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SOMALIA

Rural Health Service Delivery Project

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Project Evaluation

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Claudette Bailey

Donald Ferguson

Thomas Georges

William Oglesby

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ASSESSMENT

1. Organization of PHC

Primary Health Care (PHC) within Somalia has been established as a department and program within the Ministry of Health of the GSDR. Implementation of PHC within rural areas of Somalia is considered an important national goal by the GSDR and not by the Ministry of Health alone.

MOH organization in Somalia is regionalized. At the national level, goals and objectives of PHC and internal coordination within the Ministry is effected through the Primary Care Program which has departmental status within the Ministry, and is headed by a Director.

The MOH has a Central Coordinating Committee which deals with Ministry wide concerns, and is comprised of departmental directors and other senior officials within the Ministry. The PHC Program Director is a member of this senior body.

The country has been divided into sixteen regions for administrative purposes. Each is a Governorate, and in each region the MOH is represented by a Regional Medical Officer (RMO). Since inception of the PHC Program (PHCP), an addition to the MOH staff at the regional level has been the Regional Primary Health Care Coordinator reporting to the MOH through the RMO, but also directly to the Director of the PHCP in Mogadishu on PHC matters. This level, a middle management level, organizes and supervises regional resource allocations of MOH staff, money, and material directed to hospitals, medical care, and PHC. The Primary Health Care Coordinator is responsible for those aspects of the MOH PHCP

program involving outreach care to villages and communities, which are preventive or curative in character. Resources of donors and the Ministry are channeled through the Ministry to Regions, and Districts.

The next level in the MOH structure is the District level. In most Districts in the country a District Health Center (DHC) exists which delivers outpatient and some inpatient care. DHC's usually have from 10-25 beds for inpatient care. Most DHC's are headed by a District Medical Officer, often have associated MCH centers or workers, and have a staff complement depending upon size, population and demands upon on the particular DHC.

The next level of care is that of the Primary Health Care Unit (PHCU). This facility is planned and does not yet exist, but will come into being nationally, largely as a result of the USAID supported Rural Health Project. Sixty four PHCU's staffed by a public health nurse, a nurse-midwife, and a sanitarian, are planned and are scheduled to be built with support from this project, and staff trained with curricula and in training centers supported and developed by the Rural Health Project.

The PHCU level of care has been adopted as a fundamental feature of the National Health Plan (1980-85) of the GSDR and is to be implemented country wide over time. The National Health Plan, and Rural Health Project outputs are in close agreement.

Finally at the village or community level, Community Health Workers, CHW's) and trained Traditional Birth Attendants (TBA's) are envisioned as a first line of contact for the Somali people

with the health care system and as a point of contact through which EPI and other vertical programs will effect contact with intended beneficiaries. PHCU staff are to train, manage, and supervise village and community level workers (CHW and TBA's). PHCU staff, CHW's and TBA's are all being trained by project trainers utilizing RHP developed curricula and staff at RHP supported National Training Centers.

Each level of regionalized care has a somewhat unique role to play in the health care delivery system of Somalia, and along with infrastructure necessary will integrate PHC with other levels of care and service, and programs whether horizontal or vertical in nature.

The team finds no problem with the structural organization or overall policy of the MOH with respect to Primary Health Care Program or with the relationship of the USAID supported project to the Somali Primary Health Care Program. The intent of both Ministry and project are sound and rational.

The evaluation team assessment in the pages which follow will relate to the realities, possibilities and particulars of implementation of the Rural Health Project and not with Ministry organization or policy issues per se. The evaluation team is in basic agreement with the policy and general PHC strategy of the GSDR and the objectives of the USAID supported Rural Health Project.

Assessments made and recommendations which follow are being made in the interest of strengthening and further advancing the implementation of the Rural Health project and GSDR PHC program.

Many aspects of RHP organization are treated elsewhere in this report, and will not be duplicated in this chapter. Observations with respect to AID Health Sector Project Team

reflected in project organization will be assessed and followed by recommendations in the appropriate section.

The Project Manager/Chief of Party has been heavily involved in administrative detail, crisis management, and attention to day to day details better handled by an Administrative Officer or Administrative Assistant which would permit concentration on large project issues, on planning, and on guiding overall project progress and accomplishments. Small details while small and unimportant can and have consumed a lion's share of the time of the Chief of Party often to the detriment of other project activities. The team believes many necessary, but time-consuming and required actions should be delegated. As the RHP is now staffed, there is no person to whom these actions can be delegated, and as a result insufficient time is devoted to larger issues; to coordination, facilitation.

The need for a nurse educator, nurse-midwife educator and sanitarian at each training site is unquestioned. These categories of expatriate faculty will continue to be needed throughout the Life of the Project (LOP).

A Logistics Officer is also clearly necessary to the project. The role of such an individual will become even more important as drugs and supplies are to be procured, managed, distributed, resupplied and maintained. A Somali counterpart is also essential to work with the supply management or logistics officer. He/she must be prepared, and have experience sufficient to step in at project completion and take over these functions. The MOH

has appointed a pharmacist for this role, but to the team's knowledge he is not yet in place.

The need for a transportation and vehicle repair specialist is also unquestioned by the team. The training of mechanics and drivers and the set-up and operation of a transport system and vehicle repair and maintenance system is clearly essential to the operations of the PHC program. Properly implemented, there should be positive spinoffs for the rest of MOH operations as well.

The team saw no evidence of regularly occurring scheduled tripartite meetings among MOH, USAID, and MSC I with an agenda, minutes, and assignment of responsibility for action on particular issues and problems to speed the implementation process. USAID did hold many separate meetings with the MOH and with MSC I in an attempt to resolve by mediation existing problems. Chronic frictions among the three organizations are cited by USAID as the reason for this approach.

No single agency can act alone in RHP project related matters. In some matters, one party must take the lead, in others, another. Very often however all others must assist or contribute. Regularization of this process is essential, and joint development of priorities, a consensus, action responsibilities, a timetable, and continual monitoring by all parties is vital. Such mechanisms instituted and maintained from project inception in the team's view would have decreased delays by a third, and possibly up to one-half of the unproductive periods in question. Comparing USAID projects across a number of countries, the clear absence of such a mechanism for project decision making is noteworthy and merits immediate correction. All bear responsibility in this matter.

During 1982, the USAID Mission temporarily employed the device of a management committee in an effort to speed up facilities construction activities.

In the team's view one of the most noteworthy deficiencies in the RHP project has been the sparsity of all types of communication and inter-communication. MSCI recognizes the need for two way radio communication between project sites, but has not acted in a timely way to correct this problem. Somalia, unlike a number of other countries, puts no substantial bar to installation of such a system at this time.

We have been led to believe that radio equipment is available, but has not been given sufficiently high priority in the team's view. The cost in time, personnel, vehicle wear and tear, and human frustration in the absence of radio or telecommunications was noteworthy to the team. Early and prompt rectification of this problem should be made a high priority particularly in view of recurrent fuel unavailability for transportation.

The MOH on its own has recognized the need for a Port Clearance Officer and is in process of making a personnel assignment. Clearance activities have consumed much scarce expatriate staff time which would be better devoted to other issues and problems.

2. Qualifications of Project Staff

In addressing the important issue of criteria for selection of project staff, MSCSI stated in the November 9, 1979 Technical Proposal that criteria are:

- experience in general development problems and the training of para-medical staff;
- relevant experience in development problems of African countries;
- relevant professional experience in areas relating to this specific project, including health planning, health training and manpower development, PHN education, nurse/midwife education, epidemiology and sanitation, and supply management and transportation; and
- relevant professional education and training for this specific project.

In addition to these criteria, the Technical Proposal also cited awareness of, and ability to respond to, the sensitivities of host country professionals, and the ability to work with AID staff and to take operational responsibility as important criteria for selection.

All of the project staff are industrious and dedicated to their tasks, and all of them work under trying conditions. A few of the staff have outstanding qualifications for their assignments and meet all of the above criteria. A detailed review of the personnel records (resumes) of the long-term and short-term project personnel shows that many personnel who are working on or who have worked on this project are underqualified or marginally

qualified for their assignments.

Of the two public health nurse educators currently employed, only one has an educational background and experience in public health nursing and nurse education. The newly-approved public health nurse educator lacks both training and experience in public health and his only experience in training health workers was as a volunteer for 3 months in a Somalia refugee camp.

Neither of the two epidemiologist/sanitaricians has received formal training as an epidemiologist or as a sanitarian. One is a physician without specialty training who has supervised sanitarians as a regional and district health officer in other countries and the other has a Bachelor of Science degree in biology; spent two years in an academic program of environmental biology and worked as a sanitarian in Portland Maine for two years and as a "water engineer" for one year in Somalia.

One of the two nurse midwife educators is a physician with training in obstetrics and gynecology who has practiced and trained midwives and traditional birth attendants for many years. The other nurse midwife educator does not show clear evidence of nurses training: she received both a certificate in "premature baby care" and a midwifery diploma in 1961 from hospitals in two different English cities. She cites experience in training auxiliary nurses in midwifery in Libya from 1963 to 1968 and in training traditional birth attendants in a Somalia refugee camp for 6 months in 1981. Her degree training and the bulk of her recent experience is in nutrition. As a nurse midwife educator, her qualifications seem marginal.

The Logistics Officer worked for one year in England maintaining and repairing pumps, generators and other equipment, and then studied mechanical engineering for two years at Rycotewood College in England. He then worked at Motorspeed Ltd. in England, where he operated and maintained automatic equipment for one year. Following this, he became a Technical Advisor/Contract Instructor with a Ministry of Agriculture project in Somalia from 1980 to 1982. In this position, he was responsible for the development and implementation of training programs for mechanics and for the development and implementation of workshop programs for electrical operators and storemen. The present Logistics Officer has neither training nor experience in logistics, and no knowledge of health service supply systems.

The Automotive Maintenance Specialist has a degree of Bachelor of Science in Mechanical Engineering from the Maqua Institute of Technology in the Phillipines and has an impressive record of experience in setting up and implementing automotive maintenance programs and in training automotive mechanics. He is well prepared for this assignment.

The Chief of Party has a Master's degree in Public Health. He has worked as a sanitarian in the United States for a number of years. More recently, and following his formal education in public health, he worked as a health planner in the Oregon state health department and, for two years as a Technical Assistant in health planning in an AID project in Liberia. This Chief of Party has not had training or experience in health manpower training or in primary health care.

Of the short-term consultants who have been brought to Somalia, some have been well-qualified for their assignments and some MSCI employees have been at best, marginally qualified for their missions.

This project is a difficult developmental endeavor, and needs technical assistance from competent professionals. The progress of the project has been poorly served by the uneven and apparently haphazard use of professional standards of training and experience in the selection of long-term and short-term consultants. If the high standards used in the recruiting of some of the faculty had been applied universally in this project, many of the present programmatic problems would have been avoided. If AID had established for this project job descriptions with education and experience qualifications, AID could have acted more effectively in screening and approving job candidates.

The project clearly lacks professional leadership, not because the Chief of Party is not dedicated or industrious, but because he does not have a working knowledge of, or experience in, the important areas of health manpower training and primary health care

3. Work Plan

The technical proposal submitted to A.I.D./Washington by Medical Service Consultants, Inc. on November 9, 1979 states:

"Project management involves more than scheduling. It is intimately tied to project organization, staff qualifications, and management procedures for internal and external project communication. . . ."

"MSCI has assigned a senior member of its Washington staff as Project Director. . . . [H]e will assist the team in preparing its work plan. . . ."

"The Project Manager and the Field Team will prepare the project plan which is a more detailed version of the proposal work plan. This plan will be produced in consultation with the USAID Project Manager and the MOH after detailed review of the proposed assignment in Somalia. The detailed plan will be submitted within three months after the signing of the contract. It will include specific direction to each project team member detailing his/her responsibilities, describing the tasks to be performed, coordination required with other team members, and time performance schedule. This document will be the basis for preparing the detailed project budget and allocating planned expenditures by time period."

The MSCI Chief of Party, Field Team and Project Director have never produced a work plan. The consultations cited above appear not to have taken place. USAID/Mogadishu never required or requested that MSCI submit a work plan.

The lack of a detailed and performance schedule with fixed responsibilities is a critical flaw in contractor performance and in USAID contract management. The result has been erratic, unplanned and confused activities; an inability to focus on project goals; a preoccupation with buildings, vehicles, forms and manuals while losing sight of the overall mission of the project; and a tendency toward crisis management.

USAID/Mogadishu also lacks a strategy or plan of management for this project.

4. Financial Plan and Project Implementation

The Mission has implemented this project on an ad hoc basis without the use of an up to date financial plan or a budget to record and monitor expenditures. This does not present a problem, because the financial plan presented in the Project Paper remains valid. The pace of annual obligations (\$7.8 million through 1982) has far exceeded the pace of project activities (\$1.6 un-earmarked and only \$4.02 million disbursed as of March 31, 1983). Therefore, it has been possible for Mission management to rely on the budget and financial plan found in the original project paper of January 1979 without the need to revise these documents or to seriously question the movement of the project in financial terms. With another \$7.5 million authorized for obligation before the PACD of 30 September 85 this is not likely to change.

By and large expenditures have been within the estimates in the 1979 project paper budget which allows for contingencies and inflation compounded at ten percent. The MSCI technical assistance contract has already utilized a 10% increase in a November 1982 amendment which raised total TA costs from \$4.4 million to \$4.83 million. Even though the start of the construction of the primary health care units and the remodeling of the district health centers is three years behind schedule recent cost estimates for these buildings indicate the task will remain within the budget. Other lesser line items are expected to hold steady at this time. In spite of the apparent comfortable financial margin that this evaluation has noted it is entirely possible that greater time and effort spent on an up dated budget would prove valuable in revealing either hidden problems or opportunities for imaginative re-programin

USAID/Somalia has not been forceful enough in assuming even the most elementary responsibilities of project implementation. Individual players, within AID and the MOH, have come and gone yet the management difficulties within the project remain almost as though neglect and ineffectual attempts at problem solving were a project tradition. We note that other projects within the Mission portfolio are reported not to suffer to the degree this health project does.

We believe this unfortunate behavior which is shared to a large extent by the MSCl contractor and representatives of the MOH is rooted in poor communication both written and oral. For example, the record shows only one general Project Implementation Letter (PIL) being issued under the project (July 12, 1979); there is nothing on record to acknowledge GSDR compliance with conditions precedent. Other forms of written communication between the Mission and the MOH or MSCl have been sparse and not very useful in conveying ideas and decisions. On the other hand written communication from MSCl and the MOH has been no better. The written record of course is not critical if de facto working relationships are satisfactory. However, interviews during this evaluation indicated that day to day contact between AID, MSCl, and the MOH is not at all good

This non-communication has resulted in such things as a three year delay in placing orders for some essential project commodities. It also resulted in a year delay in preparing the concrete slabs for the prefabricated buildings of the training centers. We also found that as of this date there is still no common understanding between the MSCI contractor and the MOH with respect to the control of project vehicles, the use of PL 480 local currency counterpart, and the control system to be used supplying drugs under the project. USAID/Mogadishu has not been effective in resolving the misunderstandings. The recent establishment of technical review and project coordinating groups with the MOH may be a first step in resolving communication problems.

In spite of weak management from USAID/Mogadishu, inflexibility in the part of MSCI, and delays within the MOH with site preparation and student selection, after nearly four years a bare bones foundation has been put in place for a primary health care system in Somalia. However, the system is far from "institutionalized." How far the project goes beyond this point will be determined when the fundamental problems described above are resolved. We wish to make it clear that the basic idea of primary health care through the GSDR is still sound and that financial constraints are not apparent.

5. Training

The training activities set forth for Phase I of the project are intended to produce tutors, trained supervisors, (midwives and public health nurses) community health workers and traditional health attendants.

The project also provides for additional training activities to include:

- Participant training;
- Orientation of other health workers to the primary health care system;
- Continuing education for previously trained personnel.

The following is a list of health worker training completed to date.

Tutors	13
Trainers	81
CHWs	18
TBAs	<u>30</u>
TOTAL	142

In Addition

Orientation Training	56
Participatory Training	1

Even though a number of curricula have been developed by the members of the project team no effort has been made to combine these into standardized uniform curriculum for each training category and to identify core courses.

Moreover the Technical Advisors seem to have different ideas regarding the design and content of a curriculum. The most common

view is that it is a topical outline. In Baidoa the Sanitarian/ Epidemiologist Educator uses the topical outline of the manual as a curriculum. The manual is used for reading assignments, and the didactic sessions constitute discussions of such assignments. It is a fact that the manual is the only available reading resource and will remain so until project books, now on order, arrive. The midwife uses a curriculum that was given to her and presumably developed by her predecessor. The public health nurse uses the topical outline of the manual. The public health nurse feels that the topic of school health cannot be addressed by the program and that school visits are impossible to plan and implement. Only after much insistence did he admit that it was important and ought to be included inspite of the difficulties. In Burao there is a "Curriculum for the Course for nurse/midwives in Primary Health Care Units," prepared by the midwife trainer. This document is the composite of a topical outline, a list of nonteaching objectives, a breakdown of program into hours allotted for each course and some teaching methodology. The public health nurse has developed a curriculum which entails a detailed list of teaching objectives, relevant content, clearly stated teaching methodology and evaluation tools. The content covers the scope of primary health care adequately addressing such important components as teaching and learning, physical assessment, school health and health education. She finds the public health manual inadequate as a guide for practise and vague in providing information on some important primary health care topics. She uses her own texts as reference material.

The Technical Advisors were unaware of MOH approved curricula, job analysis and description for each cadre to be trained. These are contained in a document titled "Job Description and Curricula for Various Categories of Health Care Workers". In an interview the MOH stated that this is their mandate for primary health care education in Somalia.

A detailed perusal of the MOH document yielded topical outlines for the training of CHW and TBAs and a general topical outline for any primary health case worker.

There is no evidence that the MSCI project team did a needs assessment in preparation for developing the curriculum. The project paper (page 10) specified "The first activities will involve development of a curriculum based upon analysis of tasks to be performed by the various workers" It is not clear how MSCI prepared for MOH a document titled "Primary Health Care Tasks to be taught to Primary Health Care Trainers". The document states no specification by category of personnel and does not address the topics of physical assessment and school health. MOH was specifically asked if it desired physical assessment as a component of the Public Health Nurse curriculum. The reply was not only affirmative but it said that this was an expectation of MOH contained in the curriculum

The only mention of physical assessment in the MOH document is in examination of the pregnant woman and examination of the newborn. It is clear that the MSCI project team and MOH have not availed themselves of an opportunity to discuss nuances, ambiguity or misinterpretations of expressions or facts in the curriculum

Another aspect of curriculum design which has been ignored is the development of a philosophy for primary health care training. This exercise would have been of necessity a joint endeavor between the TAs and the Somalis with a 100% input of ideas by the Somali with TA acting as facilitators thereby enabling a worthwhile learning experience which would strengthen the students interest and confidence in the program.

The Technical Advisors seem to understand a course outline to mean an outline of the entire program. It is a synopsis of the content objectives activities and requirements of each course in the program.

Incomplete course outlines are therefore embodied in the curriculum prepared by the public health nurse in Burao and to a lesser extent the nurse midwife instructor in Barao.

All TAs have developed and used evaluation tools for the didactic aspect of the courses. However the system lacks uniformity and proper record keeping. Evaluation and monitoring of clinical experience is unstructured and for the most part unrecorded.

Apart from being an integral part of any competency based educational program these records are necessary as a basis for continued education (refresher courses) and to determine degree of supervision and guidance necessary for student or graduate. They also serve as a permanent record of competence achievement and talent and are useful in the selection of candidates for special assignment and training.

All the Technical Advisors seemed painfully aware of students attendance. Some were quite concerned about absenteeism. However

class attendance has not been made a criteria for successful completion of a program. Even if this were so it would be relegated to futility by MOH's disregard for scheduling in assigning candidates to classes in a less than timely fashion. In one case an instructor was sent additional students seven weeks after the course started.

For various reasons the MSCI project team has been able to do little supervision of students. It is generally accepted that the team has a moral and professional if not contractual responsibility to achieve quality control and continued education by supervision of graduates and by monitoring the multiplier effect of training.

Some TAs believe that senior medical staff view their supervisory activity as usurping their authority or meddling in their areas of jurisdiction. To avoid the very familiar conflict between training and service they forego supervision in the field. Others are willing and have had their efforts thwarted by lack of transportation and other constraints. The lack of planned interval between courses is probably the greatest impediment to field supervision.

The training staff in Burao have been enterprising enough to liaise with Primary Health Care Coordinator in giving course-related supervision. In preparation for this the P.H.C. coordinator is being oriented to the curriculum and will be participating in teaching.

The Technical Advisors have tried to develop and use course schedules. However some difficulties encountered in administering

the programs dictates their abandonment. Some of these difficulties are late arrival of students and the selection of unqualified candidates for training. Despite these difficulties if procedures are adhered to they may lend stature and seriousness to the program possibly evoking a like response.

Some physicians have participated in training as guest lecturers but there is still a paucity of effort to involve community leaders such as the police, political administrators, elders, veterinary service teams and representatives of organization involved in health and social services.

A product of the training activities has been the development of 4 manuals in draft or final edition for the sanitation/epidemiologist, public health nurse, community health worker and traditional birth attendant. The manuals need revision and editing of content, adaptation to Somali culture (including nomadic life), environmental conditions, and detail.

The midwife's manual does not address the following factors:

- female circumcision as it affects the anatomy and physiology of the internal and external genital organs;
- maternity care to nomadic populations;
- preparation of the home for delivery;
- cultural and environmental conditions or practices that create high risk;
- prepared childbirth (natural);
- effects of circumcision on the second and third stages of labor;
- performance, repair and care of episiotomy;

- perineal tears as a complication of labor and the puerperium
- effects of cultural practices on the antepartum, intrapartum and post partum periods;
- complete post partum assessment before discharge.

The public health nurses manual represents a departure from the established format, is not detailed enough to be regarded as a manual, and is vague if not remiss in its recognition of basic primary health care components and concepts.

The following are omitted:

- community resources
- collaboration with allied health services

The public health nurse manual states, "every family visited should have a record". The manual however does not offer a detailed list of what is to be recorded on a home visit.

The section on communicable diseases makes no reference to geographic location, estimated incidence or prevalence (high, low) in Somalia.

The community health workers manual needs to be edited for grammar, syntax, vocabulary and pictorial illustration.

The sanitarian/epidemiologist manual is fairly well adapted to Somalia, detailed and simple. It needs some minor corrections for clarity.

The MOH is now in the process of putting together a revised draft of the manuals -- the product of a 21 day conference held during October to November 1982. These will be field tested for six months, then edited, approved, and sent for final printing and

distribution. The manuals presently in circulation are therefore not final but do represent an exercise which despite heavy expenditure of time and expertise has been very poorly executed.

The MSCI project team has has very little if any participation in the process of selecting candidates for training at any level and have not observed the use of objective selection criteria in some cases. The MSCI team believes that its role is primarily advisory but feels slighted or ignored when after expending much time and effort in training counterparts, those trainees are overlooked in preference to others who lack prior or superior education, experience or orientation when selections for participant training abroad are made.

The CHW classes show a preponderance of males, and the consensus of opinion among Somalis interviewed is that female patients will willingly accept services from male health workers. What may be more important though is effectiveness not acceptance. Effectiveness can only be measured over time.

The usefulness of training TBA's as CHW's has also been posited but has not been given serious consideration.

Some of the Technical Advisors have brought to this project a repertoire of skills and experiences which can be pooled and utilized for each other professional education and edification and could eliminate the need for having some outside consultants. In spite of the fact that many skills exist within the MSCI contract

team there is a general lack of savoir-faire in curriculum design and planning.

The services of a short-term educational consultant is not only necessary but was indicated in a USAID/Mogadishu letter and MSCI's reply, since the accomplishment of tasks requested and promised was not forthcoming from the contract team. An educational consultant was not used hence accomplishment of some of the tasks that would lend structure, ease of evaluation and coordination to the training have not been effected.

In spite of the many difficulties encountered by the MSCI trainers the following achievements are commendable:

- The MOH has designated the two training sites as the national centers for primary health care training.
- A number of primary health care workers have been trained for other regions.
- MOH has expressed satisfaction with the work of the trainers.
- Graduates interviewed expressed satisfaction with the training.
- The public health nurse in Burao is outstanding in her understanding of training requirements and in her efforts to meet those requirements in the face of social and professional frustrations.

6. Health Services

Although Somalia was a participant in the International Conference on Primary Care held in Alma Ata in 1978 and is a signer of the Alma Ata Declaration, officials in the Ministry of Health state candidly that primary health care started in Somalia with this project. Since the signing of the A.I.D. Project Agreement in 1979 other donors have begun supporting regional primary health care projects.

In this project, the MSCI was to:

1. Assist the Ministry of Health in the conceptual development of the Primary Health Care Program;
2. Assist the Ministry of Health in preparing the professional paraprofessional and supportive personnel required to direct, manage and staff a Primary Health Care Program;
3. Work with the Ministry of Health to devise and implement a development plan for primary health service in the project regions, including a system of health information and planning, and a system of supply and logistics for all necessary commodities including pharmaceuticals; and
4. Collaborate with the Ministry of Health in the development of continuous primary health care system for nomadic groups.

There is modest evidence that MSCI has assisted the Ministry of Health in the conceptual development of the primary health care system. The MSCI team did prepare two papers, "The Establishment of the Primary Health Care Delivery System of Somalia" and "The Infrastructure of the Primary Health Care

Delivery System in Somalia. Review of available project documents and interviews with principals in the Ministry of Health, AID Mission and contractor's unit indicate that there have been few discussions of health services, other than discussions centered around training needs (see Section 6), commodities and logistics (see Section 8), and facilities/construction (see Section 9). Issues relating to the development of a system for integrating existing vertical services such as MCH, extended immunization and malaria control into the Primary Health Program have not been addressed by this project.

The assistance to the Ministry of Health in preparing personnel for the Primary Health Care Program is discussed in section 6 above.

The contractor has not worked effectively with the Ministry of Health in the development of management support systems for primary health care.

In the area of health information systems and health planning, the project staff has collected reporting forms currently used by the hospitals, departments and special programs of the Ministry of Health, reviewed the functions and level of training of the Division of Statistics, and conducted a twenty eight hour training course for five assistant statisticians and a forty hour training course for eight statistical clerks. In addition, the project Chief of Party has recommended to the Ministry of Health that reporting of births and deaths be made mandatory and that a list of twenty seven (27) reportable diseases be adopted by the Ministry. The project has developed many forms--for activity planning, activity reporting, patient records, births, deaths, morbidity, community assessments, and health facility assessments.

These forms are used in the project's training activities, but none of the forms have been adopted by the Ministry of Health and none are in general use. There is no system of information (data) transmission, collection and analysis. There has been no attempt to support health planning through the provision of mortality, morbidity, utilization, or community assessment information. Of the information collected by project trainees and graduates, none other than activity reports has reached the Mogadishu office of the project and none has been analyzed at the two training sites. As of this date, there is no health information system. The development of a system of supply and logistics is discussed in Section 8 below.

In support of the task of developing an approach for delivering health services to nomads, described in the Project Paper as one of the largest and most important tasks in the project, the contract brought two short-term consultants, an epidemiologist and an anthropologist, to Somalia for a cumulative total of approximately twelve months beginning in December 1981. Each consultant submitted a written report to the Chief of Party. No action has followed these reports. The Chief of Party has not discussed approaches for delivering health care to nomadic groups with the Ministry of Health or with the USAID Mission. The Chief of Party has developed no proposals or option papers on the subject. In interview he stated that he has not addressed this issue and has no plans yet for addressing it.

Project-employed personnel can identify the sites of assignment of nurses, midwives and sanitarians who have completed the project's

training programs at Baidoa and Burao. However, the project staff have no awareness of how the trained personnel are performing or precisely what they are doing in their assignments. There are at least three reasons for this lack of follow-up, which is mentioned here because it is an important element in determining and maintaining an acceptable level of quality of care:

1. There are severe transportation problems caused by inoperable vehicles, fuel shortages and rough terrain;
2. The training school faculties feel they are administratively restrained by MOH from making field visits to provide continuing technical guidance to graduates; and
3. There is no scheduled time between graduating classes for follow-up and/or retraining.

This has contributed to the discontinuity which exists between the Primary Health Care Program of the Ministry of Health and the training of trainers for that program.

The failure of USAID/Mogadishu to provide pharmaceuticals and other health service supplies has forced the Ministry of Health to be dependent on other donors to provide clinical service materials to the project service area. This is a constraint which severely limits health care within this project.

7. Commodities and Logistics

A. Commodities

The commodity and supply inputs to the project, consisting of vehicles, drugs and medicines, equipment and supplies, and other commodities such as cold chain equipment, warehouse equipment and health education equipment, were initially to have been managed directly by USAID/Mogadishu in order to ensure prompt action.

USAID/Mogadishu moved promptly to procure vehicles. Unfortunately, the first order of passenger vehicles ordered were Chevrolet Suburbans with automatic transmission, air conditioning, four-barrel carburetors and normal suspension. They proved to be unsuitable for travel conditions in Somalia. Their size, mechanical complexity, and suspension specifications limited their usefulness and caused constant breakdowns.

USAID/Mogadishu appears never to have prepared a Project Implementation Order/Commodities or to have taken any other action to determine the precise needs for drugs and medicines, and for equipment and supplies for health workers and training centers. As a result, after 3 years of project activity, no drugs or medicines for primary health care have arrived, no equipment or kits have arrived for the public health nurses, midwives, sanitarians, community health workers, or trained birth attendants, and no training materials or audiovisual equipment have arrived for the two training centers.

In recognition of this severe problem, the USAID Mission and MSCCI moved on November 1982 through a contract revision to transfer the responsibility for commodity procurement from USAID to MSCCI. Orders have now been placed for the needed commodities.

The second shipment of vehicles has since arrived and the problem of vehicle suitability has apparently been solved with a shift from the Chevrolet Suburban to the smaller, simpler, more durable, agile, and economical Jeep CJ-7 and CJ-8. The remaining complaint expressed by project personnel who have received the new vehicles is that they should be equipped with sturdier tires.

To date no classroom equipment nor clinical supplies have arrived. While the contractor has placed the orders, no extraordinary steps are being taken toward an early solution. MSCCI has not moved to purchase quickly in the U.S. and ship the most urgently needed classroom materials and equipment. Although several MSCCI personnel, including the Project Director and the Project Manager, have traveled between Washington and Mogadishu in 1983, no one has brought equipment and/or supplies with them.

b. Logistics

The project paper sets forth and the contract with MSCCI requires that MSCCI will work with the Ministry of Health to develop a system of supply and logistics for all necessary commodities including pharmaceuticals.

The Project Manager and the Supply Management Specialist (Logistics Officer) have concentrated their efforts on:

1. Development of a Logistics Center
2. Development of a Vehicle Maintenance Program

The contractor has designed a warehouse-garage with facilities for storage of medical supplies inclusive of cold chain provision, warehousing of vehicle spare parts, storage of training supplies, a print (or reproduction) shop, food storage, vehicle maintenance, and training for mechanics. The Ministry of Health has provided a site and has arranged for construction funding with PL-480 and Commodities Import Program funding. Chronic problems of building material shortages have slowed construction so that the building period has been prolonged and the currently projected completion date is June 15, 1983.

These facilities seem adequate for the needs of this project and for the Primary Health Care Program needs of the Regions immediate to this project, but this Logistics Center will not be adequate to serve the nationwide primary health care development.

The Logistics Officer has designed a system of vehicle assignment, accountability, and preventive maintenance, complete with recording and reporting mechanisms. This system has not yet been placed in effect.

Four drivers have been trained in routine (preventive) maintenance and six mechanics are being trained by the Logistics Officer and the Mechanic Training Officer for major repair work.

Procurement has been a serious problem in the history of this project. USAID was derelict in not placing appropriate orders (Project Implementation Orders/Commodities) in a timely

fashion. Three years elapsed before action was taken to procure training equipment, supplies, and health care materials.

Appropriate technology was ignored in the choice of automobiles, and the Project Implementation Order/Commodities for the prefabricated training center buildings were incompletely done, with inadequate attention to detail of specification. As a result, the classroom building, intended to accommodate three classes simultaneously, is a one-room structure with no provision for storing books, periodicals, audiovisual equipment, and with inadequate ventilation. The students dormitories were ordered without attention to male/female housing requirements, normal living space requirements, lighting and ventilation requirements, or the need for a common room or shaded outdoor area for the students. The prefabricated buildings ordered for counterpart housing and the cafeteria were similarly underplanned. No storage facility was provided. The contract employees' housing with central air-conditioning seems suited to the environment, but the remaining buildings seem to be designed for a more temperate climate.

MSCI and USAID have experienced some difficulties in the receiving of vehicles and spare parts. Received goods are reported to have been on the docks for long periods of time before possession could be taken. Slowness in taking physical possession of delivered items has been a contributory factor in losses of air-conditioners and other equipment for the prefabricated buildings, tires, automotive spare parts, and other shipped commodities.

Storage, handling, transport, inventory, accounting and

ordering of supplies through the project have not yet emerged as real processes because of the dearth of commodities. Methodologies and subsystems have not yet been devised.

In summary, while some of the physical components of a logistics and supply system are developing, the project has not yet developed a comprehensive logistics system.

A problem which has surfaced is the allocation of vehicles. It is important because it is symptomatic of a large issue which will have to be resolved promptly if the supply/logistics development is to have value for this project and for the Ministry of Health.

The contractor's Project Manager expresses the inflexible opinion that he must have and maintain complete control over all vehicles and commodities purchased under the contract. The Director General and other officials of the Ministry of Health cite the Project Paper statement that the bulk of the vehicles are intended for Ministry of Health need and also point out that the logistical system for the project should not duplicate the supply and logistical system of the Ministry. The Project Manager asserts that he must have a separate and parallel supply system entirely under his control.

It is apparent that a separate and parallel supply line within this project will not assist the Ministry of Health in developing its capabilities to support a primary health care system. It is equally apparent that it would be counter productive for the Project Manager to continue to maintain physical

control of all project vehicles. This practice has already proven counter productive; only contract employees have been assigned new CJ-7 and CJ-8 vehicles.

8. Facilities/Construction

AID retained responsibility for managing the construction and procurement components of the project. Assembling a construction progress chronology was attempted through several file reviews, interviews and discussions. Firm dates for events were not found in available documentation but were determined by interviewing those familiar with the event, or present at the time.

Progress for each of the construction components in the PP will be discussed in this chapter.

National PHC Training Centers (Baiodoo and Burao)

Prefabricated buildings for housing field staff at the Training Centers were suggested in the PP. USAID interpreted this to mean prefabricated units for all buildings in the training center, and placed orders for prefabricated classroom, dormitory, and cafeteria buildings as well. Three classrooms were specified for each training center in the PP. One classroom was actually ordered by USAID for each training center. There is a need for four classrooms at each site. Scheduling and teaching problems will continue until additional two or three classrooms are constructed at each site.

Construction of the Training Centers has presented operational, logistical, contracting, coordinative, managerial and implementation problems which are not all yet corrected. A

number of deficiencies remain to be corrected, and though now the remaining deficiencies are of smaller magnitude will continue as irritants and impede progress until corrected.

The purpose of this review is to review and detail milestones and a chronology to permit suggestions for corrective action to follow in recommendations.

It is important to bear in mind that health manpower project outputs are dependent upon, and follow from two fully operational training sites and teaching centers. It is important that these centers be functional. A partial chronology of construction related milestones follows.

Training Center Construction Chronology

Project Agreement signed	June 28, 1979
USAID order for prefabricated bldgs	July 31, 1979
Prefabricated buildings shipped	May 4, 1980
Arrival of prefabricated buildings in Mogadishu	May 31, 1980
Customs clearance by USAID	June 22, 1980
Containers delivered to Baidoa	August 1, 1980
Containers delivered to Burao	August 12, 1980
MOH attempts to obtain signed contract with Somalia Custodial Corps to erect	May 1980 to Jan 1981
Rain damage to contents of containers-Burao	June 1981
Panelfab construction advisor arrives for first of six return trips	Nov 9, 1981
Work begins by Somalia Custodial Corps on foundation slabs in Baidoa	Nov 27, 1981
Panelfab team departs without construction.	December 22, 1981

One three bedroom unit erected-Burao	Jan 26, 1982
Two of nine slabs poured-Burao	Jan 30, 1982
Slabs reversed, backwards, plumbing holes in wrong places-Burao	July 21, 1982
Health officer reports 2 units erected Burao	August 6, 1982
Slab demolition, report and 6 buildings erected-Burao	August 15, 1982
Teaching staff (Burao) move into partially completed housing	Sept 10, 1982
Wiring, plumbing defective, dormitory and partitions incomplete (both sites)	December 29, 1982
Teaching staff moves into partly completed housing and compound - Baidoa	April 14, 1983.

Primary Health Care Units (PHCU's)

The project provides for construction of 64 one story PHCU's with attached living quarters. Construction of these units has not yet begun.

Design of these units was found to be an issue on which only recently has a specific decision been reached. Contractor (MSCI) Mission Health Officer, and MOH all have had somewhat different notions of an acceptable design. An architectural firm was engaged in Kenya to draft a design which proved unrealistic economically, and also in terms of availability of local materials. This plan has now been shelved in favor of a design which the Ministry and Mission believe to be suitable.

The MOH is preparing a request for bids at this writing for 15 PHCU's to be constructed in Bay and Togdheer regions (which include Baidoa and Burao districts.). The Director General of

the MOH and the Director of the Primary Health Care Program in meetings with the team on April 18th and April 29, 1983 stated that tenders would be published in the next two to three weeks for bids, that a single firm in the private sector capable of undertaking all 15 PHCU's would be selected, that close inspection would be provided by the Ministry, and that completion of construction of the 15 PHCU's is planned by November 30, 1983.

A timetable for building the remaining 49 PHCU's has not been firmed up, but we were assured by Ministry officials that remaining PHCU's would be completed by the Project completion Date (PACD) of September 30, 1985.

It was suggested, though not explicitly stated by Ministry officials that the private contractor selected to construct the first 15 PHCU's would have a good chance of being awarded the balance of the PHCU's if performance on the initial PHCU's was satisfactory and timely. Informal inquiry suggests there are at least two contractors in country of size sufficient to undertake such a task. Both are joint ventures, but Somali owned.

The team believes the MOH will make every effort to ensure that PHCU's are completed before PACD, and has no reason at this point to believe this is not possible. Our assessment is that delays in the teaching center construction component occasioned through use of a government GSDR Custodial Corps Construction Agency, and the many attendant problems which followed have strongly motivated the MOH towards moving to a private construction firm with proven capability so as not to endanger continued support on the part of the USAID mission for this project component.

District Health Center Renovation

Renovation of 16 district Health Centers is provided for in the PP. This activity is to be monitored by USAID. At the time of this evaluation a firm plan had not been put forward by the Ministry in writing, but they have intimated they would prefer to build two or more new District Health Centers where they do not presently exist, or where facilities are so unsatisfactory as to fail to warrant renovation. At time of the team visit none of the DHC's had either been renovated or constructed by the project.

Mission and Ministry have not yet had substantive discussion on this aspect of the construction program leading to an agreed upon plan with cost projections developed for each agreed upon DHC site.

It is the stated intention of both USAID and the MOH that renovations and/or construction of DHC's will be carried out in the Bay and Togdheer regions. The evaluation team believes this to be a sound plan.

The MOH will continue to expand the PHC program subject to availability of funds, supplies and personnel. To have a working model system in at least two regions, with the experience of developing them will make it possible for the MOH to act expeditiously when other donors express interest in supporting aspects of Somalia's DHC program or wish to invest resources in its DHC physical infrastructure.

Health Posts

Another element of the construction component is that of 256 health posts of simple local construction to provide a base of operation for CHW's and TBA's at the community level.

Since the time the PP was written, the MOH has come to feel that health posts can be provided most effectively through involvement and participation of village health committees, and through self-help activities in which villages build or provide the space in which the CHW's work, or in some instance through making space available in presently constructed buildings.

As CHW's and TBA's are trained, they are being deployed. Their deployment will be treated elsewhere in this report. Suffice it to say that construction of health posts to date has not proved problematic for the project though none have been built by it. Drugs and supplies, also treated elsewhere in this report have been a much greater impediment to the project and PHC program.

Recommendations

General Revision Plan

As the assessment above indicates, this project is beset with chronic problems and the performance of USAID/Mogadishu and the contractor have fallen short of initial expectation.

The evaluation team is unanimous in the conviction that there is a need in Somalia for a project strongly oriented to meet the manpower development needs of primary health care.

The health problems documented in the Project Paper exist; the Ministry of Health has selected a Primary Health Care Program as the principal vehicle for improving the health status of the people, beginning in rural areas; other donor agencies are providing supportive activities; the training of health personnel is a salient need; and the Ministry of Health expects this project to provide two national health training centers.

The serious project problems cited above in the project assessment must be corrected with revision of the project activity strengthening of the project staffing, and redesign of the programmatic methodologies. The project must also be more effectively coordinated with the Ministry of Health, other donor-supported projects, and with USAID.

The evaluation team unanimously recommends that this project be focused on the development of the training centers at Baidoa and Burao as national training centers which will be able to meet the quantitative and qualitative needs for public health nurse trainer-supervisors, nurse midwife trainer-supervisors, and sanitarians. This developmental activity will require some staffing changes to provide a technical assistance faculty which is able to assist Ministry personnel in the design and implementation of sound task-oriented, competency-based health personnel training programs. The revised training programs must be more responsive to the specific primary health care needs of Somalia and the faculty must be provided with more appropriate training resources (books, periodicals, audiovisual equipment, films).

case study material, etc.) to allow the training centers to move away from the rather static rote lecture method of teaching.

A good clinical training program requires a health service setting for the practicum or clinical aspects of learning; therefore the evaluation team recommends that the Regions of Bay and Togdheer, where the training centers are located, should be fully developed with primary health services to provide optimal curative, preventive, and promotive care, to serve as training sites, and to provide a model of primary health care.

To enable this project redirection it is recommended that a series of actions take place:

1. When the present Chief of Party departs at the end of the current cycle in July 1983, USAID and MSCI should ensure that the new Chief of Party will be a health professional who is trained and experienced in primary health care and health manpower training. The success of this project is dependent upon competent professional leadership.
2. At the end of the current training cycle the Project Director for MSCI should join with the designated USAID Project Officer and a USAID-provided health training specialist to write clear educational and experience criteria for the MSCI faculty of the training centers and to review the employment of current faculty against those criteria. Where indicated, new faculty should be promptly recruited and employed.

3. At the end of the current training cycle, the two training schools should not accept the next training classes until MSCI, the Ministry of Health, USAID, Unicef and other significant organizations have acted together to design curricula, adopt training methodologies, competency testing standards, student selection criteria and training schedules for the training of public health nurse supervisor-trainers, nurse midwife supervisor-trainers, and sanitarians. With the strengthened training program and strengthened faculty, the two training centers should then return to full operation.
4. MSCI, MOH and USAID should promptly develop and implement a plan for the construction, equipping, supplying and staffing of the fifteen Primary Health Care Units to serve Bay and Togdheer Regions. A plan should also be developed and implemented to construct/renovate the District Health Centers and to meet their equipment, supply and staffing needs.
5. At the end of the current training cycle, MSCI should recruit a Logistics Officer with significant experience in Primary Health Care supply systems and cold chain management. This Logistics Officer, with appropriate short-term technical assistance, should work with the MOH to develop and implement a supply and logistics system and a program for the maintenance and repair of automotive vehicles and other mechanical equipment.
6. The new MSCI Chief of Party, with appropriate short-term technical assistance, should assist the MOH in the development and implementation of a health information and planning system.

7. There should be early action to allocate cars and trucks to MOH and project staff with appropriate provision for maintenance, and repair.
8. MOH, USAID, and MSCI should discuss and assess the need for MOH technical and professional strengthening for primary health care through participant training, seminars, short courses and third country training exercises.
9. MOH, USAID and MSCI should establish regularly scheduled project management meetings complete with agenda, minutes, and a record of actions.
10. USAID must review its management of this project and designate one specific USAID person who will be given the authority and the responsibility to act for USAID in the management of this project. To enable this action USAID should have assigned as soon as possible a public health professional staff member with training and experience in health manpower development and primary health care to assume project management responsibility after the current training cycle. USAID should clearly determine how this individual should coordinate his/her activities with other USAID staff who have related responsibilities. Should direct hire personnel not be available, the evaluation team encourages USAID/Somalia to explore use of IPA or PASA.
11. MSCI, after consultation with MOH and USAID, should develop a project work plan (see Assessment section 4 above) for submission to USAID by September 1983.

12. The Mission should submit a request for a two year extension of the PACD. Because of the delays cited in the assessment section it will be impossible by 1985 for the project to reach the output levels of 900 trained health workers as envisioned in the Project Paper. Achievement at the purpose level will be even further away. The 900 health workers are the keystone of the project. Unless they are in place nothing else makes sense. While the construction and logistical elements of the project could perhaps be speeded up and completed by mid-1985, it would be better to phase these activities in increments along with the health workers.