

3 HEALTH STATUS AND DEMOGRAPHICS

Somalia – one of the harshest places on the planet, an extreme environment that presents huge challenges to its people just in terms of simple survival. The combination of a hostile, predominantly arid environment, difficult terrain with settlements scattered over vast distances, the legacy of a nomadic way of life and a civil conflict that has shattered social structures and exacerbated poverty add up to mean that a Somali child's chances of surviving to adulthood are among the lowest of children anywhere in the world. Add to this the fact that the odds of the child's mother dying during pregnancy or in childbirth are also extremely high. These high death rates stem from the interaction of a number of causes set within a complex socio-political context, but are largely attributable to disease, dehydration, malnutrition, lack of safe water, and poor sanitation.

The 2000, UNDP's Human Development Report ranked Somalia lowest in all health indicators except life expectancy. In the latest HDR the country is not even ranked, due to the lack of reliable data. As a result, it was noted that "most Somalis spend most of their time trying to stay alive and keep their families alive" (UN, 2005). Extreme poverty in Somalia is estimated to be 43% with large disparities noted between the urban population at 23% and the rural and nomadic populations at 53% (UNICEF, 2001). The MDG health-related indicators in Somalia are among the very worst of the world. The infant mortality rate was estimated at 132 per 1,000 live births in 1999, with the rate of under-five mortality at 224. Maternal mortality was estimated as high as 1,600 per 100,000 live births in 1999 (WB, 2005). Achieving the MDG 5 target -i.e. reducing the 1990 rate by three quarters- would imply to lower the rate to 400/100,000 by 2015, which seems very unlikely when one takes into account the available human resources, the emergency obstetric care (EOC) infrastructure and the services and the range of interventions that would be required to obtain such a dramatic improvement. The most recent survey (UNDP 2004) confirms that 80% of deliveries occur at home in all regions of Somalia. According to a survey of nine regions conducted by UNDP, only 28% of deliveries were attended by qualified personnel. Life-time risk for maternal death has been estimated in 1 in 10 women (WHO, 2005). Other estimates, however, returned lower figures. The proportion of under-five children who are underweight is 26%. The immunization coverage (1 year-old children fully immunized) was only 36% in 2000. Measles is reckoned to be responsible for most deaths resulting from vaccine-preventable diseases in children under-5 years (WHO, 2005).

The epidemiological profile of the country is characterized by common communicable diseases, which could be controlled with simple and relatively cheap measures. Malnutrition, another important cause of mortality, especially among children, is discussed in a separate chapter of the cluster report. Malaria is a major health problem, affecting all strata of the population and representing the leading cause of death in under-five children. The burden of malaria is highest along the rivers and settlements with artificial water reservoirs where there is all year round transmission. TB is one of the leading causes of morbidity and mortality especially among adult men. Somalia has one of the highest incidence rates estimated in the world -372 per 100,000 population- with 1 in every 270 people infected and an average of 25,000 expected cases every year. Overall, there has been an increase in the number of TB cases detected. Malnutrition is also common among TB patients and the HIV/AIDS co-infection is expected to increase. Since 1994 cholera has shown an endemicity trend with seasonal

outbreaks coinciding with the dry season especially in the Central and Southern zones. Outbreaks of acute cholera have continued to occur in various parts of the country since 1994. Leishmaniasis is an old disease with outbreaks reported in 1930 in Jowhar in the Middle Shabelle, and in Darbuluk in the North-West Region in 1950. The most recent detected outbreak occurred in 2000 in the southern Somalia, Bakool, Gedo and Bay regions. Potential vector breeding sites are numerous and scattered in Central and Southern zones of Somalia^{vi}.

While Somalia is one of the most sparsely populated countries in the world (seven persons/square mile), with a relatively small population, war, clan politics and nature's vagaries have led to a large, and continually expanding, population of internally displaced persons (IDPs). This 'push' factor is leading to rapid urbanization, with most cities and towns having a number of IDP settlements. With high levels of unemployment, women have entered the workforce at the bottom end of the informal labor market and there are a large number of women headed households. Diarrhoeal disease-related dehydration, respiratory infections and malaria are the main killers of infants and young children, together accounting for more than half of all child deaths. Cholera is endemic in Somalia, with the threat of outbreaks recurring annually during the "season" from December to May, when in many crowded communities the pre-conditions are set as a result of critical water shortage. The major underlying causes of diarrhoea are the lack of access to safe water, and poor food and domestic hygiene. In a survey carried out in 2000, it was found that almost a quarter of children aged under five years had diarrhoea in the two weeks preceding the survey—a very high rate. Malnutrition is a chronic problem in all areas, and becomes acute when areas are struck by drought or flood, or where localized conflict flares up, scattering populations. A persistent shortage of food (mainly due to successive droughts and conflicts), low quality diet, poor feeding practices and inadequate home management practices contribute to many children being inadequately nourished. Neonatal tetanus and other birth-related problems are a further cause of many infant deaths, while measles and its complications result in widespread illness. Immunization coverage is not yet sufficient to prevent measles outbreaks. Susceptibility to measles is compounded by poor nutrition and transmission is rapid where living conditions are crowded, resulting in a high death rate.^{vii}

3.1 Health Status Indicators

Table 3-1 Indicators of Health status

Indicators	1995	2000	2002	2003
Life Expectancy at Birth:***	44 (99)	46.2	46.9	47.3
HALE:	-	-	36.8	-
Infant Mortality Rate:	152 (90)	132**	122***	113*
Probability of dying before 5 th birthday/1000:	225***	224**	225***	187*
Maternal Mortality Rate	-	1100"	-	1600
Percent Normal birth weight babies: +	84	0.3	-	-
Prevalence of low-weight for age	-	15.8**	-	26

Source: World health report 2005

*'World Population Prospects: The 2004 Revision', New York, United Nations, 2005

** <http://www.emro.who.int/somalia/countryprofile>

*** CIA World Factbook 2000, UNDP Human Development Report 2001, UNDP Human Development Report 2002, UNDP Human Development

" Maternal mortality in 2000, Estimates developed by WHO, UNICEF, UNFPA

+Somalia Human development report 2001

UNICEF http://www.unicef.org/infobycountry/somalia_statistics.html

Health indicators suggest there has been no improvement in the health of the population over the past three years. Indeed, indicators show a slight increase in levels of infant and under-five mortality and pockets of chronic malnutrition persist in southern Somalia. Health facilities are concentrated in urban centers so that rural populations have limited access to health services. There are very few newly qualified medical personnel taking up work. Drug importation is unregulated with the consequence that the privatized health services are supplied with expired and poor quality medical drugs.

Table 3-2 Indicators of Health status by Gender and by urban rural - 2003

Indicators	Urban	Rural	Male	Female
Life Expectancy at Birth:	-	-	43	45
HALE:	-	-	36.1	37.5
Infant Mortality Rate*: (99)	129	144	134	130
Probability of dying before 5th birthday/1000:	218	244	222	228
Maternal Mortality Rate:	-	-		
Percent Normal birth weight babies:	-	-	-	-
Prevalence of low-weight for age	-	-	-	-

Source: World health report 2005

*Somalia Human development report 2001

Table 3-3 Top 10 causes of Mortality/Morbidity

Rank	Mortality	Morbidity
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		

Rank	Mortality	Morbidity
10.		

Source:

Table: Key Indicators for Somalia based on Multiple Indicator Cluster Survey (MICS) 2000, UNICEF

Indicator	Somalia	Central and Southern zone	North East zone	North West zone
Infant mortality rate	132	137	133	113
Under-five mortality rate	224	231	225	188
Percentage of the population with access to safe drinking water	23.1	17.8	25.9	31.3
Percentage of the population with access to safe sanitation	48.5	50.8	41.5	47.4
Percentage of under-five children with acute global malnutrition	17.2	21.2	14.8	10.1
Gross enrolment ratio for primary school age children (Primary School Survey 2001/2)	17			
Percentage of children aged 12-23 months currently vaccinated against childhood diseases	BCG DPT3 OPV3 Measles All	69.3 32.6 36.9 15.6 10.6		

A baseline KABP survey on Reproductive Health and Family Planning in Somaliland and Puntland was carried out by WHO Somalia in October 1999. The main findings include:

- Fertility rate of around 7.9
- NMR, IMR and CMR, which are estimated to be 28,113 and 328 respectively.
- FGM Prevalence of 99%
- 18% of married underage (<18) girls

Several studies showed that Maternal Mortality Rate (MMR) is exceptionally as high as 1600/100 000. The high Maternal Mortality ratio is primarily related to limited access of pregnant women to trained midwives and non-availability or limited accessibility of referral services. The midwifery profession was one among those professions that has suffered the biggest attrition in terms of number. Many of them have left the country after the civil war and those who were left behind are getting old, thus the number of midwives decreased dramatically in Somalia.

Certain underlying causes of this high MMR are:

- Post FGM related complications

- In adequate maternal health services
- Unskilled birth attendants
- Low level of education
- Malnutrition with anaemia during pregnancy
- Poor and delayed referral system.

Ten women between the ages of 15-45 die every day in Somalia (including Somaliland) as a result of pregnancy related complications, so in every year up to 110 000 pregnancies result in severe complications, illnesses or permanent disability of the mother and Child. Over ¼ of all under-five deaths occur in the first week of life due to complications during pregnancy and/or delivery. So to reduce neonatal deaths it is an utmost importance to reduce maternal complications in its various forms.

Major health problems documented in the literature review

a. Sexually transmitted diseases including HIV/AIDS.

It has been claimed that the prevalence of HIV/AIDS in the country is relatively low <1% (*UNICEF, 1999*) While among study TB cases the Prevalence of HIV/AIDS was up to 8.8% in Some regions(WHO, 2000). The prevalence of other sexually transmitted disease was as high as 30% (*Gillian Duffy, 1999*). There is a danger of deterioration of the situation of HIV/AIDS in the country and this high prevalence of STIs can be a good indicator of this possible threat, in addition to the neighboring countries in which the disease is hyper-endemic. The widespread practices of harmful traditional surgical operations, which are usually performed during the childhood, are increasing the danger of HIV/AIDS in the country, since un-sterilized sharpened materials are used in all these operations. The knowledge and awareness of STIs among 975 youth interviewed in a study was very poor; most of them even refused to respond the questions on the topic (*UNICEF/MOHL, 1999*).

b. Neonatal mortality rate (NMR), Infant mortality rate (IMR) and Child Mortality rates (CMR)

It is not possible to list all possible contributors of the children's mortality and morbidity, following health problems affecting children highlighted:

- **Immunization coverage against the six childhood illnesses is very low** through out the country, and estimated to be less than 20% (*Unicef, May 1998*). Apparently the lowest immunization coverage is found in the Nomadic settlements, followed by Rural and Urban. Only 9.3% of children had immunization cards (*Unicef Somalia 2001*) but it is found that 69% of children aged 12-23 months received BCG vaccination, whereas only 35% of children had 3rd dose of DPT. Recurrent outbreaks of measles in almost all the regions of the country is a good indicator of low immunization coverage, and the situation is more severe in the Nomadic and rural areas.
- According to the Multi-indicator Cluster survey (MICS) conducted by Unicef in the year 2000, Only 39% of children aged 6-59 months received the high dose **Vitamin A supplement** and this could lead, theoretically, high prevalence of Vitamin A deficiency disorders, although such deficiencies are not reported in the health settings.

- **Breast feeding practices are not satisfactory:** as mentioned in the Multi-indicator cluster survey (MICS) of the 2000 conducted Jointly by UNICEF & MOH&L, only 20% of children aged less than 4 months were exclusively breast-fed.
- **Unavailable safe drinking water in more than 70% of Households** (UNICEF/MOHL, 2000). Sufficient and safe drinking water is the main cornerstone of health for every person in general, and children in particular; water scarcity usually results in poor sanitation and hygiene measures and thus probable outbreaks of certain communicable diseases. Water shortage is a common phenomenon in the Somaliland, by the fact that the highest annual rainfall ever recorded was 836mm in 1986 and the lowest was 156mm in 1965 (*Hargeisa water agency, 1996*). Availability of water in the urban settlements is also very low. It is estimated that the capital city of Hargeisa gets ¼ of its daily water requirements (*ibid, 1996*). In this situation of scarce safe and clean water, it is no wonder that diarrhoeal diseases ranked number One among the endemic and epidemic communicable diseases, including Cholera.
- **Female genital mutilation (FGM)** is widely practiced in the country with severe subsequent complications for young girls and women from the day the operation took place to the rest of their lives. 99% of the girls were circumcised and 94% of them had the worst type, which is the pharonic circumcision (*WHO, 1999*). Girls as young as 3 years of age were found to be circumcised, but most of the girls were circumcised between the ages of 5-10 years. The most common complications reported are: Severe hemorrhage during the operation, infection including septicaemia that sometimes results in death of the young girls, urinary and menstruation retention. Later there is a severe complication during the child delivering that mostly endangers (and sometimes kills) either the mother or the child or both (*WHO, 1999*). According to the surveys conducted by WHO and Unicef, most of the people, wrongly, believe that the practice has religious basis, so they are against eradicating this harmful tradition; However, nowadays many people accepted to change the typology of the circumcision from pharonic to Sunne type.
- **Lack of child spacing:** The fertility rate of women in Somaliland is as high as 7.9 (WHO, 1999). Given that there is no family planning and the low percentage of breast feeding mothers after 4 months of delivery, it is clear that there is no child spacing procedures and this will have negative health impact both to the concerned mothers and their children.
- **Early marriage:** Some studies show that 18% of women interviewed told that they give their first child before the age of 18 years (*Unicef 2000*). Early marriage usually results in adverse effects on the young mothers and their new-born, especially during delivery. Complicated and obstructed labor is very common among the young girls. Early age also predisposes some genetic disorders to the offspring such as Down's syndrome.

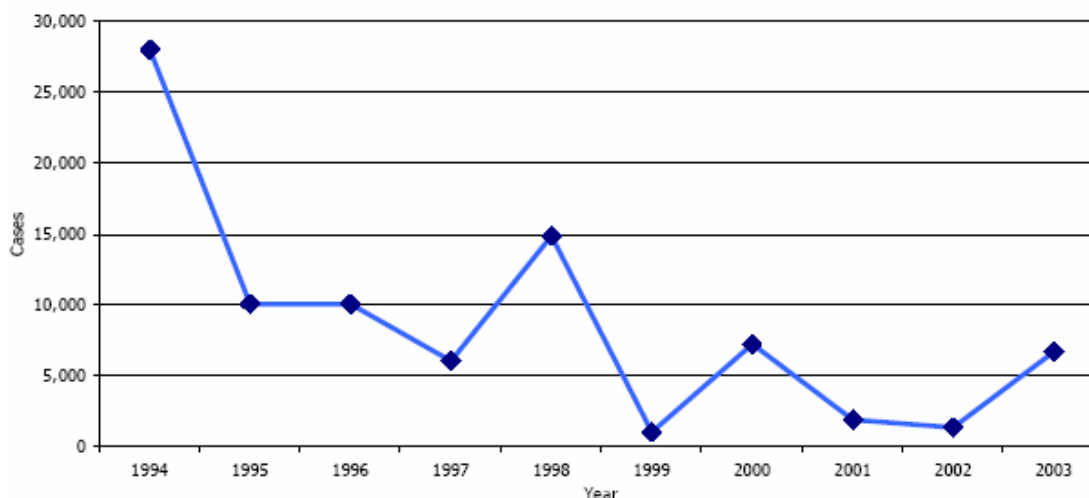
The most prevalent diseases that are responsible both the high morbidity and mortality rates are:

1. **Diarrhoeal diseases:** Like all other developing countries in General and the least developed of the under developed countries in particular, Children's diarrhoeal diseases remains one of the leading killer diseases. In the multi-indicator survey conducted in Somaliland in the 2000, **17%** of children have had diarrhea two weeks prior to the survey. In this MICS only **31%** of household have been identified having safe drinking water, so the main underlying cause of high

prevalence of Diarrhea could be due to poor sanitation and unsafe drinking water. Intestinal parasites are also very common causative agents of diarrhea in children. Giardiasis, Entrobmius Vermicularis and Ascaris Lumbricoides are the most common intestinal parasites among the children although reliable and recorded statistics are not available.

2. **Tuberculosis:** Tuberculosis is a major public health problem in Somalia and is one of the leading causes of morbidity and mortality, especially among productive age groups. Somalia has one of the highest estimated incidence rates of TB in the world (374 per 100,000 population) with around 22,000 cases of TB expected every year. It is estimated that around 10,000 new cases of pulmonary TB occurred in 2002, out of which 46% (4501) were detected and treated in supervised DOTS programs. The rest of the patients are most likely approaching the private sector or not receiving any type of cure.^{viii} Twice the number of males to females affected. The number of cases of all forms being detected and put on treatment each year grew from 2,504 in 1995 to 5,662 in 2000.
3. **Cholera:** Prior to the war, cholera outbreaks were recorded only in 1970 and 1985. Since 1994 cholera has become endemic with annual outbreaks. Between 1994 and 1998, there were 70,250 cases recorded, and between 1994 and 1996 there were 1,867 recorded deaths. Relatively low fatality rates (1.9% - 4.6%) are attributed to a well-coordinated and funded cholera prevention and response programme. Cholera outbreaks have been most frequent in southern Somalia, and fatality rates have been higher in rural villages and small towns where there are lower levels of preparedness and fewer treatment facilities.

Figure: Number of Cholera cases since 1994



Source: WHO Somalia annual report, 2003

4. **Measles.** Measles epidemics recur every two years in Somalia, due to low levels of immunization, with 3,965 cases reported in 2000. It is assumed to be an important contributor to under-five child mortality. Generally, 7% of Childhood deaths in the developing countries is due to Measles. In Somaliland the low immunization coverage, less than 17% among the 12 months age groups (*UNICEF, 2000*), epidemics of measles are reported now and then, not only in the nomadic and rural areas where lowest coverage are expected, but also in some urban cities. It

worthies-to- mention that the high mortality and morbidity rates of this childhood illness is well known.

5. **Malaria:** Malaria is one of leading diseases as far as morbidity and mortality is concerned. In year 2003 a total of 30,920 malaria cases reported out of which only 7571 were laboratory confirmed.viii The disease is hypo- endemic in the country, but epidemics are very common and all the regions and districts of the country are considered as epidemic prone areas. Children and Pregnant women are usually the highest risk groups of Malaria, especially plasmodium falciparum that is the causative agent of more than 90% of all malaria cases in Somaliland. 9% of children experience an episode of malaria in Somaliland according the cluster survey. (*Unicef, MoHL, 2000*). Anti-malarial programmes all but collapsed prior to the war, with the government allocating only US \$6,000 for malarial control. A Roll Back Malaria strategy is only just being initiated in Somalia.
6. **Acute respiratory tract infections (ARI):** In the developing countries 19% of child mortality is due to ARI. Pneumonia (plus other acute respiratory tract infections) is considered to be next to Diarrheal diseases as far as morbidity and mortality are concerned. In one survey 2% of children interviewed reported that they have had an episode of ARI two weeks prior to the survey (Unicef, MoHL, 2000)
7. **Malnutrition:** Although actual figures are not available at national level, UNICEF supported household survey show relatively good nutritional status among Somaliland children with severe Malnutrition of 3% and moderate malnutrition of 9%, mainly in the urban areas (*UNICEF, MOHL, 1999*)^{ix}
8. **Anemia:** High levels of anemia amongst women due to iron deficiencies and repeated malaria episodes are a contributor to maternal death. The high prevalence reported in the 1980s is probably unchanged, but there is no recent data to confirm this.
9. **Yellow Fever:** Due to the collapse of health services, there has been no vaccination against Yellow Fever in the past decade¹³. An outbreak could be catastrophic for Somalia and neighbouring countries.
10. **Rift Valley Fever (RVF):** RVF vectors exist in southern Somalia and can be stimulated by heavy rains in semi-arid areas. Cases of RVF occurred during the 1997 floods, causing minor loss of human life, and resulted in an embargo by Saudi Arabia on livestock imports from Somalia in 1998. Fatalities from RVF in Saudi Arabia in 2000 led to the imposition of a comprehensive ban on livestock imports into the Gulf States from the Horn of Africa.
11. **Kala Azar:** Kala Azar was sporadically reported prior to the war, mainly in the Middle and Lower Shabelle Regions. Cases have been reported since the mid-1990s and since July 2000 an outbreak was recorded on both sides of the Kenya-Somalia border. The complex epidemiology, high cost of treatment and high mortality without treatment make this a significant health risk for Somali populations.

Key health trends

- No improvement in basic health indicators since 1998
- Increasing incidence of TB and malaria
- Low HIV/ AIDs prevalence

- Increase in preventative services
- Unregulated curative services
- Diminishing numbers of qualified medical personnel

3.2 Demography

Somalia has a population of around 8,591,000. However, estimates are very difficult because of the continuing situation. The last census was in 1975. Most outside analysts use this estimate but Somalia is one of the fastest growing countries in Africa and the world. Some estimates range between 6 and 15 million.

Because of the war, Somalia has a large diaspora. Ethnic Somalis have lived for centuries in large areas of what is now Ethiopia and Kenya. They are also a majority in Djibouti, where they share area with the Afars. There are over a million Somalis (including the minorities) outside Africa. Somalia now has one of the largest diaspora communities of the whole continent. All of these factors and the mostly nomadic nature of the Somalis has made proper estimates very difficult. ii

Table 3-4 Demographic indicators

Indicators	1990	1995	2000	2002	2003
Crude Birth Rate:	46 [^]	45.5 ^{**} (97)	-	-	46.4 ["]
Crude Death Rate:	22 [^]	18.3 ^{**} (97)	-	-	17.6 ["]
Population Growth Rate ["] :	2.5	2.5	2.9	3.4	3.4
Dependency Ratio:	101 ^{***}	88.5 ^{**} (97)	116 ^{**}	-	102
%population <15 years [*]	45.4	-	44	44.7	44.7
Total Fertility Rate:	6.8 [^]	-	6.8 ^{**}	-	6.3 ⁺

Source: World health report 2005

["] CIA world fact book

^{*}'World Population Prospects: The 2004 Revision', New York, United Nations, 2005

^{**}<http://www.emro.who.int/somalia/countryprofile.htm#demographic>

^{***} Somalia Human development Report 2001

[^]http://www.unicef.org/infobycountry/somalia_statistics.html

Demographic patterns and trends

As early as the seventh century, indigenous Cushitic peoples began to mingle with Arab and Persian traders who had settled along the coast. Interaction over the centuries led to the emergence of a Somali culture bound by common traditions, a single language, and the Islamic faith.

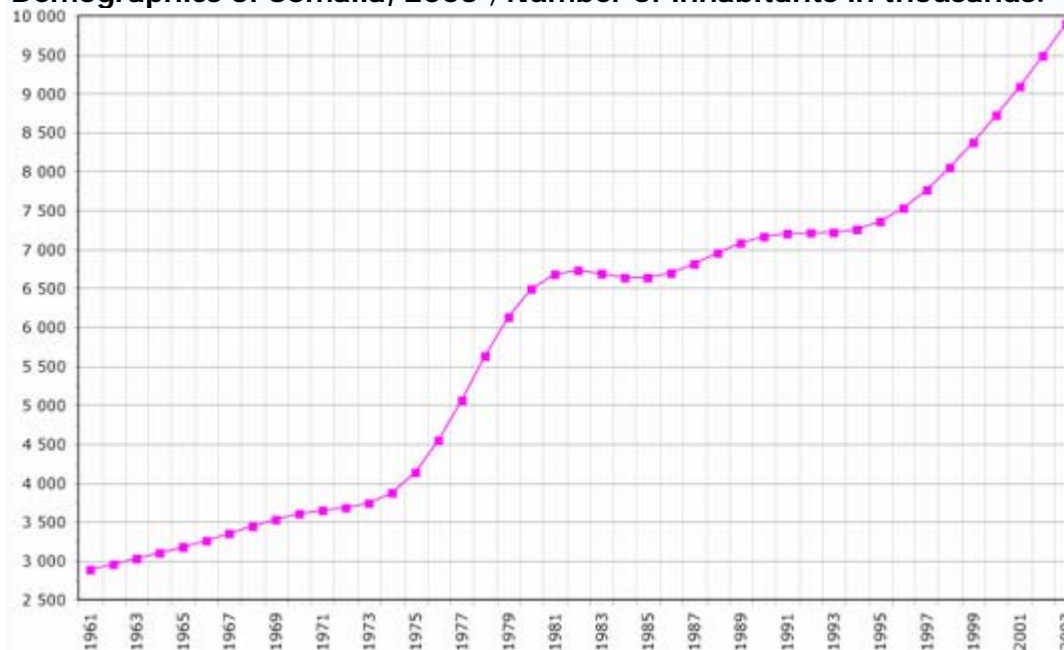
Today, about 60% of all Somalis are nomadic or semi-nomadic pastoralists who raise cattle, camels, sheep, and goats. About 25% of the population are settled farmers who live mainly in the fertile agricultural region between the Juba and Shebelle rivers in southern Somalia. The remainder of the population (15%-20%) is urban.

Sizable ethnic groups in the country include Bantu agricultural workers, several thousand Arabs and some hundreds of Indians and Pakistanis. Apart from the Brava people who speak a language similar to Swahili, nearly all inhabitants speak the Somali language. A population of Italian descent, which dated back to Somalia's colonial era,

began to emigrate following independence and by the outbreak of war most Italian Somalis had left the country.

The language remained unwritten until October 1973, when the Supreme Revolutionary Council (SRC) proclaimed it the nation's official language and decreed an orthography using Latin letters. Somali is now the language of instruction in schools, which are few. Arabic, English, and Italian also are used extensively.

Demographics of Somalia, 2005 ; Number of inhabitants in thousands.



Source: <http://en.wikipedia.org/wiki/Somalia>

Population:	8,591,629 <i>Note:</i> this estimate was derived from an official census taken in 1975 by the Somali Government; population counting in Somalia is complicated by the large number of nomads and by refugee movements in response to famine and clan warfare (July 2005 est.)
Age structure:	<i>0-14 years:</i> 44.5% (male 1,918,209/female 1,905,974) <i>15-64 years:</i> 52.9% (male 2,278,406/female 2,263,602) <i>65 years and over:</i> 2.6% (male 96,256/female 129,182) (2005 est.)
Median age:	<i>Total:</i> 17.59 years <i>male:</i> 17.53 years <i>female:</i> 17.65 years (2005 est.)
Population growth rate:	3.38% (2005 est.)
Birth rate:	45.62 births/1,000 population (2005 est.)

Death rate:	16.97 deaths/1,000 population (2005 est.)
Net migration rate:	5.19 migrant(s)/1,000 population (2005 est.)
Sex ratio:	<i>At birth:</i> 1.03 male(s)/female <i>under 15 years:</i> 1.01 male(s)/female <i>15-64 years:</i> 1.01 male(s)/female <i>65 years and over:</i> 0.74 male(s)/female <i>total population:</i> 1 male(s)/female (2005 est.)
Life expectancy at birth:	<i>Total population:</i> 48.09 years <i>male:</i> 46.36 years <i>female:</i> 49.87 years (2005 est.)
Total fertility rate:	6.84 children born/woman (2005 est.)
HIV/AIDS - adult prevalence rate:	1% (2001 est.)
HIV/AIDS - people living with HIV/AIDS:	43,000 (2001 est.)
Literacy:	<i>Definition:</i> age 15 and over can read and write <i>total population:</i> 37.8% <i>male:</i> 49.7% <i>female:</i> 25.8% (2001 est.) http://www.cia.gov/cia/publications/factbook/geos/so.html

There are some favorable demographic trends. The numbers of refugees and internally displaced persons have declined over the past three years, indicating an improved security environment. However, migration to strong economic centers, such as Mogadishu, Hargeisa, Bosasso, Burco, Galkaiyo, and Baidoa, is creating new human development challenges in the provision of services and employment that are typical of rapid urbanisation. The most vulnerable people are the internally displaced, returning refugees, the urban poor, destitute pastoralists, and southern riverine farming communities.^{iv}

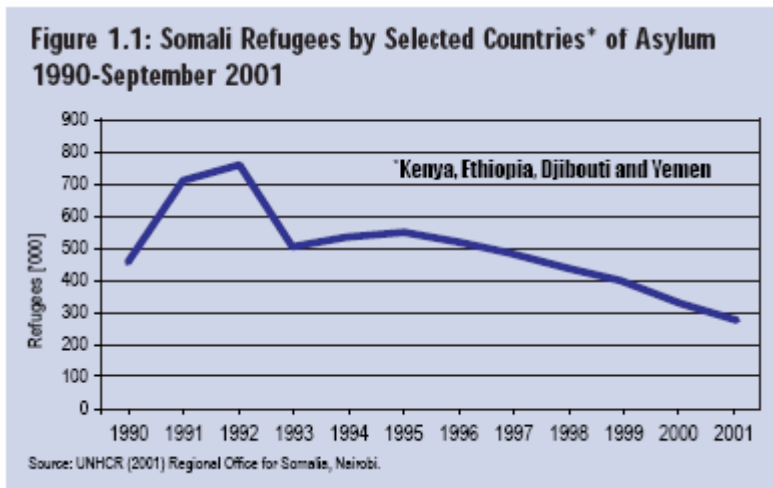
Urban Migration

Although the population of Somalia is predominantly rural, there are strong patterns of urban migration. In the 1980s, Somalia's rate of urban migration was one of the highest in Africa, estimated to be 6.5%³³. For a time during the war this process was reversed as people fled the main towns and moved to areas that their clans came from. Consequently, the populations of previously small regional towns such as Beletweyne, Galkaiyo, Qardo or Baidoa, and rural villages such as Jeriban, rose dramatically³⁴. The population of Bosasso is estimated to have increased from 10,000 to 60,000 since 1991, as people fled fighting in Mogadishu, the Lower Juba and the inter-riverine areas. Rapid urban migration has become a particular issue in Hargeisa, where some 62 per cent of Somali refugees returning from Region 5 of Ethiopia have chosen to settle. The concentration of businesses and aid programmes in the administrative capitals serves to attract the rural population, Somalis returning from the diaspora and economic migrants from Bay and Bakol regions. Smaller towns are experiencing similar trends, which present a challenge for urban planning. The

concentration of aid agencies in urban centers such as Hargeisa, and a lack of clear policies by the administrations on investment in rural areas, exacerbate this trend. It is reminiscent of prewar Somalia and indicates that development policies have changed very little.

Refugees and refugee returnees

Prior to 1991, Somalia hosted one of the largest refugee populations in Africa, from the Ethiopian Ogaden. In 1987, one in six persons resident in Somalia was registered as a refugee³⁵. The civil war reversed this situation. In 1988 when war erupted in the northwest, over 600,000 people fled to Ethiopia in one of the fastest and largest forced population movements ever recorded in Africa³⁶. During 1989, a significant number of Somalis sought refuge in Kenya from fighting in southern Somalia. The mass flight of Somalis, however, took place from early 1991 when over one million are estimated to have fled to countries in the region and outside Africa. People continued to leave southern Somalia in large numbers up until 1995. Since then there has been a decline in refugee flows from Somalia and a gradual process of repatriation and reintegration

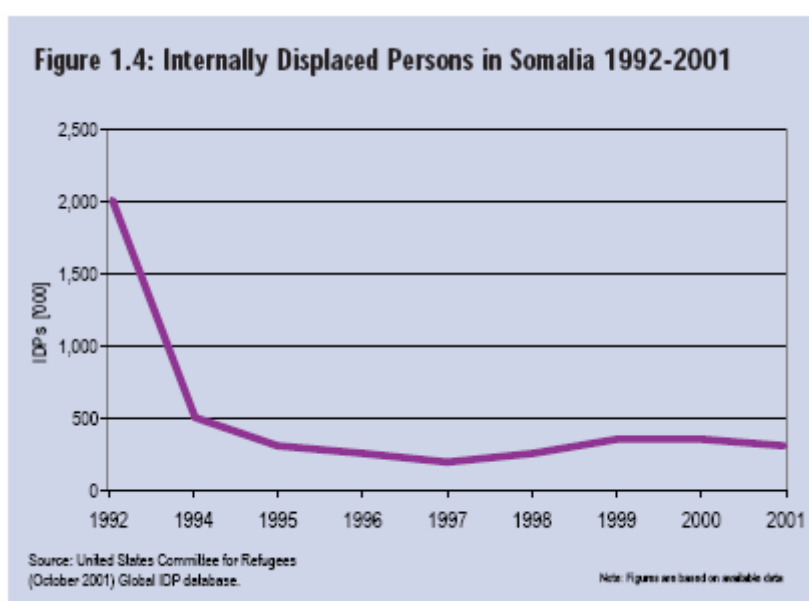


Many have returned to Somalia, while others have obtained permanent residence rights in countries of asylum. Some 400,000 refugees in Ethiopia spontaneously returned to Somaliland in 1991 after the fall of the government, although 90,000 fled again in 1994 when civil war erupted in Hargeisa and Burco. Voluntary repatriation from Region 5 in Ethiopia restarted in December 1998 and after a decade in exile the last refugees from Somaliland resident in Ethiopia and Djibouti are expected to repatriate in 2001³⁷. The decline in Somali refugee numbers is, in part, due to improved security inside Somalia, the difficult and unwelcoming environments in refugee camps, and the tighter asylum policies in the West.

Internally Displaced Persons

Another demographic trend is the leveling off of numbers of internally displaced persons (IDPs) in Somalia. Internal displacement as a result of conflict has a long history in Somalia, although the numbers of displaced were never recorded prior to 1991. The largest war-related displacements from central and southern Somalia took place between 1991 and 1993. Prior to May 1992 the main cause of displacement was fighting and drought, and after May 1992 it was mainly food scarcity. In September 1992 there were estimated to be between 556,000 and 636,000 'visible' displaced people in static camps, 50% of whom were living in Mogadishu. In addition there were 'invisible' displaced who were supported by kinfolk. Some estimates numbered the

displaced at that time to be over 1.6 million. Since then there have been smaller displacements caused by fighting in the Juba valley (1993), in Bay and Bakol (1995-1999), and in Somaliland (1994-1996). In late 1997 and early 1998, extensive flooding displaced people from central and southern Somalia. In 2001, some 10,000 people were temporarily displaced from Gedo region into Kenya as a result of armed clashes. It would appear that the overall trend since 1993, however, has been one of diminishing internal displacement, as the war subsided and people either returned to their homes or 'resettled' in different regions of Somalia. Over the years, there has been a clear pattern of people from northern clans moving to the northern regions from the south, which has radically altered the demography of those regions.



As violent conflict has declined and food deliveries have been reduced, displaced camps have also diminished. Climatic stress and economic hardship are now the main causes of population movement. In 2001, there were estimated to be 300,000 internally displaced, including 40-50,000 newly displaced. These figures should be treated with some caution, as there has been no comprehensive study of IDPs since UNOSOM withdrew from Somalia. There is little information on Mogadishu, which is thought to have the biggest concentration of IDPs. IDPs today constitute over 60% of those Somalis considered to be food insecure. The majority is from the poorest rural families or minority groups and lives on the peripheries of the urban centers. Bereft of assets and with limited access to stable employment, their access to education, health and other services is restricted by an inability to pay user fees.

Among IDP populations malnutrition rates as high as 25% have been recorded in the last two years⁴³, compared to a global malnutrition rate for Somalia of 17%, and 10% among more affluent populations. The declining incidents and scale of internal displacement is a positive trend. However, few of the existing displaced seems to be returning to their original homes. For some who were displaced from rural areas such as Bay and Bakol, there is little economic incentive to do so. For others who were originally residents of Mogadishu, a significant proportion does not feel it is safe or viable to return there. This is a potential obstacle to future reconciliation. First, because it reflects the continuing instability of several regions, and second because it reflects a

consolidation of population realignments and the violent transfer of property, such as land, that occurred during the war.

The Somali diaspora

An important, but largely unstudied demographic phenomenon, is the large population of former Somali nationals now settled outside Somalia – the so-called diaspora⁴⁴. Some estimates put the number of Somalis living abroad today to be over one million⁴⁵. The diaspora are an extremely important force in the Somali economy and in Somali politics. Several ministers in the TNG, the Somaliland administration, as well as the faction leaders and their family members hold non-Somali passports, for example. The remittances from the diaspora are a key part of the economy and critical to people's livelihoods. The large diaspora means that the Somali 'nation' is no longer confined within territorial borders, but has been globalised, and the diaspora links Somalia into global economic networks. Somalis returning from the diaspora have brought new businesses, restaurants, ideas, and technologies. While many in the diaspora express a desire to return to Somalia, insecurity and poor social services and employment opportunities mean that there are few inducements to do so. In 2000, for example, airline companies estimated that as many as 15,000 Somalis from the diaspora returned to Somaliland during the European summer school holidays. However, few remained.