

SOMALIA

HEALTH NEWSLETTER



The International Committee of the Red Cross (ICRC), in collaboration with the Somali Red Crescent Society (SRCS) has been supporting the health care system in Somalia since the collapse of the government in 1991, which led to the breakdown of the health care system and infrastructure. They started providing support by opening health posts, expanding them to health centers and hospitals offering care to those injured during the conflict.

The ICRC is currently supporting the first aid program, primary health care, hospitals, nutrition activities and referral of patients from one level of care to the next depending on their needs (continuum of care). The SRCS runs the **first aid program** with the support of the ICRC first aid team. The program focuses on building the capacity of SRCS first aid volunteers and the training of communities on first aid, equipping them with the necessary skills to respond to emergency situations and administer first aid care. In 2016, three First Aid (FA) action teams were initiated across 3 major towns namely Mogadishu, Galkaiyo and Las Caanod to respond to emergencies and refer the injured to hospitals.

In addition to the first aid program, the ICRC supports SRCS in running of 29 **primary health care (PHC) facilities** (20 fixed clinics and 9 mobile clinics), all providing curative, preventive and promotion services. Eighteen of these health facilities also provide nutrition services to children under five years with Severe Acute Malnutrition (SAM) across South Central Somalia. In

2018, the ICRC introduced a Basic Emergency Obstetric and New Born Care (BEmONC) services as a pilot project in two of the PHC facilities. In addition, community health-based program in Dalhiska and a community-based surveillance in Baidoa were also started as pilot projects with the aim of linking PHC program to the community.

The ICRC **war surgery** and emergency medical care for combatants and non-combatants across the country have a longstanding history. Presently, ICRC supports four hospitals with a total bed capacity of 410 beds in South Central Somalia. The hospitals are Keysaney (since 1992), Medina (2001), Kismayo (2013) and Baidoa (2014), all offering war surgery. In addition, Baidoa and Kismayo hospitals also provide inpatient nutrition care for SAM children with medical complications. In 2016, ICRC together with the Norwegian Red Cross provided 20 beds to Keysaney Hospital for the fistula surgery support. The SRCS does community mobilization and referral of patients with fistula from PHC facilities to hospitals.

The overall support that the ICRC provides to hospitals and SRCS clinics includes medicines, medical equipment, capacity building and staff incentives. The ICRC is supporting the transformation of health programs in Somalia with the collaboration of SRCS, Partner National Societies (PNS) and hospital management teams, to align ICRC health activities in Somalia with the concept of continuum of care.

HEALTH PROGRAMS - PRIMARY HEALTH CARE

Primary Health Care (PHC) is a community approach to health and well-being centered on the needs of individuals, families and communities.

The 29 PHC facilities in south central Somalia are run by the Somalia Red Crescent Society (SRCS) with the support of ICRC. The facilities provide treatment to sick children and adults, as well as vaccination services to children under five years old and pregnant women in line with the national immunization schedule. Antenatal and postnatal care are also provided.

Children are screened for malnutrition and treatment is given to those under five years with severe acute malnutrition. Those over five years are treated for other ailments as cases of malnutrition from that age are rare. Also, two of the PHC facilities (Radaar and Dusamareeb) provide 24-hour Basic Emergency Obstetric and Newborn Care (BEmONC), which means that care is provided to mothers and newborns during and after labour. This program started in August 2018.

Nutrition

The nutrition services provided by the SRCS clinics with the support of ICRC include: Outpatient Therapeutic Program (OTP) for treatment of severe acute malnourished children under five years; and Targeted Supplementary Feeding Program (TSFP) for children under five years and pregnant /lactating women in collaboration with Economic Security department (ECOSEC).

Currently, there are 18 clinics that provide OTP services and 8 clinics in Baidoa, Kismayo, Bardhere and Huddur that are providing TSFP as part of a pilot project. The aim of the nutrition pilot project is the implementation of the Integrated Management of Acute Malnutrition (IMAM)



Mothers attending postnatal clinic in Baidoa.

programme that follows the Somali IMAM guidelines. It has 4 components namely; community approach (community mobilization and sensitization; targeted supplementary feeding program; outpatient therapeutic program and a stabilization center. It is important to treat children with moderate acute malnutrition before they become severely malnourished. The malnourished children receive therapeutic nutrition treatment as well as systematic medical treatment and in case of other pathologies, they receive the medical assistance needed.

ICRC also provides support to two stabilization centers in Baidoa and Kismayo where the medical complications linked to the severe acute malnutrition are treated. After treatment, the children are transferred to OTPs for treatment until they are cured from malnutrition. Food is then provided to the caregiver when the child is admitted in the SC and health, IYCF education is given. Malnutrition can be caused by diseases, inadequate food intake and other factors.

Maryan Maalin stares at the nurse as he reads her mid-upper arm circumference (MUAC). The measurement is an indicator of the level of malnutrition. Fortunately, she's in the green. The colour red is at the extreme end of the colour chart and indicates severe acute malnutrition, a situation in which the child would require urgent life-saving treatment.





A health team member addressing women on the advantages of breastfeeding, vaccination, proper hygiene and sanitation practices. There's a sudden burst in activity as people from surrounding villages congregate whenever the health team comes visiting.

Reproductive health

Some 95 female community health workers (FCHWs) are attached to SRCS clinics across south central Somalia. The FCHWs collaborate with midwives in providing health education to women and referring pregnant women to clinics running BEmONC services, antenatal care services, postnatal care and maternity services. They also refer women with gynecological fistulas to the clinics for assessment by the midwives. The FCHWs are trained on health education, fistula awareness and identification and danger signs to observe in women during pregnancy and labour, for early referral and treatment. A FCHWs kit is provided to help them carry out their activities. The FCHWs provide weekly reports on their work.



A team from the Fistula department during a six weeks obstetric fistula training at Hamlin Fistula hospital in Addis Ababa, Ethiopia.

The SRCS is running a community health program in the Dalxiska IDP camp in Kismayo where community volunteers are trained on health promotion, identification of the sick in the community and referral processes to mobile and fixed SRCS clinics for treatment or further referral. The volunteers are provided with materials to carry out their activities. They are also required to provide data every month on the activities that were carried out.



Somali Red Crescent Society (SRCS) volunteers wash their hands at the cholera treatment centre. A number of SRCS volunteers are helping hospital staff care for the patients. SRCS mobile health teams are also making door to door visits within the district promoting hygiene and proper sanitation.

ONE ON ONE WITH SEYNAB MOALLIM NOR, MIDWIFE/NURSE

Seynab Moallim Nor is a midwife/nurse by profession. She's a graduate of SHIFA University and SIMAD university. Seynab has been a primary health care practitioner for three decades now, offering technical support to several Mother and Child Healthcare services in several districts around the country at different times as well as working in different capacities within the Ministry of Health and with various humanitarian agencies working in Somalia. She's now with SRCS as a reproductive health manager. We had a chat with her about her work.

Q: What are the reproductive health services provided in SRCS clinics?

A: SRCS is one of the national humanitarian institutions that provide the largest reproductive health services across the country. SRCS runs 29 PHC clinics all of which provide a comprehensive package of reproductive services in remote and hard to reach areas in both urban and rural context. This reproductive health is also integrated with nutrition across all facilities in a bid to improve the maternal health care. The specific activities done in SRCS facilities are:

- Complete package of safe motherhood services (Antenatal/Postnatal care, child spacing, STD treatment, BEmONC service in some places and Referral of Obstetric emergencies)
- Referral of fistula patients to Keysaney Hospital
- Clinical management of rape

Q: How do you ensure that the community knows about the reproductive health services offered in the clinics?

A: Most SRCS clinics have been existing for a long time and had been providing free services to the communities particularly in areas where they are predominantly present. Each clinic works with several well-respected, well-trained Female Community Health Workers (FCHWs) and volunteers based in the community. These FCHWs and the volunteers routinely visit the

facilities and subsequently facilitate community level referrals and connections between the community and the health facility services. These two arms are the bonding mechanisms SRCS use as a source of service dissemination.

Q: How do you convince pregnant women to visit the clinic for antenatal and post-natal care (ANC/PNC)?

A: There are number of ways our clinic midwives convince pregnant women to attend the routine recommended ANC/PNC. Firstly, our midwives in the clinics are very professional and well-known in the area. The trust and confidence pregnant mothers have in the midwives, and which has been built over the years has prompted them to attend regular antenatal and postnatal clinics for checkups. During the routine visits, pregnant mothers are given a schedule of their respective gestational visits to the clinic and in detail, a form of why each visit is required. Secondly, there are well-trained health promoters who are always talking to patients visiting the facilities, advising pregnant mothers on good health-seeking behaviours while emphasizing on the importance of attending ANC/PNC visits. Lastly, there are FCHWs who work with our midwives from the community level and routinely do referral and follow ups of pregnant mothers to link them to the clinics.



Seynab Nor
attending to patients
in her clinic.

Nasra Jamal Ali, 18, is pregnant with her first child. She walked 14km to Dhagahyale to see the midwife, who is a member of the mobile health team that comes to the village every Tuesday. Antenatal and postnatal care form a huge part of the case load for this mobile health team.



Q: What are the most common maternal complications seen in the different clinics?

A: SRCS clinics are in areas where there are limited health services available and no secondary level referral. Most commonly seen maternal complications in the clinics are: Eclampsia, obstructed labor, post-partum hemorrhage, anti-partum hemorrhage, severe anemia and gynecological complications.

Q: How do you handle pregnant women who come to the clinic at the last minute or when they have complications?

A: Most of the clinics with BEmONC services work 24/7 and there are always midwives who are ready to stabilize the patient and refer on time. For those that need secondary level management, we use the referral Standard Operating Procedure (SOP). In addition, there is a monthly allocated budget to assist those mothers needing referrals.

Q: Can you elaborate on the collaboration with the female community health workers (TBA's)? How did it start and how is it working now?

A: Collaboration with the female community health workers started when we realized the need to have a working relationship with the community and improve community level referral. To ensure we have balanced and strong FCHWs, we placed three FCHWs selected from their respective community cluster/village in the fixed facilities. But, because of the different villages they must visit and the distance they must cover moving from one village to another, the mobile health team has 6 FCHWs. All these FCHWs were trained on a completed health package designed for them. So far, there is a close working relationship between the FCHWs and the respective facility midwives. On the other hand, we have some reporting tools which we developed for the FCHWs to report on a weekly basis to the midwives.

In addition, FCHWs refer all cases in need of health care to the facilities and make home visits in their respective villages/locations. Every month, the branch health officer compiles the weekly FCHWs reports into a monthly report. ICRC also provides the FCHWs with a working kit, which they use during their home visits.

Q: What is BEmONC and where has it been implemented in South Central Somalia?

A: As a term, BEmONC refers to Basic Emergency Obstetric and Newborn Care. This is a program recently integrated to SRCS Reproductive Component due to the high demand of such services.

Q: What are the challenges of the reproductive health file?

A: One of the challenges that the reproductive health file encounters has to do with the fact that people do not go to the hospital when expected to due to stigma and other social issues. The worst of it is when pregnant women fail to attend the recommended ANC visits which in most cases is as a result of cultural barriers and local myths or attend at the last stage of the pregnancy. Another challenge we encounter is on accessibility. Some of the facilities are in remote areas which makes accessing a health facility very difficult. Poor infrastructure and insecurity are also major contributing factors.

Q: What are the goals of the reproductive health file?

A: The goals are to reduce the maternal mortality rate (MMR) and maternal complications by providing the best care to pregnant and lactating mothers at the health centres and making proper referral. We also plan on offering more training to the SRCS Midwives in a bid to enhance their skills for better service delivery to pregnant mothers.

FIRST AID

The First Aid Program is present throughout the country and aims to provide training, support and response capacity to various groups and communities.

Together with the Somali Red Crescent Society (SRCS), the ICRC has been working to deliver important skills to remote and rural communities and areas affected by conflict. Information, response materials and first aid skills are provided to community members, volunteers and responders in what has become our flagship activity.

In addition to the grassroots work, the program is expanding into new areas – working with various health teams and interlocutors to enhance the emergency response capacity in Mogadishu, developing the continuum of care between first intervention and definitive care, working on projects to improve the sustainability of the SRCS and working more closely with the SRCS action Teams.



First aid team in action

CURRENT PROGRAMS

Basic First Aid for Communities

Communities that are prone to conflict, violence or disadvantaged are selected to receive basic first aid training on how to attend to injuries caused by various firearms. The trainings last for 3 days and usually have 25 community attendees.

Basic First Aid for Volunteers

SRCS Branches routinely train their volunteers in basic first aid to maintain a pool of potential responders. These volunteers often go on to become trainers in their own right or join action/response teams.

Training of Trainers

The ICRC has been committed to maintaining a pool of SRCS trainers, available to facilitate community or routine volunteer first aid trainings. The trainers are introduced to standard messaging, practical techniques and technical skills in order to enhance the experience of their trainees.

Mass Casualty Incident Management Gap Analysis

A relatively new initiative, the ICRC is conducting a gap analysis and assessment of the Mass Casualty Incident Management mechanisms in Mogadishu. This

will inform and focus on future pre-hospital care and continuum of care related activities.

First Aid Action Team Support

The action teams are available 24hrs in Mogadishu and on-call in Laas Caanood, Taleh, Kalabaydh, Hudun, Galkayo North and Galkayo South. These teams are operated by the SRCS trained teams and supported by the ICRC.

Pilot Projects

The below pilot projects are going to be launched by SRCS with the support of ICRC in 2019 around Somalia.

- Commercial First Aid: With technical support from the ICRC, the SRCS plans to launch a Commercial First Aid Pilot Project in 4 locations around Somalia in 2019. This project will see SRCS market first aid training services to corporations as a way of generating its own revenue.
- Motorcycle Response Units: Together with the SRCS, the ICRC plans to launch a Motorcycle Response Unit (MRU) as a pilot project in Mogadishu in 2019. The aim is to increase the response capacity while testing the efficiency of this unit.
- Beacon: In conjunction with the SRCS, the ICRC is assessing the possibility of launching a pilot project to improve the dispatch of emergency responders.

ONE ON ONE WITH FIRST AID ACTION TEAM LEADERS

Abdullahi Adan Abdi, Muxudiin Adan Mayow, Adan Ali Adan and Abdi Samad Hassan Boore, First Aid Action Team leaders in Mogadishu

Abdullahi, Muxudiin, Adan and Abdi have been part of the First Aid Action Team since the beginning, leading their teams offering first aid services to the injured and the sick. The four team leaders who are based in Mogadishu tell us about their experiences:

Q: When did you join the first aid action team and what motivated you to be first aiders?

A: We all joined the first aid action teams since inception in 2016. We were all interested in taking part in first aid especially after we saw the gap that existed in Mogadishu when it came to provision of first aid services to people injured in explosions, war and other occurrences and the response rate that was there then.

Q: ICRC has been conducting first aid training for a couple of years now. How beneficial has the training been to you in the execution of your duties as first aiders?

A: The first aid trainings offered by ICRC have been very helpful. We have gained a lot of experience in safer access, safety and scene management as well as prioritization of victims according to the gravity of their injuries. Overall, we have gained a lot of knowledge and experience of first aid.

Q: What are some of the challenges that you have encountered so far, while on duty?

A: We encounter so many problems in our line of work. Some of these challenges include: check points or road blocks erected by armed forces which delay our movements within the city; shortage of ambulances to ferry the injured to hospitals especially when there are mass casualties; and communication problems brought about by poor or lack of networks around the area of operation.

Q: What safety measures do you take into consideration when at work? For instance, if attending to the wounded in a blast or in a crowded place?

A: We try as much as we can to ensure the crowds are kept at a distance of 300 to 400 meters from the scene and that proper management of the scene is taken into consideration. Also, proper communication is vital especially when managing a team during an emergency response. Therefore, there must be a pre-briefing to

coordinate the evacuation of the wounded or the sick and the type of first aid offered to various victims.

Q: When responding to emergencies, how do you ensure that you protect yourself from infections when attending to the sick and the wounded?

A: We make sure all the first aid action team members have the most important gear like gloves, masks and boots. This is so that we do not expose ourselves to infections when handling the sick and wounded.

Q: I'm sure some of the scenes you encounter leave you very traumatized. How do you cope? Do you go for counselling?

A: Yes, some of the scenes, if not all, can be very traumatizing. But, the pre-briefing we get from our supervisor before we attend to an emergency helps us know what to expect. We are somehow prepared psychologically for what lays ahead. After the deadly blast that occurred in October 2017, ICRC sent a psychologist to come and offer counseling to the FA team members.

Q: How big is the SRCS first aid team in Somalia?

A: Currently, the FA teams focus on priority areas such as Mogadishu, Galkayo and Las Anood. The FA teams offer the most effective and efficient first aid interventions compared to the other private ambulances operating in Somalia. Private ambulances only offer transport but not first aid care unlike SRCS FA team who provide first aid services at the scene and offer transport to the hospital for specialized care.



HOSPITALS AND SRCS CLINICS SUPPORTED BY ICRC



RAISING AWARENESS ON HEALTH CARE IN DANGER THROUGH PAINTINGS



This is one of seven other artworks painted on the perimeter wall of the hospital which is an initiative by the ICRC aimed at creating awareness on health care in danger (HCiD) in Somalia.

“No weapons allowed in the hospital”

This is the first sign that invites you to Kismayo General Hospital – the largest hospital that provides health care in the town.

HCiD is an ICRC-led global initiative which seeks to address the issue of violence against patients, health workers, facilities and vehicles, and ensure safe access to and delivery of health care within hospitals in conflict prone areas. It also documents violence-related incidents that affect the provision of healthcare, with the view to discuss and examine with concerned parties and stakeholders how to better ensure safe access to health care services.

“These health care in danger (HCiD) and health care promotion messages painted on the wall will help create more awareness not only to patients entering the hospital but to everyone passing along the busy hospital road” says Hussein Sheikh Kasim, Hospital Director.

The hospital receives patients from Kismayo town and outcasts villages. Cases received vary from weapon wounded persons, malnutrition, acute water diarrhea (AWD) and measles.

“Carrying weapons within the hospital premises creates fear amongst patients and we have been urging people visiting patients to leave the weapons at the main gate of the hospital where there is a guarded weapon storage box and they can pick it upon leaving” Hussein adds.

Attacks on health-care personnel, facilities and vehicles during armed conflict are wrong. They are specifically prohibited under international humanitarian law (also known as the law of war), because they deprive sick and wounded people of much-needed care.

WHAT'S IT LIKE BEING A MIDWIFE IN SOMALIA?

There's an overbearing feeling of helplessness that sets in when you are unable to do anything to ease a woman's ordeal during child labour.

Imagine having to deliver a baby while traveling to the clinic. Now imagine holding a new-born baby you thought had passed away in your arms, only to feel a faint heartbeat. These are just some of the real-life experiences shared by midwives working in Somalia.

Yes, deliveries can go wrong sometimes, but proper planning and the antenatal care offered during the pregnancy helps to anticipate complications that could threaten the life of the new-born and the mother.

**FARTUN NUR ABDULLE, 25,
DUSAMAREB, GALGADUUD REGION.
EXPERIENCE AS A MIDWIFE: 3 YEARS**

"My mother inspired me to be a midwife. She once went through labour pains with no one around to help. She was not in a clinic and at one point became unconscious. The people came and sprinkled water on her. I felt sorry for her and helpless at the same time. I decided then that the only way to prevent such a scenario was by becoming a midwife."



Fartun holds a dummy baby during an obstetrics training held in Nairobi for SRCS midwives.

Unfortunately, in areas affected by conflict, where access to basic health care is a challenge, specialized care remains out of reach for most pregnant women. In Somalia, most deliveries fall in the hands of the midwives located in the Somali Red Crescent Society (SRCS) clinics spread across the country.

Twelve of these midwives took part in an obstetrics training that was held in Nairobi, Kenya in December 2018. We asked a few of them what their inspirations were and some of their unforgettable moments while ushering in new-borns in Somalia.



Barlin removes secretions from the 'baby' in preparation for neonatal resuscitation.

**BARLIN CABDI MOHAMED, 43,
BARDHERE, GEDO REGION.
EXPERIENCE AS A MIDWIFE: 20 YEARS**

"There was a mother who had labour for two days. There was no hospital in the area. She was carrying twins. I delivered one of them safely but ran into complications with the second baby. We were forced to take her by car to Beled Hawa [the closest district in Gedo]. She delivered the second baby while we were on our way. That was one of my happiest moments on the job for me and I was in the car with her the whole time."



In Somalia, maternal mortality rate is **732** maternal deaths for every **100,000** live births, placing Somalia as the 6th country in the world with the highest maternal mortality rate (WHO Global Health Observatory, 2015).



Nimco Hussein watching a demonstration of a breech birth. This is when a baby is born bottom first instead of the head. Most babies in the breech position are born by caesarean section because it is seen as safer than being born vaginally.

NIMCO HUSSEIN OSMAN, 22,
DUSAMAREB, GALGADUUD REGION.
EXPERIENCE AS A MIDWIFE: 3 YEARS

“The SRCS clinic is equipped to handle normal [low risk] deliveries. One time, a mother who had just given birth at home with the help of a traditional birth attendant came in. She still had the placenta inside her but the baby was out. Fortunately, her cervix was still open and I was able to stabilize her and remove the placenta. There was a lot of bleeding.”



Nadifa is taken through active management of the placenta.

NADHIFA ABUKAR MOHAMED, 32,
MOGADISHU, BANADIR REGION.
EXPERIENCE AS A MIDWIFE: 6 YEARS

“I was on night duty alone at the clinic when a mother in labour came in. She was already in severe pain having spent a lot of time with a traditional birth attendant with no success. Her cervix was fully open ready to let the baby through. So there was no time to check her condition or give medication. She started convulsing as I was putting on the gloves. There I was, alone, with the mother shaking on the delivery bed and a baby about to come any minute. I called for help but the watchman was too far away. I did not know what to do. Should I hold the shaking mother to prevent her from falling off the bed or I should deal with the baby instead. I took the risk and strapped her using belts on the bed. I then dashed to the nearest shelf to get some medication and gave it to her before turning my attention to the baby. Alhamdulillah, the mother delivered a healthy baby.”



Fardosa manoeuvres the ‘baby’ around during a session on managing complicated deliveries.

FARDOSA ABDI ABDULLAHI (RIGHT), 24,
MOGADISHU, BANADIR REGION.
EXPERIENCE AS A MIDWIFE: 4 YEARS

“There is a high maternity mortality rate in Somalia. My mum had trouble finding a midwife during her pregnancy. At the clinic where I work, a pregnant woman once came in bleeding severely. We managed to save both the baby and mother. I try to do my part to reduce the number of maternal deaths.”



Ayni listening for the foetal heart rate.

AYNI OSMAN HIDING, 44,
BAIDOA, BAY REGION.
EXPERIENCE AS A MIDWIFE: 9 YEARS

“The presentation/position of the baby was off. Before the mother was brought in, a traditional birth attendant had tried to deliver the baby but was not able to. The mother was in a lot of pain. We realized vaginal delivery was impossible and had to wait for a doctor who would operate on her. All the while, the mother was in agony, screaming for help asking why we just stood there staring. We finally transferred her to the theatre and the doctor operated on her. We believed the baby was stillborn. I started wrapping cloth around the baby when I thought I felt a faint heartbeat. The baby seemed disfigured and had a swollen face from the complications and I could not really tell. I immediately began to resuscitate and this worked. In the end both mother and baby were safe. This was a daunting experience.”

HEALTH PROMOTION MESSAGES FOR PREGNANT WOMEN

Mothers and their children are advised to visit maternal child health clinics when expecting and after birth. This will help reduce complications that could occur during pregnancy and childbirth. The clinics also provide advice that will ensure the wellbeing of both the mother and her baby.

HEALTH IS EVERYONE'S CONCERN



GO ON TIME TO DELIVER IN THE HEALTH CENTRE







SAFE MOTHERHOOD



DO NOT FORGET TO CHECK YOUR BLOOD PRESSURE REGULARLY



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