries of health. Ministries of Health are overburdened by post-war problems and unable to appoint maternal health a top priority within the health sector.
- Finally, in many parts of Somalia, harmful cultural practices abound. The practice of praying and reading the Koran to relieve obstructed labour during home delivery can delay seeking health care. Traditional healers and traditional healing practices of introducing hot iron rods in the vagina for a wide range of female health problems can lead to later obstetric complications. The overwhelming prevalence of childhood FGM among pregnant Somali girls and women might present a special challenge for correct management of childbirth. Many adolescents get married, with a potential for increased obstructed labour and a high risk for developing fistulas.

Ways Forward

EMOC and Maternal Health:

- **Rehabilitate** maternal health facilities for EmOC based on the model of the GYN/maternity ward at Hargeysa Group Hospital, Somaliland, to make them welcoming,

culturally acceptable, essentially equipped, respecting human rights, as well as geographically well-distributed;

- Working with medical associations, support **revision, adaptation, translations, distribution of national standards and protocols for EmOC and OF**, including basic and comprehensive functions and good obstetric practices such as *inter alia* partogram, active management of third stage of labour and infection control. Add a chapter on local problems such as handling childbirth in circumcised women;
- Assist in the formulation of appropriate **human resource strategies**, including investing in **public health staff training**, on the job and basic training, with a focus on EmOC;
- Support and supervise **new and existing schools for midwives and nurses** with special focus on EmOC, maternal morbidity, in particular OF, and newborn care;
- Invest in **health system management, leadership, and monitoring**, through the use of HMIS and introduction of EmOC process indicators, procurement and distribution of RH/FP commodities.
- Support **community involvement** through community leaders, NGOs, hospital management committees, endowment funds, solidarity schemes; linkages with TBAs for patient referral and interventions regarding traditional practices;
- Introduce specific components related to **adolescent sexual and reproductive health** within UNFPA-sponsored RH projects, as adolescents carry the burden of the highest maternal morbidity and mortality, and are particularly vulnerable to developing OF.
- Take every opportunity to integrate **gender and human rights** approaches to women's health, in order to improve fast access to health services for child mothers and pregnant women.

Obstetric Fistula: Phased approach

First phase:

- Prepare an initial campaign for fistula treatment by establishing an outreach program, starting in Hargeysa or Borama in Somaliland. Eventually roll out to the rest of the country;
- Invite Dr. Tom Raassen, currently AMREF, who has trained many East African fistula surgeons, to precede the fistula surgery sessions and select, then train and supervise local surgeons according to their willingness, dedication and record of fistula operations;
- Identify, select a background team: nurse (preferably with special interest in fistula patients, physiotherapy, psychology/psychiatry, OB/GYN, urogynecology), social

worker, physiotherapist, former fistula patients and dedicated family members of fistula patients – in order to ensure continuity and follow-up;

- The campaign should be preceded and followed-up by a media campaign in order to sensitize population, health managers and political leaders;
- Incorporate upstream work (prevention of OF through adequate nutrition, delayed first pregnancy, institutional delivery of the first birth, availability, use and quality of EmOC facilities, C-section etc.) and downstream (social rehabilitation, reintegration, counselling, instruction and follow up of operated women);
- Write a national fistula plan of action together with background team and politicians in health sector.

Second phase:

- Provide training and education to nurses, midwives and doctors in remote locations on EMOC and how to anticipate, prevent and identify OF and how to refer, treat and rehabilitate patients who have developed OF;
- Increase the number of skilled health personnel in remote areas who can recognize and treat obstetric complications in all pregnant women, and who can also manage obstructed labour in women at high risk through appropriate interventions. They should also be willing to engage in psychological, social, and/or physiotherapy work with the aim to rehabilitate and reintegrate fistula patients into local society.

Third phase (or in parallel):

- Conduct community awareness campaigns on obstructed labour aimed at village elders and religious leaders, TBAs and pregnant women and girls to counteract the belief that delivery becomes problematic only after the second or third day of labour (e.g. using slogans such as, "**The sun should not rise or set twice on a labouring woman.**" **Every pregnancy is at risk**). The campaign has to be in Somali language transmitted via radio, television, websites and newspapers;
- Use recovered fistula patients as informers/ ambassadors. This strategy will help shy fistula patients to seek help and get the necessary local support from family members and local decision-makers.

Other Recommendations

- **Improve logistics:** For effective and fast transport and communication between health care facilities, encourage motorized and, where possible, semi-private emergency transportation.
- **Improve communication:** Establish VHF radio network at all maternity wards in order to facilitate communication to MCHs, delivery homes and other child delivery facilities.

Encourage TBAs and family members to use this communication network when difficulties arise during home deliveries.

- **Funding:** Establish fistula funds through Hospital Boards, dedicated clan and family members.
- **Buildings:** Consider establishing maternity waiting homes / shelters in conjunction with hospitals in order to prevent obstetric complications, especially obstructed labour, thus ensuring direct access to timely and appropriate obstetric interventions.
- **Policies:** Incorporate into a fistula plan of action the recommendations of the International Obstetric Fistula Working Group, Training for Fistula Treatment Workshop, Niamey, Niger - 19-20 April 2005 (see References).
- **Prepare a full-fledged Needs Assessment in the whole of Somalia:** when the political situation permits, giving first priority to the Central South Zone, which has not been visited during this mission, and second priority to Puntland, which only has been assessed minimally. Preparation must be made over a longer period, simultaneously at the Somalia Country Office in Nairobi, Kenya, and by partners in the field, so as to minimize ineffective working conditions and expenses for security measures in Somalia.

3. General Background Information

Background

Somalia is one of the least developed countries in the world. Chronic instability and civil war resulted in the fall of the government in 1991. Since then, Somalia has never had a central government, and the country remains divided into zones, regions and political districts. Some areas (Somaliland and Puntland) have established significant stability and security measures and enjoy increased programme activities. Other areas (South and Central Zone) are still in a volatile situation with frequent ethnic clashes and insecurity.

Health infrastructure including health training institutions collapsed during the civil war, and equipments and materials disappeared. Most of the hospitals are either under equipped or non operational. Although the number of health facilities might have increased due to the growing private health sector, it is believed that less than 28 percent of the Somalis have access to conventional health services. As well, the number of qualified health professionals and technicians dropped drastically. Before the civil war, it was estimated that 5,600 personnel were employed in the public health sector, of which about 66 percent were qualified professionals and trained technicians. In 1994 the health sector employed 5,100 persons, but fewer than 37 percent were trained professionals.

Available data on place of deliveries and the attendance of skilled health personnel during delivery are inconsistent and in some cases controversial. However, it's estimated that 95% (rural areas) and over 82% (urban) of the deliveries take place at home attended by family members or TBAs. Similarly there are conflicting reports on maternal mortality rates: some reports indicate as high as 1600 maternal deaths per 100,000 live births. Most of these deaths are due to lack of access and delivery of quality health services in general and in particular emergency obstetric care (EmOC). The latter in turn contributes to the incidence and prevalence of obstetric fistula (of).

Situation in Somaliland, North West Zone of Somalia

The North West Zone, now known as the "Republic of Somaliland", declared independence in 1991 and has enjoyed relative peace and stability that has enabled the country to re-establish political and administrative structures. However, Somaliland remains without international recognition to date.

The establishment of the Government in Somaliland and the ability of the administration to ensure relative safety and security for development agencies have facilitated an increase in rehabilitation and development activities supported by international agencies and an evolving civil society. The private sector in Somalia is also a strong force, providing resources for social services as well as filling in gaps in social service provision, though at considerable cost to individuals.

The situation in Puntland

Puntland in north-east Somalia, declared itself an autonomous state in August 1998. Unlike Somaliland, Puntland did not seek international recognition and independence, but rather wants to be an autonomous element of a federal Somalia. The region has seen sporadic fighting with Somaliland, specifically over the Sool and Sanaag regions. Most Somalis living in Puntland are nomads.

Puntland has a particular challenge as a hub for a large population of internally displaced persons (IDPs) from South Somalia. This influx strains already very limited resources. Many of the IDPs come to Puntland en route to Yemen. Many health care facilities were damaged by the war and are being rebuilt. The Red Cross has set up a number of integrated health care centers in Puntland.

Reproductive Health in Somaliland

Since the establishment of Somaliland central government, many development activities have commenced. A number of international NGOs and UN organizations are present and provide support in cooperation with the Ministry of Health and Labour (MOHL) and other ministries. Local NGOs are also playing an important role in health service provision, but on a more limited scale than international NGOs and UN agencies.

Many organizations have focused on projects that provide support to individual elements of maternal and child health and family planning services. This has led to a fragmented approach to reproductive health support in Somaliland. Though structures exist for coordination of aid activities in Somalia through the Somalia Aid Coordination Body (SACB), efforts on the ground have not been well coordinated. With increased capacity in the MOHL over the last few years, the Ministry has begun to take a more active role in coordinating health sector activities. There is now an attempt to bring international agencies together to standardize systems and procedures; the first steps taken were to standardize the

Health Information System (HIS) and standardization of cost recovery system for drugs at both hospital and mother and child health clinics (MCH) levels.

Thus, the health system in Somaliland is becoming more structured, especially in urban areas, staff are being retrained, and facilities are being reequipped and repaired. However, there are a number of major operational and cultural challenges that require long-term commitment in order to effectively contribute to the reduction of maternal and neonatal morbidity and mortality rates in Somaliland.

The major challenge in provision of health services by the government is inadequate national budget allocation for health. Somaliland is a poor country, and the MOHL is therefore dependent on international NGO/GO financial support.

Shortage of health manpower and brain drain at all levels results in limited access to reproductive health services. For example are 18 midwives in public service in the whole country of 3.000 000 population, seven of whom are based in one place, Hargeysa hospital.

There is still concern for delay in referral of patients because of delayed transport and TBA practice of retaining patients too long for fear of losing service fee.

Identification of women at high risk during pregnancy and delivery does not only involve the knowledge and practices of the health care provider but the more complex issue of access - both physical and social. Physically, health services are centralized. About one-half of the population are mobile nomads, who have no stable access to health services. Public or private transport is unavailable for most of these outlying populations. Socially, both family and health service provider attitudes influence access. For example, if there is an obstetric complication during a home delivery and the woman needs to be transported to a health centre, the TBA and the family must be willing to refer and must have confidence in the services available at the referral facility.

The vast majority of deliveries in Somaliland still occur in the woman's home. The baseline survey and final project evaluation conducted by CARE in October 2002 and August 2004 respectively found that the majority of births (66.5%) occurred at home and only 32.1% took place at a health facility. Comparatively, 73.8% and 26.2% of births occurred at home and health facility respectively according to the 2002 baseline survey. There is evidence from the baseline survey that more women in the urban area prefer to deliver at a health facility. 52.5% deliveries as compared to 39.6% recorded in the 2002 survey occurred at a health facility among urban women. This shows that women can utilize the service of the skilled service provider. There is need to encourage more mothers to deliver at a health facility rather than at home.

The average Somali woman can expect to have is 7.7 children throughout her lifetime. Frequent and numerous pregnancies increase the risk of maternal death. Child spacing using modern methods is estimated at 5 percent. The most common method used by women is injectable (Depo-Provera) followed by oral contraceptives and natural FP. Child spacing is a sensitive issue in Somalia due to the strong belief that family planning is contrary to the teachings of the Koran. In addition, women are frequently under pressure from their husbands to produce many children, especially sons, to strengthen the husband's lineage and

to replace the large numbers lost during the war. However, with increased knowledge of safe motherhood and the need for child spacing, the demand for contraceptives is growing.

3. Obstetric Fistula

Introduction to a neglected female reproductive health issue

Obstetric fistula represents a critically important and largely neglected issue in the field of reproductive health. The World Health Organization (WHO) estimates that at least two million girls and women currently live with fistula and that an additional 50,000 to 100,000 are affected each year. For the vast majority of these girls and women services to repair their condition remain unattainable for a number of reasons: their lack of knowledge that such a condition can be repaired; the distance they must travel to reach a facility that provides treatment; the low likelihood that, even if they can get to a facility, it will offer fistula repair in its portfolio of services; their inability to pay for the services, if they are available; and the backlog with which facilities that do provide repairs are faced.

The clinical component of fistula care presents a number of difficulties. The context in which fistula surgery facilities are based and the degree to which communities are equipped to reintegrate women once repaired may also present obstacles to treatment. The social rehabilitation of women after a successful fistula repair is challenging, as these clients are often extremely poor, abandoned by their husbands or partners and without skills to earn a living on their own. These conditions may render them especially vulnerable once they return to a community.

So far, the experience from Kenya, Tanzania, Uganda and Nigeria is that once the repair has been a success, i.e. without residual incontinence, these women reintegrate into local society without major problems. Often they remarry or return to their husbands and become pregnant.

In 2003, UNFPA and its partners launched the global Campaign to End Fistula, www.endfistula.org, with an overall goal of making the condition as rare in the South as it is in the North. This includes interventions to prevent fistula from occurring, treat women who are affected, and renew the hopes and dreams of those who suffer from the condition. This includes bringing it to the attention of policy-makers and communities, thereby reducing the stigma associated with it, and helping women who have undergone treatment, to return to full and productive lives. The Campaign currently covers more than 30 countries in sub-Saharan Africa, South Asia and some Arab States. In each country, the Campaign proceeds in three phases:

- First, needs assessments are undertaken to determine the extent of the problem and the resources to treat fistula.
- Second, each country that completes a needs assessment, receives financial support for planning, including raising awareness of the issue, developing appropriate national strategies and building capacity.

- Finally, a multi-year implementation phase begins, which includes interventions to prevent and treat fistula, such as improving obstetric care; training health providers; creating or expanding and equipping fistula treatment centres; and helping women reintegrate into their communities.

Medical background

Obstetric fistulae are well known in remote settings in developing countries, while virtually unknown in countries, where there is easy access to caesarean section. Major aetiology is obstructed labour,

An obstetric fistula is the last and most serious obstetric complication, whenever obstructed labour has occurred. It is preceded by a disastrous chain reaction of obstetric complications, often resulting in neonatal death (estimated more than 90 %). It represents a neglected medical taboo problem and is characterized by long term maternal morbidity.

Anatomically, vesicovaginal, urethrovaginal, ureterovaginal and rectovaginal fistulas and often some more complex changes of the female genitals (e.g. vaginal stenosis, lack of urethra, anal sphincter injuries, see References: Waaldijk) can be seen, ranging from simple to extremely difficult challenges for surgical repair.

Symptoms include urinary and faecal incontinence making the affected woman smell of urine and stools and unable to keep clean; peroneal paralysis (drop foot) resulting in impaired physical mobility; painful skin changes in the genital region; recurrent urinary tract infections; infertility; menstrual disorders; dyspareunia and psychological disorders.

These women all experience different grades of social marginalization often leading to outcast status. Moreover, there are psychological, sexual and social consequences for their surviving offspring, if any, and families.

In general, in low resource settings, fistulas are caused by obstructed labour: the baby's head cannot pass through the pelvis and remains pressed against vaginal, bladder and rectal wall tissue for a prolonged period of time, sometimes for days, causing necrosis, and ultimately a fistula develops. Moreover, some women develop iatrogenic fistulas following a hysterectomy or C-section.

The underlying causes include malnutrition (and possibly repeated infections) leading to small stature which, when combined with pregnancy at a young age, results in pronounced cephalo-pelvic disproportion. Insufficient access to emergency obstetric care and the culture of delivering babies at home, often without skilled attendance, create dramatic scenarios, where women, especially young women and child mothers, are at high risk for developing a fistula or often die. Poorly managed instrumental deliveries and C-sections at under equipped health facilities contribute to fistula incidence as well.

Exact prevalence rates in Somalia (and the world) are not known. But Dr. Kees Waaldijk, Dr. Tom Raassen and Dr. Festus Llako (see References: Waaldijk and Needs Assessment from 9 African Countries) extrapolate a figure of 6,000 to 15,000 new fistulas occurring each year in East Africa. This figure is based on the knowledge that every year three million women survive deliveries in the region; for each thousand of these surviving mothers, there are an estimated one to five cases of fistula.

Crude birth rate for Somalia calculated by Dr.Vincent Fauveau (see References, UNFPA Mission Report No 38) is 45 per thousand (population) per year.

Estimated obstetric fistula incidence for Somalia:

1-2-5 /1000 deliveries

Population estimate 6 Million (Health Authorities' estimate): 270, 540, 810

Population estimate 8 Million (Political Authorities' estimate): 360, 720, 1080

4. Rationale, Terms of Reference, and Methodology for the Rapid Needs Assessment

Since 2003, UNFPA and its partners have decided to work globally for prevention, treatment and rehabilitation of obstetric fistulas. Needs assessments have been carried out in several countries in order to assist GOs and NGOs to address the problem.

UNFPA-Somalia is expanding its reproductive health programs. The need for delivery of effective emergency obstetric care is felt to be vital for reduction and prevention of maternal deaths and complications from pregnancy that could affect the quality of life of women of child bearing age. There is special focus on the condition of obstetric fistula, as it results in long-term maternal morbidity and often outcast status.

This current mission is meant to assist the UNFPA Somalia country office and UNFPA Headquarters in formulating a detailed plan of action for future activities on EmOC and of in Somalia.

Recommendations for intervention are made in this report so as to form a basis for a fistula plan of action in the different parts of Somalia. The aim is to reduce obstetric fistula incidence and to help women living with the condition by offering fistula surgery within the country and reintegration into the local social context.

Terms of Reference for this mission were defined by the UNFPA Country Representative

1. Assess the existing health care delivery systems in Somalia aimed at reducing the morbidity and mortality patterns related to EmOC, and the prevention and treatment of Obstetric Fistula.
2. Aim at establishing some baseline data to give an indication of the prevalence of Obstetric Fistula among Somali women in the targeted regions.
3. Identify existing health delivery gaps and outline a sustainable Emergency Obstetric Care strategy for UNFPA within the context of the overall UN system-wide efforts for affected populations in Somalia.
4. Prioritize the required UNFPA interventions and activities in these two areas (EmOC and OF), in conformity with the strategies of the regions concerned, and devise an appropriate course of action for UNFPA's envisaged priority interventions in a specified timeframe.
5. Assess the Human Resources Capacity, their knowledge and skills necessary to effectively address the obstetric-related maternal mortality and morbidity causes in the population.

6. Provide practical steps for UNFPA to assist the local health authorities in the area of capacity-building in order to ensure that the delivery of EmOC interventions is sustainable and effective.
7. Assess the capacity of the potential implementing partners (NGOs) in selected regions, and advise the best implementation arrangements/modalities to be followed by the Country Office.
8. It is important for the mission members to also closely appraise the capacity of the referral health infrastructures; the status and conditions of the basic and essential equipment; and how effectively these facilities are operated and maintained.

Rapid Needs Assessment

To begin to grasp how best to address the range of possible interventions, it is important to understand what facilities exist, how they operate and whether they are accessible to the population in need. This rapid fact finding mission could only provide a glimpse of the generally poor state of health facilities seen through the eyes of an external consultant.

The data gathered during one week are primarily qualitative and represent one moment in time. Some few quantitative data provided by GOs, NGOs and individual physicians and politicians can be found in the appendix.

The intention was to draw a picture of the reproductive health situation with special regards to EmOC and of in various locations in order to assess the capacity of local institutions and the scarce human resource base.

Methodology

The rapid needs assessment was conducted by one male intern (paediatrician and senior maternal health advisor) and one female extern (OB/GYN) medical consultant accompanied by the National Program Officer (male ethnic Somali) from the UNFPA Somalia country office, which is based in Nairobi, Kenya.

During 3 days in Nairobi, Kenya, the mission was briefed by the UNFPA Representative and UNFPA National Program Officer. Meetings with current and potential future partner organizations were held.

Subsequently, parts of Somalia (Somaliland and Puntland) were visited for one week, where GOs, NGOs, health personnel and health facilities offering EmOC services and OF care were seen. Public and private health sector hospitals were visited. Clinical facilities were toured; wards, operating theatres and maternity operating theatre logbooks were seen, whenever possible. Few mother and child health clinics were assessed at random. NGOs, GOs, administrators and medical staff (physicians, nurses and midwives) were interviewed, as well as NGO women's groups and a few fistula patients. Meetings with representatives from the Ministries of Health (MOH) and local policy makers took place as well. There were no structured meetings with TBAs.

A simple questionnaire (see appendix) was used for assessing the current situation on obstetric fistula. For EmOC the UN process indicators were used (see appendix).

5. Situation Analysis

There is awareness at all levels within the health sector and amongst women of childbearing age that obstetric fistula is a major complication to childbirth, but no plan or program yet exists for organized prevention, treatment or rehabilitation so far.

From meetings with GOs / NGOs in Kenya and Somalia it can be concluded, that a number of local and international NGOs have engaged in reproductive health programs, addressing different components. Some are even trying to incorporate EmOC into their agenda, but none have been able so far to streamline their efforts together with the local ministries of health in order to live up to the United Nations Process Indicators for Emergency Obstetric Care ((UNICEF / WHO / UNFPA, 1997, see appendix).

Thus, neither criteria for **Basic EmOC facility** nor **Comprehensive EmOC facility** were fully met at any health facility visited. The majority of facilities visited were far from being able to meet the 6 basic EmOC functions:

Parenteral administration of Antibiotics (IM/IV)

Parenteral administration of oxytocics (IM/IV)

Parenteral administration of anti-convulsants (IM/IV)

Manual removal of Placenta

Removal (by aspiration) of retained products in uterus

Assisted vaginal delivery (by vacuum extractor)

As a consequence, major obstetric complications for the time being cannot be prevented or treated effectively.

No NGO/GO has so far addressed the issue of obstructed labour and / or obstetric fistula separately.

Ministries of Health are overburdened by post war problems and unable to appoint maternal health a top priority within the health sector.

Consequently, the burden of long-term maternal morbidity resulting from obstetric fistula is constantly affecting the life of the women, who have developed a fistula, their families/clan, and ultimately their local society, in a negative way. The majority of a largely nomadic population struggling with the aftermath of decades of war, famine and poor access to water is not able to cope with this condition. Fistula patients thus suffer from tragic, desperate, sometimes grotesque incidences, as described during the visit of Borama Hospital in Somaliland (see: Fact sheets on facilities visited, C.)

There is a severe lack of qualified human resource and hospital facilities to address the issue of obstetric fistula. Only few surgeons engage in fistula repair sporadically, 2 of them (one in Somaliland, one in Central South Zone) have been trained at a fistula centre. One of these doctors submitted a proposal for establishing a fistula centre at a district hospital at the North West border of Somaliland (see appendix). Seven (7) doctors expressed interest in doing fistula surgery in the future (see list in appendix).

There are 3 hospital sites visited, that could be identified as future EmOC centres as well as fistula training, treatment and rehabilitation sites. Two of these are situated in Hargeysa, the capital of Somaliland. Edna Adan Hospital is a private health facility and for economic reasons not accessible for the majority of the population. The public Group Hospital could be a promising site in the future, as the operation theatre is undergoing major renovation by UNHCR, and if surgical equipment can be provided once it is finished. Both hospitals have relatively well functioning maternity and gynaecological wards. The third site, Borama public hospital in the north west corner of Somaliland, has currently the most qualified human resource (see proposal for fistula centre, References) to address treatment of fistulas, but is logistically not as easily accessible as Hargeysa and would need substantial rebuilding and provision of medical equipment.

The Situation in Puntland

Due to a lack of time and security, only two centres were visited in Puntland.

In the first, the Community Hospital of Garowe, is a public regional referral hospital, where neither Basic nor comprehensive EmOC were met. The hospital carried out about 10 deliveries a month, less than one c-section a month. There seemed to be few maternal deaths, and the hospital was clean, stable electricity and water supply. The hospital had, in collaboration with CARE, established VHF radio communication at maternity admission room with round the clock. Without a blood bank, relatives are used as donors.

The second facility visited was the Galkayo hospital, Public Regional Referral Hospital in south centre of Puntland. The hospital was dilapidated, and here as well, neither basic nor comprehensive EmOC were met. The staff had seen a many OF cases, and are familiar with catheter treatment. There is no fistula surgery in this hospital, apart from an expatriate doctor who visits temporarily. The hospital carries out around 30 deliveries each month, and 10 c-sections for the month. Staff carry out the surgical obstetric procedures by themselves except for c-section. There were no drugs at the hospital, they had to get them from the pharmacy, which often has a drug shortage, and has to rely on MSF for resupply. It was a congested hospital with a severe lack of staff at all levels.

Facilities and supplies	Garowe (public)	Galkayo (public)
Bloodbank	No.	No
Number of beds	40	
Basic Emoc	No	No
Comprehensive Emoc	No	NO
Radio Communication	Yes	
Magnesium Sulfate	No	No
Catheters	Yes	Yes
IV fluids	Yes	Yes
Anesthesia machines	No, Ketamine and local analgesia	No
Staffing:		
Medical doctors	2, 1 female (no C-section)	4
Surgeons	0	1 foreign
Midwives		1

The situation in the zone of Puntland and South Central Zone is worse than in Somaliland, but could not be assessed sufficiently due to lack of time and security.

From the interviews with health personnel in both Puntland and Somaliland it can be concluded, that a large amount of patients of all categories migrate from Central South Zone and insecure parts of Puntland and from Ethiopia in order to get access to health services. Fistula patients are often weak and marginalized. Many of them will therefore not be able to undertake long journeys and reach health facilities, which so far in general have nothing to offer.

6. Issues and Challenges

Culture

Islam is one of the corner stones of Somali society. There are a number of practices and beliefs in connection with pregnancy and childbirth that can delay appropriate action, when obstetric complications occur: f. ex. praying and reading the Koran to relieve obstructed labour during home delivery; or reluctance to leave home during and after child delivery (40 days appropriate according to Koran).

Traditional healers and traditional healing practices are widely used and are often the only access to some kind of health service. Some of these practices can be deleterious for future female reproductive health such as harmful physical manoeuvres to relieve obstructed labour or so-called “traditional burning” (e.g. introduction of hot iron rods in the vagina for a wide range of female health problems such as vaginal discharge, itching or infertility).

The fact that almost 100 % of pregnant girls and women have undergone FGM in childhood presents a special and so far unaddressed challenge for correct management of childbirth, especially when obstructed labour occurs. Home deliveries attended by female family/clan member and/or TBA are the rule, and often TBAs do not recognize or are reluctant to transfer complicated cases from home to health facility.

There are strong taboos around certain family planning methods and devices. Early and unprotected intercourse results in adolescent pregnancies, which are at high risk for developing fistulas. After having developed a fistula with incontinence, women are reluctant to leave home, become extremely shy and feel shame. They often get socially isolated and can be conceived as cursed in their local context, especially as the baby is born dead in the vast majority of cases.

Finally, the Somali society is male dominated, women are seldom decision makers. Moreover, males in all social classes practice daily chewing of khat, a euphoric plant, from midday, thus hampering continuity of work in health and other sectors 24 hours around the clock, which is essential for EmOC and prevention of fistulas.

Population

A large part is nomadic / semi-nomadic with no access to the few centralized health facilities. There are a large number of refugees and internally displaced people in the country living under miserable conditions.

It is estimated that more than 45 % of the population in Somalia is under 15 years, and their special reproductive health needs have not been sufficiently addressed yet. At the same time, adolescent and child mothers are at high risk to develop an obstetric fistula.

Politics

Somalia is in a stage of post war, the country is extremely poor and generally destroyed. For the time being there is a controversial splitting of the country into 3 zones with 3 parallel public systems. RH and maternal health are not yet a major MoH priority, although they are perceived as major female health problems. There is a political taboo on RH issues, currently on condoms, long-term on many other, e.g. adolescent sexual behaviour and child spacing. National and international NGO/GOs have different and competing agendas. There is so far no effective streamlining of program aims at the field level, nor is there a collection of health data, although the will is expressed in many program documents.

Economics

A large portion of the population has little or no access to money, in particular females. Large parts of the public health sector are financed by foreign donors and thus influenced by different health agendas. The practice of cost sharing has been introduced into the public health sector, preventing equal access to health services for the whole population. An expensive private parallel health sector is evolving quickly and is totally inaccessible to the majority of the population. Discontinuity of staff payment in the public health sector is a serious threat for reliable health service delivery; a lack of incentives to keep qualified staff in the public health sector causes brain drain. Competition between an expanding private and weak public health sector causes confusion and inadequate delivery of a minimum of public health services.

Education

There is a lack of training facilities in the health sector at all levels. The few existing public training facilities are badly equipped. Severe lack of qualified trainers of many potential young trainees is a key problem at all levels. No public education facilities of good quality and / or free of charge exist at this point; marked differences between the standard of private and public midwife/nursing school in Somaliland were observed. There is a lack of educational incentives and continuous medical education in order to keep qualified staff in public health sector – clearly deficient in comparison with private and foreign donor activities. Overall, there is a lack of updated educational materials and national guidelines.

The vital educational tools of registration and reporting systems within the health sector are seriously deficient. There is total lack of educational materials on anticipation, prevention, diagnosis, treatment and rehabilitation of patients at risk for or with a manifest obstetric fistula.

Although many ongoing projects are addressing the practice of FGM, there is total lack of rational educational materials on handling patients with FGM during childbirth, especially the situation of obstructed labour. No formalized training for managing child delivery in infibulated women is offered for TBAs, midwives or nurses, although WHO has produced a step-by-step manual for this condition (see References).

There seems to be misconception on the relationship between FGM scarring and possible causes of obstetric fistula. A simple conception that FGM is a direct cause of obstetric fistula was met several times, as opposed to the fact that it can be an indirect contributing factor during mismanagement of labour in circumcised females. Could this conception be created by inadequate awareness and reasoning as part of FGM education programs? Far too few women are aware of obstructed labour and its dangers and how to avoid or handle it.

Human Resources

Severe lack of qualified staff at all levels in the public health sector, especially midwives, was observed at all visited sites. Discontinuity of reporting at work occurs regularly. Brain drain to foreign countries and parallel private health sector has been and is ongoing. The very scarce qualified staff prefers to stay and work in urban areas.

Medical supplies

Discontinuity of supplies in the public health sector was met everywhere; there seemed to be no control or streamlining of foreign NGO/GO donor, private donor and MoH supplies.

The observed consequences were:

- Severe lack of hospital technical equipment (e.g. surgical instruments, sterilizers, lamps and operating tables at operating theatre)
- Severe lack of maintenance and performance / quality control of technical equipment
- Severe lack of essential drugs at all public health facilities
- At the same time well equipped, efficient private pharmacies in urban areas unaffordable to the majority of the population.

Buildings

Public sector hospital buildings are old and deteriorated, sometimes destroyed by war. Lack of maintenance was observed at all public hospitals and MCHs visited. Very basic and limited set-up for fistula surgery was seen at 2 public hospital sites visited, but there was no set-up for rehabilitation of fistula patients.

Logistical Issues

Roads are not at all or not sufficiently maintained, having been destroyed during war or being unpredictably deficient due to sudden climate changes. For the many poor people only primitive and very slow means of transportation exist.

Communication & Advocacy

Access to electronic devices (such as cell phones, VHF, radio, television, video, and computer) is widespread in urban areas, so far without benefit to the majority of the population and so far with no effect on referral of patients in critical medical conditions. There are no radio programs on integrated management of pregnancy and childbirth, thus EmOC and Obstetric Fistula and prevention of the latter are not yet addressed on a wide scale. As a result, the taboo status of women with OF is neither addressed nor recognized publicly. No specific radio programs have focused on interviewing and thus getting females to stand out in public and tell about their experience of complicated pregnancy or childbirth with subsequent foetal death and longstanding morbidity such as OF.

Security

Differing parts of the country are inaccessible due to ongoing fighting, restricting movement of users and providers of health services. For foreign aid workers there are still many restrictions and expenses on maintaining personal security, resulting in ineffective working conditions.

7. Recommendations and Critical Needs

(for specific recommendations on EmOC see Vincent Fauveau's UNFPA report on this mission, N38, 2005)

Overall aim: Lower the high maternal mortality rate and to decrease maternal morbidity, in particular the number of severe obstetric complications - with special focus on OF.

- **Rehabilitate** maternal health facilities for EmOC based on the model of the GYN/maternity ward at Hargeysa Group Hospital, Somaliland: make them welcoming, culturally acceptable, essentially equipped, respecting human rights; geographically well-distributed. Institutional child delivery facilities need a stable supply of clean water, a minimum of sanitation and risk waste management. This will increase the number of institutional versus unsafe home deliveries and thus decrease obstetric fistula incidence.
- Support **revision, adaptation, distribution of national standards and protocols for EmOC and OF**, including basic and comprehensive functions and good obstetric practices such as *iner alia* partogram, active management of third stage of labour and infection control. Use WHO IMPAC guide (see References) as a standard, and facilitate its **translation** to Somali language, adding a chapter on local problems such as handling childbirth in circumcised women, TBC, traditional practices, etc. Use medical associations (midwives and doctors in collaboration) for discussion, ensuring quality, supervision, ongoing revision and adaptation of guidelines.

- Invest in **public health staff training**, on the job and basic training, with a focus on EmOC, to prevent mismanagement during childbirth, especially obstructed labour. Assist in the formulation of appropriate **human resource strategies** to retain staff on the job (incentive schemes, improvement of living and working conditions).
- Support and supervise **new and existing schools for midwives and nurses** with special focus on EmOC, maternal morbidity, in particular OF, and newborn care.
- Invest in **health system management, leadership, and monitoring**, through the use of HMIS and introduction of EmOC process indicators, procurement and distribution of RH/FP commodities. Try to involve “quarterly health coordinating meetings” (SACB) in these activities. In the same forum continuously argue for preparation of full-fledged Needs Assessment for EmOC and OF, when and where the political situation permits.
- Support **community involvement** through community leaders, NGOs, hospital management committees, endowment funds, solidarity schemes; linkages with TBAs for patient referral and interventions regarding traditional practices (e.g. FGM, harmful physical manoeuvres to relieve obstructed labour, introduction of hot iron rods in the vagina for various reproductive health problems such as vaginal discharge, itching or infertility).
- Introduce specific components related to **adolescent sexual and reproductive health** within UNFPA-sponsored RH projects, as adolescents carry the burden of the highest maternal morbidity and mortality, and are particularly vulnerable to developing OF. Disseminate these components to other partners: NGOs, Ministry of Education, Ministry of Youth; TV and radio programmes (e.g. sports programmes), local websites, SMS campaigns and newspapers.
- Take every opportunity to integrate **gender and human rights** approaches to women’s health, in order to improve fast access to health services for child mothers and pregnant women.

Specific recommendations on Obstetric Fistula

- **Current political instability in the country and lack of human resources make it difficult at this point to establish a centre for treatment of obstetric fistulas and rehabilitation of fistula patients, although the need is immense. An alternative specific scenario is proposed below, followed by general recommendations.**

3 Phase Scenario

First phase:

Prepare an initial campaign for fistula treatment by establishing an outreach program, starting in Hargeysa or Borama in Somaliland. Consider and assess Bossaso in Puntland and cooperation with existing fistula surgery activities in Mogadishu in the Central South Zone. The overall aim would be to cover the country geographically and avoid political turmoil (preference of one of the three currently existing political zones).

Invite Dr. Tom Raassen, currently AMREF, who has trained many East African fistula surgeons, to precede the fistula surgery sessions and select, then train and supervise local surgeons according to their willingness, dedication and record of fistula operations. In that way, it can be assessed who is capable and willing to continue working for fistula patients within the country.

Identify and select a background team: nurse (preferably with special interest in fistula patients, physiotherapy, psychology/psychiatry, OB/GYN, urogynecology), social worker, physiotherapist, former fistula patients and dedicated family members to fistula patients – in order to ensure continuity and follow-up.

The campaign should be preceded and followed-up by a media campaign in order to sensitize population, health managers and political leaders.

Incorporate upstream work (prevention of OF through adequate nutrition, delayed first pregnancy, institutional delivery of the first birth, availability, use and quality of EmOC facilities, C-section etc.) and downstream (social rehabilitation, reintegration, counselling, instruction and follow up of operated women).

Write a national fistula plan of action together with background team and politicians in health sector.

Second phase:

Provide training and education to nurses, midwives and doctors in remote locations on how to anticipate, prevent and identify OF and how to refer, treat and rehabilitate patients who have developed OF. EmOC is the cornerstone in this education.

Increase the number of skilled health personnel in remote areas who can recognize and treat obstetric complications in all pregnant women, and who can also manage obstructed labour in women at high risk (e.g. those who are malnourished, stunted, young, and/or circumcised with significant scar tissue) through appropriate interventions (such as timely referral for C-section and insertion of urinary catheter), suspect and recognize manifest fistulae, and are willing to engage in psychological, social, and/or physiotherapy work with the aim to rehabilitate and reintegrate fistula patients into local society.

Third phase (or in parallel):

Community awareness campaigns on obstructed labour aimed at village elders and religious leaders, TBAs and pregnant women and girls to counteract the belief that delivery becomes problematic only after the second or third day of labour (e.g. using slogans such as, "**The sun**

should not rise or set twice on a labouring woman." Every pregnancy is at risk). The campaign has to be in Somali language transmitted via radio, television, websites and newspapers. Use recovered fistula patients as informers/ ambassadors. This strategy will help shy fistula patients to seek help and get the necessary local support from family members and local decision-makers.

Other recommendations on OF and severe obstetric complications interventions

Improve logistics: For effective and fast transport and communication between health care facilities: “Forget donkeys, camels, wagons, overloaded trucks, hitchhiking, bush walking”.

Improve communication: establish VHF radio network at all maternity wards (as CARE in Garowe Community Hospital, Puntland, see Fact Sheets on visited sites) in order to facilitate communication to MCHs, delivery homes and other child delivery facilities. Encourage TBAs and family members to use this communication network when difficulties arise during home deliveries.

Funding: establish fistula funds through Hospital Boards, dedicated clan and family members.

Buildings: consider establishing maternity waiting homes / shelters in conjunction with hospitals in order to prevent obstetric complications, especially obstructed labour, thus ensuring direct access to timely and appropriate obstetric interventions.

Policies: incorporate into a fistula plan of action the recommendations of the International Obstetric Fistula Working Group, Training for Fistula Treatment Workshop, Niamey, Niger - 19-20 April 2005 (see References).

Prepare a full-fledged Needs Assessment in the whole of Somalia: when the political situation permits, giving first priority to the Central South Zone, which has not been visited during this mission, and second priority to Puntland, which only has been assessed minimally. Preparation must be made over a longer period, simultaneously at the Somalia Country Office in Nairobi, Kenya, and by partners in the field, so as to minimize ineffective working conditions and expenses for security measures in Somalia.

8. Fact Sheets on Health Facilities Visited

Somaliland Site Visits

A. Edna Adan Hospital (Private)

Hargeysa, visited 17 March 2005

www.angelfire.com/mn2/ednahospital/ and www.ednahospital.netfirms.com

Together with Acting Hospital Director Maryam Abdullahi

Characteristics: Originally exclusively a Maternity and Teaching Hospital, founded by a Somali midwife and politician Edna Adan

Size: approximately 2000 patients admitted per year. One maternity ward, one operating theatre.

1. EMOC

Basic and comprehensive process indicators fully met, but no proper recording of obstetric complications, therefore hazardous to record needs and frequency of obstetric complications. Catchment area unknown, patients come from all over the country. Selected population (economic means)

2. OF

Medical staff: Various local medical doctors work as on-call consultants. One local OB/GYN & surgeon, Dr. Ibrahim Said Osman, who has been trained at the Fistula Centre in Addis Ababa, www.fistulahospital.org, Ethiopia, regularly attends the hospital (according to his own statistics he has a record of operating around 50 fistula cases per year (see References: Progress Report on Fistula activities in Somaliland 2003-2004). Absent during current visit, therefore scarce information on fistula management at this hospital.

Caseload: In 2002 (together with visiting expatriate surgeon Dr. John Kelly) Dr. Ibrahim Said Osman operated 29 cases; in 2003 he operated 1 case, in 2004 6 cases, and to date in 2005, 2 cases on his own at this hospital.

Provenance of clients: Women come from a wide region, sometimes several hundred kilometres, and also from Puntland, Central South Somalia, Ethiopia and Djibouti.

Typical fistula client profile: not assessed, as only one fistula inpatient during the visit.

Post-operative care: Patients remain at the hospital for about 2 weeks.

Rehabilitation/reintegration: no information

Community outreach: Prior to 2002 fistula surgery session with expatriate surgeon mobilization of patients via radio announcement.

Perceived support at the policy level: None known

Estimated fully-loaded cost per procedure: not provided. Outside of hospital second-hand information: normal child delivery 30 USD.

Resources: different international donor agencies and “Friends of Edna”, see website <http://www.angelfire.com/mn2/ednahospital/>

Barriers: not affordable for typical fistula patient due to hospital fees

Other hospital functions: Private Nursing/Midwife School, admission fee. 3 years. Written curriculum, where obstetric fistula is named shortly, but not in index. Big medical library, missing updated literature, e.g. WHO IMPAC guide for midwives and doctors.

B. Group Hospital, public, Hargeysa, visited 19 March 2005

Together with Dr Ibrahim Bixi, Ob/Gyn, Maternity, Dr. Abdi Rahman, Regional Medical Officer, and the Chairman of the Regional Health Board, Ms. Tasmu, midwife, and several nurses

Size and characteristics: National Referral Hospital built in 1953, 330 beds (including 40 beds for OB/GYN). Maternity and gynaecological ward recently renovated by UNFPA/CARE. The ward houses two run down operating theatres; currently a new operating theatre is under construction (financed by UNHCR), as is therefore a potential future site for fistula repair surgery. There is a stable supply of electricity and water, however there are no anesthesia machines; operative procedures are done in Ketamine and under local analgesia.

1. EMOG

Basic and comprehensive process indicators are not fully met: MVA (Manual Vacuum Aspiration) is not performed; instead D&C (Dilatation and Curettage) is still practiced.

Medical staff: only assessed for maternity/delivery ward. There are 7 midwives (nightshift 14 hours), 2 nurses, and 4 assistant auxiliary midwives.

Caseload: only assessed for delivery ward, where there are 240-300 deliveries per month.

Typical client profile: not assessed. At the delivery ward there are many local patients, and too many normal deliveries for a referral hospital.

Estimated fully-loaded cost per procedure:

(1 USD = 6000 SL (Somaliland) Shillings)

Normal delivery	70 000 SL Sh (US\$ 11.67)
Twin delivery	100 000 SL Sh (US\$ 16.67)
D&C	50 000 SL Sh (US\$ 8.33)
Forceps	100 000 SL Sh (US\$ 16.67)
C.section	70 000 SL Sh (US\$ 11.67)

Resources: not fully assessed, but comes from public and various international donor agencies. The Director of the Hospital Board is responsible for private fund raising as well.

Barriers: cost sharing, but a waiving/exemption system exists.

2. OF

Medical staff: 3 different local medical doctors operate very few cases. Dr. Ibrahim Said Osman (see under A. Edna Adan Hospital) is the only doctor, operating around 50 fistula cases per year; he attends the hospital and has operated 4 patients in 2003-2004.

Caseload: not known, estimated less than 10 per year

Provenance of clients: Women come from near and far, sometimes several hundred kilometers, and also from Puntland, Central South Somalia, Ethiopia and Djibouti.

Typical client profile: not assessed, as there was only one fistula inpatient during the visit.

Case history: 19 years of age, first pregnancy, dead fetus delivered with forceps in remote health facility after obstructed labour for several days, developed vesico vaginal fistula.

Second pregnancy 8 months ago dead fetus delivered by emergency c-section. 3 months ago primary fistula repair, now waiting for secondary repair of recurrent fistula. Husband abandoned her; her family takes care of her.

Community outreach: none

Perceived support at the policy level: none

Resources: Hospital Board in contact with expatriate surgeon John Kelly in order to request funding from King's College, London, UK

C. Regional Hospital, Borama, visited 20 March 2005

**Together with medical staff of the Regional Hospital (Public)
Borama, Somaliland**

Dr. Ismail H. Muhumed, Hospital Director

Dr. Ibrahim Said Osman "Qows", OB/GYN & Surgeon

Prof. Hassan Ismail Yusuf, COOPI

Dr. Ismael Ayad

Dr. Abdirahman Jama Hadi, Regional Medical Officer

Dr. Nimo Haji Abubakar, OB/GYN

Size and characteristics: Public Regional Hospital on North West Border of Somaliland serving as training and teaching facility, supported by NGOs COOPI and Handicap International. COOPI supports buildings, diagnostic facilities, training of staff and pays incentives to local staff, who also receive a public salary.

The hospital has one clean operating theatre with a suitable table for fistula surgery, stable electricity and water supply. There are no anesthesia machines, and surgical procedures are done in Ketamine and under local analgesia.

See Appendix: Borama Hospital monthly statistics, COOPI

Background information:

The population of Borama Region is between 400,000 and 450,000. Since 2000 there has been one private hospital in Borama town: Allaale.

Amoud University, different faculties, 50 medical students per year, offers a full (nursing?) diploma after 3 years of study. TBA training is done by one hospital midwife. There are many well equipped, private pharmacies in Borama town, including supply of family planning devices including condoms, which are still a controversial issue.

EmOC & OF:

Basic and comprehensive EmOC not fully met.

Dr Ibrahim Said Osman "Qows", Ob/Gyn&Surgeon is stationed at this hospital and works as fistula surgeon all over Somaliland. He has been trained at the Fistula Center in Addis

Ababa, www.fistulahospital.org, Ethiopia. According to his own statistics he has a record of operating around 50 fistula cases per year, see his “Progress Report on Fistula Activities in Somaliland 2003-2004”. Difficult cases are discussed with or referred to Adis Ababa. In february 2005 he has submitted a “Proposal to Build a Borama Fistula Center in Awdal Region, Somaliland” to Care International in Hargeysa (see both documents under References).

Medical staff: There are six medical doctors, including one female OB/GYN. There are a total of 11 medical doctors in Borama region, 3 of whom are OB/GYNs.

Caseload: 8 fistula patients have been operated within the last 1½ year.

Provenance of clients: Population of Borama Region 400-450.000, many migrating from Ethiopia, where there are no functioning health facilities in border region. Fistula patients come from all over ethnic Somalia.

Typical client profile: insufficient time to assess

Case story: 25 years, obstructed labour for days, delivery alone. RVF/VVF. Husband tried to cut her throat. She was transported by her mother to Burao hospital, where she was operated for her throat injury. She was then referred to Borama Hospital where her VVF/RVF was operated successfully at Edna Adan Hospital, Hargeysa, where she was kept and got employment.

Barriers: There is a general shortage of hospital supplies, and there are no family planning supplies. There is a lack of logistics for transport of patients and hospital supplies. More than 80% of home deliveries are attended by TBAs, who are reluctant to refer to health facilities for loss of income and respect.

D. Allaale Hospital, private, Borama, 20 March 2005

No time to visit, seen from outside, modern and well-kept building.

Dr Ibrahim Said Osman “Qows”, ob/gyn & surgeon from Borama General Hospital, has operated 46 fistula patients within the last 1½ year at this site.

E. Regional Hospital, public, Berbera, visited 21 March 2005

Dr. Haggar, surgeon and Director

Very much decayed hospital, not rehabilitated except for TB ward by COOPI

One surgeon, Dr. Haggar, has operated only a few obstetric fistulas.

He is overburdened by the many requests and needs.

Fact Sheets on Puntland Site Visits

A. Community Hospital, public, Garowe, visited 21 March 2005

Together with Director General

Size and characteristics: Public Regional Referral Hospital in the center of Puntland. 40 beds.

EMOC & OF:

Basic and comprehensive emoc not met.

No fistula surgery in public hospitals in Puntland except for Bossaso. Only visiting expatriate surgeon Dr. Jama, stationed temporarily in Galkayo, can do fistula repairs.

Midwife on duty was aware of many women with the condition in the community.” They are shy and stay home. Some go around with catheter to keep continent without shifting it up to two months”.

1. Maternity ward: clean, stable electricity and water supply.

one office with 2 registration books (deliveries/inpatients-gyne as well). Deliveries are registered with name, age, number, date, parity, dilatation, alive or dead baby, mode of delivery, apgar score (one number: 10 minutes?). Maternal deaths are registered in inpatient book under “discharged”, could not be verified. “Few “ maternal deaths, the last one, which the midwife could remember, was in 2004.

Impression: training is needed for registration, registration itself is done on the backbone, no logical approach

CARE has established VHF radio communication at maternity admission room, functioning with staff 24hrs / 7days linked to all MCHs

About 10 deliveries pr. month, “only complicated cases, many referrals”, a little less than one c-section pr. month, no vacuum extractor, 2 forceps deliveries were registered in record book for surgical procedures since feb.1, 2005.

Delivery room with 2 delivery beds, a cupboard with medicine locked, not in order, but relevant medicine. No cold chain. A small amount of oxytocine is kept at the delivery room, the rest in hospital laboratory in the only functioning refrigerator. No Magnesiumsulfate in Puntland, diazepam is used for eclampsia. No shortage of urinary catheters or iv. fluids.

No books or clinical guidelines to be seen anywhere, but impression that people know, how to handle common obstetric complications.

Induction is done with oxytocine drip; there used to be prostaglandine for induction of IUFD – intrauterine fetal death, but now out of stock.

Bloodtransfusions: no bloodbank. Relatives are used as donors. Often problem to find relatives, as referrals come from far. The Mosque is used in those cases to ask for blood donation.

3. Operating theatre: clean. No anesthesia machines, surgical procedures done in Ketamine and local analgesia.

Medical staff: 2 medical doctors trained in foreign countries. One female, married in town, cannot perform cesarian sections. One male, lives 120 km from hospital, has to be called over radio or mobile phone for emergencies. He has used his private car so far, which now has broken down. Consequently, MOH has bought a car for him, fuel is paid for by the hospital.

Caseload: according to Director General car accidents and gunshots biggest problem

Provenance of clients: both local and from very far

Estimated fully-loaded cost per procedure: no time to assess

It was stated, that rich people have to pay for c-section, poor can get exemption

Resources: no time to assess

Barriers: Maternal health not first priority

B. Galkayo Medical Centre, private, Galkayo, visited 22 March 2005

Hospital Director Dr. Jama, neurosurgeon

See References: “ A Brief Description of GMC and COMSED Activities”

Italian NGO. COMSED website www.comsed.org

Under major reconstruction, therefore maternity ward closed.

Dr. Abdulkadir Mohamed Jama “Dagaade”, expatriate surgeon, only doctor doing fistula repairs in Puntland, had planned to be present during visit, but was occupied with urgent business in Nairobi, Kenya.

He comes several times a year from Italy and performs different kinds of surgery.

He has now decided to stay 6 months at the hospital.

2 fistula patients were seen as inpatients, 2 weeks postop., waiting for final check by Dr. Abdulkadir Mohamed Jama.

C. Galkayo Public Hospital, Galkayo, visited 22 March 2005

Together with Medical Doctor on duty

Size and characteristics: Public Regional Referral Hospital in south center of Puntland. Miserable and deteriorated buildings. Supported by MSF. See photographic documentation.

EMOC & OF:

Basic and comprehensive emoc not met.

All staff present at maternity ward know and have seen obstetric fistulas. There are many cases, and the midwives see them in their private clinics as well. All know catheter treatment. All are aware of prevention during obstructed labour by urinary catheter and c-section. No fistula surgery in public hospitals in Puntland except for Bossaso. Only visiting expatriate surgeon Dr.Jama, stationed temporarily in Galkayo, can do fistula repairs at GMC COMSED private hospital in Galkayo.

Maternity and gyn. ward: around 30 deliveries pr. month, only complicated cases. Around 10 c-sections pr. month, verified in record book for surgical procedures at operating theatre. Forceps is done and recorded; vacuum extraction as well, but could not be verified. Staff do all surgical obstetric procedures by themselves except for c-section. Many cases of hydatide mole.

No drugs at maternity, have to be fetched from hospital pharmacy.

Hospital pharmacy almost empty, drug shortage at end of each month, MSF supplies.

Hospital laboratory very basic and deficient

Bloodtransfusion yes, but no bloodbank. Testing for HIV, hepatitis B, VDRL. Malaria.

Operating theatre clean theatre, dirty room for storage and changing clothes. No anesthesia machines, operative procedures done in ketamine and local analgesia. One poorly functioning table (has to be held by personnel, moves during operations). Poorest of working conditions of all visited hospitals.

Medical staff: 4 medical doctors on call, live in town, where they have private clinics. One “qualified” midwife, otherwise non qualified and auxiliary nurses at maternity ward.

Caseload: Enormous patient load from far away. Most congested of all hospitals visited in Puntland and Somaliland. Some patients have to lie outside on bare ground.

Provenance of clients: both local and from far, especially Central South Zone and Ethiopia

Typical client profile: no time to assess.

Case story 1: Vesicoaginal fistula patient post obstructed labour from several hundred kilometers away, inpatient for several weeks now. Hospital staff has tried to treat with repeated insertion of urinary catheter, fistula is too large, catheter falls out. No one knows, what to do. Peculiar, as two fistula patients have been operated recently at the private hospital Galkayo Medical Center, most probably economical constraint.

Case story 2: young primipara with living child now for weeks at maternity ward, no family or clan members to return to. Hospital staff consider collection of funds in order to be able to dismiss her and the baby.

Resources: insufficient time to assess, perceived none at all

Barriers: There is a severe lack of staff at all levels, and the physical hospital environment is severely deteriorated.

9. Fact Sheet on Meetings in Kenya, Somaliland, Puntland including information on Central South Zone

A. UNICEF Somalia, March 15, 2005, Nairobi, Kenya

Dr. Marjatta Tolvanen-Ojutkangas, Head of Health & Nutrition Section

Website: <http://www.unicef.org/somalia>

UNICEF operational in Somalia since 1970s, now divided into 3 zones:

1. Somaliland (SL) administrative capital Hargeysa
2. Puntland (PL) administrative capital Garowe
3. Central South (CS) with recently established transitional federal government (TFG) with intention to move from Nairobi and be operational from national capital Mogadishu after May 2005

UNICEF has “zonal offices” in Hargeysa (SL), Bossaso (PL), Jodwar (CS), and operates in 18 regions. UNICEF Somalia has a list of health facilities HPs, HCs and hospitals.

Challenges: logistics – long distances, lack of adequate funding, doctors and other health personnel working simultaneously in public and private sector (parallel health system), quacks, traditional healers, security, diversity of private donors

Referral system of patients between health facilities: UNICEF supports voucher system - MCH or hospital reimburses for transport costs on patient arrival via UNICEF project funding.

Advocacy is done via radio programmes, several local radio stations reach out to the whole of ethnic Somalia.

Unicef has produced a Reproductive Health training module in English, , translated to Somali; 8 modules very basic, life saving skills manual for midwives, 8 modules, written by Noreen Hertz, Irish consultant, in 1997, complimented by an excerpt booklet:

“Maternal health services - Guidelines for qualified health personnel 1999”

Good initiative, but no flow sheets, too few pictograms, not educational and not updated according to WHO IMPAC (Integrated Management of Pregnancy and Childbirth) guide 2000.

OF is not a key issue for UNICEF in Somalia: there is no specific information available on the number of women with fistulas, drop foot (peroneal paresis), nor how many child mothers, malnourished, incontinent women in childbearing age.

References to OF: “FGM Advocacy Paper” linking it indirectly to FGM

http://www.unicef.org/somalia/SOM_FGM_Advocacy_Paper.pdf

**B. Joint meetings with UNFPA partners in Somalia
March 15, 2005, Nairobi, Kenya**

1. CARE Lex Kassenberg, Assistant Country Director

http://www.careinternational.org.uk/cares_work/where/somalia/

See Appendix: “Integrated Reproductive Health Project 2002” and “Expanding Access to RH: proposal to UNFPA 2004”

The IRHP (Integrated Reproductive Health Project) funded by UNFPA and implemented by CARE in partnership with Ministry of Health and Labor (MOHL) in Somaliland, was a two-year project designed to address critical areas in the provision and access to reproductive health services. CARE is seeking funds from UNFPA to build on what was achieved during the Integrated Reproductive Health Project by focusing on quality, accessibility, availability and affordability of reproductive health service that will fetch the greatest impact in lowering maternal mortality in the long run.

The “Expanding Access to Reproductive Health” project seek to increase utilization of the reproductive health services by upgrading the skills of the service providers and health facilities to give mothers greater access to emergency obstetric care and routine reproductive health services. Apart from increasing greater access to the health facilities, the project will also focus on raising awareness about maternal mortality, available reproductive health services, in addition to sensitizing the community on harmful reproductive health practices and creating awareness STD/STI and HIV/AIDS issues.

2. IFRC Zaitun Ibrahim

www.ifrc.org

http://www.ifrc.org/cgi/pdf_appeals.pl?annual05/05AA002.pdf

Somalia; Annual Appeal no. 05AA002, chapter [Somalia Health and Care 2005](#)

Strengthening the National Society

Health and Care

Background and Achievements

Somalia, a country in political turmoil, is faced with many health problems with an increase in the number of acute and chronic diseases over the recent years; cases of TB, HIV/AIDS as well as malaria are on the rise. Among the contributing factors include lack of awareness among the population, lack of or inadequate medicine, diagnostic material and trained personnel and inadequate access to safe WatSan. Maternal and child health indicators demonstrate the need for increased community health awareness and improved quality of mother and child health care.

The health programme has been a key activity for the Somali Red Crescent since 1993 with support from the Federation and the ICRC. The national society and the community will assume greater responsibilities for the health programme for increased sustainability. In view of this, the national society will be assisted to strengthen the quality of the programme and

the local capacity in line with its five -year strategy (2005-2009) and the human resource strategy to be developed.

The Health service Recovery Project in Puntland and Somaliland, run jointly by the national society, the Federation and the World Bank, was extended to December 2004 to ensure the completion of the development and production of learning and programming tools for use by the national society and other international organizations working in post conflict situations. Following management gaps observed in the Puntland branches, there will be a restructuring initiative to strengthen management structures and systems at the Garowe branch so as to improve coordination and support to the MCH/OPD in Puntland as well as to enhance outreach services. The cost effectiveness of outright purchase vis-à-vis renting branch vehicles for operational and outreach services will be assessed.

The Garowe Community Hospital increased its professional staff for improved services in the respective specialties (medical/paediatric, surgical and obstetrics/gynaecology). WHO also assisted in the expansion of the hospital laboratory to improve diagnosis in anticipation of expanded services including DOT for tuberculosis (TB). Capacity building of both clinic and hospital staff including the management will continue to be strengthened through relevant training and skills building.

The IHCP comprising 24 MCH/OPD continued to provide preventive, promotional and limited curative services.

The Somali Red Crescent will develop a comprehensive reproductive health package and actively participate in organized campaigns such as measles and polio. The national society will also explore possibilities of incorporating Health Promotion/Education into the ongoing basic First Aid activities under a defined strategy. It works closely with partners including UN agencies in its health delivery services. UNICEF throughout last year provided kits for the MCH/OPD; the same is envisaged to continue in 2005. The Federation will only complement with the missing drugs in the kits as well as keeping some buffer stock in case of any delays or increased needs.

Community participation in the management and resourcing of the national society's health facilities was enhanced with the re-organization and training of 20 Community Health Committees (CHC) in Somaliland and Puntland under the Health Service Recovery Project. The CHC were further provided with 'operating and communications guidelines' and terms of reference to improve their operations. The project was replicated in four clinics (two in Somaliland and two in Puntland) following positive results and lessons learnt through the evaluation of both community contribution through pre-payment and user fee models. It is envisaged that the replication exercise will continue in 2005 to cover the remaining clinics and bridge gaps identified in the external evaluation of the project that was conducted in June 2004.

The Somali Red Crescent continued its community HIV/AIDS awareness activities targeting different segments of the community. IEC materials have been developed and field tested. Branch volunteers have also been trained in Participatory Education Theatre (PET). These initiatives will be used and strengthened in 2005 to reinforce community awareness activities

through organized campaigns, rallies and peer education. The national society will also explore and facilitate involvement with networks of PLWHA and the mobilization of communities to address issues relating to stigma and discrimination. This will help to create an enabling environment for HIV/AIDS/STI prevention and control. Three VCT will be established in three selected Somali Red Crescent clinics in addition to the Garowe Community Hospital based on the ongoing sero-prevalence study being undertaken by the WHO. This will involve increasing and strengthening the capacity of the health staff in counselling as well STI case surveillance.

The Somali Red Crescent will prepare its HIV/AIDS strategy in line with the SACB strategy for Somalia. While the focus of the strategy will be on prevention and control of the spread of STI/HIV/AIDS, advocacy against stigma and discrimination through community awareness creation, the programme will expand to progressively establish VCT centres and the introduction of preventive measures against PMTCT. The capacity of the national society will be strengthened in line with the expanded HIV/AIDS programme and will include recruitment of a National HIV/AIDS co-ordinator as well as three counsellors to address issue of co-ordination and VCT services, respectively.

The national society will continue to work closely with the SACB and the local authorities on the provision of ART or its application to the vertical transmission (mother to child). There will also be enhanced collaboration with the Nairobi regional delegation and other partners on sharing of “best practice” and experiences through round table meetings and conferences. The national society will further explore possibilities to access the HIV/AIDS and TB components of the Global Fund as well as the World Bank- and UNDP-funded LICUS fund. Tuberculosis in Somalia remains a major health concern as well as an opportunistic disease to HIV/AIDS. According to the WHO, Somalia has one of the highest incidences in the world with approximately 25,000 suspected cases a year. The Garowe Community Hospital has completed the construction of a TB centre at the hospital with support from the Federation to provide DOT services. At the primary level, the Somali Red Crescent will continue with the integration of TB awareness creation and follow ups into its IHCP activities.

Goal: The health status of the Somali population is improved.

Objective: The quality and range of services provided by the network of Somali Red Crescent health facilities inclusive of STI/HIV/AIDS, TB, malaria prevention and control through community participation is increased.

Expected Results:

1. Comprehensive maternal and child health care services have been provided in the 24 MCH/OPD of the Somalia Red Crescent.
2. Vulnerability of targeted population to diseases has been reduced.
3. Support in supervision, monitoring and evaluation of health activities has been provided at all levels of implementation.
4. Community involvement and participation in the management and resourcing of the Somali Red Crescent MCH/OPD has been increased.
5. Awareness on STI/HIV/AIDS and TB among the Somali Red Crescent volunteers and the general population in the targeted areas has been increased, leading to behaviour change.

6. VCT centres in three selected MCH/OPD and the Garowe community hospital focussing on preventive measures against vertical transmission (mother to child) of HIV/AIDS have been established.
7. Stigma and discrimination against PLWHA and TB has been reduced.

3. SRCS Mohammed Abdi Warsame

Information from their website, same as quoted in IFRC document, see above under **2.** and see http://www.bishacas.org/English_files/Activities/Healthcare.htm

SRCS currently runs Mother and Child Health (MCH) clinics as well as outpatient dispensaries throughout the different branches in the country. The Somali community supports the running of these centres in their respective areas.

The centres provide preventive, promotive, and curative health service to the community with the support of the International Federation of Red Cross and Red Crescent Societies (IFRC), International Committee of Red Cross (ICRC), participating National Societies, UNICEF, and WHO.

Currently, the SRCS runs 49 MCH/OPD clinics throughout the country. During the year 2001, a total of 741'972 persons were either consulted, given treatment or vaccination services by the clinics.

4. IMC Lucy Maina

http://imcworldwide.org/loc_somalia-motherhood.shtml

Information from their website, 2 quotes: http://imcworldwide.org/loc_somalia.shtml

IMC's commitment to the Somalian people began in 1991, when it was the first American non-governmental organization to arrive in battle-torn Mogadishu. For the last 13 years, IMC has continued to provide health care and training in this African country where clan rivalry, droughts and epidemic disease present ongoing perils to the population.

IMC medical teams currently work throughout the Bay, Hiraan, and Bakool regions, bringing critically needed health care to more than 600,000 people. IMC-trained health workers provide diagnosis and treatment of preventable diseases, prenatal and postnatal care for mothers, health education classes, and immunizations. In the Bay region of Somalia, for example, IMC supports the operation of 41 health posts and two maternal-child health centers; in Bakool, IMC works with 23 health posts and three maternal-child centers; and in Hiraan, IMC supports 25 health posts and one maternal-child center, representing some 95 IMC-supported health facilities in total.

IMC's long-term commitment to Somalia has enabled the organization to respond to health emergencies quickly and effectively. For example, IMC's knowledge of local conditions and its long-standing ties to the Somalian health community enabled it to respond during the earliest phases of a cholera outbreak in the Belet Weyne region of Somalia.

IMC is also committed to strengthening the capacity of local health care providers through ongoing training programs in prevention of malnutrition, as well as malaria and other epidemic diseases. IMC medical teams work closely with local community leaders to provide education on disease prevention and public health issues in a culturally appropriate manner.

Making Motherhood Safer in Somalia

Since gaining independence in 1960, Somalia and its people have suffered countless disasters, both natural and political. The country's first president was assassinated just months into his term; Mohammed Siad Barre promptly took his place, a commander in the Somali military and an avowed socialist. Overnight, Barre transformed Somalia's post-colonial democracy into a brutal dictatorship, purging the government rolls of non-socialists and executing potential rivals. Despite growing internal unrest, he continued to rule until 1991, when a concerted group of Somali clans forced him into exile. But, instead of order, anarchy and famine followed.

In recent years, the quality of life for Somalis has plummeted to global record lows. As drought and famine continue to plague the country, particularly the Lower Juba Valley, the average life expectancy has dropped to 46 years. Even more alarming is the effect this healthcare crisis has had on Somalia's mothers and children; 240 children die per 1,000 live births and 1,600 women per 100,000 live births. In the United States, those numbers are only 7 and 12 respectively. In addition to a dearth of basic health services, one gender-based Somali custom poses a particularly formidable threat to women's health.

According to World Health Organization (WHO), obstructed labor and severe bleeding account for more than one-third of all maternal deaths in underdeveloped countries. In Somalia, a leading cause of both obstructed labor and severe bleeding is female genital mutilation (FGM). FGM involves surgically removing a woman's clitoris, generally when she is not a woman at all but a pre-teen girl. In FGM's most severe form, infibulation, the labia is also sewn together to cover the vagina. Though a small hole is left for the passage of urine, infibulation inevitably complicates childbirth, exponentially endangering both mother and child. UNICEF/USAID have estimated that as much as 97% of Somali women have undergone infibulation.

International Medical Corps (IMC) was one of the first humanitarian relief organizations to recognize the growing health crisis in Somalia following Barre's ouster and, thanks to strong ties with community and clan leaders, has maintained a steady programmatic presence ever since. IMC staff now operate 89 health posts and 6 maternal and child centers, serving 600,000 Somalis – almost 8% of the country's population. However, much remains to be done in the struggle to improve the health of Somalia's mothers and children.

In collaboration with the United Nations' Populations Fund (UNFPA), IMC will soon implement a new Safe Motherhood program in Somalia's Bakool region. The program will prepare local staff to better treat the resultant complications of FGM, provide emergency obstetric training for local birth attendants and midwives, and supervise the distribution of UNFPA-supplied birthing kits. Furthermore, IMC plans to launch a comprehensive information campaign in collaboration with the regional authorities in all three of its operational districts. This campaign will address myriad maternal health issues, from the prevention of potential pregnancy complications to understanding the transmission of STIs

and HIV/AIDS.

In the past year, Somalia's political landscape has finally given Somalis reason to hope. Rival warlords and politicians recently joined forces to install a new Parliament and elect a new President. Still, forging a legitimate government will take years, and the women and children of Somalia do not have the luxury of time. IMC is committed to serving their needs, building a healthcare infrastructure that will continue to function years from now, after the rule of law has at last returned to Somalia.

5. JHPIEGO Catherine Ayuko
www.jhpiego.org

The organization has a Kenya country office and program with spotlight on Family Planning/ Reproductive Health /HIV. There is currently no activity in Somalia, but they are willing to start working in the country. The organization is specialized in teaching reproductive health, providing guidelines, and has many reproductive health programmes (including HIV/AIDS) worldwide.

Quote from <http://www.jhpiego.org/about/what/index.htm>

JHPIEGO works on the front-line in low-resource settings throughout the world to help save and enhance the lives of women and their families. Through advocacy, education and performance improvement, JHPIEGO assists policymakers, educators and trainers in increasing access and reducing barriers to high-quality health services related to maternal and child care, family planning and reproductive health, HIV/AIDS prevention and care, infection prevention and cervical cancer prevention. JHPIEGO's work is carried out in an environment that recognizes individual contributions and encourages innovative and practical solutions to meet needs identified in close collaboration with host-country stakeholders.

Somalia is mentioned in one of their publications on maternal and neonatal health:

<http://www.jhpiego.org/resources/pubs/mnh/mnhpolcomp.pdf>

6. World Vision Betty Oloo
www.worldvision.org

Work with TBAs. Programs on FGM, malaria. The organization has helped fistula patients by sending them to the Fistula Hospital in Addis Ababa, Ethiopia.

Quote from <http://domino-201.worldvision.org/worldvision/master.nsf/home>

WV is a Christian relief and development organization dedicated to helping children and their communities worldwide reach their full potential by tackling the causes of poverty.

7. CISP Michah Busieka
www.cisp-ngo.org

Many emergency medical programmes, especially Central South region of Somalia

See http://www.cisp-ngo.org/ENG/ENG_frame_attivita.html

Profile according to http://www.cisp-ngo.org/Progetti/sche%eog_africa.pdf

CISP has been working in Africa since 1983 and has consolidated its presence in 8 countries: Algeria, Ethiopia, Gambia (The), Kenya, Malawi, Namibia, Somalia and South Africa. Furthermore, it carries out specific activities in support of local organizations in the Democratic Republic of Congo and in Senegal.

CISP has a geographical operational approach and is specialised in various sectors. This approach derives from its deep knowledge of local realities as well as the permanent dialogue with local actors, ensuring a greater effectiveness of the actions implemented and leading to a stronger impact on the problems affecting the poorest people and those most at risk of social exclusion.

CISP's various activities have led to considerable experience in the following sectors: food security and the fight against poverty, microcredit and development of small enterprises, management of basic services (in particular health and education). Moreover, a particular emphasis is given to capacity building promotion, with the aim of strengthening the operative capacities of local institutions and organizations.

The Geographic Area Manager, in close cooperation with the Head of Programmes at the Headquarters in Rome and with the Regional Coordinator in the field, prepares and coordinates the annual strategic plan, taking into account the following elements:

- Primary assessed needs,
- Priorities identified by donors as well as by national and local development plans,
- Characteristics of local partners, and
- Experience and specialisation gathered in the various sectors.

According to publication presented during the meeting:
"CISP FGM Strategy 2004-2006 Italy-Somalia-Kenya", page 7,

29 cases of OF were referred to and treated at District Hospitals of Eldere and Harardere in 1996-99, Central South Zone of Somalia.

Several ongoing projects in Somalia related to reproductive health issues except for fistulas

C. WHO Somalia, March 15, 2005, Nairobi, Kenya

Dr. Ibrahim Betelmal, Representative & Dr Daher Aden, Medical Officer

www.emro.who.int/somalia

Quote from <http://www.emro.who.int/somalia/collaborativeprogrammes-motherhood.htm>

WHO Collaborative Programmes

Safe motherhood, reproductive health and family planning

Somalia has one of the highest Maternal Mortality rates (MMR 1600/100,000). The midwifery profession was one among those professions that has suffered the biggest attrition in terms of number (WHO 1994 data). As a result, RH/FP services have deteriorated with the consequence of increased maternal and infant mortality rates.

In the majority of the health facilities, RH/FP services are operated and run by unqualified health personnel. Accordingly, there is low demand and limited access to qualitative maternal health care services at these facilities.

From 1995 to 2000, WHO executed and implemented a UNFPA RH/FP project in 4 regions of Somalia. The project activities included; health professional training programmes, IEC and advocacy seminars and workshops with regular provision of essential RH drugs and contraceptives. In 1998/99 WHO in collaboration with the UNFPA project supported and provided funds for an SSA (special services agreement) recruitment and tutor training fellowships for re-establishment of basic MW training.

Continued collaboration and provision of funds from WHO and UNFPA will be needed for the establishment and sustainability of a comprehensive RH care programme including FP services in Somalia.

One of the causes of maternal mortality is repeated pregnancy, which is also related to infant mortality.

Achievements

1. Supported 43 health facilities; 21 in C an S and 21 in NE and NW
2. Increased the number of clients utilizing STD services 17,559 in 1996 to 44,305 in 1998
3. Trained Traditional Birth Attendants (TBAs) and mid-wives

Constraints

1. Insufficient funding
2. Deteriorating security situation in Central and South Somalia
3. Infant mortality has a bearing on pregnancy, which has a direct bearing on maternal mortality and reproductive health.

Objectives

1. To contribute to the improvement of health of mothers and children by reducing the high levels of maternal and infant mortality and morbidity in Somalia, with support from IMCI

2. To ensure healthy population development through protecting and promoting RH/FP services

D. SACB March 15, 2005, Nairobi, Kenya

Dr. Imanol Berakoetxea, Somalia Health Coordinator for International Organisations

www.sacb.info

Briefing on political situation and health sector in Somalia

SACB handbook, introduction, page 3 <http://www.sacb.info/MainHandbook.htm>:

“Since 1994 the SACB has been the platform for co-ordination of international aid to Somali. It provides a forum for all partners to discuss humanitarian, rehabilitation and development issues. SACB includes donor governments, UN agencies, inter-governmental organisations, international and national NGOs. It is an important forum, whereby main aid constituencies share information and develop strategies for the provision of assistance in the following sectors: education, food security and rural development, governance, health and nutrition, water, sanitation and infrastructure.”

And page 72 -76:

Reproductive Health and Safe Motherhood Working Group (RH/SM WG)

The Reproductive Health and Safe Motherhood Working Group was established in October 2001 in an effort to improve technical discussions and information exchange on pertinent issues related to reproductive health in general and safe motherhood specifically. Below are details of the Terms of Reference for the group as well as priorities and workplan for 2004.

Terms of Reference:

- Coordinate RH/SM activities inside Somalia based on the RH Strategy Framework Package;
- Share information among partners and programmes on RH/SM activities;
- Advise and recommend on funding requirements and relevant projects and studies required for implementation;
- Advise and recommend on relevant agencies to execute RH/SM programmes and projects and studies;
- Provide technical support and guidance in the area of RH/SM. Also provide technical assistance in reviewing methodologies and survey/research;
- Undertake special tasks on further technical elaboration and strategic analysis of certain aspects and issues on RH/SM as advisers and as requested by SACB;
- Act as the focal point and reference group for RH/SM programmes and projects;
- Undertake task oriented meetings to coordinate and discuss issues as necessary;
- Assist in development of training standards and protocols, and

- Report to the HSC on issues of concern.

Workplan for 2004

- Undertake coordination among partners and programmes (especially FGM, HIV/AIDS and Gender) and task oriented meetings;
- Collect relevant materials for review and develop an RH package for actors to use until the RH Strategic Framework is developed and finalized;
- Collect information on TBAs' tasks and performance to review what has worked and what has not worked including reasons for this and provide recommendations on how to improve TBAs' performance;
- Provide necessary support in the development of the RH Strategic Framework;
- Provide necessary support in the development of the Integrated RH/SM/FP Training Curriculum and guidelines
- Support UNFPA missions planned for the year in monitoring RH projects activities and in developing new projects and programmes;
- Provide necessary support in the development of protocols and standards related to RH/SM;
- Support the development of appropriate IEC materials and activities on RH/FP and promote and monitor use of these materials;
- Review ANC activities, home deliveries, and hospital delivery and provide recommendations for improvements;
- Provide necessary support in the development and improvement of data collection activities, analysis on RH/SM (including formats and registers, etc). This data is to be collected in an integrated manner within the overall SACB existing HIS system;
- Provide support (in close collaboration and cooperation with Gender and Human Rights and FGM Working Groups) in undertaking assessments of the status of women (including fulfillment of RH rights) and provide recommendations for improvements of the status of women; and
- Provide necessary support in the undertaking of operational researches and in reviewing methodologies, analysis and studies reports on maternal mortality and morbidity (cervical cancer, VVF, abortion, etc).

Co-Chaired by UNFPA and UNICEF (February 2004)

Similarly, an HIV/AIDS and FGM Working Group has existed since 1999

See also "Brief Update on the health sector in Somalia", References

E. COOPI March 16, 2005, Hargeysa, Somaliland

Dr. George Yang, Representative

www.coopi.org

Dr. Yan has been in Somaliland for 4 years and shared a lot of valuable local insight.

Barriers: lack of qualified human resource and medical management

Recommendation: organize training for midwives and nurses

COOPI supports 3 hospitals in Somaliland: Borama, Berbera, Burao (see Fact Sheets)

See http://www.coopi.it/en/progetti_bancadati.asp

Quote from <http://www.coopi.org/en/lassociazione.asp>

Cooperazione Internazionale is an Italian non-governmental organization founded in 1965. It carries out development programs and emergency interventions in Africa, Latin America, Asia and the Balkans. It organizes activities in Italy to foster the knowledge and exchange of different cultures

And http://www.coopi.it/en/progetti_sviluppo_salute.asp#1

Almost all our projects, both those dealing with cooperation of development and those dealing with emergencies, foresee interventions in the healthcare sector. We supply basic assistance, preventive and therapeutic, to the more vulnerable communities, paying particular attention to maternal-infant care; we build or rehabilitate dispensaries in minor centers and isolated areas, favoring the local management of the services; we emphasize the existing competences and train others so as to be able to independently answer to the needs of the population.

Our projects are carried out in close collaboration with the local health authorities: they are inserted in the programs and stimulate increasing improvement on an open and equal level.

F. WHO Somalia, March 17, 2005, Hargeysa, Somaliland

See core information under **A. UNICEF Somalia**

Ms Asiya Osman, program officer, and teacher at nursing school

Since pre-war time experience as Nursing School Midwife Teacher under MOH, now MOHL

G. Visit to MOHL Public Nursing School, March 17, 2005, Hargeysa, Somaliland

Ms Asiya Osman, WHO Program Officer, and teacher at nursing school

This nursing school needs support of buildings, library and other teaching materials. Poor standard in comparison to Edna Adan Hospital Nursing/Midwife school in the same town. Curriculum exists, needs revision and updating.

H. UNICEF Somalia, March 18+19, 2005, Hargeysa, Somaliland

See core information under **A. UNICEF Somalia**

Mr Awil Hadj Ali, Head for Health and Nutrition
Ms Mariam Yussul Fahiye, maternal health officer

Meeting with Project officer and assistant:

2004 COAR (Country Annual Report) can be obtained at Nairobi office
Somaliland population estimate: 1.5 million
Health sector reform since 1997

Reproductive Health

UNICEF supports 54 MCHs and 120 HPs in the 3 zones of Somalia. 15 of these MCH are in Somaliland - 7 of those in the SL capital Hargeysa. They keep inventories of all health facilities.

Life-Saving Skills Manual for Midwives, adapted from American College for Nurse-Midwives, UNICEF Somalia (1998), 8 modules, Noreen Hertz, Irish consultant complimented by excerpt booklet, is distributed and taught. Not updated according to **WHO IMPAC guide for midwives and doctors** and missing flow sheets and pictograms, therefore not easily educational, **BUT translated to Somali.**

No coordinating meetings between WHO, UNICEF, CARE on reproductive health activities. No streamlining or updating of training materials. No national clinical guidelines.

Clean delivery kits are only given to multiparae for home delivery with the intention that primiparae should deliver at health facility.

Family planning is not included in UNICEF program, still sensitive issue in Somaliland, although public demand. Currently condoms have been burnt publicly.

I. Health Unlimited, March 19 and 24, 2005, Hargeysa, Somaliland

1. **March 19, 2005** Mrs. Shukri H. Ismael, executive producer/trainer
www.healthunlimited.org, www.healthunlimited.org/hornofafrica/index.htm quote:

The Well Women Media Project works with local audiences to develop interactive radio and television programmes that promote positive attitudes to women's reproductive and sexual health. Programmes include soap operas and phone-in shows, dealing with issues such as HIV/AIDS, domestic violence, female genital mutilation and birth spacing.

The project has been launched in three regions, the Somali-speaking Horn of Africa, the African Great Lakes Region and Cambodia, reaching a total audience of 27 million people. Our partner organisation for this work is the BBC Somali Service.

Saxan Saxo or 'Fresh Breeze', has produced two series for broadcast on the BBC Somali Service. The first series of 20 programmes explored the issue of female genital mutilation and the second series of 5 programmes on HIV/AIDS broke new ground, raising the issue on air for the first time in the region. The series used drama, songs, poems, educational interviews, vox pop and studio discussions to address these sensitive issues. [Click here to read the story of 17 year old Saynab.](#)

Saxan Saxo first went on air in June 1999, broadcasting twice a week on Mondays and Thursdays reaching a potential audience of 11 million in Somalia, Somaliland, Djibouti and Eastern Kenya. On the 26 January 2004 Saxon Saxo II began its second series of weekly broadcasts on the BBC Somali Service and on other regional networks. The regular radio drama is supported by a magazine programme, community theatre and outreach activities with women's organisations and youth groups.

The national production team is based in Hargeisa, Somaliland, where programme materials are mixed and edited. Information is gathered from audience groups throughout the Somali-speaking Horn, using surveys and interviews, in order to provide a full picture of the issues in their programmes.

This radio station has special focus on women's and reproductive health, as opposed to others in the area with focus on allround information, e.g. Radio Hargeysa.

This and other local radio stations could be used for future advocacy programs on emoc and of, and for mobilization of fistula patients (e.g. by interviewing fistula patients) prior to fistula surgery outreach sessions.

2. March 24, 2005 Meeting with women NGOs

Facilitated by Mrs. Shukri H. Ismael, executive producer/trainer Health Unlimited

Hawo Hussein from WAAPO, Hargeysa, Women's Action for Advocacy and Progress Organization: advocacy on human rights, women and girls, fgm

Mamina Yusuf from HOYO, a women NGO Umbrella organization from the region of SANAG: 8 groups working with agriculture, education, FGM, womens rights, political framing, child rights

Fowsia Cilmi from SWDO, Somali Women Development Organization: environment, health and income generating projects, outcast girls' education, teaching of Somali and english language, producing different goods (i.e. soap)

Khadija Aywo from PPP, Partner Prosperity and Progress, Sahil region: education of returnees and idp's and other poor people, HIV/AIDS and FGM awareness-raising

Hodon Barre from WOED, Women's Organization for Education and Development: fgm, hiv/aids and human rights

All organizations have evolved within the last decade, choosing their issues according to international agendas and funding

Question: Do you know the term fistula and why it occurs?

Answers: All can specifically tell stories about cases in their nearest environment. "These fistula women are often shy and hide. The husbands usually return them to their own family."

Comment: All women name fgm, specifically scar tissue in female genitals, as direct, not indirect cause. This conception was also met in Puntland, could it be created by fgm programs? According to the women interviewed, this came after fgm awareness raising. Few of the women are aware of obstructed labour and its dangers, one of them a midwife. All women, who had met up, reported fistula cases in their nearest environment.

J. MOHL March 19, 2005, Hargeysa, Somaliland

Ministry of Health and Labour

HE Osman Qasim Qodah, Minister
Mr. Ahmed Abdi Jamaa, DG Health
Mr Khader Mahmoud, Planning Division
Dr Abdi Dahir, HMIS

www.somalilandgov.com

Discussion of population and health policies, extension of UNFPA funded projects

See References, and see full text in appendix:

Country Cooperation Strategy between Ministry of Health & Labour & World Health Organization, Final Draft, Situational Analysis Report, Republic of Somaliland, Ministry of Health & Labour, October, 2004, Hargeisa, Somaliland

and Health Policy, Minister of Health and Labour, Somaliland, April 1999

and Somaliland MOHL compilation 2004 activities, HMIS section, with recording of few diagnoses of obstetric complications.

There is no recording of OF

K. UNDP March 21, 2005, Garowe, Puntland

Bashir Ali Osman, Zone Security Officer

Security briefing

Formerly 5, now 7 regions in the zone of Puntland

Health Activities by numerous international GO/NGOs

Extreme poverty, f.ex. public police has not been paid for 8 months, which has created a critical situation.

L. MOH March 21, 2005, Garowe, Puntland

Dr. Abdurahman Said, Minister of Health

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e-mail drdhagaweyne@yahoo.com

and the **Director General, former (pre-war) Director of Medical Services**

Puntland population 2.4 million (political estimate), 1.5 million MoH estimate. Those are working figures, no validation so far.

Garowe, administrative capital, 40.000 inhabitants, 1 public hospital

Bossaso, 300.000 inhabitants, 1 public/ 2private hospitals

Galkayo, 150.000 inhabitants, 1 public/ 2private hospitals

Garowe has been chosen as administrative center due to geographical situation in the middle of Puntland.

Many IDPs everywhere, migration for health services from Ethiopia and Central South Zone

Puntland as a whole is extremely poor, since 1998 introduced cost sharing in health sector.

Only in Bossaso, harbour town, and commercial center of Puntland, the health system is somehow in place.

Currently ongoing (see References: "Puntland Health Situation Assessment Tools, facilities level assessment") health situation assessment as a joint venture between MOH, FSAU, MDA, WHO and UNICEF in order to get an overview over public health facilities and human resource. Duration 10 days. Result can be requested from Minister of Health.

70% of population are treated in public health sector, but the very few qualified health personnel are not eager to work in public sector: too many constraints, mainly economical.

In 1998 “Somalia Standard Treatment Guidelines and Rational Use of Drugs at the PHC Level, vol I and II” were distributed to hospitals and health facilities. MOH/WHO joint publication: simple clinical guidelines for most common diseases, not updated since. MOH is looking for funding for translation to Somali language.

Currently no national policy of essential drugs, previously there used to be one

13 hospitals in Puntland – 4 regional / 9 district, only one of the 9 district hospital is functioning sufficiently. In 4 hospitals c-sections can be done.

65 medical doctors, 5 qualified midwives. Most of qualified health staff has left, public health nurses and auxiliary nurses try to cope with enormous workload.

Constant shortage of money, which is generated by revenue, in public health sector. Salaries are not paid regularly. People have to rely on private beside their public jobs.

Nursing School in Bossaso, enrolled are 30 public health nurses, 25 other nurses. Diploma after 3 years; 1 additional year, to qualify as a midwife.

Quarterly Health Coordinating Meetings with GO/NGOS and MOH

EmOC

In 2002 CARE initiated a project, with the aim to establish a referral system for emergency obstetric care, baseline study. The report was shown to the needs assessment team by the Minister of Health: “PHPP – Public Health Partnership Project”, full documentation should be available at CARE office in Nairobi

Vast majority of deliveries at home, TBAs report via MCH; they keep monthly statistics, which are turned in to the MOH. Statistics are done on computers and available for us to see.

Distribution of:

1. TBA kits
2. Clean delivery kits: 500 at a time are given out to MCHs – specific system of distribution was not explained
3. Delivery kits for trained medical staff like midwives

In Puntland there is a system of private “delivery homes” beside hospital and home deliveries. There are no deliveries at MCH level.

OF

The Minister of Health, the Director General and the midwife on duty at maternity ward in Garowe Community Hospital were all aware of the condition and have seen it. No fistula surgery is currently done at public hospitals except in Bossaso. Only visiting expatriate

surgeon Dr.J ama, stationed temporarily in Galkayo, can do fistula repairs. A few of the cases seen at public hospitals are referred further on.

Asked specifically for most urgent issues in public health sector of Puntland:

1. **Training of qualified human resource for public health sector**
2. **Baseline assessments**

M. SAACOM March 23, 2005, Garowe, Puntland

Mrs. Roda Yasin Farah and other female NGO members
e-mail: Roodo70@hotmail.com

Somali Agro Action Community, local women NGO

See References: “SAACOM organisational profile 2003” and “Certification of Partnership with MOH Puntland”

Operational in Puntland since 1995 with support from WFP, UNICEF, IFRC – initial target group IDPs, agricultural, food generating activities.

Since 2003 (see 2003 organizational profile) they have been expanding into the health and education sectors. Vocational school for poor women and girls, who cannot afford public school fees; 10 teachers (8 women, 2 men). Income generating activity such as sewing, weaving.

One midwife within the group of women explains about delivery homes on private basis in town, however there was insufficient time to observe this as part of this mission.

Question: Do you know the term fistula and why it occurs?

Answers: They all know fistula cases in their nearest environment, the midwife knew of 5-6 cases in town, named specifically RVF/VVF term.

Most important perceived female health problem: fgm – the challenge remains, since there is no money for training people at village level in order to stop the practice.

(During the meeting, a local female CARE representative made her appearance shortly, as she was attending a workshop another place in town, further information can be obtained from UNFPA National Programme Officer Mr. Abdikarim Musse.)

N. AMREF March 25, 2005, Nairobi, Kenya

Dr. Tom Raassen, fistula surgeon, AMREF Specialist Outreach programme

Longstanding work as AMREF outreach surgeon in East Africa including many years in ethnic Somali context; subspecialized in obstetric fistula surgery; has trained fistula surgeons in the East African countries; willing to work as consultant, if UNFPA decides to start fistula outreach program in Somalia.

Since 2004 fistula surgery at SOS Medical Centre, Mogadishu, a hospital with maternity and pediatric department; local surgeon Dr. Bashir has been trained in fistula surgery and has in April 2005 gone for further training at fistula center in Addis Ababa, Ethiopia, see <http://www.fistulafoundation.org/hospital>

(According to Dr. Bashir, who was interviewed for a few minutes on an airstrip near Mogadishu, Somalia, on March 24, 2005, when the needs assessment team returned from Somaliland to Kenya, the SOS hospital in Mogadishu runs a busy maternity ward with an average of 4-5 cesarian sections per day. Fistula surgery is done regularly by Dr. Bashir and AMREF Outreach fistula surgeons, more than hundred cases a year.)

Exact prevalence rates in the region (and the world) are not known. Dr. Kees Waaldijk, Dr. Tom Raassen and Dr. Festus Llako (see References: Waaldijk and Needs Assessment from 9 African Countries) extrapolate a figure of 6,000 to 15,000 new fistulas occurring each year in East Africa. This figure is based on the knowledge that every year three million women survive deliveries in the region; for each thousand of these surviving mothers, there are an estimated one, two or five cases of fistula.

Crude birth rate for Somalia calculated by Dr. Vincent Fauveau (see References, UNFPA Mission Report No 38) is 45 per thousand (population) per year.

Estimated obstetric fistula incidence for Somalia:

1-2-5 /1000 deliveries

Population estimate 6 Million (Health Authorities' estimate): 270, 540, 810

Population estimate 8 Million (Political Authorities' estimate): 360, 720, 1080

Maternal Mortality Rate for Somalia 1600 pr 100000 live births, rising from 1100

Website: www.amref.org

See Annual Report 2004 <http://www.amref.org/AnnualReport2004%20PDF.pdf> page 9-20

“Fistula programme in East Africa”, specifically Mogadishu, Somalia, page 20

and <http://www.amref.org/clinical.htm>

“The African Medical Research Foundation (AMREF) Flying Doctors have been carrying out an Outreach Programme across East Africa since 1957. AMREF’s planes take specialist surgeons to areas where there are no communications, limited medical services and little or

no surgical services. We travel to inaccessible areas that can only be reached by plane, where health clinics and hospitals try to support hundreds of people staying in outlying villages where the only health facility may be a man selling paracetamol in a roadside kiosk.

We currently provide specialist health care and training in 75 hospitals in Kenya, Tanzania, Uganda, Rwanda, Ethiopia, Somalia and Sudan. Those patients who have problems outside of the hospital's capacity are helped by AMREF specialists, and refresher and training courses are carried out at the same time in the hospitals."

and <http://www.amref.org/family.htm>

"In the context of AMREF's new strategic direction, Family Health has several components: sexual and reproductive health; adolescent health; maternal health; child health; community based rehabilitation; food security; and issues relating to the elderly.

Family health indicators, in the countries where AMREF works have continued to show a reversal trend, mainly because of the HIV/AIDS pandemic. This is particularly so in child and maternal health. Figure 4 illustrates the situation in maternal health.

AMREF's main interventions in Family Health were aimed at improving the quality of reproductive health care services, empowering communities to manage child health initiatives, and supporting children in difficult circumstances. They included new approaches for enhancing parent to child communication, community rehabilitation, assessment of TBA practices, IMCI, HIV/AIDS among the PWDs, quality of maternal services and child vulnerability."

O. MSF-CH (Switzerland) March 25, 2005, Nairobi, Kenya

Iza Ciglonecki, Medical Coordinator

e-mail: msfch-somalia-medco@msf.org

Website www.msf.ch

Somalia activities, see <http://www.msf.ch/Somalia.86.0.html?&L=1>

MSF is operational in Central South Zone of Somalia and in Puntland. According to website no activities in field of maternal and reproductive health, but it was stated during the short meeting that MSF-CH is interested in emoc, longterm as well.

MSF-CH is currently operating in Dinsor, supporting an MCH and hospital with 35 beds, 10 deliveries pr. month, about 1 c-section per month.

In Beletweyne, Central South Zone, there is a non-functioning hospital, MSF-CH is considering running it in the future.

It was stated that MSF-Belgium and MSF-Espana operate in Somalia, but not in the field of maternal and reproductive health.

MSF-Holland is operational in Galkayo, Puntland, supporting the public hospital (see fact sheets on visited hospital sites).

**P. UNFPA Somalia Country Office, March 15 and 30, 2005,
Nairobi, Kenya**

Mrs. Jacqueline Desbarats, Representative
Mr. Abdikarim Musse, National Programme Officer
Mrs. Mumina Aden, Admin/Finance Officer

Organizational profile and work in Somalia, see References: UNFPA Country Office Annual Report 2004, Nairobi, March 2005 and Somalia Country Paper, prepared for the Arab Population Conference Beirut, Nov 2004, as well as www.unfpa.org, www.unsomalia.net, and www.endfistula.org

10. Key Contacts

The needs assessment team is deeply grateful to the following individuals in Kenya and Somalia for their assistance with this project.

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Mr. Abdikarim Musse, National Programme Officer
Mrs. Mumina Aden, Admin/Finance Officer

UNSECOORD / UNDP Somalia, Nairobi, Kenya

Mr. Joe Gordon, Field Security Coordination Officer

Ministry of Health

Hargeysa, Somaliland

HE Minister of Health Osman Qasim Qodah, Minister
Mr. Ahmed Abdi Jamaa, DG Health
Mr Khader Mahmoud, Planning Division
Dr Abdi Dahir, HMIS

Garowe, Puntland

Minister of Health Dr. Abdurahman Said
Director General, former Director of Medical Services

Hospitals

Edna Adan Maternity Hospital, Hargeysa, Somaliland

Mrs. Mariam Abdullahi, Acting Hospital Director
Midwives and nurses

Group Hospital, Somaliland

Dr. Ibrahim Bixi, Ob/Gyn, Maternity Ward
Dr. Abdi Rahman, Regional Medical Officer
Chairman of the Regional Health Board
Mrs. Tasmu, midwife
Nurses

Regional Hospital Borama, Somaliland

Dr. Ismail H. Muhumed, Hospital Director
Dr Ibrahim Said Osman “Qows”, Ob/Gyn & Surgeon
Prof. Hassan Ismail Yusuf, COOPI
Dr Ismael Ayad
Dr. Abdirahman Jama Hadi, Regional Medical Officer
Dr Nimo Haji Abubakar, Ob/Gyn

Regional Hospital, Berbera, Somaliland

Dr. Haggar, surgeon and Director

Community Hospital, Garowe, Puntland

Director General
Midwives and nurses

Galkayo Medical Centre, Galkayo, Puntland

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Dr. Abdulkadir Mohamed Jama, surgeon

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Midwives and nurses

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Mrs. Roda Yasin Farah

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Dr. Tom Raassen, fistula surgeon, Specialist Outreach programme

MSF

Iza Ciglenecki, medical Coordinator, MSF-CH (Switzerland)

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Mail from Dr. Jama, Galkayo Medical Centre, COMSED, Puntland: Request for fistula center in Galkayo, Puntland, see appendix

Mail from Dr. Ismail H. Muhumed (BRH Director) & Dr. Abdirahman Jama Hadi (RMO),
COOPI, Borama Regional Hospital, Somaliland:
Project proposal - Establishment of reproductive health program and safe delivery practices