World Health Organization
Somalia

Policy brief

Time to act–Making motherhood and childhood safer in Somalia

Published: 01 September 2023

Prioritising reproductive, maternal, neonatal, child and adolescent health (RMNCAH) in Somalia

Reproductive, maternal, neonatal, child and adolescent health (RMNCAH) interventions are essential to reducing maternal and child mortality and morbidity rates globally. **These interventions are designed to address the health needs of women, children, and adolescents throughout their life cycle and include ensuring safe pregnancies and childbirth, promoting access to family planning services, improving neonatal and child health, and promoting the health and well-being of adolescents *(1)*.**

RMNCAH is particularly important in Somalia, where health outcomes for women and children remain among the poorest in the world due to many reasons ranging from limited access to health services, prolonged conflict and insecurity to recurrent droughts, floods, and subsequent food insecurity *(2)*. Furthermore, Somalia has some of the highest rates of maternal and child mortality globally *(3)*. Improving RMNCAH outcomes in Somalia is crucial to reducing maternal and child mortality rates, improving overall health outcomes and promoting sustainable development. Implementing effective RMNCAH interventions can also address underlying social and gender inequalities, empower women and girls to make informed decisions about their health, and promote gender equality and social inclusion *(1,2)*. These interventions will certainly help the country get closer to achieving the sustainable development goal (SDG) 3, ensure healthy lives and promote well-being for all at all ages.

The Federal Ministry of Health, with the support of its partners, has developed the national RMNCAH strategy to "ensure that every Somali woman of childbearing age, newborn child and adolescent realize their rights and enjoy the highest attainable standards of health and wellbeing" *(2)*. The strategy aims to promote and provide quality RMNCAH services to all women, neonates, young children and adolescents to achieve better health outcomes and reduce all preventable maternal and child deaths. It focuses on key interventions such as antenatal, postnatal and delivery care, Integrated Management of Neonatal and Childhood Illness (IMNCI) and essential newborn care *(2)*. However, there are challenges in implementing the strategy. These include the lack of resources, a shortage of skilled workforce, especially in rural and hard-to-reach areas, unequal distribution of health facilities, and lack of essential equipment and medicines. Similarly, the lack of a Maternal and Perinatal Death Surveillance and Response (MPDSR) system hampers evidence-based decision-making and strategic planning due to inadequate data on maternal and neonatal deaths. Moreover, lack of coordination, fragmentation, and limited government capacity to implement key RMNCAH interventions nationwide have hindered progress *(2)*.

Key maternal, newborn and child health indicators in Somalia

Maternal mortality ratio	692/100 000 live births* 621/100 000 live births**
Stillbirth rate	36 per 1000 births***
Newborn mortality rate	37 per 1000 live births***
Under five mortality rate	117 per 1000 live births***
Pregnant women had at least four ANC visits	24%*
Percent of women who received at-least two doses of tetanus toxoid vaccine	17%*
Number of deliveries by skilled birth attendants	32%*
Institutional delivery rate	21%*
Postnatal checks mothers	11%*
Total fertility rate	6.9 children/women*

Sources:
* Somalia Health Demographic Survey report, 2020 (9)
** Trends in maternal mortality 2000 to 2020 (4)
*** Country Cooperative Strategy Somalia, 2021-2025 (3)

Maternal mortality – A public health crisis

Major disease and economic burden

Maternal and neonatal morbidity and mortality are major public health concerns in most developing countries and especially so in under-resourced and challenged settings. In 2020 an estimated 287000 women died globally from pregnancy-related causes, equivalent to **almost 800 maternal deaths every day and approximately one every two minutes** *(4)*. These deaths are inequitably distributed across the globe – Sub-Saharan Africa alone accounted for approximately 70% of global maternal deaths in 2020. Similarly, more than half (3.3 million) of all under-5 deaths occurred in sub-Saharan Africa *(3)*. Despite significant improvements in its maternal health indicators, sub-Saharan Africa remains one of the world's most dangerous regions to give birth *(4)*.

Furthermore, in fragile and humanitarian settings, an estimated 500 women and girls die from complications of pregnancy and childbirth every day, **and women and children are 14 times more likely than men to die during a natural disaster *(5)*.** Almost 70% of neonatal deaths and 80% of maternal deaths and stillbirths are preventable, including in the most challenging situations *(6,7)*. Therefore, improving maternal and newborn survival requires a renewed focus on the unique needs of pregnant women and children born into crisis and a commitment to strengthening maternal and newborn health in humanitarian settings.

Definitions	
Maternal death	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from unintentional or incidental causes.
A death occurring during pregnancy, childbirth and the puerperium (also known as a pregnancy-related death)	The death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the cause of death (obstetric and non-obstetric); this definition includes unintentional/accidental and incidental causes.
Direct obstetric deaths (or direct maternal deaths)	Maternal deaths resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), and from interventions, omissions, incorrect treatment or from a chain of events resulting from any of the above.
Indirect obstetric deaths (or indirect maternal deaths)	Maternal deaths resulting from previous existing disease or disease that developed during pregnancy, and that were not due to direct obstetric causes but were aggravated by the physiologic effects of pregnancy.
Sources: International classification of diseases 11th Revision (8) Trends in maternal mortality 2000 to 2020 (4)	

Maternal, neonatal and nutritional diseases are among the leading causes of death in Somalia. **One in 1000 women aged 15 to 49 die due to pregnancy- or birth-related complications, and one in 20 women is expected to die from pregnancy-related causes during their reproductive lifetime.** Similarly, the under-5 mortality rate is considered the highest in the Eastern Mediterranean Region *(3)*. The leading causes of maternal and neonatal morbidity and mortality globally and in Somalia are postpartum haemorrhage, pre-eclampsia, obstructed labour and sepsis, whereas pneumonia, diarrhoea and measles are the most common causes of under-5 mortality (9). Most of these causes are preventable by adopting and implementing evidence-based, high-impact, cost-effective interventions at policy, programme and service levels to improve maternal and newborn health outcomes.

Moreover, maternal morbidity and mortality are associated with significant economic consequences to individuals, communities, and the entire health system *(10)*. Various studies suggest that pregnancy-related complications and maternal deaths lead to significantly higher health service utilization costs and can lead to catastrophic health expenditures due to high out-of-pocket payments *(11)*. For instance, in Somalia, 65% of women have mentioned lack of money as the main barrier to accessing health care services during pregnancy (9).

Challenges in making progress

The ongoing drought since 2021 caused by five consecutive failed rainy seasons *(12)* and the emergence of the COVID-19 pandemic has highlighted the gaps in Somalia's basic health service delivery and the health system's weaknesses in serving the vulnerable population with quality care. These recurrent crises have further strained the already fragile health sector impacting the delivery of essential maternal and child health (MCH) services. Women and children from marginalized rural communities and camps for internally displaced persons (IDPs) have been significantly impacted, resulting in major inequities and inequalities in the health status of women and children in the country *(5)*.

The shortage of functional health facilities has been a persistent challenge in the health care system *(2)*. The 2016 Somalia's service availability and readiness assessment survey found that the density of public health facilities with inpatient and maternal beds was only 28.3% in Somalia, indicating a significant 72% shortage in health facility infrastructure *(13)*. The core health workforce density was 18.6%, and the service utilization level was only 6.3%, leading to a total general service availability rate of 17.7% *(13)*. In addition, basic emergency obstetric and neonatal care services were provided among 45% of urban and 20% of rural facilities, whereas out of the 66% of facilities reporting to provide antenatal care (ANC) services could provide only 45% of the service package *(13)*. These findings highlight a major gap in resources and access to critical and life-saving services in the country.

Another critical challenge in Somalia is the shortage of skilled workforce, particularly in midwives and nurses, especially in rural areas. A large proportion of maternal deaths can be attributed to limited access to skilled health care during childbirth and the postnatal period *(14)*. It is estimated that 45% of maternal and 36% of neonatal deaths globally occur during the first 24 hours after birth. These deaths are mainly preventable, and even life-threatening conditions are treatable if skilled health care is provided at the primary health care (PHC) level during the intrapartum and early postnatal periods. However, only 32% of births in Somalia are delivered with support from skilled health care providers, and the majority of health workers lack the skills to identify, prevent and manage major causes of maternal and newborn mortality *(9)*.

Likewise, the lack of effective health governance combined with poor coordination and integration of RMNCAH with other program areas has led to a lack of progress towards achieving sustainable development and enhancing MCH outcomes. The health sector is extremely fragmented, and numerous vertical programmes run side by side. To improve resource utilization and efficiency, it is imperative to enhance coordination and integration platforms, strengthen government capacity and align RMNCAH activities.

Community based interventions as a solution

Training health care workers is critical for improving maternal and newborn survival. Similarly, community-based interventions are required to reach the nearly 70% of women delivering outside of health facilities and women living in rural and hard-to-reach areas. **The WHO recommendations on antenatal care for a positive pregnancy experience mention antenatal home visits as a way to improve ANC utilization and perinatal health outcomes,** particularly in low-resource settings with low access to health services *(15)*. Moreover, some studies show that community based MCH interventions can reduce maternal and neonatal mortality by up to 30% *(14)*.

In Somalia, community health workers (CHWs) have been trained to provide a range of PHC services. With further training and capacity-building, their responsibilities can be expanded to encompass preventative, promotive and curative care for common pregnancy-related complications and childhood illnesses. Furthermore, **the utilization of Community Based Midwives (CBMWs) is crucial in replacing untrained traditional birth attendants, who currently attend to 60% of anticipated births** *(2)*. CHWs and CBMWs play an important role in strengthening the continuity of care and improving referral system.

Advancing access to universal health coverage (UHC) is vital for reducing maternal and child mortality

Somalia is currently in the early stages of its health transition, as it faces significant health challenges regarding maternal, infant, and under-5 mortality *(16)*. It is one of the 10 countries in sub-Saharan Africa, contributing to 70% of global maternal mortality, and has the highest maternal mortality ratio (MMR) in the Eastern Mediterranean Region *(4)*. **It is considered one of the most dangerous places to give birth or to be born in due to high morbidity and mortality rates stemming from limited access to services and inadequate quality of care, and it is ranked second in the fragile country index** *(4,17)*. Despite a modest decrease in maternal,

infant and under-5 mortality rates over the past 30 years, these figures remain among the highest in the world, compelling the implementation of preventive measures among vulnerable populations *(16,4)*.

While it is unlikely for Somalia to reach the SDG 3 targets, including reducing the global MMR to less than 70 per 100 000 live births and ending preventable deaths of newborns and children under 5 years of age by 2030, immediate action is necessary, with a focus on scaling up access to UHC to accelerate the progress (2). In particular, the country's MMR must decrease at a rate six times higher than that observed from 2000 to 2017 to effectively address the issue. **Despite an eight-point decrease in stillbirth and neonatal mortality rates between 1990 and 2019, Somalia is not expected to meet the SDG 3.2.2 target of reducing neonatal mortality to below 12 per 1000 live births.** Additionally, Somalia is not projected to achieve the SDG 3.2.1 target of reducing under-5 mortality to below 25 per 1000 live births by 2030 unless there is a decrease at a rate three times higher than that observed between 1990 and 2019 *(16)*.

To accelerate progress towards achieving the SDGs and UHC, tackling the underlying causes of fragmentation within the health sector is crucial. Separate parallel structures and funding sources cause further fragmentation creating additional barriers to accessing care. Therefore, aligning with the Essential Package of Health Services (EPHS) 2020 is necessary to establish a more streamlined and efficient health care system.

WHO has developed various guidelines for policy, program and service levels that recommend evidence-based, high-impact, low-cost interventions to improve outcomes related to maternal, newborn and child health *(18)*. The evidence shows that high maternal, perinatal, neonatal and child mortality rates are associated with limited coverage and inadequate quality health services and suggests that explicit, evidence-based, cost-effective packages of interventions can improve the processes and outcomes of health care when appropriately implemented *(19)*. By adopting these guidelines and recommendations in Somalia, great improvements can be made in health outcomes for women and children and significant reductions in mortality can be achieved.

Evidence-based interventions to improve MCH are well documented

WHO's vision is that **"Every woman, newborn, child and adolescent receive quality health services throughout the continuum of their life course and level of care".** This vision is aligned with the SDGs and well-articulated in the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030) To accomplish the vision, the WHO Somalia country has supported the Federal and State Ministries of in strengthening service delivery, especially for children and vulnerable populations.

Recommendations based on WHO global guidelines

Recommendation 1: Provision of quality ANC and tetanus diphtheria (Td) vaccine

Antenatal care coverage in Somalia is only 24%. **Antenatal care is one of the most important services in health care, and every pregnant woman should have full access to it.** The provision of quality antenatal services and improved access to pregnant women in urban, rural, IDP and inaccessible areas could help improve maternal and newborn health (21). The provision of TD immunization reduces the risk of neonatal deaths from tetanus by 90% and improves immunity in adolescent girls, especially for teenage pregnancy *(22)*. A package of interventions could be provided through ANC, such as (i) information and counselling on self-care at home, nutrition, HIV screening and support, breastfeeding, family planning, a healthy lifestyle including harmful effects of substance abuse (kat is a commonly used stimulant in Somalia) and use of insecticide-treated bed nets, (ii) monitoring of the progress of pregnancy and assessment of maternal and fetal well-being including nutritional status,(iii) detection of problems complicating pregnancy (e.g., anaemia, hypertensive disorders, bleeding, mal-presentations, multiple pregnancies, (iv) provision of TD vaccine, anaemia prevention and control, iron and folic acid supplementation, (v) treatment of mild to moderate pregnancy complications (mild to moderate anaemia, urinary tract infection, vaginal infection) Syphilis testing and treatment of syphilis (woman and her partner) and (vi) early detection of complications and referral to the nearest referral health facility *(22)*.

To implement the aforementioned package, there is a need to (i) make available the updated antenatal package of care to the health facilities, (ii) establish referral linkages between first-level and referral facilities, (III) capacity-building of the service providers on the updated packages, and (iv) securing of essential medicine and ultrasound in the service provision sites.

Recommendation 2: Harnessing skilled birth attendance, use of partograph, active management of the third stage of labour

In Somalia, only 21% of deliveries happen at a health facility with the support of a skilled birth attendant (21). The largest risk for maternal mortality occurs during labour, birth and within 24 hours following birth. **Many of the interventions known to save the lives of women and their newborns during this critical phase of childbirth depend upon the presence of a skilled birth attendant.** The use of the WHO updated partograph during labour, a tool to monitor the condition of the mother and infant during labour, can prevent stillbirths and neonatal deaths. Active management of the third stage of labour consists of interventions designed to facilitate the delivery of the placenta by increasing uterine contractions and to prevent primary postpartum haemorrhage (PPH) by averting uterine atony¬ – all women who deliver should receive this intervention *(23)*. As PPH is the leading cause of maternal death, active management of the third stage of labour could prevent PPH and averts maternal deaths. Counselling for immediate postpartum family planning during and after labour is also a vital part of reducing the risk of maternal morbidity and mortality *(23)*.

Recommendation 3: Provision of early essential newborn and Kangaroo Mother Care (KMC)

Early essential newborn care is an essential package which should be provided immediately after birth. **It includes immediate skin-to-skin contact, initiates exclusive breastfeeding, use of chlorhexidine to prevent cord infections and resuscitation when needed.** Essential newborn care can be provided at the facility and community levels *(24)*.

KMC for preterm infants through prolonged and continuous skin-to-skin contact is initiated in the hospital and can be continued at home with adequate support and follow-up. It improves the health and well-being of infants born preterm or with low birth weight, promotes better bonding between mother and child, facilitates exclusive breastfeeding, which strengthens the baby's immune system, and provides effective thermal control, reducing

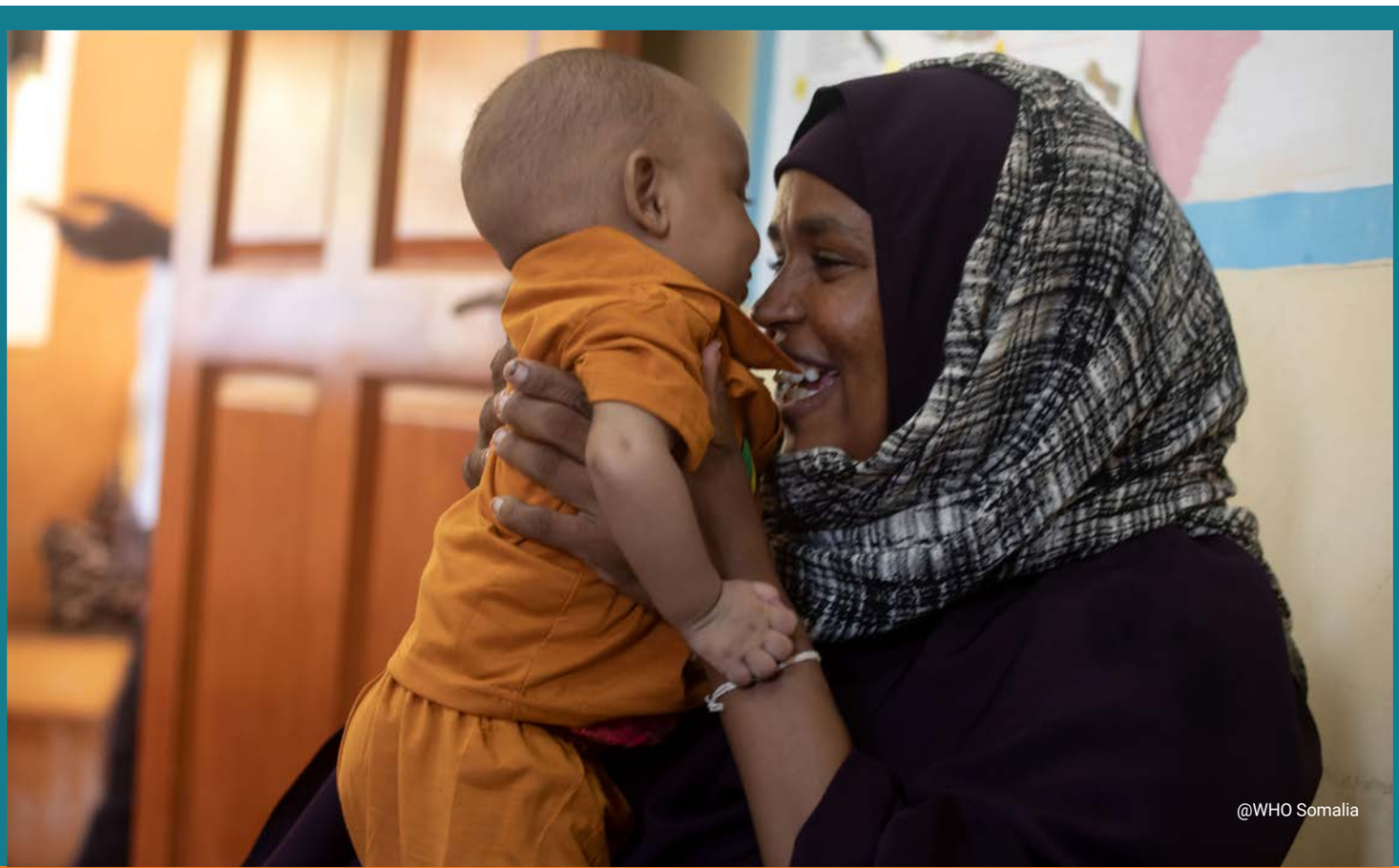
the risk of hypothermia. Fathers can also provide skin-to-skin contact through KMC. Furthermore, KMC is a climate-resilient and environmentally sustainable intervention as it optimizes the use of resources, reduces facility costs and contributes toward reducing the carbon footprint of health facilities due to its low dependency on electricity.

Recommendation 4: Ensure access to postnatal care

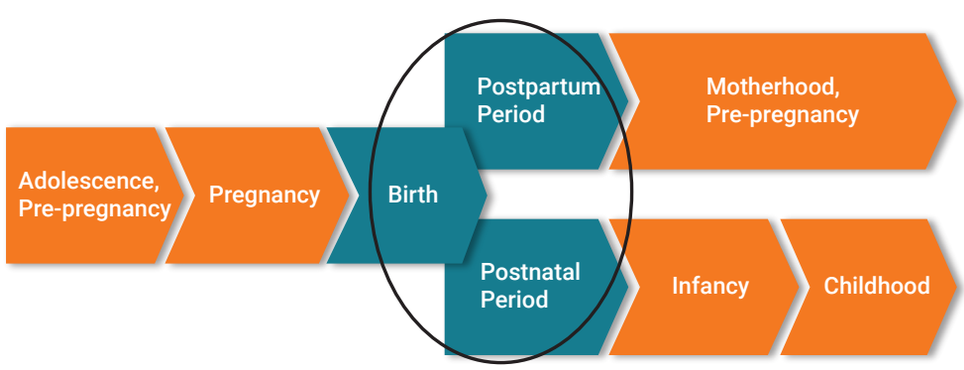
Postnatal care, especially within the first 48 hours after birth, is critical to the management of postpartum haemorrhage, a leading cause of maternal deaths in many low- and middle-income countries (LMICs), including Somalia. **Postnatal care is also key to neonatal survival through the prevention of neonatal sepsis and asphyxia/hypothermia, which are the leading causes of neonatal deaths in low-income countries.** Postnatal care also helps to promote healthy maternal behaviours, such as exclusive breastfeeding, cord care and family planning. This can be made possible by capacitating frontline workers such as CHWs, community midwives and service providers at the facility levels.

Recommendation 5: Improve child health services at the PHC level through IMNCI and hospital care for children under 5

IMNCI is a proven strategy to tackle childhood illnesses, as it enables the clinical management of priority public child health problems through a standardized, fully integrated approach based on clinical guidelines presented all in one training package. Somalia has adopted IMNCI guidelines at the national level but is yet to roll it out owing to a lack of resources and a skilled workforce. **It is paramount to support the rollout of IMNCI at the PHC level to reduce child mortality and advance UHC.** It is vital to establish a triage system at the facility level to identify emergency signs/cases for urgent treatment and non-urgent cases for routine care and, in addition, to provide emergency treatment for lifethreatening conditions.



The evidence base – What we know

Intervention	Evidence of effectiveness of the intervention
ANC	• ANC is vital in reducing maternal and perinatal mortality and morbidity by providing health promotion, disease prevention and diagnosis. It has a triple life protection purpose and improves a wide range of health outcomes for women and newborns. Vaccines, screening for complications and preventive treatments during ANC can significantly reduce neonatal and maternal deaths. Screening for pre-eclampsia reduces the risk of maternal deaths due to hypertension by 48% and neonatal deaths due to prematurity by 15%. In addition, intermittent preventive treatment can reduce neonatal mortality by up to 61% *(22)*. • A study conducted in 59 LMICs including Somalia reveals that a comprehensive ANC programme is cost-effective as average cost-effective ratio (ACR) of 26.8, at a cost of US$ 1 019 342, and 37 988 healthy life years (HLYs) gained *(25)*.
Td vaccine	• Maternal vaccination protects pregnant women, fetuses, and neonates when they are more susceptible to infectious diseases *(26)*. Td vaccine can reduce neonatal deaths from tetanus by 90% *(22)*. The benefits of maternal immunization are threefold: protecting the mother from antepartum infection; reducing poor pregnancy and fetal outcomes; and providing immunity for infants during the first few months of life. Maternal immunization is an important strategy to reduce morbidity and mortality in women and newborns *(27)*.
Skilled birth attendance, partograph, active management of third stage of labour	• Complications of preterm birth, birth asphyxia, intrapartum-related neonatal death, and neonatal infections account for more than 85% of newborn mortality. Therefore, the time of childbirth and the period immediately after birth is particularly critical for maternal, fetal, and neonatal survival and well-being. Effective care to prevent and manage complications during this critical period is likely to significantly reduce maternal deaths, stillbirths and early neonatal deaths – a triple return on investment, increasing the continuum of care through an integrated service delivery system offering a package of cost-effective, high- impact interventions *(28)*. • Effective management of complications during this critical period can significantly reduce maternal and neonatal mortality, resulting in a triple return on investment (28). A study conducted in 59 countries including Somalia founds that skilled assistance for normal delivery is cost-effective an ACR of 29.6, at a cost of US$ 4 558 206, and 153 977 HLYs gained *(25)*. • Active management of the third stage of labour involves giving a prophylactic uterotonic, early cord clamping and controlled cord traction to deliver the placenta. Oxytocin is the most used uterotonic agent and the primary drug of choice for the management of the third stage of labour and the one evaluated in this report. Prophylactic administration of oxytocin reduces rates of postpartum haemorrhage by over 77% *(23)*. **Continuum of Care** 

Intervention	Evidence of effectiveness of the intervention
Essential newborn care and KMC	• Globally, 2.7 million neonates die yearly, accounting for 45%, 58% and 75% of under-5, infant and neonatal mortality, respectively *(29)*. *Among those, neonatal deaths in LMICs* accounted *for most of the growing proportion of* all under-5 mortality. If the trend continues like this, the share of neonatal deaths to under-5 death is projected to increase from 45% in 2015 to 52% in 2030 *(29)*. • Essential newborn care is provided to the neonate after birth within the delivery room by skilled personnel, including drying and stimulating, assessing breathing, cord care, skin- to-skin contact, initiating exclusive breastfeeding, eye care, vitamin k provision, place of identification band, and weighing (30). Breastfeeding is the recommended method for infant feeding, and if the global breastfeeding rate increased to 50%, it could prevent the deaths of around 823 000 children under the age of five every year *(29)*. WHO recommends early initiation of breastfeeding within one hour of birth to reduce newborn mortality, protect against infections, promote bonding and stimulate milk production. Exclusive breastfeeding for the first 6 months is recommended by WHO and UNICEF *(29)*. • KMC is already known to be effective in reducing mortality by 40% among hospitalized infants with a birth weight of less than 2.0 kg but only after they are clinically stable. However new evidence shows an additional 25% reduction when initiated immediately after birth, either with the mother or a surrogate. It also reduces infections and hypothermia and allows for increased breastfeeding opportunities *(31)*. • KMC is cost-effective and a study conducted in 59 LMICs including Somalia reveals that an average cost ratio ACR 20.1, at a cost of US$ 249 627, and 12 411 HLYs gained *(25)*.
Postnatal care	• The postnatal phase is critical in the lives of mothers and newborn babies. A significant number of maternal deaths occur during the postnatal period, and an estimated 2.8 million newborn die in the first month of life (32). Considerable progress has been made globally in improving MCH, yet in South-East Asia and sub-Saharan Africa, less than 67% and 48% of women give birth with skilled personnel. Moreover, less than half of women receive postnatal care within two days of childbirth. WHO recommends at least four postnatal visits within six weeks after giving birth for all mothers and newborns, yet only a small percentage of women in sub-Saharan Africa receive postnatal care within 2 days of birth, with just 13% of those who deliver at home receiving care.
IMNCI	• IMNCI is a global initiative introduced by WHO/UNICEF in the mid-1990s to reduce under-5 mortality, morbidity and disability while improving child growth and development. It adopts a holistic approach to child health, combining curative, preventive, promotive and development aspects of child health care into one strategy. This standardized approach is based on clinical guidelines presented in one training course package, enabling the clinical management of priority public child health problems. IMNCI has shown to improve health workers› performance and quality of care, reducing childhood mortality by up to 6% per year if fully implemented. Additionally, IMNCI can increase breastfeeding and reduce neonatal mortality if all components are implemented, potentially leading to fewer deaths among children from birth to 5 years of age *(25)*. • IMNCI is cost-effective. In India, the implementation of IMNCI results in a cumulative reduction of 57 384 illness episodes, 2369 deaths and 76 158 DALYs among infants at the district level from 2007 to 2022. Overall, from a health system perspective, the IMNCI program incurred an incremental cost of US$ 34.5 (INR 1554) per DALY averted, US$ 34.5 (INR 1554) per life year gained, US$ 1110 (INR 49 963) per infant deaths averted *(33)*.
Hospital care for children	• Newborn and child deaths in paediatric emergencies are often preventable with timely and accurate identification and treatment of very sick children. Most of these deaths occur within 24 hours of admission, highlighting the importance of improving health worker's skills in identifying and treating very sick children. The Emergency Triage Assessment and Treatment (ETAT) course has been designed to provide health workers with the necessary knowledge and skills to apply the ETAT guidelines, including triaging sick children into three groups upon admission and providing emergency treatment for life-threatening conditions. Additionally, WHO guidelines for hospital care for children focus on managing major causes of childhood mortality in low-income countries and cover common procedures, patient monitoring, supportive care and some surgical conditions that can be managed in small hospitals.

Conclusions

Somalia is facing significant challenges regarding MCH, worsened by the ongoing drought and COVID-19 pandemic. **The health system's weaknesses and the limited access to critical and life-saving services have significantly impacted the health and well-being of women and children from vulnerable and marginalized communities.** The shortage of functional health facilities and skilled health care workers, particularly midwives and nurses, are persistent challenges which have led to limited access to skilled attendance and care during childbirth and the postnatal period. Additionally, the lack of effective health governance combined with poor coordination and integration of RMNCAH with other program areas has led to a lack of progress towards achieving sustainable development and enhancing MCH outcomes.

To address these challenges, there is a need to improve coordination and integration platforms, strengthen government capacity and align RMNCAH activities. Similarly, training health care workers is critical for improving maternal and newborn survival. Additionally, **community-based interventions are necessary to reach the nearly 70% of women delivering outside of health facilities and women living in rural and hard-to-reach areas.** CHWs and CBMWs can play a critical role in reaching these populations. Furthermore, with additional training, CHWs can provide a range of PHC services, including preventative, promotive and curative care for common pregnancy-related complications and childhood illnesses.

Advancing access to UHC is vital for reducing maternal and child mortality. Although it is unlikely for Somalia to reach the SDG 3 targets, immediate action is necessary, with a focus on scaling up access to UHC to accelerate progress. It is imperative to implement preventive measures among vulnerable populations and take urgent action to improve the health status of women and children in Somalia.

Investing in RMNCAH is critical for reducing morbidity and mortality among women and children and promoting health throughout the life course. **By focusing on RMNCAH interventions, it is possible to achieve a triple return on investment, improve the health and survival of mothers, newborns, and children and contribute to long-term socioeconomic development.** RMNCAH interventions, such as antenatal care, skilled birth attendance, postnatal care and immunization, are cost-effective and have proven to save lives and improve health outcomes. The national RMNCAH strategy has outlined key interventions for addressing maternal and newborn morbidity and mortality. However, implementing the strategy has been challenging due to a lack of resources, skilled workforce and coordination. Overcoming these challenges will require increased investments in the health sector, improved coordination among stakeholders and strengthening the government's capacity to implement these interventions. Improving RMNCAH implementation will contribute significantly to improving MCH outcomes and can also have a positive impact on economic growth, social development and gender equality by empowering women and girls and promoting their rights and health.

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World Health Organization
Somalia

World Health Organization (WHO) Country office,
Mogadishu, Somalia
Tel: +252616695096;
Email: emacosomwr@who.int; emacosomexr@who.int
URL: http://www.emro.who.int/countries/somalia/index.html

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