



The invisible burden: A critical surveillance gap for cytomegalovirus in Somalia

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Dear Editor,

Cytomegalovirus (CMV) remains a leading infectious cause of congenital disabilities and a major complication among immunocompromised individuals globally. In sub-Saharan Africa, seroprevalence is generally modeled as near-ubiquitous, with estimates frequently approaching 87% to 100% among adult populations [1]. However, relying on regional extrapolations creates severe geographic blind spots. A striking example is Somalia, a nation of over 18 million people, where contemporary epidemiological surveillance for CMV is virtually nonexistent.

A review of the available medical literature reveals that the primary baseline data for CMV seroprevalence within Somalia originates from studies conducted nearly four decades ago. A landmark study published in 1987 in Mogadishu reported a high CMV antibody prevalence of 90% across varied population groups, including pregnant women and neonates [2]. A follow-up study in 1990 corroborated these high exposures within male cohorts in the capital [3]. Since those early publications, direct, field-based clinical tracking of CMV within Somalia's borders appeared to have stalled or that findings are not readily available to the public. Decades of structural instability have forced the domestic public health sector to understandably prioritize acute, high-mortality crises such as cholera, measles, and malnutrition, leaving chronic or largely asymptomatic viral pathogens unmonitored.

This data vacuum presents severe clinical risks, particularly concerning congenital CMV (cCMV). While high ambient seroprevalence typically implies widespread natural immunity, it also creates a dangerous landscape for the remaining seronegative minority. In hyper-endemic regions, seronegative pregnant women face an elevated risk of primary infection, which carries a high rate of vertical transmission and severe fetal sequelae, including sensorineural hearing loss and neurodevelopmental delays [4,5]. Without active surveillance or antenatal screening, infants born with cCMV in Somalia go entirely undiagnosed and unsupported.

This surveillance gap also impacts global health systems due to international migration patterns. Research examining Somali diaspora communities, such as in the United States, reveals persistent health disparities and low baseline awareness regarding cCMV risks and screening options [6]. Because baseline epidemiology from the country of origin shapes the immunologic landscape of migrant populations, filling the domestic data gap is essential for clinicians worldwide who manage maternal health, neonatology, and organ transplantation for Somali patients.

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Received: 03-09-2026, **Accepted:** 16-09-2026, **Published:** 28-09-2026

How to cite: Omar AA (2026) The invisible burden: A critical surveillance gap for cytomegalovirus in Somalia. *Global Virology Reports*, 1(1): 18–19.

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Addressing this gap does not require cost-prohibitive infrastructure. Public health authorities and international partners can implement low-cost, opportunistic surveillance. By utilizing existing biobanks or collecting de-identified, leftover serum samples from routine antenatal care clinics and blood donation centers, researchers can establish a modern seroprevalence baseline.

The complete absence of contemporary CMV data in Somalia undermines the global commitment to infectious disease equity. We cannot manage what we do not measure. It is time for global health initiatives to look past regional assumptions and support localized surveillance in Somalia to finally bring this invisible pathogen into the light.

Funding

None.

Competing interests

None.

Informed consent statement

Not applicable.

Declaration of generative AI and AI-assisted technologies in the manuscript preparation process

During the preparation of this manuscript, ChatGPT (OpenAI) was used to improve grammar. The content was reviewed and edited. The author takes full responsibility for the accuracy, integrity, and final content of the manuscript.

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