



Memorandum

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Subject: Foreign Trip Report (AID/RSSA): Assessment of AID Population and Family
Planning Assistance to Somalia, February 15-March 4, 1981

To: William H. Foege, M.D., Director, Centers for Disease Control (CDC)
Through: Horace G. Ogden
Director, Center for Health Promotion and Education (CHPE) *HGO*

SUMMARY

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SUMMARY

At the request of DS/POP/AFR, DS/POP/FPSD and USAID/Somalia, Mr. Monteith participated as a member of a 4-person team established by the American Public Health Association (APHA) to assess the present status of AID population assistance to Somalia and the climate for acceptance of a national family planning program. The development of a national family planning program in Somalia is in its very early stages, with mixed prospects for the future. Child spacing is recognized in Somalia as a permissible and desirable health measure for the protection of mothers and children, while controlling high fertility to enhance social and economic development is not. There is a demand for child spacing services in Somalia, but this demand is largely unmet. The unavailability of contraceptives and the Ministry of Health's conservative attitude toward family planning have acted as obstacles to the establishment of services. There is a potential for developing a family planning program in Somalia but it will have to be a broad-based, conservative, expensive program, providing services in the context of maternal and child health. Although laying the groundwork for a national program will be a slow and difficult process, AID can take steps toward this end. They include:

- (1) continue to strengthen and extend primary health care, including family planning, to all Somalis,
- (2) procure through an intermediary donor, i.e. Pathfinder, Family Planning International Assistance (FPIA) or International Planned

Parenthood Federation (IPPF), sufficient quantities of contraceptives to ensure their continuous availability,

- (3) assist the Ministry of Planning in developing a data base on which an objective case for a national family planning program could be made.

• A detailed report of the team's findings was submitted to the APHA on March 18, 1981, and will be made available to AID/POP/W and to FPED/CDC after final typing.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

At the request of DS/POP/AFR, DS/POP/FPSD, and USAID/Somalia, to participate as a member of a 4-person team established by the American Public Health Association to assess the status of AID population and family planning assistance to Somalia. The FPED/CDC member of the team was Mr. Richard S. Monteith, Program Analyst, PEB. This travel was in accordance with the Resource Support Service Agreement (RSSA) between the Office of Population, AID, and CDC/FPED.

II. PRINCIPAL CONTACTS

A. USAID/Somalia

1. Mr. Michael Adler, Mission Director
2. Mr. Arjuna Abayomi-Cole, Health and Population Officer
3. Dr. Rukiya Mohammed Seif, Family Health Initiatives Project Coordinator

B. Ministry of Planning

1. Mr. Hussein Celeste Fabiye, Director General
2. Mr. Aril Mohammed Farah, Director, Department of Statistics

C. Ministry of Health

1. Dr. Ahmed Mohammed Hassan, Director General
2. Dr. A. S. Abbas, Director, Department of Maternal and Child Health and Nutrition
3. Dr. M.A. Gulaid, Director, Department of Primary Health Care
4. Dr. Warsame Ali, Director, Benadir Hospital
5. Dr. Hassan, Department of Planning and Statistics

D. Other

1. Mr. Olaf Svennevik, Director, U.N. Development Programme (UNDP)
2. Mr. C. Bonanni, U.N. International Children's Emergency Relief Fund (UNICEF) Representative
3. Mr. John Cipolla, Medical Services Consultants, Inc.(MSCI) Team Leader
4. Ms. Laura Altobelli, Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO) Consultant
5. Mrs. Imtiaz Kamal, IPPF Consultant
6. Mr. Asman Ali Jama, Director General, Ministry of Education
7. Ms. MUSAAGED GALAAD AHMED, Chairperson, Somali Democratic Women's Organization

III. SCOPE OF WORK

The American Public Health Association (APHA) team was composed of Dr. Willard Boynton, public health physician; Dr. M. Nizamuddin, Ph.D. demographer, POPLABS; Ms. Fran Simmons, Ph.D. Candidate in demography, Princeton University; and Mr. Richard S. Monteith, M.P.H., Program Analyst, FPED/CDC. The purpose of the team's visit to Somalia was to assess the present status of AID population assistance to that country, assess the climate for acceptance of a national family planning program, and to make recommendations for a country strategy for population assistance.

The team briefed the USAID/Somalia Mission Director and Health and Population Officer on its findings before departing Somalia. The team also briefed AID and APHA officials in Washington, D.C. on March 13, 1981. A detailed written report of the team's findings and recommendations was submitted to APHA on March 18, 1981, and will be available to AID/POP/W and FPED/CDC after final typing. Thus, this report will only summarize the team's major findings and recommendations.

IV. HIGHLIGHTS OF FINDINGS AND RECOMMENDATIONS

A. General

Somalia is an archetypical developing country, additionally burdened by the Sahelian drought, a border war resulting in perhaps one million refugees, and a faltering, socialist planned economy. It is a large country of 637,000 square kilometers, averaging six persons per square kilometers.* The country is hot and dry with only a small percentage of land suitable for agriculture. Perhaps 75 percent of the population are poor nomads or semi-nomads largely engaged in raising goats, cattle and camels. Per capita income is US \$120 per year. The people are racially homogenous and primarily Muslim. A one party, socialist government is highly organized down to the village level.

*NOTE: All statistics should be considered estimates and vary with source.

The population of Somalia is about four million, plus one million ethnic Somali refugees from Ethiopia. Twenty-five percent of the population lives in Mogadishu, the capital. A birth rate of 48 per thousand and a death rate of 20 per thousand gives a natural increase of 2.8 percent. The maternal mortality rate is more than 100 per 100,000 births and the infant mortality rate is around 150 per 1,000 births. Approximately one third of children born alive die before reaching the age of five. The population is young, with 45 percent less than 15 years of age.

Health problems abound, and the health status of the population is poor.* Malnutrition is extensive with studies showing almost 40 percent of children with second and third degree malnutrition. With little safe water, sanitation, or knowledge of hygiene, diarrheal diseases take a high toll of children. Tuberculosis affects one third of children aged 5-9 years, and one percent of the population have positive sputums. Schistosomiasis, malaria and childhood infections are common.

Health services in Mogadishu are fair, but primitive in the 15 regions outside Mogadishu, even by LDC standards. There is a dearth of resources in general, a lack of trained staff, insufficient medicine, supplies, non-functioning equipment, intermittent transport, and little information feedback for management. Although the Government of Somalia (GDRS) recognizes the need to strengthen health services, health now receives less than two percent of the total budget.

The GDRS plans to provide primary health care for all by the year 2000. AID, through a contract with Medical Services Consultants, Inc. (MSCI), will assist the Ministry of Health (MOH) in establishing primary health care in four of the country's 16 regions while the UNFPA will help establish services in the remaining 12 regions. AID also proposes to contract with International Training in Health (INTRAH) to assist the MOH in training auxiliary health workers. In summary, the GDRS has the correct concept for delivering primary health care to the bulk of the people consistent with their socialist philosophy. However, the execution lies largely in the future.

B. Population/Family Planning

The development of a national family planning program in Somalia is in its very early stages with mixed prospects for the future. There is no national population policy and it is unlikely there will be one in the near future. Tradition, low population density and an expressed desire for children because of high infant mortality and military needs favor a pronatalist policy.

*Centers for Disease Control: Fifth Report of the CDC Epidemiologic Teams to the Somali Ministry of Health, Atlanta, Ga., November 6, 1980

However, the Parliament of Somalia has approved child spacing* as a health measure for the protection of mothers and children. All government officials we interviewed agreed that child spacing was permissible and desirable, but nobody supported controlling high fertility to enhance social and economic development. The Director General of the Ministry of Planning felt a population policy would not be considered until a more convincing case for the need for population control could be buttressed by better demographic and economic data.

To date, child spacing has depended almost entirely on the custom of nursing children for two years and the absence of men while tending their herds. MOH officials recognized that breastfeeding does not always protect against pregnancy for two years, and further recognized that the high rate of hospitalization for complications of "miscarriage" probably results partially from induced abortions.

The availability of contraception through public sector facilities has been minimal. The 10 doctors trained by Johns Hopkins (JHPIEGO) have already trained 20 others and will train 60 more this year. None of those trained, however, have a regular supply of contraceptives. They depend on samples from drug companies, but most of their family planning clients have to buy oral contraceptives at pharmacies for two dollars a cycle. The Director of Maternal and Child Health (MCH) of the MOH has an undetermined amount of oral contraceptives and IUDs on hand, but to date has not distributed them to the JHPIEGO trained physicians or to the 13 MCH centers and 10 Ob/Gyn clinics in Mogadishu under his control. By cabling AID/POP FPSD, the team learned that UNFPA provided the MOH through WHO the following contraceptives in 1980: 44,111 cycles of oral contraceptives, 5,600 IUDs and 41,920 condoms. The MCH director's policy is to distribute oral contraceptives and IUDs only when training of physicians and nurses has been completed. In addition, oral contraceptives will be initially dispensed only after examination by a doctor who visits a given MCH clinic only two days per week.

On the positive side, the 10 doctors trained by Johns Hopkins are enthusiastic to do family planning and only need a good supply line. Their leader estimates there are 10,000 contraceptors in Somalia despite the severe restrictions on supplies. Most of these, however, have had to purchase their contraceptives at pharmacies so use cannot be verified by clinic records. IPPF trained 12 nurse supervisors in service delivery last year and is currently training 12 MCH nurses, with a promise from the MOH that contraceptive supplies will be made available to MCH centers with a trained nurse.

*GDSR officials preferred to use the words "child spacing" rather than "family planning" because for them the latter was synonymous with "birth control," "population control" and "genocide."

There is a demand for child spacing in Somalia, but the demand is largely unmet. The team was told repeatedly that as many as half of postpartum patients request help for spacing children as they wish to "rest." The IPPF consultant the team met surveyed 66 women at home last year and found 64 of them desiring contraception to space their children. The medical need for spacing is supported by the very high maternal and infant mortality rates and malnutrition in children.

There are certain favorable social and political factors, as well. The Somali Democratic Women's Organization (SDWO) is a powerful political and social organization that reaches to the village level. It is favorable toward child spacing and could instruct women on child spacing in their orientation centers. The Family Life Program of the Ministry of Education could be utilized similarly. Finally, the GDRS and MOH have the desire to build a network of MCH services which could provide the vehicle for contraceptive services.

In summary, a need for family planning exists in Somalia. There is a potential for developing a program but it will have to be a broad-based, conservative, expensive program, providing services in the context of MCH. An aggressive program sharply focused on population control would not be acceptable at this time. It should be noted that it will be a slow and perhaps difficult process to establish the climate and experience necessary for a real national population/family planning program in Somalia. However, AID can take steps to increase the availability of child spacing services in Somalia and to lay the groundwork for a national program. These steps are outlined below.

C. Recommendations

1. AID should continue to strengthen and extend the health care delivery system to provide primary health care, including family planning, to all Somalis.

For the most part family planning services will be provided as one element of MCH services since this is the only generally accepted mechanism in Somalia. Therefore, it is incumbent upon AID to ensure that MSCI and INTRAH include child spacing in their training. The team detected a reluctance on the part of MSCI to include family planning because of the fear of alienating counterparts.

2. USAID/Somalia should immediately procure, through an intermediary donor, i.e., Pathfinder, FPIA, or IPPF, 72,000 cycles of oral contraceptives, 4,000 IUDs (Copper T), and 51,840 condoms (Tahiti).

Only a small quantity of these contraceptives, which were donated by the UNFPA, are reportedly on hand in the country. USAID/Somalia has provided a limited amount to the family planning effort in Somalia, but the combined UNFPA stock and USAID's contribution is not sufficient to meet current demand and to ensure continuous availability of contraceptives.

3. Both AID/W and USAID/Mogadishu should coordinate with IPPF in the procurement of contraceptive supplies.

IPPF is playing a pioneering role in training nurse supervisors in family planning and is actually getting some contraceptives into clinics where they could be used. AID will need to coordinate contraceptive supplies with IPPF and might induce IPPF to supply injectable progesterone while AID supplies oral contraceptives and condoms. Injectable progesterone is acceptable in Somalia and desirable as a postpartum contraceptive in a population with widespread malnutrition, since it does not decrease lactation.

4. The JHPIEGO Reproductive Health Training Program should be evaluated to assess its impact on increasing the availability of family planning services in the country.

The JHPIEGO program is the pioneer in establishing services in the country. However, the physician training has not resulted in an appreciable increase in the availability of contraceptive services especially in the regions. The reasons should be investigated and JHPIEGO's program modified if justified.

5. USAID/Somalia should investigate the reasons behind the delay in implementation of the Primary Health Care Project, and provide the necessary assistance to expedite its implementation.

This project is the main vehicle to extend maternal and child health and family planning services to rural areas, but by conservative estimates the project will be 15 months behind its original schedule once it gets into the field.

6. USAID/Somalia should clearly define the roles of each participant in the Primary Health Care Project and the timing of their intervention. The proposed role of INTRAH in the project is not clear, nor does the timing of its intervention appear to be coordinated with other project participants. In addition, INTRAH may duplicate training already underway by IPPF.
7. The proposed KAP studies to be done by the Department of Social Sciences, University of Somalia, as a part of the Family Health Initiative Project, should be strengthened by providing technical assistance from a U.S. institution such as CDC, Westinghouse, or POPLABS.

It is the team's professional judgment that the Department of Social Sciences does not have the expertise to conduct a scientific sample survey without technical assistance.

8. AID should explore, through an experienced intermediary such as P.S.I. or Westinghouse, the possibility of a CRS program with the appropriate governmental agencies.

Contraceptives (orals and condoms) are openly sold in pharmacies indicating that Somalia has no laws restricting their importation or

across-the-counter sale. Presently, pharmacies are the primary source of contraceptives in the country. It would be worthwhile to explore the possibility of a CRS which, if implemented, would reduce the cost of contraceptives to the public.

9. The Department of Planning and Health Statistics of the MOH should be strengthened to provide an adequate information system so the Somalia health care system can be made more responsive to the health needs of the people.

Presently, little data are collected and analyzed by the MOH. An MCH/Family Planning reporting system will be essential for effective management.

10. The health education component of the Somali Women's Democratic Organization training program should be utilized for communicating family health/child spacing information. District level workers who are responsible for health information should be trained in techniques of disseminating and promoting child spacing information.

Since all women are encouraged to attend the SWDO orientation centers, a health component which informs women of child spacing practices has the potential for reaching many women in need of services. Attention should be given to the preparation of materials such as posters and audiovisual aids in the Somali language which will be sensitive to the culture of the country. Training should begin first in the orientation centers of Mogadishu where MCH clinics have trained staff ready to discuss and dispense contraceptives, subsequent training could include other districts as MCH clinic staffs become trained in family planning services.

11. The family life teacher trainers of the Women's Education Center, Ministry of Education, should be given inservice training in family health to include child spacing and reproductive health.

The curriculum of the teachers who teach family health education currently does not include child spacing and reproductive health topics. Teacher trainers should be given a course in these topics for the purpose of training teachers in the field. In the long run, the curriculum for family life teachers should be modified to include reproductive health and child spacing.

12. A series of family health/child spacing programs should be developed for use by the Ministry of Information's radio programs on health.

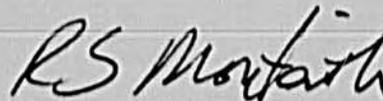
Given the importance of the radio as a tool in the dissemination of information in Somalia, the preparation and release of programs on child spacing have the potential for reaching many people. The MOH already airs health programs on national radio. Organization with expertise in the development of media materials, such as the University of Chicago, should be used to provide technical assistance to the MOH.

13. Assistance should be given to the GSDR to lay the groundwork for a national population policy.

Although the GSDR is not ready for a population policy now, the groundwork for a policy can be started and would be acceptable. VIPs could be sent to Indonesia, a Muslim country with an excellent population program. In addition RAPID could assist the MOP in analyzing the impact of the GSDR five-year plan on population growth.

14. Provide fellowships to strengthen the Statistical Training Institute and the MOP Data Processing Center.

The training of personnel will assist the MOP in collecting and processing data on which to base a population policy.



Richard S. Monteith