Programmes of Primary Health Care in Somalia

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The Primary Health Care (PHC) programme, as it is reported in the Declaration of Alma Ata of 1978, is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

Its main components include:

1. Education about prevailing health problems;
2. Prevention and controlling of commonly endemic diseases;
3. An adequate food supply and proper nutrition;
4. An adequate supply of safe water and basic sanitation;
5. Maternal and child care including family planning;
6. Immunization against the major infectious disease;
7. Appropriate treatment of common diseases and injuries;
8. Provision of essential drugs.

The actual putting into effect of the PHC progamme in Somalia has drawn upon different documents from the Somali Ministry of Health. From them, we learn that the Democratic Republic of Somalia is situated in the north eastern corner of Africa (the horn). The total area of the land is 638,000 sq. kms. It has a coastline that stretches about 3,380 kms along the Gulf of Aden in the north and the Indian Ocean in the east. On the west, it is bounded by Ethiopia, in the north-west by the Republic of Djibouti, and in the South-west by the Republic of Kenya.

The total population of Somalia, exclusive of refugees living in the country, is 5.3 million of which 51% are nomads, 23% are rural-settled farmers, and the rest, 26%, are urbans.

The crude birth rate is 44 per 1,000, while the crude death rate is 13 per thousand, giving an average of population growth rate of 31 per thousand. The infant mortality rate is estimated to be 140-180 per 1,000 live births and the life expectancy at birth is 43 years (45 years in urban areas and 40 in rural areas). Morbidity and mortality rates by cause, are very sparse and inaccurate. However, all available

evidence suggests that tuberculosis is a major problem with perhaps one-in-three children aged 5-9 years being naturally affected.

The figures on the distribution of health facilities are taken from the development plan of 1982-86. Eighty hospitals and 308 Basic Health Units have so far been established in the capital, incorporating regional and district levels for the population of 5 million. There are few facilities at the subdistrict *beel* or village level and it is estimated that 85-90% of the rural and nomadic population do not have reasonable access to adequate health services. The distribution of health facilities is shown in the following table.

Distribution of Health Facilities by Region, 1979

	Population (1980)	Number of hospitals	Hospital beds 1/	Population per bed	Basic units 2/	Population/ units
Benadir	520,103	8	2,034	256	20	26,000
North-West	654,990	10	941	696	24	27,291
Togdher	383,867	3	288	1,333	14	27,419
Sanag	216,539	3	98	2,210	6	36,090
Bari	222,287	6	77	2,887	21	10,585
Nugal	112,162	3	132	850	9	12,462
Mudugh	311,230	1	60	5,187	14	22,230
Galgadud	255,856	5	80	3,198	9	28,428
Hiran	219,328	5	261	840	14	15,666
Middle Shebelle	352,040	4	132	2,667	22	16,002
Lower Shebelle	570,649	10	682	837	56	10,190
Bay	450,986	4	169	2,669	20	22,549
Gedo	235,061	5	69	3,407	19	12,372
Bakol	148,724	4	146	1,019	11	13,520
Lower Juba	272,368	5	310	879	25	10,895
Middle Juba	147,810	4	232	637	24	6,159
TOTAL	5,047,000	80	5,711	888	308	16,474

1/ Including beds in tuberculosis and mental hospitals.

2/ Basic health units include dispensaries, health centres and maternal and child health clinics.

Source: Ministry of Health, Health and Health-Related Information 1978 - 1979, February 1980.

The National Health Plan 1980-85 is carefully prepared according to the global strategy for « Health for all by the Year 2000 » (HFA/2000) forecasting one primary health care post for every 450-1,500 inhabitants, staffed by one community health worker (CHW) and one locally recruited traditional birth attendant (TBA). At the zonal level (1,500 to 10,000 inhabitants), primary health care units will be established, each with a complement of two CHWs and two TBAs. Finally, in each district (40,000 to 60,000 inhabitants), a primary health care centre will be constructed to be staffed by one medical officer, two public health nurses, two midwives, one sanitarian, one pharmacist and one logistics support officer. The hospital system will be designed to support the PHC programme and a central PHC unit is being established in the Ministry of Health together with a Central Coordination Committee.

The primary health care programme will cater for the essential health care

needs of the population, including maternal and child health care, the provision of safe drinking water and adequate sanitation, the prevention and control of endemic diseases and the treatment of common diseases and injuries which include:

1. Tubercolosis,
2. Common communicable diseases of children,
3. Diarrhoeal diseases,
4. Malaria,
5. Schistosomiasis,
6. Malnutrition,
7. Sexually transmitted diseases,
8. Respiratory infections,
9. Accidents,
10. Common obstetric problems,
11. Anemia,
12. Leprosy,

and receive support from a number of external sources.

The programme will gradually extend to the entire country. Areas not yet covered by the PHC system will be served by independent health care activities, in particular, communicable disease control compaigns, until such times as the PHC infrastructure has been sufficiently developed to allow for complete integration. The PHC system, particularly at village level, will rely heavily on community participation.

The regions where the PHC programme was implemented and sponsored, and their agencies, are as follows:

1. North-West Region and Awdal	UNICEF	Sept. 1982
2. Sanag Region Community Aid Abroad	C.A.A.	Sept. 1982
3. Togdheer Region	USAID	Sept. 1981.
4. Bay Region	USAID	Sept. 1981
5. Middle Shabelle (JNSP)	UNICEF	Sept. 1982
6. Lower Shabelle (JNSP)	WHO	Sept. 1982
7. Gedo Region	AMREF	1986 (Negotiation)
8. Middle Juba	SCR/WC/CISP	Jan. 1984
9. Lower Juba (Project Concern Inter.)	PCI	1986 (Negotiation)
10. Hiran Region (Italian Medical Team)	IMT	1984
11. Sol Region	BOCD	1986 (Negotiation)
12. Galgaduud Region (Italian Medical Team)	IMT	1986 (Negotiation)

Achievements in Summary

1. *Training of PHC Staff*

316 health staff have been trained in the PHC training centres in Baidoa and Burao. This includes 92 nurses, 96 midwives, 85 sanitarians, and 43 laboratory technicians during the period October 1981 to June 1985.

These on return to their respective posts, have trained 363 traditional attendants and 359 community health workers.

2. *Infrastructure and Health Manpower*

The following infrastructure was put into place or renovated: seven health centres were renovated and equipped; 20 dispensaries were similarly renovated and equipped and 16 PHC units were completely built and equipped. Five PHC teams are working in temporary houses provided by the communities in Bay and Togdheer until the above-mentioned constructions are entirely completed and equipped. Equipment and supplies were distributed to 27 districts. The following health personnel were assigned in 1981-85;

* 9 Regional medical PHC co-ordinators,
* 31 District medical officers and PHC co-ordinators,
* 7 Training officers,
* 92 Public health nurses,
* 96 Midwives
* 85 Sanitarians,
* 43 Laboratory technicians,
* 363 TBAs and 359 CHWs at the community level.

3. *Output*

To estimate the actual performance of the programmes, a monthly return was requested from the district and regional PHC co-ordinators which should include:

a) information about outpatients and the number of patients per disease,
b) information about MCH activities,
c) information about community sessions,
d) information about health education,
e) information about community assessments and sanitation,
f) information about vaccinations,
g) information about laboratory analysis.

Problems

1. *Delay in the progress foreseen in the health plan*

a) Building and renovation at district and PHC Unit levels; the health centres existing need to be renovated and some of the districts need to have health centres constructed.

b) Supplies — there are some supplies for the programme but there are not enough at present. Essential drug supplies need to be increased.

c) To distribute at the regional and district levels, suitable vehicles, which the programme is presently lacking.

The main factors, responsible for the low health standards, are inadequate supplies of safe water, lack of proper water disposal in rural areas, poor food hygiene, and chronic nutritional deficiencies in rural areas. There is a lack of resources to provide health care facilities at the grassroots level, a lack of technically qualified health care personnel, and a serious shortage of essential drugs, medicines, and equipment.

The Department of Community Health within the Faculty of Medicine at the Somali National University is concerned about getting the PHC intervention under way in order to provide operational support for its implemention by the Faculty

of Medicine in this field. Such activities deal with the control carried out in the rural and urban communities whether it be at the community diagnoses or at the environmental levels. The information derived from such studies, with knowledge of the socio-economic, anthropological, demographic and therapeutic levels, have been at the basis of the finalised intervention/s to control the more common pathology, and at the same time, promote a system of health education as fundamental support of primary health care.

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