

Report

Somalia: Medical treatment and medication



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SUMMARY

Public health and the standard of healthcare services in Somalia are among the worst in Sub-Saharan Africa, due to years of conflict, widespread poverty and natural disasters. The country has no health insurance system. Public hospitals and health centres are funded, operated, and to some extent also staffed by international or local organisations. The ineffective coordination and control of services within the healthcare sector has contributed to rural-urban disparities in access to basic healthcare services. Urban and secure areas benefit the most from initiatives by charity organisations and private actors, due to poor security and lack of access to other regions in the country.

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1. INTRODUCTION

This report addresses medical treatment options and access to medication for conditions such as diabetes, hypertension, hepatitis and HIV/AIDS. Statistics regarding demographics and health in Somalia are compared with corresponding figures from neighbouring countries and Norway. This report is based on publicly available written sources and on fact-finding interviews with professionals and international organisations in Nairobi and Mogadishu in November 2013. The focus of this report is the situation in South/Central Somalia, and to a lesser extent on the conditions in the breakaway Republic of Somaliland.

Source material is relatively limited, and some of the information in this report is indicative of this. It is worth noting that both the written sources as well as the international representatives Landinfo has met with, describe the conditions of the Somali healthcare sector in quite negative terms. There is no doubt that conditions are poor in a wide range of areas. For many conditions and serious illnesses treatment is non-existent, while antibiotics and medicines for more common conditions such as hypertension and diabetes are generally available¹ in Somalia.

This report uses terms such as “basic healthcare services”, “second-line” and “third-line” treatment and services. Healthcare services in Norway are divided into primary healthcare services, also called first-line services, and secondary healthcare services, also called second-line services or specialist healthcare services. These encompass both specialists and hospitals, as opposed to primary healthcare services, which are the patient’s first point of contact, or first-line healthcare services. The term “third-line services” refers to university hospitals. When describing conditions in Somalia, the term “basic services” is used to refer to information provided on health and prevention of disease, proper nutrition, potable water and essential sanitary conditions, mother-child services, vaccination programmes and treatment of common diseases (respiratory infections, gastrointestinal infections, etc.) as well as injuries. Second-line and third-line services are specialist healthcare services.

2. POVERTY AND PUBLIC HEALTH

Due to long-standing conflict, widespread poverty and frequent drought disasters, public health and the standard of healthcare services in Somalia are among the worst in Sub-Saharan Africa. According to data from the World Health Organisation, life-expectancy in Somalia is 50 years (WHO 2014a). In comparison, life expectancy in neighbouring Kenya is 60 years. The mortality rate for children under five is 180 per 1000, whereas the figure for Kenya is 73, and the regional average is 58 per 1000

¹ ¹ “Generally available” means that the medicines are likely to be found in the capital and other larger cities. However, the situation in rural areas is different.

(WHO 2014a; b; 2013).² Maternal mortality is also very high: 1000 per 100,000, compared to 360 in Kenya, and the regional average of 480.

The government's health sector strategic plan for 2013-2016 states that:

[...] the major determinants of population health are poverty, lack of security, lack of access to health services, poor nutritional status of the population, the low status of women and high rates of female genital mutilation, high fertility, low immunization rates, lack of access to potable water and safe sanitation, poor health behaviours and - increasingly - unhealthy life styles (Ministry of Human Development and Public Services. Directorate of Health n.d., p. 5)

Poverty, lower education levels and illiteracy all have an impact on public health, since poor people often have little knowledge about diseases and their prevention.³ They may also have a higher threshold for seeking out a physician or healthcare services. This is in part due to the cost of such visits for the family or the individual.⁴ There are therefore fewer opportunities to prevent disease. Poverty often leads to malnutrition or undernutrition as well, which further weakens the immune system, thereby increasing the likelihood of disease.⁵

A survey ordered under the auspices of the UN in 2002, revealed that 95 per cent of the urban population, and 60 per cent of both the nomadic population and rural population had access to some form of healthcare service (World Bank & UNDP 2003). However, only a third of people living outside of the cities could afford to use the existing services, while more than half of the urban population had that opportunity (see chapter 4).

3. HEALTHCARE IN SOMALIA

Prior to 1991, Somalia had a public healthcare system, but the civil war and conflicts in the wake of the war destroyed these services. Hospitals and other healthcare facilities were looted, and the buildings were occupied by internally displaced persons and other homeless persons. The authorities in South Somalia offer certain basic services, i.e. vaccinations and basic healthcare services for mothers and children.

² In 2011, UNICEF reported that major causes of mortality among children under five are: acute respiratory infections including pneumonia, diarrhoea, congenital deformities and intestinal parasites (Ministry of Human Development and Public Services. Directorate of Health n.d.).

³ The level of education in Somalia is low, and a high percentage of women have no education at all. Literacy among adults on a national scale is an estimated 25 per cent. Approx. 23 per cent of compulsory primary school-age children attend school. There is a clear correlation between women's education level and their behaviour related to health, ability to care for children and fertility (Ministry of Human Development and Public Services. Directorate of Health, n.d.).

⁴ The lack of transportation is a significant barrier to accessing healthcare services, and is closely linked to the security situation in the area. Public transportation is almost non-existent, especially in remote areas (Ministry of Human Development and Public Services. Directorate of Health n.d.).

⁵ Access to potable water and safe sanitation facilities is limited. 29 per cent of the population have access to potable water, while 37 per cent use some form of sanitation facilities (toilet, latrine, etc.). Access to soap and hand sanitisers varies, and especially differs between urban dwellers and the rural population. Non-potable water, poor sanitary conditions and poor hygiene are indirectly responsible for one of five deaths among children under five (Ministry of Human Development and Public Services. Directorate of Health n.d.).

There is no health insurance system in any region of the country. Public hospitals and health centres are funded, operated, and partly staffed by international or local organisations.

There is a lack of efficient coordination and regulation within the healthcare sector, which has contributed to rural-urban disparities in the access to basic healthcare services, and disparities between the different regions (Eng 2013; Capobianco & Naidi 2011). Urban and secure areas benefit the most from initiatives by charity organisations and private actors, due to poor security and lack of access to other regions of the country.

There are eight referral hospitals, ten regional hospitals and 26 district hospitals in South Somalia, but none of them can offer specialist services of significance. There are also 198 health centres / mother-child clinics providing basic services. Moreover, there are 269 health clinics intended to provide minimum services for the local population, but many of them are inoperative (Ministry of Human Development and Public Services. Directorate of Health n.d., p. 21).



Daynile Hospital in the Daynile district of Mogadishu.

Relief projects to provide better nutrition, combat polio, control tuberculosis, malaria and HIV/AIDS, and provide vaccinations, are run by international aid organisations, and the private, unregulated healthcare sector has expanded substantially in the absence of public services. In 1997, an estimated 90 per cent of all treatment was provided by private actors (WHO 2006).

Federal authorities in Mogadishu (and donors) spend on average three U.S. dollars – approx. 20 Norwegian kroner – annually, per capita, on health (Ministry of Human Development and Public Services. Directorate of Health n.d.), and 70-80 per cent of

healthcare costs are covered by the patients themselves.⁶ In Kenya, approx. 200 Norwegian kroner are spent per capita, and in Norway, approx. 35,000 Norwegian kroner (WHO 2013).

Governments of the breakaway Republic of Somaliland and the federalist state of Puntland also allocate funds to the healthcare sector. In 2012, this amounted to 3 per cent of Somaliland's budget, less than one and a half per cent of Puntland's budget, and most of it was used to pay wages (Tiilikainen 2012; Geopolicy 2012, p. 65). In other parts of Somalia, these services are heavily subsidised by local communities, international aid organisations or Islamic foundations (WHO 2006).

3.1 PHYSICIANS AND HEALTHCARE PERSONNEL

According to the World Health Organisation (WHO 2014a) there are 0.4 physicians per 10,000 citizens in Somalia. The figure for Kenya is 1.8 (WHO 2013), and the regional average is 10.8 (41.6 in Norway). The number of nurses and midwives is 1.1 per 10,000 (7.9 in Kenya and 319.3 in Norway).⁷ According to international representatives engaged in health efforts in Somalia, the healthcare sector also lacks personnel who are qualified to use advanced medical equipment such as dialysis machines etc. (interview in Nairobi, 15 November 2013).

There are seven private medical education institutions in South and Central Somalia, seven nursing schools and a public midwifery school (Ministry of Human Development and Public Services. Directorate of Health n.d.).

4. ACCESS TO HEALTHCARE SERVICES AND MEDICAL TREATMENT

According to a 2002 survey, approx. 95 per cent of the urban population in Somalia and 60 per cent of the rural population (nomads and farmers), had access to some type of healthcare facility within 1.3 to 2.4 km from their home (World Bank & UNDP 2003). This survey is more than ten years old, and there have been some significant changes in the situation in parts of the country due to local conflicts and natural disasters such as droughts and floods. Hundreds of thousands of people have been forced to flee over the last decade, and have therefore lost their livelihood. The same survey indicated that approx. 63 per cent of the urban population and 36 per cent of the rural population could afford available healthcare services.⁸ There is nothing to suggest that these figures have changed significantly since 2002, which indicates that a sizeable portion of the population has no genuine access to healthcare services.

⁶ From 2007 through 2009, various donor countries contributed an estimated 100 million U.S. dollars or approx. 700 million Norwegian kroner annually to the Somali healthcare sector. There are no figures for the share allocated to South and Central Somalia (Ministry of Human Development and Public Services. Directorate of Health n.d., p. 24).

⁷ According to local authorities, there are approx. 100 physicians and a similar number of midwives in the private and public sector in Somaliland. In 2011, there were 15 hospitals, 87 mother-child clinics and 165 health centres in this area (Ministry of Health, Somaliland 2011).

⁸ The study revealed that 88 per cent of all births in 2001 took place at home, without assistance from healthcare personnel, and approx. 9 per cent of births took place in hospitals.

Living conditions for internally displaced persons are generally worse than for others, and the lack of access to healthcare services is a serious problem for many (Radio Ergo 2014). Although the costs are low by Norwegian or regional standards, they are substantial for both internally displaced persons and for the local population.

The existing healthcare facilities include mother-child clinics and hospitals in the cities, and health centres and mother-child clinics in the rural villages. There are also some pharmacies, mobile clinics and private clinics.

The various healthcare institutions generally offer basic healthcare services, and according to representatives from the different international organisations engaged in health efforts in Somalia, specialist healthcare services are very limited in all regions of the country (interviews in Mogadishu and Nairobi, November 2013). Certain private clinics may have specialists, but there is no exhaustive overview of clinic standards or their services. Healthcare services in Somalia are either operated by, or receive considerable support from various aid organisations. When Doctors Without Borders (MSF) decided to withdraw from Somalia in August 2014, people in several cities were at risk of losing an important healthcare option: In 2012, the organisation had more than 624,000 consultations and referred 41,100 patients to hospitals.⁹

Hospital standards vary. The Shifa hospital in Mogadishu, run by the Turkish organisation Doctors Worldwide Turkey, is considered to maintain a good standard. The same applies to the Zam Zam hospital, run by another Turkish aid organisation; Humanitarian Relief Foundation, IHH. Zam Zam performs cataract surgeries. The Digfer Hospital in Mogadishu, which was rehabilitated with Turkish aid, is scheduled to open in April 2015 (Republic of Turkey. Ministry of Foreign Affairs 2014). This is to be a modern hospital offering advanced treatment, but it will likely only be an option for those with the ability to pay (interview in Mogadishu 15 November 2013).



The Madina Hospital in the Madina district of Mogadishu.

⁹ The aid organisations Cesvi (Italy) and International Medical Corps took over operations of the hospital in Beled Weyne, Hiran, from Doctors Without Borders (Nimkar 2014). It is not known whether other aid organisations assumed operations of (the other) initiatives that Doctors Without Borders had in other cities.

4.1 ACCESS TO MEDICATION

Access to medication is influenced by at least four factors: rational selection, affordable prices, sustainable financing and a reliable healthcare system (Myhr 2011).

We have no overview of all medicines available in Somalia. No list has been compiled of what are known as essential medicines in the country since 2003 (WHO 2007),¹⁰ however, most common medicines can be acquired in the capital. It is also possible that such medicines can be acquired elsewhere in the country, but there is no authority to ensure stable access or to monitor proper storage conditions.

The price of medicines is another factor influencing accessibility. Myhr (2011) notes that there is no global correlation between price and the ability to pay. His claim, based on a number of studies, is that measures such as fair pricing and differential pricing are still at the drafting stage, and that medicines in poorer countries are therefore expensive for the majority of the population, both in terms of absolute price and purchasing power. The price level of medicines in Somalia is market controlled, and because there is no functioning public healthcare system, whereby medicines can be subsidised, costs must be covered by the patient. The exception is medicines dispensed under the auspices of aid organisations as part of a treatment programme. The price level is generally far lower than that of the Norwegian market, as it is generally more expensive to run a business in Norway than in Somalia. Regardless, the purchase of medicines entails a considerable financial burden for very many people. A consultation with healthcare personnel costs between 2-3 U.S. dollars or 12-20 Norwegian kroner. In a country where more than 40 per cent of the urban population lives in extreme poverty, i.e. on less than one U.S. dollar a day, or approx. seven Norwegian kroner, people may have to choose between food and health.

WHO (2011, p. 1) states in a report on medicines, access and prices that:

High medicine prices increase the cost of treatment. For example, treatment of an adult respiratory infection with a 7-day course of treatment with ciprofloxacin would cost the lowest-paid government worker over a day's wage in most countries. Costs escalate when originator brands are used: the same treatment would cost the lowest-paid unskilled government worker over 10 days' wages in the majority of the countries studied; in Armenia and Kenya, over a month's salary would be needed to purchase this treatment. Additional problems of affordability face people living with chronic diseases due to the lifelong nature of treatment and the frequent need for combination therapy.

Somalia is no exception, and according to representatives from the various international organisations engaged in health efforts in Somalia, serious diseases such as cancer, cardiovascular disease, HIV/AIDS, schizophrenia, psychosis and other serious mental illnesses, will not be properly treated, due to the lack of specialists (interviews in Nairobi and Mogadishu, November 2013). Most private pharmaceutical

¹⁰ Not all medicines are equally important. The World Health Organisation (WHO 2002) defines essential medicines as those "which satisfy the priority healthcare needs of the population". It is believed that approx. 400 different substances are enough to prevent and treat most common illnesses. They can be used to treat many different bacterial infections, malaria, intestinal parasites and other parasites, anxiety disorders, psychosis, pain, hypertension, epilepsy, cramping, nausea, asthma, allergies, rheumatism, vomiting and diarrhoea, and also provide local anaesthetics. The WHO's list of essential medicines includes both older substances which are no longer under patent protection, as well as newer patent-protected medicines.

importers do not procure medicines for such illnesses because they are costly and few patients are able to pay for them. Medicines for diabetes and hypertension can be obtained at pharmacies, however, there are few pharmacists, and these medicines are usually sold over the counter without prescription, involving a risk of medication error. Patients with money or connections can acquire most of what they need from Kenya or other countries.

4.2 QUALITY ASSURANCE OF MEDICATION

There is no public – or private – control of medication in Somalia, and the pharmaceutical market is controlled by local importers.¹¹ Whether medicines work the way they should depends on correct labelling, proper storage at the point of sale, proper storage during transportation, and knowledge of, and compliance with the medicine's expiration date.

All the representatives for organisations engaged in health efforts in Somalia told Landinfo that the quality of many of the medicines sold over the counter is questionable, due to lack of control (meetings in Nairobi and Mogadishu in November 2013). However, medicines that patients receive from the public hospitals supported by the UN and charitable organisations, are generally of good quality as they are procured through recognised channels. Somali health authorities would like to introduce a control system, but the lack of technical equipment, personnel and financial resources has thus far rendered this impossible. False medicines and expired medicines can therefore be dumped in Somalia. Those who attempt to stop this activity may risk being killed. The mayor of Mogadishu has claimed that the government is cracking down on these dealers, but central businesses behind the importation of such medicines are not affected by such operations (interview, international organisation 5 November 2013).

Somali health authorities acknowledge the problem:

In urban areas people regularly buy drugs direct from pharmacies. The quality of care provided by private providers (traditional and allopathic) is variable, but there is no comprehensive information on quality of health care in the private sector (Ministry of Human Development and Public Services. Department of Health n.d., p. 20).

Scarcity of, and unstable access to medicines also poses significant problems. In other words, there is no guarantee that one can receive essential, effective medicines or routine follow-ups from a physician or from healthcare personnel when the need arises. Low education levels and lack of knowledge may also cause many patients to ignore advice from healthcare personnel regarding the use of medicines and necessary lifestyle changes, such as healthier diets and more exercise.

The lack of control of medicines as well as the lack of guidance and follow-up for patients also increases the risk that resistant bacteria will develop. Dosage errors and incorrect use of medicines without prior contact with healthcare personnel may also

¹¹ The exception is Somaliland where authorities in 2010 established a food and drug inspection agency, but the operation currently lacks the necessary laboratory equipment to conduct inspections (Rydell & Elmi 2012; Dahir 2013)

cause serious damage to health (international organisation, interview in Nairobi, 15 November 2013).

4.3 COSTS OF HEALTHCARE SERVICES

Treatment costs money, even in hospitals financed by international organisations, and although the patient contribution is low, not everyone can afford it. In a meeting with Landinfo in Mogadishu in November 2013, the representative for Somali Health Cluster informed that medical treatment at the public hospitals should in principle be free of charge for patients with no income. Despite this, poor people will occasionally have to pay, and the representative claimed that there had been situations where patients were either forced to sell their possessions or borrow money to pay for treatment. For instance, patients who require regular change of bandages must pay for this, and the same applies to necessary medicines, x-rays and tests which can amount to approx. 14 Norwegian kroner (interview in Mogadishu, 5 November 2013). Even for families with some resources, a sick family member can quickly become a burden. Rather than contributing to the household, they may drain the family of financial resources and, at worst, ruin them entirely.

4.4 MEDICAL EQUIPMENT

Advanced medical equipment is in short supply at the hospitals, and there is also a shortage of qualified personnel to operate equipment, such as dialysis machines. One of Landinfo's interlocutors in Nairobi in November 2013 described a case in which Somali expatriates had donated three dialysis machines to the Keysaney and Madina hospitals. The hospitals, however, did not have the equipment needed to operate the machines, and there were no personnel qualified to use them.

4.5 EQUAL ACCESS FOR ALL?

In response to the question of whether all residents in local communities have equal access to healthcare services, a representative for an organisation with a long-standing presence in large parts of the country stated that this is not the case. Conflicts between clans create divides and cause some people to be shut out, or to have more limited access than others. In Galkayo, for instance, there is one hospital in the south of the city and another in the north. Aid organisations must negotiate for access when necessary, and these conditions may prevent certain patients from obtaining the care they need. The conflicts in Jowhar in Middle Shabelle (between the Shidle and Abgal clans), in addition to corruption, prevent equal access to services in this area. The same is true in Beled Weyne, Hiraan, where different clans dominate different parts of the city, and can thereby limit their adversaries' freedom of movement (interview in Nairobi, 15 November 2013).

5. HEALTHCARE SERVICES IN MOGADISHU

The capital has far more healthcare services than other Somali cities and communities. This is partly due to the presence of several international aid organisations and partly due to investments made in private clinics by returning Somalis. These establishments are made possible because of the improved security situation over the past few years,

and although daily grenade attacks and assassinations in various districts naturally contribute to fear and greater vigilance, this does not prevent residents from seeking out the existing healthcare services. In the daytime, people can normally make their way to hospitals and health centres. After nightfall, however, road blocks and crime restrict freedom of movement. Suicide attacks and larger bombings occur irregularly, and these situations also affect civilians. Large numbers of casualties naturally lay claim to substantial resources at the city's hospitals, and in emergency situations such as these, other aspects of patient treatment may be given lower priority.

5.1 SPECIALIST HEALTHCARE SERVICES

Specialist healthcare services are very limited – both in the capital and in other parts of the country (interviews in Nairobi and Mogadishu, November 2013).

An overview of health facilities and partners in Mogadishu from January 2013, prepared by Somali Health Cluster, see page 19, provides an idea of the available treatment options, but there are no guaranteed services for heart disease or neurological disorders. Advanced surgery for the treatment of cancer, cardiovascular diseases or brain surgery cannot be performed. Surgical procedures to remove uncomplicated tumours are possible, but there is no chemotherapy or radiation treatment (international organisation, interview in Nairobi, 15 November 2013).

Surgical procedures performed at Mogadishu hospitals include caesarean sections, treatment of gunshot wounds, hernias operations, appendectomies, and treatment of gastrointestinal disorders due to tuberculosis or intestinal parasites. In a conversation with Landinfo in Mogadishu in November 2013, UNHCR informed that it had become increasingly difficult for Somali citizens to obtain visas to Kenya for medical treatment. For instance, UNHCR described an incident in October 2013, when a child died because the family was not granted a visa to Kenya in time (interview in Mogadishu, 12 November 2013).



Mother-child clinic in one of Mogadishu's districts (photo: Bjørn Claussen)

6. HEALTHCARE SERVICES IN OTHER CITIES AND IN RURAL SOUTH/CENTRAL SOMALIA

Access to healthcare services in rural areas and in other larger cities in South and Central Somalia varies depending on the security situation and on those administering or controlling the area in question. However, most of the cities do not have functioning hospitals, and the hospitals that are functional, are run by international aid organisations and can therefore only provide basic services. In cities such as Baidoa and Galkayo, the hospitals lack even the most basic equipment. Hospitals in other parts of the country lack equipment, medicines and qualified physicians (Australian Doctors for Africa 2012; interviews with international organisations in Nairobi and Mogadishu, November 2013). For instance, the hospital in Baidoa treats on average 60 patients a day, but is meant to serve one million people, and in emergency situations the shortage of medicines is a significant problem (Warsame 2014; Bass 2013).

The International Organization for Migration, IOM, runs a healthcare programme for internally displaced persons via mobile clinics in hard-to-reach areas. The organisation has also established health centres at the Kenyan border in Dhobley and at the Ethiopian border in Doolow to assist refugees returning home (interview in Nairobi, 8 November 2013).

6.1 ACCESS TO HEALTHCARE SERVICES IN AREAS CONTROLLED BY AL-SHABAAB

A representative for Somali Health Cluster explained in a conversation with Landinfo (interview in Mogadishu 12 November 2013), that the Shabaab areas generally only provide basic healthcare services. A representative for another Western aid organisation did not believe that Shabaab placed much emphasis on healthcare services for its residents, and claimed that the availability of medical treatment is therefore more limited in these areas than in other parts of the country (interview in Nairobi 14 November 2013). None of the representatives could explain what this specifically entailed.

7. TREATMENT OF DIABETES

Diabetes is a health problem in Somalia, even though the prevalence among adults in the 20-79 age bracket is lower than in many other countries (Boutayeb et al. 2012; IDF 2013). This is not necessarily due to a lack of access to insulin. Both tablets and insulin injections are available, but insulin must be stored in refrigerators – which many people do not have. Moreover, many Somali diabetics develop serious or even fatal complications because they fail to follow medical advice or treatment plans. Because many of the type 1 diabetes patients have died due to complications, aid workers have found that most diabetic patients who seek hospital treatment have type 2 diabetes. Diabetic patients without complications can be treated at the hospitals, whereas complex cases with complications cannot be treated in any of the country's hospitals. Those who can afford it therefore seek treatment outside of the country (interview with international organisation in Nairobi, 5 November 2013).

Proper education and instruction in how to manage diabetes, is beneficial for diabetics in their daily lives. Nevertheless, even highly educated individuals with good knowledge of their own condition will face the same challenges as other diabetics in Somalia: an almost non-existent public healthcare system, unreliable access to medicines, lack of technical equipment, and expenses that many will have difficulty paying, even those with a stable income. The price of insulin at points of sale in Mogadishu (and other cities) is unknown, but as previously noted, the price level is likely to be lower than in Norway, see chapter 4.1.

Landinfo has no information on whether devices for measuring glucose levels are available for private individuals.

In preparation for surgical procedures, usually an amputation, which is a frequent complication for many diabetics, patients may need to be stabilised with insulin. When a patient is discharged from hospital, he or she is not given any medicine for daily use. This must be purchased at a market or from a pharmacy.¹²

8. TREATMENT OF HYPERTENSION

According to the World Health Organization (2013), approx. 40 per cent of the Somali population over 25 years of age suffers from hypertension or high blood pressure.¹³ In comparison, the regional average is 29 per cent. However, this does not mean that everyone in this cohort requires anti-hypertensive medicines, as this depends on the severity and known risk factors for cardiovascular disease. Uncomplicated cases can be treated in Somalia, but not severe cases (Somali Health Cluster, interview in Mogadishu 12 November 2013). At the Keysaney and Medina hospitals, patients hospitalised with hypertension are treated with beta-blockers. As with the treatment of other illnesses, patients must purchase essential medicines themselves after completion of treatment and discharge from hospital.

9. TREATMENT OF HEPATITIS¹⁴

According to the information brochure from the Norwegian Institute of Public Health, treatment options for chronic hepatitis B involve repeated blood tests, and in time, also

¹² Norwegian hospitals or emergency care services do not provide more than one “emergency dose” and prescription.

¹³ These figures are from 2008, and the ratio of men and women is 39.9 per cent men and 35.7 women.

¹⁴The *hepatitis A virus* is generally contracted from water polluted by sewage or via food handled by infected persons with poor hand hygiene. The disease can also, in rare cases, be sexually transmitted. There are vaccines against hepatitis A. Hepatitis A is usually a relatively benign, but unpleasant disease which disappears on its own. It never becomes chronic.

Hepatitis B is transmitted via blood and bodily fluids. This disease is very common on a global scale. Hepatitis B occurs in both chronic and acute forms. Approx. 5 per cent of those infected with hepatitis B, never get rid of the virus. In such cases, the virus “becomes lodged” in the liver, making the infected person a chronic carrier. The chronic carrier condition does not usually manifest any symptoms and can only be detected by a blood test. Most people who contract chronic hepatitis B are therefore healthy carriers. Some, however, may develop a chronic liver

medicinal treatment (FHI n.d.). Blood tests are taken to detect the presence of liver cancer or other signs of liver damage. If there is a high risk of liver damage, the patient may receive medicinal treatment, in tablet form and/or by injections.

There are laboratories in Mogadishu that can analyse blood tests, but medicines for the treatment of hepatitis B are not available. This is because they are very expensive, and are therefore not provided by the UN or other international aid organisations (Somali Health Cluster, interview in Mogadishu 12 November 2013; international organisation, interview in Nairobi 15 November 2013).

Medicines used in the treatment of hepatitis are also expensive in Norway. The price of the most common medicines for one month of treatment varies between approx. 1800 to 7000 Norwegian kroner (The Norwegian Pharmaceutical Product Compendium 2014). Some patients will require a liver transplant, which is not possible in Somalia.

10. HIV/AIDS

Surveys conducted among pregnant women suggest that the prevalence rate of HIV in Somalia is an estimated 1 per cent. Among female prostitutes, the rate is approx. 5 per cent (Ministry of Human Development and Public Services. Directorate of Health n.d.). Compared with the neighbouring countries of Kenya, Djibouti and Ethiopia, the rate of HIV in Somalia is low.¹⁵ WHO (2013) estimates that 35,000 people are living with HIV in Somalia and that 1100 of them are receiving treatment with antiretroviral drugs. The rate of sexually transmitted diseases, however, is generally high, and people have little knowledge of how such diseases are transmitted etc. (WHO 2006; 2013). Unless preventive measures are implemented, the rate of HIV is likely to increase in the years to come.

Deficiencies in the healthcare sector in Somalia are considerable, and as the general need for services is significant, HIV/AIDS has not been an area of priority, either for the government or for international aid organisations. Moreover, it has been difficult to make the government acknowledge that HIV/AIDS is a phenomenon in Somalia. Antiretroviral drugs have only recently been utilised in the treatment of rape victims, to prevent HIV transmission, and blood donors are tested, but there are few initiatives beyond this (international organisation, interview in Nairobi 15 November 2013).

infection. After several years, this may lead to cirrhosis of the liver, and also increase the risk of liver cancer. It is therefore essential that chronic carriers of the hepatitis B virus have regular blood tests. Individuals with chronic hepatitis B can infect others, regardless of whether or not they exhibit symptoms.

There is no vaccine against *hepatitis C*. As with hepatitis B, hepatitis C is usually contracted through the use of dirty needles. Sexual transmission may also be the cause in rare instances. Anyone who is found to have hepatitis C antibodies must be considered contagious and chronic carriers of the virus. Only long-term follow-up and special blood tests can determine whether the virus is still present in the body. Chronic carriers of the hepatitis C virus normally experience few symptoms. Some carriers will develop liver damage after many years (FHI n.d.).

¹⁵ The rate in Kenya is approx. 6 per cent, Djibouti 1.4 per cent and Ethiopia approx. 2 per cent (IndexMundi 2013).

Based on available information, there is reason to believe that there is access to consultations, testing and medical treatment – at least at one of the hospitals in Mogadishu. More comprehensive follow-up of this disease is unlikely due to the lack of equipment and qualified personnel.

11. MENTAL HEALTH SERVICES

WHO (2009) and others note that there is no national action plan for mental health, and that treatment options in all parts of the country are seriously deficient. This means that assessments, treatment and rehabilitation of individuals with mild or severe mental disorders – if assessment and rehabilitation services are provided at all – do not adhere to standard protocols for assessment and treatment. There are three psychiatric hospitals in South and Central Somalia¹⁶, but only three or four psychiatrists, and only one qualified psychologist, according to an international organisation, engaged in health efforts in Somalia (interview in Nairobi, 15 November 2013), but many have false credentials. There are no therapeutic or support services for psychotic patients, and it is quite common to see people with clear mental disorders on the streets of Mogadishu.

The only clinic in the capital – Habeb Public Mental Hospital and Rehabilitation – that can offer any type of treatment is owned and run by a nurse – Abdirahman Ali Awale.¹⁷

Conditions at the three psychiatric hospitals are generally poor, and it is common for aggressive patients to be restrained with chains. Some patients have been restrained in this manner for several years (Harper 2014; Osman 2013).

As of 2005, there were five qualified nurses (with three months of training in psychiatric healthcare) who could prescribe antipsychotic medicines in South and Central Somalia (WHO 2009). Until 2012, essential medicines for various mental disorders were, in principle, free of charge for patients who were registered at a public healthcare facility. The medicines were donated by WHO, but this scheme was apparently discontinued in 2012 due to lack of resources (Harper 2014), and the medicines must now be purchased on the private, unregulated market.

In a conversation with Somali Health Cluster in Mogadishu in November 2013, the representative noted that antipsychotic medicines are sold at markets, but the quality is questionable, and there is therefore no guarantee that these medicines are effective. Beyond this, the representative stated that access was very limited.

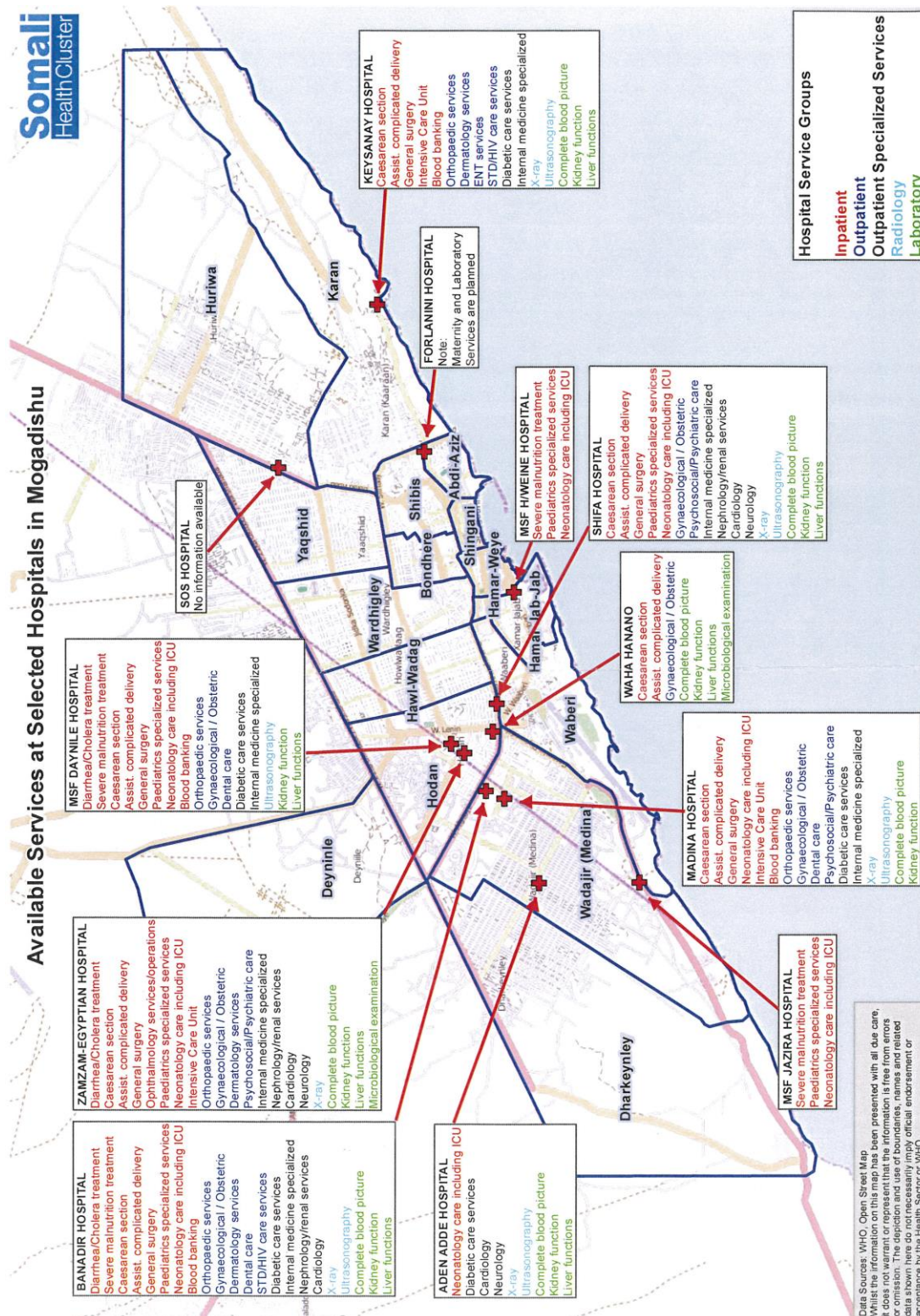
The price level for antidepressants and antipsychotic medicines is relatively high: in 2007-2008 it was estimated that patients spent between two to five per cent of their daily wages on antidepressants and antipsychotic medicines, respectively (WHO 2009).

¹⁶ In the breakaway Republic of Somaliland there are two treatment options – Berbera Mental Hospital in the city of Berbera, which has 42 beds, and a wing at the hospital in Hargeisa with 110 beds (Sheriff et al. 2010).

¹⁷ The hospital is located in the district of Waberi and has 53 beds. According to WHO (2009), 1094 patients were treated at this hospital in 2007. The rehabilitation centre has 170 beds and is intended for long-term stays.

An overview prepared by the owner of Habeb Public Mental Hospital and Rehabilitation, among others (as cited in WHO 2009), indicates that older antipsychotic medicines, such as Chlorpromazine, cost approx. 0.15 U.S. dollars, i.e. approx. 0.60 Norwegian kroner per 200 mg tablet from 2007 to 2008. Weekly and monthly costs depend on the dosage. According to the Norwegian Pharmaceutical Product Compendium (n.d.) the daily dose of Chlorpromazine varies between 25 and 600 mg.

Available Services at Selected Hospitals in Mogadishu



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