

COVID-19 IN SOMALIA: HIGH RISK OF INCREASED DEATHS AS PANDEMIC DISRUPTS FRAGILE HEALTH SYSTEM

SOMALIA

The COVID-19 pandemic has disrupted the resilience of Somalia's fragile health system more than any other African nation. Somalia is already affected by multiple humanitarian crises, having experienced conflict, drought, floods, and a locust invasion within the last nine months alone. The COVID-19 crisis will inevitably inflict more harm on a weakened and fragile health system. The number of confirmed COVID-19 cases in Somalia increased rapidly from 25 as of 13th April to 2,894 as of 29th April, with 18 deaths and 10 recoveries recorded. The number of cases in Somalia quadrupled in just one week (18th – 24th), with 97 percent of the cases reported in Banadi. 11 of the 16 COVID-19-associated deaths were reported in just one week¹. Among those infected were 15 health workers, including doctors who, according to the country's Health Ministry, contracted the virus from patients in the capital, Mogadishu. 13.1 percent of children in Somalia suffer from acute malnutrition. While the links between undernutrition and COVID-19 need further research, we are concerned that malnourished children are at heightened risk of contracting COVID-19. Children's access to nutrition treatment will be severely curtailed, further undermining their nutritional status and potentially placing them at higher risk of contracting the virus.

BURDEN ON HEALTH SYSTEM

HIGH NUMBERS OF VULNERABLE POPULATION

Somalia's vulnerable population includes more than 2.6 million internally displaced persons (IDPs), and approximately 2.7 percent of the elderly population live in overcrowded sites with poor hygiene. This population lacks safe drinking water, clean latrines, and hygiene kits, including soap, and many have limited to no access to health care services.

In the 2016 Health Emergency Preparedness Index, Somalia's capacity to prevent, detect and respond to any global health security threat scored 6 out of 100. This exacerbated by the fact that there are just two health workers for every 100,000 persons, well below the global standard of 25 per 100,000. Less than 20 percent of health facilities have the required equipment and supplies to manage epidemics². The health system is fragile, ill-prepared, and equipped to respond to both the current burdens and increased caseloads. A widespread outbreak may cause health services to break down at all levels, leading to high morbidity and mortality. Measures to close mosques and Koranic schools have been met with mixed reactions from religious leaders, while the Al-Shabaab group has insisted the disease is a Western plot. Opposition figures have pre-emptively called for elections to go ahead regardless of the dangers of infection it may pose for those participating.

THREAT TO HEALTH WORKFORCE AND INADEQUATE FACILITIES

Despite the training health and frontline workers have received on infection prevention and control, case management, and continuation of essential health services, a total of 15 health workers, including doctors and two staff from partners, have tested positive for COVID-19. The threat of further infections to essential health workers, due to inadequate personal protective equipment (PPE) and the potential closure of 90 percent of private clinics, will have a devastating impact on the already weak response.

Somalia is on the verge of a catastrophe if the isolation centers are not completed urgently. As of 2 July, there are two fully operational quarantine sites, with a total capacity of 108 beds. There are also 14 operational isolation sites, with an expected capacity of 230 beds. 176 primary health facilities have been identified for patient triage and referral.

With an upsurge in community transmissions, mass movement to access more advanced treatment and management is predicted. This will result in high congestion in hospitals and increased risk of further transmission. The De Martini Hospital in Mogadishu is the country's only medical facility dedicated to treating its growing number of coronavirus patients.

GAPS IN FUNDING FOR ESSENTIAL HEALTH AND LIFE SAVING SUPPLIES

Investment in the health system is very low. Somalia's public expenditure on health per capita (including donor financing) is about \$10–12 per person per year, which is very low, and increases the financial burden for marginalized groups³. Somalia's joint health and nutrition program is funded by the UK (52.9%); Sweden (25.1%); Finland (12.8%); Switzerland (3.6%); US (2.8%); and Australia (2.7%). The federal Ministry of Health & Human Services launched a 6-month National Preparedness and Response Plan for COVID-19 on 26 March with a \$57.76 million budget. The Federal Government of Somalia committed an initial \$5 million to the COVID-19 response. To date, the government reports that, in addition to their own commitments, the World Bank has committed \$7.5 million and the Islamic Development Bank has committed \$3.2 million to the response⁴. WHO has received contributions from ECHO, CERF, Italian Agency for Development Cooperation, and Embassy of Switzerland for its appeal to support government-led COVID-19 operations.

The contributions have enabled the scaling up of operational responses to COVID-19, including building

1 UN Office for the Coordination of Humanitarian Affairs

2 UN OCHA Somalia Situation Report (5 April 2020)

3 JRF Mission Report 2015

4 MoH: Federal Government of Somalia and WHO Somalia: Covid-19 situation report- 7 18 -24 April, 2020



and rapidly scaling up laboratory diagnostics and testing facilities. A funding gap of more than 80 percent remains, which has resulted in a critical shortage of medical supplies and personnel in Mogadishu and across Somalia. Prices for PPE have quadrupled in recent weeks and, without additional funds to the COVID 19 response, much-needed health services will not meet anticipated demand. Aid will become even more scarce as funding foreseeably drops while donor countries focus on repairing the damage caused by COVID-19 at home.

Reported cases of corruption within senior management of the National Coordination Team could pose dangerous threats to additional donor investment in the response and slow the momentum and progress. The pandemic will exacerbate the economic crisis and could hinder humanitarian actors' ability to secure lifesaving supplies. Not only is the country's economy impacted by travel bans and lockdowns, but as the global economy slows, Somalia could suffer further if there are reductions in remittances from abroad, which total approximately \$1.6 billion per year.

WEAKNESSES IN COORDINATION, PLANNING AND MANAGEMENT OF NATIONAL RESPONSE

Recent changes in leadership of the National Task Force has slowed the progress already made in Somalia towards reducing the spread of COVID-19. The slow pace of the response means the government must move with haste to consolidate gains so far. The shift of leadership from the Ministry of Health & Human Services to the Office of the Prime Minister risks creating a transitional gap in coordination and stakeholder engagement. The government has already limited space available to humanitarian actors in decision-making processes. Despite the large number of INGOs in Somalia, only a few (mainly those funded by ECHO and DFID) focus on humanitarian health programs, and the lack of inclusion in decision-making could further exacerbate the withdrawal, and reduce the valued support of non-state actors.

Most humanitarian partners have already scaled down and adapted their field activities in response to the government's movement restrictions and social distancing. COVID-19 directives have restricted access to IDP sites and the delivery of basic services by humanitarian partners. All organizations have instructed their staff to minimize movement, and work remotely. The lack of coordinated action is a potential recipe for chaos, violence, criminality, and, in the worst case scenario, Al-Shabaab attacks.

Government efforts to implement prevention measures have been stalled as many communities have disregarded government COVID-19 directives. Living conditions, social practices, and socio-economic factors all threaten to worsen the spread of the disease. Population movements and social gatherings continue in Middle Shabelle, despite the Governor's directive to suspend these activities. Markets, restaurants, and cafés remain open, and mosques continue to host prayers.

ACTION AGAINST HUNGER'S EFFORTS

- Leading and supporting the rapid training of healthcare workers; reinforcement of health systems, and advocacy for equitable distribution of medical supplies, such as PPE.
- Strengthening the capacity of health facilities through the provision of salaries for response staff at De Martini Hospital; deployment of two vehicles for MOH contact-tracing response team in Mogadishu.
- Provision of life-saving nutrition, FSL, and WaSH programs through procurement of medical supplies and PPE for FMOH and consortium partners
- Support of 15 health facilities with PPE for triage & referral (gloves & face masks), basic case management, gowns & face shields, and essential medicines for continuity of services.
- Support and active engagement with the national coordination through existing structures (health cluster, FMOH), and bilaterally with WHO to harmonize national and sub-national governance responses, including planning, coordination and surveillance.

CALL TO ACTION

- Government, donors, and the private sector must increase spending to flatten the curve by investing in all aspects of health to strengthen capacity to prevent, detect, and respond to diseases and to reduce the impact of COVID-19 on existing health systems. Funding for the COVID-19 response must not come at the expense of funding for ongoing humanitarian and resilience programming.
- Humanitarian actors must actively support efforts to innovate and find point-of-care diagnostics and treatments that could become centers of excellence that provide high-quality services that are accessible to all.
- National and sub-national response mechanisms must work to ensure that affected populations, community influencers (e.g. community leaders, religious leaders), and networks (women's groups, community health volunteers, youth associa religious groups, unions, and care groups) be involved in the design and implementation of COVID-19 actions.
- Humanitarian actors, including INGOs, local partners, and donors, must be fully engaged and participate in COVID 19 national and sub-national planning and decision-making processes that strengthen multilateral coordination and a harmonized national response.
- Government and key stakeholders must heed the UN Secretary-General's call for a ceasefire to allow health and humanitarian actors to safely access populations in need and mount a robust response to COVID-19 .
- Government must review existing directives to adapt and ease restrictions on the movement of essential humanitarian personnel, humanitarian and COVID-19 supplies, essential medicines, and food.

