INTERNATIONAL ORGANIZATION FOR MIGRATION

# IOM SOMALIA MIGRATION HEALTH STRATEGY

SEPTEMBER 2017 - SEPTEMBER 2018

*An IDP receiving antenatal care at a health clinic in an IDP Camp in Doolow*

*Photo Credit: Muse Mohammed IOM 2017*

## THE SOMALI CONTEXT

One third of the Somali population are pastoralists (UNFPA 2014) and 1.6 million are internally displaced persons (IDPs) - an increase from 1.1 million before the drought in November 2016 (IOM DTM).

## IOM SOMALIA

IOM has been operational in Somalia since 2006 and in 2015 relocated the majority of operations to Mogadishu. IOM Somalia has an annual operating budget of USD 55 million per year with plans for continued expansion with existing and new partners in 2017.

## IOM SOMALIA'S MIGRATION HEALTH PROGRAMME

IOM's Health programme is active across all regions of Somalia, with staff located across all major cities and strategic migration routes.

In response to the drought, IOM Health scaled up from 10 static clinics and 4 rapid response teams (RRT) in 2016 to 15 static clinics and 33 RRT by early 2017 – a more than threefold expansion in operations. The Somali Joint Health and Nutrition Programme (JHNP) ended in December 2016 leaving vast gaps in primary health care (PHC) across Somalia, to which IOM is responding, in collaboration with the Ministry of Health (MoH), the Health Cluster, and partners.

1. Health Service Delivery
2. Health workforce
3. Health information system
4. Access to essential medicines
5. Health system financing
6. Leadership and Governance

### Priority 1: Health Service Delivery – Expansion of mobile health teams to underserved areas

- An innovative and flexible service delivery model ideal for the Somali context where health services are concentrated in urban areas and as a result of conflict, insecurity, and environmental shocks displacement is extensive.
- IOM's model builds the capacity of the existing health system by utilizing MoH human resources in a hybrid service delivery model comprising both MoH and IOM staff-reducing donor dependency and building the capacity of the national workforce.
- This model is sustainable compared with traditional aid models whereby development and humanitarian partners provide the infrastructure, medical supplies, and human resource capacity and at end of the project service provision reduces or halts altogether.
- Investment in mobile health teams in place of static clinics accommodates the shifting paradigm whereby many countries remain in crisis for long periods—decades in the case of Somalia. The model has been piloted globally in acute and protracted conflicts settings, including in Yemen, South Sudan and Somalia.
- This model is adaptable for all aspects of the humanitarian, development and transition and recovery phases, enabling financial and human resources to be deployed and re-deployed across the country based upon the rapidly changing context.

*Ahmed is a nurse from Finland, deployed to Bali Hiile village in Somaliland, through IOM's Migration for Development in Africa (MIDA) programme. The nearest doctor is over 50km away.*
*Photo Credit: M. Mohamed IOM 2017*

### Priority 2: Health workforce

- Placement of technical health experts in collaboration with IOM's flagship project – Migration for Development in Africa (MIDA). Since 2008 IOM has placed 103 diaspora health professionals in temporary assignments in various health training institutes and public institutions to improve the capacity of local public healthcare systems by transferring knowledge and skills to local health professionals.
- Evaluation of the MIDA projects show significant improvements in policy creation and strategic planning, and skills development and capacity of health professionals.
- Training and on-the-job mentorship for clinical health professionals across MoH through IOM's hybrid service delivery models.

### Priority 3: Leadership and Governance

- Coordination support and capacity building of Federal and State MoH, including cross cutting thematic capacity building such as the newly formed Drought Committees.
- IOM will aim to support the Government to promote a migrant-inclusive health policy, as well as pass health bills through parliament including a policy delineating roles of the State and Federal entities.
- The Somali Joint Health and Nutrition Programme (JHNP) ended in December 2016, and at the same time the Health Sector Coordination across the country became fragmented. IOM hosts a secretariat for the Global Fund Steering Committee, and is proposing a similar coordination mechanism for the Health sector in Somalia.

### Additional priorities and future programming

- IOM contributes to the Global Fund project to reduce morbidity and mortality associated with HIV and AIDS, TB and Malaria through:
    1. Undertaking HIV surveillance with key populations at higher risk of HIV
    2. Distribution of long lasting insecticide treated nets (LLIN)
    3. In discussion with World Vision to become a sub-sub recipient for TB
    4. IOM hosts the Global Fund Steering Committee Secretariat for Somalia
- Development of rapid response team (RRT) mechanism to ensure preparedness for disease outbreaks, continued conflict and drought/flooding/natural disasters.
- Implementation of the International Health regulations (IHR), port health, travel health and cross border healthcare for Migrants and Mobile Populations (MMPs).

> *"It is not just the fact that it is not raining but the fact that when it does eventually rain, all of that rainwater is just going to run across the land picking up disease from all of the dead animals and then feed into their water supplies. That is when more diseases will come. - Ahmed, MIDA partcipant"*

## IOM'S COMPARATIVE ADVANTAGE

- Successfully tested mobile health model in Somalia – tailored to the current climate including political situation, complex displacement and multiple and simultaneous disease outbreaks.
- Multisectoral integrated in-house capacity including Health, WASH, NFI-Shelter, Camp Coordination and Camp Management (CCCM), and Displacement Tracking and Monitoring (DTM).
- Cross border approach including the ability to monitor populations on-the-move and provide services adapting to the migration flow.
- Ability for direct implementation and partnerships with implementing partners to reach inaccessible areas.
- Ability to absorb funds quickly, and adapt funds and programming as required for the changing context.
- Strong relationships with the Government –IOM has placed over a hundred technical staff with multiple line ministries over the past decade, and works closely with MoH through the hybrid human resources model.

*Children recover alongside their mothers at the Cholera treatment center in Kismayo. Photo Credit: M.Mohamemd IOM 2017*


*Pharmacists dispensing prescriptions at IOM Clinic in Dollow. Photo Credit: M.Mohamemd IOM 2017*

# IOM SOMALIA
# HEALTH RESPONSE

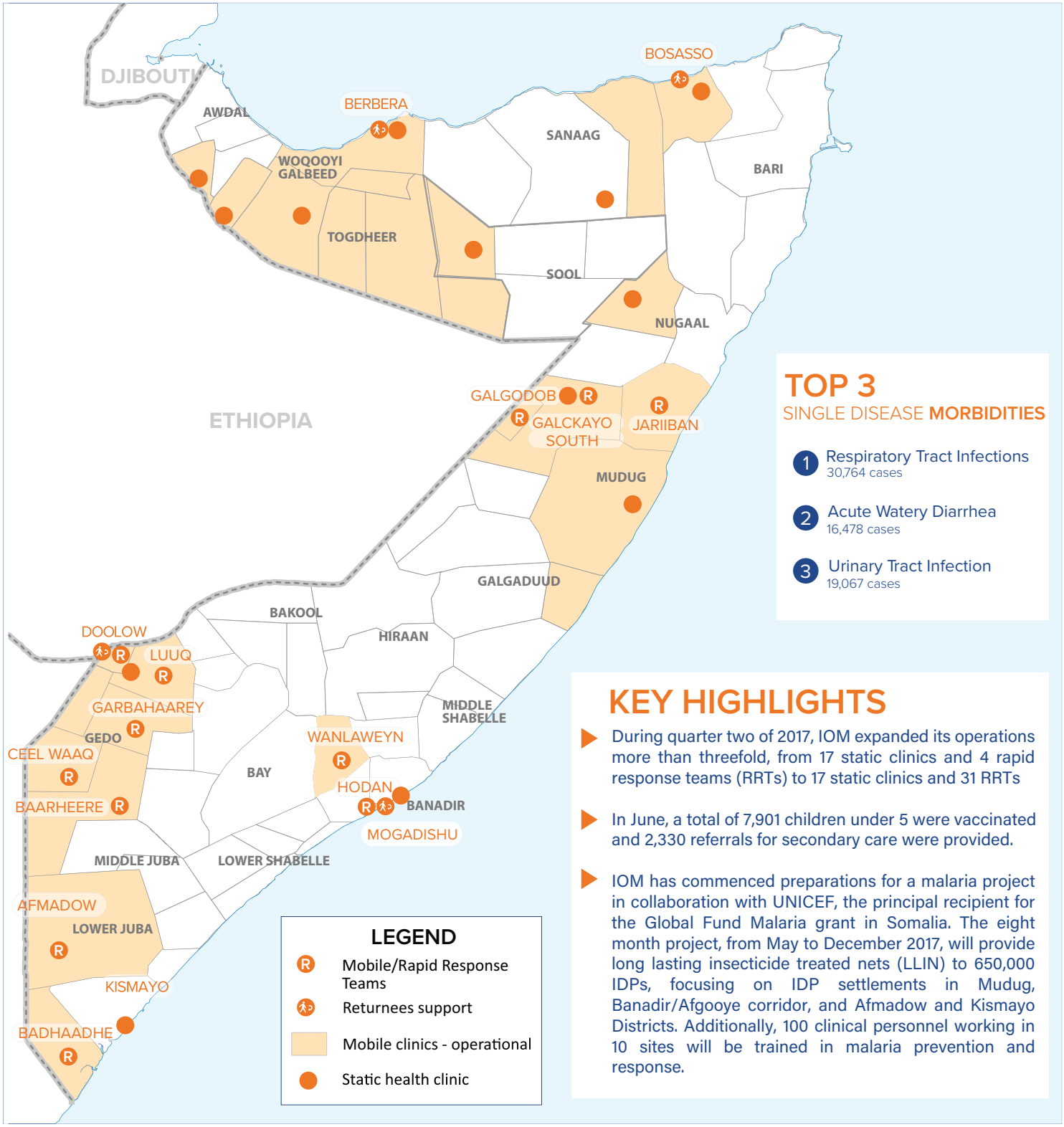
**JAN - JUNE 2017**

**277,795** individuals provided with health consultations

**33,209** children under 5 vaccinated since Jan 2017

**184,492** individuals reached with health promotion activities

**17** ➡ **31** Emergency primary healthcare consultations are provided through 17 static clinics and 31 mobile teams across the country




## TOP 3 SINGLE DISEASE **MORBIDITIES**

1. Respiratory Tract Infections — 30,764 cases
2. Acute Watery Diarrhea — 16,478 cases
3. Urinary Tract Infection — 19,067 cases

## KEY HIGHLIGHTS

- During quarter two of 2017, IOM expanded its operations more than threefold, from 17 static clinics and 4 rapid response teams (RRTs) to 17 static clinics and 31 RRTs
- In June, a total of 7,901 children under 5 were vaccinated and 2,330 referrals for secondary care were provided.
- IOM has commenced preparations for a malaria project in collaboration with UNICEF, the principal recipient for the Global Fund Malaria grant in Somalia. The eight month project, from May to December 2017, will provide long lasting insecticide treated nets (LLIN) to 650,000 IDPs, focusing on IDP settlements in Mudug, Banadir/Afgooye corridor, and Afmadow and Kismayo Districts. Additionally, 100 clinical personnel working in 10 sites will be trained in malaria prevention and response.



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unicef
SHF Somalia Humanitarian Fund
UNHCR The UN Refugee Agency
KINGDOM OF SAUDI ARABIA

# MIGRATION HEALTH DIVISION: 12 MONTH EMERGENCY APPEAL
## SEPTEMBER 2017 – SEPTEMBER 2018

**Priority One:** Primary healthcare provision for vulnerable and underserved communities through static and mobile health teams

| Geographical Areas | Activities | Justification / Why IOM? | Financial Requirements |
|---|---|---|---|
| Gedo (Dollow and Bardhere) | • Rehabilitation and construction of semi-permanent PHCU in IDP sites<br>• Expansion to provide 24 hour maternity care<br>• Rehabilitation and support for PHCUs in Bardere, Burshulbo, Elwak and Bardhere Hospital<br>• Deployment of up to 10 mobile teams across Gedo | • Influx of IDPs since 2017 due to drought<br>• Two large IDP sites in Dolow (>12,000 IDPs) – Kabasa and Qansaxlay (>9,000 IDPs).<br>• Joint cluster and IOM assessments show acute multisectoral needs – particularly Health, WASH, and Shelter | $2,000,000 USD |
| Lower Juba (Afmadow and Kismayo) | • Rehabilitation and support to Hosingo PHCU<br>• Continuation of 2 PHCU + OTP in Kismayo town and in IDP sites (Allanley and Dalhiska)<br>• Deployment of 4 mobile teams in and around Afmadow | • Focus on border areas with Kenya and Ethiopia to stop communicable disease spread given concurrent regional AWD/ cholera and measles outbreaks in the region<br>• 43% of households in Afmadow reported difficulty in accessing health services in August 2017 compared with previous month (REACH) | $ 1,300,000 USD |
| Somaliland (Hargeisa, Boroma, Lan Anod) and Puntland (Bosaso, Dhahr, Israac, Galkayo) | • Support to existing PHCUs in IDP settlements across Somaliland and Puntland and Sanaag in particular<br>• Deployment of mobile teams to either side of the disputed border of Sanag | • Sanag is underrepresented in terms of health facilities due to insecurity and access challenges<br>• 68% of households reported increased difficulty in accessing health services compared to more than three months ago (REACH) | $ 1,700,000 USD |

**Priority Two:** Development of rapid response team (RRT) mechanism to ensure preparedness for disease outbreaks, continued conflict and drought/flooding/natural disasters

| Geographical Areas | Activities | Justification / Why IOM? | Financial Requirements |
|---|---|---|---|
| To be determined based on disease outbreaks and epidemiological trends | • Recruitment and training of qualified roster of clinical and public health professionals for rapid deployment<br>• Establishment of a rapid response team (RRT) working group within the health cluster | • IOM will replicate the successful RRT model implemented in SS, which resulted in more than 30 rapid response missions over two years, serving more 300,000 beneficiaries | $1,000,000 USD (pilot) |

**Priority Three:** Health Sector Coordination to provide cohesion for State and Federal Ministries of Health and restoration of a uniform Health Sector Coordination forum

| Geographical Areas | Activities | Justification / Why IOM? | Financial Requirements |
|---|---|---|---|
| Federal and State MoHs | • Development of ToR including membership, roles and responsibilities<br>• Quarterly coordination meetings<br>• Online platform for information sharing<br>• Training and capacity building for coordination body members | • The Somali Joint Health and Nutrition Programme (JHNP) ended in December 2016, and at the same time the Health Sector Coordination across the country became fragmented<br>• IOM hosts a secretariat for the Global Fund Steering Committee, and is proposing a similar Coordination mechanism for the Health sector in Somalia | $500,000 USD |

# IOM GLOBAL MIGRATION HEALTH STRATEGY

Figure 1 : Operational Framework based on the World Health Assembly Resolution 61.17 on the "Health of Migrants" - Key priorities in alignment with IOM's Global Migration Health Strategy

## Monitoring migrant health:

- Develop health information systems, collect and disseminate data.
- Assess, and analyse migrants' health.
- Disaggregate information by relevant categories.

## Policy and legal framework:

- Promote migrant sensitive health policies.
- Include migrant health in regional/
- national strategies.
- Consider impact of policies of other sectors.

## Migrant sensitive health systems:

- Strengthen health systems, fill gaps in health service delivery.
- Train health workforce on migrant health issues, raise cultural and gender sensitivities.

## Partnerships, networks & multi-country frameworks:

- Promote dialogue and cooperation among Member states, agencies and regions.
- Encourage multistakeholders/ technical network.

## DONORS

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