PD-AAP-636

AGENCY FOR INTERNATIONAL DEVELOPMENT

PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number: _____

DOCUMENT CODE: 3

COUNTRY/ENTITY: Somalia

3. PROJECT NUMBER: 649-0131

4. BUREAU/OFFICE: Africa — 6

5. PROJECT TITLE (maximum 40 characters): Family Health Services

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 06 DD 30 YY 89

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)

A. Initial FY 84 B. Quarter 4 C. Final FY 88

8. COSTS ($000 OR EQUIVALENT $1 =)

A. FUNDING SOURCE	FIRST FY B. FX	C. L/C	D. Total	LIFE OF PROJECT E. FX	F. L/C	G. Total
AID Appropriated Total	1,600		1,600	8,500		10,100
(Grant)	(1,600)	( )	(1,600)	(8,500)	( )	(10,100)
(Loan)	( )	( )	( )	( )	( )	( )
Other U.S. 1.						
Other U.S. 2.						
Host Country		10,300	10,300		--	10,300
Other Donor(s)						
TOTALS	1,600	10,300	11,900	8,500	--	20,400

9. SCHEDULE OF AID FUNDING ($000)

A. APPROPRIATION	B. PRIMARY PURPOSE CODE	C. PRIMARY TECH. CODE 1. Grant	2. Loan	D. OBLIGATIONS TO DATE 1. Grant	2. Loan	E. AMOUNT APPROVED THIS ACTION 1. Grant	2. Loan	F. LIFE OF PROJECT 1. Grant	2. Loan
(1) POP	483	460				1,600		10,100	
(2)									
(3)									
(4)									
TOTALS						1,600		10,100	

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each): 440 | 450 | 420

11. SECONDARY PURPOSE CODE: 413

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

A. Code	BVW/BWW	RPOP	PVON	TNG	DEL		
B. Amount							

13. PROJECT PURPOSE (maximum 480 characters)

To strengthen the capabilities of Somali institutions to promote, support, coordinate and sustain family health programs.

14. SCHEDULED EVALUATIONS

Interim MM 09 YY 86 | MM 05 YY 88 | Final MM 10 YY 89

15. SOURCE/ORIGIN OF GOODS AND SERVICES: ☒ 000 ☒ 941 ☐ Local ☐ Other (Specify) _____

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a _____ page PP Amendment.)

I concur in the methods of implementation and the financial arrangement under this project.

Charles Brooks, Controller

17. APPROVED BY

Signature: Louis A. Cohen

Title: Mission Director

Date Signed: MM 07 DD 08 YY 84

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION: MM 08 DD 15 YY 84

Project Authorization

Name of the Country: Somali Democratic Repbulic

Name of the Project: Family Health Services

Number of the Project: 649-0131

1. Pursuant to Section 104 of the Foreign Assistance Act of 1961, as amended, I hereby authorize the Family Health Services Project (the "Project") for the Somali Democratic Republic (the "Cooperating Country") involving planned obligations not to exceed ten million one hundred thousand dollars ($10,100,000) in grant funds over a five year period, subject to the availability of funds in accordance with the AID OYB allotment process, to help in the financing of foreign exchange and local currency costs of goods and services required for the Project. The planned life of the Project is five years from the date of initial obligation.

2. The Project will assist the Cooperating Country to develop population policies and programs, including an expanded family health services program which will improve maternal and child health. To carry out the objectives of the Project, AID will provide financing for technical assistance, training and commodities, including vehicles.

3. The Project Agreement, which may be negotiated and executed by the officer to whom such authority is delegated in accordance with AID regulations and delegations of authority, shall be subject to the following essential terms and covenants and major conditions, together with such other terms and conditions as AID may deem appropriate.

4. a. Source and Origin of Commodities, Nationality of Services:

   Commodities financed by AID under the Project shall have their source and origin in the United States, the Cooperating Country or in any other Code 941 country, except as AID may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States, the Cooperating Country, or other Geographic Code 941 countries as their place of nationality, except as AID may otherwise agree in writing. Ocean shipping financed by AID under the Project shall, except as AID may otherwise agree in writing be financed on flag vessels of the United States.

   b. Conditions Precedent to Disbursement:

   First Disbursement:

   Prior to any disbursement of funds or to the issuance of any commitment documents under the Grant, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to AID in a form and substance satisfactory to AID:

(1) A statement indicating that the GSP Committee has reviewed the annual local currency requirements for the Project and that such requirements will be included in the annual budget programming document.

(2) Evidence that the Project Coordinating Committee has been established and the names, titles and functions of the persons who will serve on this Committee.

Louis A. Cohen
Director, USAID/Somalia

8 July 1984
Date

Clearances:
Frank Pavich, RD/RA
Raga Elim, RD/RA
Akim Martinez, PROG
Charles Brooks, CONT 1-8-84 Funds received $1,[illegible]
Edward Birgells, PROJ 7 July 84
K. Hansen, RLA (draft)

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GLOSSARY

AID	Agency for International Development
BUCEN	Bureau of Census
CDC	Curriculum Development Center
CDSS	Country Development Strategy Statement
CENTS4	Census Software Program
CHW	Community Health Worker
CIPL	Commodity Import and PL 480 Funds
CSD	Central Statistical Department
CSM	Contraceptive Social Marketing
DFHS	Demographic and Family Health Surveys Project
FH	Family Health
FP	Family Planning
FSU	Field Support Unit
GSDR	Government Somali Democratic Republic
IEC	Information, Education and Communication
IPDP	Integrated Population Development Planning
IUD	Intra-Uterine Device
JHPIEGO	John Hopkins Program for International Education in Gynecology and Obstetrics
MCHD	Maternal Child Health Division
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MING	Ministry of Information and National Guidance
MONP	Ministry of National Planning
OR	Operations Research
PHCD	Primary Health Care Division
RAPID	Rapid Assessment of Population in Development
REDSO	Regional Economic Development Support Office
RFP	Request for Proposals
RHS	Rural Health Services
SFHCA	Somali Family Health Care Association
SOSH	Somali Shilling
STD	Sexually Transmitted Disease
SWDO	Somali Women's Democratic Organization
TBA	Traditional Birth Attendant
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VSC	Voluntary Surgical Contraception
WED	Women's Education Department

SUMMARY AND RECOMMENDATIONS

A. The Project

The long-term goal of the Family Health Services Project is to improve the quality of life for the Somali people. Achievement of this goal will be indicated by improved maternal and child health and improved population data.

The purpose of the Family Health Services (FHS) Project is to strengthen the capabilities of Somali institutions to promote, support, coordinate, and sustain family health programs. These programs include: the collection and analysis of demographic data; educational activities; delivery of clinical services; and the conduct of operations research. Each of these programs constitutes a component of the Project.

The Population Data and Policy Component will support family health by quantifying demographic conditions and facilitating the development of a policy framework for the delivery of services. The Information, Education, and Communication (IEC) Component will provide information and explanation to the public concerning the role of family health services. The Clinical Health Services Component will deliver and administer services. Finally, the Operations Research Component will monitor, evaluate, and undertake special research for family health programs and services. Together these four components will enable the Government of the Somali Democratic Republic (GSDR) and other non-government institutions involved in family health to develop programs which will improve the quality of life for the Somali people.

The Project has four target groups. The first to benefit are the personnel of the Somali family health institutions. Second, the national policy-makers and local leaders will be the target group for both the policy activities and the dialogue which develops with the implementation of family health services. Third, the general population will be engaged in discussions and campaigns which are aimed at soliciting information and feedback on population issues and family health services. Fourth, married Somali couples will be closely involved in the development and distribution of family health services.

The Project will require the following inputs:

USAID Contribution:

a. Technical Assistance including: 9 person-years of long-term technical assistance provided for the IEC Advisor (4 PY), Operations Research Advisor (2 PY), Training and Management Advisor (3 PY), in addition an Administrative Assistant (4 PY) will be hired locally; and, 76 person-months of short-term technical assistance will be provided.	$ 4,300,000
b. Training including: 60 person-months for Somalis trained in the United States; and 40 person-months of training provided in Third Country Institutions.	400,000

c.	Commodities including: a mainframe computer for the Central Statistical Department, office equipment, medical equipment, contraceptive supplies, and vehicles. (See Procurement Schedule.)	$ 4,300,000
d.	Contingency	1,100,000
	TOTAL	$ 10,100,000

GSDR Contribution:

Overall contributions include local costs for the 1986 Census of Population, salaries, office and equipment use, and transport. (Census = approximately $3,800,000)	$ 10,300,000

B. Background

USAID/Somalia has supported four major family health activities since 1979. These include the JHPIEGO Reproductive Health Training Program; the INTRAH Family Health Training Project; the Westinghouse Family Health Survey; and the Family Health Initiatives Project. Together these projects represent an investment of almost US$1.0 million for family health activities. They have provided the experience and helped to establish the foundation upon which the present Project is based.

The development of this Project has occurred over a two-year period. In addition to the various centrally-funded projects mentioned above, a review of Somalia's population activities was undertaken by USAID technicians in 1983, and the Project Identification Document (PID) was completed in January of this year. Throughout the preparation of the Project Paper, numerous meetings have been held with Somali officials and technicians who have contributed to the design of the Project.

The Project addresses two related issues. First, infant and maternal mortality is believed to be excessively high and the GSDR is intent on reducing these deaths. Secondly, even with these high mortality rates, the population growth rate is accelerating. With lower mortality rates, there is likely to be a substantial jump in population growth which may adversely affect the development prospects for Somalia.

Many Somalis support child spacing as a means to reduce infant and child mortality and promote good reproductive health. To date there is less consciousness and understanding of the effects of high population growth rates on socio-economic development. Sensitivities regarding population and family planning services remain.

The Project's approach is to stress the relationship of family health practice and the improvement of maternal and child health. Family health services will be incorporated with Maternal and Child Health and Primary Health Care Programs to help reduce infant and maternal mortality. At the same time the development of family health services will offer a potential

counterbalance to adjust the growth in population that results from lower mortality rates. In addition the Project will provide population data and policy support which will enable Somali leaders to reach their own conclusions about the conditions and future prospects arising from a growing population.

C. Grantee and Executing Agencies

The Grantee will be the Government of the Somali Democratic Republic (GSDR) represented by the Ministry of National Planning. The primary executing agencies will be the Central Statistical Department of the Ministry of National Planning, the Family Health/Family Planning Division of the Ministry of Health, and the Somali Family Health Care Association. Other contributing agencies include: the Somali Women's Democratic Organization, and the Ministry of Education's Curriculum Development Center, Population Education Unit and Women's Education Department.

D. Recommendations

1. A grant in the amount of $10,100,000 over a five year period commencing June 1984 should be authorized to the Government of the Somali Democratic Republic for the execution of the Family Health Services Project. The GSDR contribution to the Project will amount to $10,300,000 which represents 51% of total Project costs.

E. Summary Findings

The Design Team has examined the social, administrative, economic, financial, and technical implications of the Project's activities. All of the activities are feasible and beneficial.

F. Project Issues

1. The ability of the Somali Family Health Care Association to implement the IEC and Operations Research Components and at the same time arrange for the coordination of the entire Project. (See Sections 4.0 and 13.4.)

2. The ability of the GSDR institutions to provide proper maintenance for the equipment purchased under the Project; especially the mainframe computer, vehicles, and IEC equipment. (See Sections 13.1 and 13.4.)

3. The implications of recurrent costs on the continuation of Project activities. (See Description of Component Four, Section 2.44.)

4. The efficiency of short-term technical assistance as a means to develop family health programs, and the management requirements of such an approach. (See Sections 4.0, 5.0 and 13.4.)

G. Major Conditions Precedent

1. A statement indicating that the GSP Committee has reviewed the annual local currency requirements for the Project and that such requirements will be included in the annual budget programming document.

2. Evidence that the Project Coordinating Committee has been established and the names, titles, and functions of the persons who will serve on this Committee.

3. A written service contract from the manufacturer's service representative for the regular maintenance of the GSDR computer equipment purchased by the Project.

4. An implementation schedule and financing plan for the 1986 National Population Census.

5. A written contract with a firm to complete the site preparation for the GSDR computer equipment purchased by the Project.

6. Evidence that the following positions for the 1986 National Population Census have been funded by non-USAID funding sources: a) Census Advisor; b) Census Cartographer; c) Data Processing Advisor.

H. Project Design Team

The design of the Family Health Services Project is the result of the joint collaboration of the USAID Design Team and Somali Counterparts.

Somali Counterparts

Dr. Mohamed Warsame - President, Somali Family Health Care Association
Dr. Rukia Mohamed Seif - Director, Family Health/Family Planning Division, Ministry of Health
Dr. Raqiya Haji Duale - Executive Director, Somali Family Health Care Association
Dr. Osman Arare - Director, Community Health Department, Ministry of Health
Ms. Hawa Aden - Director, Women's Education Department, Ministry of Education
Mr. Hassan Dahir Obsiye - Director, Curriculum Development Center, Ministry of Education
Mr. Michael Kiernan (Advisor) - Curriculum Development Center, Ministry of Education
Mr. Awil Farah - Director, Central Statistical Department, Ministry of National Planning

USAID Design Team

Margaret Neuse - Population Advisor, USAID
Suzanne Bacon - Computer Specialist, BUCEN
Anne Cross - Demographer, Consultant
Rosalie Fanale - Behavioral Scientist, REDSO/ESA
Farah Aboka Khayre - Sociologist, USAID
Kathleen Hansen - Legal Advisor, REDSO/ESA
William Jeffers - Project Design Officer, REDSO/ESA
Barbara Kennedy - Population Officer, REDSO/ESA
Thomas Murray - Financial Analyst, Consultant
Scott Radloff - Population Economist, AID/W
Guy Roppa - IEC Specialist, Consultant
Sandra Rowland - Census and Survey Specialist, BUCEN

1.0 PROJECT RATIONALE

1.1 The Development Setting

Tradition and history play a major role in Somali life. The Somali people have inhabited portions of the present day Somalia for over 1,000 years. Over this long period social systems have evolved which have defined the Somali culture and ensured the survival of the Somali people. In present day Somalia these systems continue to be used as standards against which new ideas and changes are evaluated.

The Somali Democratic Republic (SDR) occupies 638,000 sq. km. of the Horn of Africa. The austere physical features of the land combined with the harsh climatic conditions have created an environment which has tested the ingenuity of Somalis for centuries. Only 13% of the land in Somalia is suitable for arable agriculture and 45% for grazing livestock. The remaining 42% of the land is considered unusable for agricultural purposes because of its marginal qualities. Productivity of usable land is periodically diminished by droughts. Drought is expected in two out of every five years and devastating droughts have been occuring in ten year cycles -- the last being in 1974-75. Even in years of good rains the average annual rainfall in most areas is only between 300-600 mm. Temperatures are hot throughout the year with mean temperatures between 30-40 degrees Centigrade except at the higher elevations and along the Indian Ocean.

Somalia is one of the poorest countries in the world. For the past twenty years per capita incomes have shown little or no improvement. In 1981 per capita Gross National Product was only US $280, which places Somalia among the lowest twenty-five countries in the world. Estimates of food supply vs. caloric requirements of the population indicate an overall unmet food need in Somalia, which compares unfavorably with averages for Africa and other parts of the world.

Agricultural production provides the largest source of income for Somalia. The livestock subsector alone provides 40% of the Gross Domestic Product (GDP) and 80% of total foreign exchange earnings. Arable agriculture contributes 7-10% of GDP and provides 8-12% of total foreign exchange earnings. Other productive non-agricultural activities together (including manufacturing, quarrying, construction and electricity) provide less than 12% of GDP.

Population statistics are controversial in Somalia and open to a wide range of interpretations. There is, however, a general convergence of opinion that the total population is approximately 5,300,000 people. Two principal characteristics stand out: (1) a large proportion of Somalis are pastoral nomads; and (2) a significant percentage of the population are refugees. The difficulties in surveying these mobile segments of the population partially account for the absence of consensus on demographic parameters.

Population data for Somalia are drawn from the 1975 National Census and small scale and regional surveys. The results of the Census have just recently been published. The accuracy of the Census statistics has been questioned, but as ten years have passed since the data have been collected, these questions may be merely academic. More recent small scale and regional survey sources

have been used for estimating Somalia's national demographic statistics. Survey statistics can be fairly reliable but the validity of projecting statistics from these surveys to the entire population is sometimes questionable as nomadic and refugee segments of the population have been excluded from some of the survey sampling frames. Nevertheless, these surveys represent the best information available and can provide a rough profile of the population upon which future demographic work can elaborate. Using the limited Census data and information from the various surveys, the Ministry of National Planning has drawn the following demographic parameters. These include: a crude birth rate of 46 per 1000 people; a crude death rate of 15 per 1000 people; an infant mortality rate of 170 per 1000 births; a total fertility rate of 6.1 children per woman; a rate of natural increase of 3.1% per annum; and a life expectancy at birth of 43 years. As can be seen in Table I, these fertility and mortality rates are among the highest in the world. These rates translate into a population growth rate which is slightly higher than Africa as a whole and is among the most rapid in the world.

TABLE I
BASIC DEMOGRAPHIC/ECONOMIC INDICATORS

	Somalia	Africa	LDCs	MDCs
Crude Birth Rate (per 1000 Pop)	46	46	33	15
Crude Death Rate (per 1000 Pop)	15	16	12	10
Rate of Natural Increase	3.1	3.0	2.1	0.6
Total Fertility Rate	6.1	6.5	4.5	1.9
Infant Mortality Rate (per 1000 live births)	170	120	93	19
Life Expectancy at Birth	43	50	58	73
GNP per Capita	280	667*	728	8657
Calories Available/ Calories Required (in percentages)	92	100	101	134

* excludes South Africa
Source: Population Reference Bureau, 1983

1.2 Family Health Conditions in Somalia

By rough estimates, 44% of Somalia's population is under the age of 15 years. The health status of these children and their mothers is an important concern in Somali society. Inaccessible health services and harsh environmental conditions, contribute to the health problems of this group. These problems are manifested by high incidences of malnutrition especially among women and children, high infant mortality, and high maternal mortality. While the magnitude of these problems differs between regions, groups, families, and even between the different times of the year, there is a general consensus that at the national level these problems are serious and require immediate attention.

Somalia's institutional framework for alleviating family health problems is built upon the Ministry of Health. The Community Health Department in the MOH includes the Primary Health Care Division (PHCD), the Maternal and Child Health Division (MCHD), and the Expanded Program of Immunizations. Together these bodies have the responsibility for improving the health conditions of Somali mothers and their children. Among the services provided are ante-natal and post-natal care, immunizations, health education and distribution of food. The MCHD delivers its services through the 89 MCH Centers located primarily in towns and other urban centers; PHCD provides comparable services in the rural areas.

Experience in other countries suggests that one of the first effects of improved health services is a reduction in infant and maternal mortality. This forecast carries the implication that there may be a corresponding rapid rise in the rate of population growth at least in the short term. Since Somalia's population growth rate is already high by world standards such an increase could further strain its meager resources. To counteract such a possibility, health programs should include family health services which give adequate information and methods for child-spacing.

The Family Health/Family Planning Division was established in 1981, also under the Community Health Department, within the MOH and given the responsibility for planning and coordinating all Family Health activities in the country. One of the major accomplishments of this Division has been the integration of Family Health services into the services provided at MCH centers. Currently, 30 MCH centers are providing family health information and services.

1.3 Environment for Expanded Family Health Services

Large families are common in Somali society and are still highly regarded. Traditionally, large numbers of children have been valued for their contribution to family agricultural activities, for strengthening the size of the clan, and for providing parents with a measure of old age security. Due to high infant and child mortality, Somali couples have required large numbers of children to produce their desired family size. In contrast, there appears to be little understanding of the potential negative implications of large numbers of children, or of the relationship or impact of high population growth to socio-economic development. The GSDR Development Strategy and Public Investment Program (PIP) 1984-86, stresses the need to "create conditons for

permanent increases in real income per head..." but even this does not appear to directly relate to population growth. The PIP includes specific mention of one investment program in family health/family planning, which is the continuation of the Family Health Initiatives Project begun under AID funding:

> "This is a programme to educate people on child spacing, nutrition, and related matters. The areas of concentration in 1983 are Hargeisa, Kismayo, Burao, and Baidoa. The project will also help create an awareness of the socio-cultural consequences of female circumcision. (PIP, p.135)

There is, however, general recognition of the health benefits of family planning to mothers and children. First, there is evidence that health benefits of child spacing were recognized in traditional Somali society. It is commonly believed that Somali customs included methods of child spacing to protect the health of mothers and children. Some of these traditional methods involved prolonged breast feeding and, in polygamous marriages, separation, where the husband stays away from the wife for a period of time after the birth of a child. Secondly, the Government of Somalia has recognized these health benefits in its decision to integrate Family Health/Family Planning Services into the operations of Maternal Child Health and Primary Health Care.

While there are no written GSDR policies on population and family health, there has been growing awareness and concern for these topics. The Family Law, which provided equal status and rights for Somali women in 1975, has been used as a springboard for many family health activities. The Somali Women's Democratic Organization (SWDO) has waged a campaign to abolish female circumcision; one of the main arguments used is the clinical hazards of female excision on reproductive capabilities. The concommitant impact on knowledge of reproductive health has been widespread. Also, the establishment of the Family Health/Family Planning Division has been a major step for family health activities. In 1983, under a mandate of the Ministry of Health, the Family Health Division started to include in their family health training programs staff from Primary Health Care and the Refugee Health Programs, as well as from the MCH program.

During recent months several developments have occurred which will accelerate the awareness of family health programs. The most important of these has been the formal establishment of the Somalia Family Health Care Association by Parliament with the endorsement of the President. This non-government organization will provide support for on-going family health programs and sponsor complementary activities. The MOH has just conducted a Family Health Survey, which among other things, will provide data on knowledge and attitudes of Somali women to family health and family planning and the percentage of women using family health services including contraceptive use. Finally, physicians are now authorized to have private practices. Many physicians are already and more are expected to provide family ehalth services. This will significantly increase the capacity to distribute information and services especially in urban areas.

In the future, there are likely to be a number of factors which will lead to greater interest in family health both by individuals and by Government. One of these factors will arise as a result of Government's efforts to settle

the nomadic population. As the population becomes more sedentary, fewer laborers will be required for herding and maintaining multiple households. At the same time, the recently settled households are likely to become acutely aware of the limitations of the land in relation to the size of the population and be more concerned about the small amount of land which will be available for extra children. Another important factor will come into play as more women are educated and economic growth generates employment opportunities for them outside the household. At this stage the family will have the opportunity to choose whether it wants additional cash income by employing the wife or instead to use her time to bear and raise more children.

1.4 Relationship of Family Health to CDSS

The development of national family health services is consistent with USAID Somalia's medium and long-term strategies as outlined in the 1985 Country Development Strategy Statement (CDSS) and the recent CDSS Update. The latter document outlines USAID's strategy for the population sector and remarks that "We believe that this program could have significant impacts over the coming 3 to 4 years, and is essential over the longer term."

USAID has been increasing its support to the development of family health service programs. USAID/Somalia has supported four major family health activities since 1979. These include the JHPIEGO Reproductive Health Training Program; the INTRAH Family Health Training Project; the Westinghouse Family Health Survey; and the Family Health Initiatives Project. Together these projects represent an investment of almost US $1.0 million for family health activities.

Likewise, the development of family health services is complementary to USAID efforts under the Rural Health Services Project, by supplementing and re-inforcing existing health services. With regard to the new Policy Initiatives and Privatization Project and the proposed Education and Human Resources Development Project, the FHS Project has an important but less direct relationship in that it will provide services which can reduce the need for enormous resource allocations for health and education in future years.

1.5 Assistance Strategy for Family Health Services

The development of this Project has occured over a two year period. In addition to the various centrally-funded projects mentioned previously, a review of Somalia's population activities was undertaken by AID technicians in 1983, and the Project Identification Document was completed in January of this year. Throughout, numerous meetings have been held with Somali officials and technicians. During the preparation of the Project Paper, all Somali institutions have contributed both to the contents of the document and to the review process.

Nevertheless, the responsibility for the final project design rests with the Design Team. Without the benefit of valid and complete population statistics, the Team has had to make decisions on more subjective criteria. Basic

to the decision to develop a Family Health Services Project is our perception that awareness is increasing among a few critical personnel in the GSDR about the relationship between population, family health, and socio-economic development. Furthermore, the GSDR understands, and the Design Team concurs, that unless more detailed population and health information is available and well understood by both decision makers and the general public, Somalia will not be able to move forward with the necessary population and family health policies.

The Design Team believes that the development of Family Health Services is justified from a number of viewpoints. First, from a strictly health perspective, experience in other parts of the world has shown child spacing as one method to reduce infant and maternal mortality. Specifically, family health clinic services can help to identify and assist women at high risk to avoid pregnancy, thereby reducing maternal mortalities. Second, from an economic perspective, family health services are desirable because they provide an option for Somalia to keep population growth within the means of the nation's resources. Finally, from a social standpoint, the development of family health services provides greater freedom for Somali couples to determine how many children they want and when they want to have them.

Although the Design Team has recommended a five year time frame for the Family Health Services Project, it looks to a ten year time frame for planning purposes. The Design Team views this first five-year period as time to initiate and expand family health services and to test various methods of delivering these services.

The Design Team is fully aware of the sensitivities surrounding population issues and family health services in Somalia. The approach which has been taken in the design of this Project is to stress the relationship between family health practice and the improvement of maternal and child health. In addition, population data and policy support will enable Somali leaders to reach their own conclusions about the condition and future prospects for the population.

Finally, the Design Team has identified four target groups for this Project. The first is the personnel of the Somali family health institutions. Second, the national policy makers and local leaders will be the target group for both the policy activities and the dialogue which develops with the implementation of family health services. Third, the general population will be engaged in discussions and campaigns which are aimed at soliciting information and feedback on population issues and family health services. Fourth, married Somali couples will be closely involved in the development and distribution of family health services.

2.0 PROJECT DESCRIPTION

The Family Health Services Project is designed to provide assistance to the GSDR to develop national public and private institutions involved in population activities and family health services. The Project will provide

support for four components: Population Data and Policy; Information, Education and Communication; Family Health Services; and Operations Research. The Project will operate for five years.

2.1 Project Goal

The long-term goal of the Family Health Services Project is to improve the quality of life for the Somali people. Achievement of this goal will be indicated by improved maternal and child health and improved population data.

2.2 Project Purpose

The purpose of the Project is to strengthen the capabilities of Somali institutions to promote, support, coordinate, and sustain family health programs. The principal institutions which will receive assistance include: the Somali Family Health Care Association; the Central Statistical Department of the MONP; the Family Health/Planning Division of the MOH; the Somali Women's Democratic Organization; and the Curriculum Development Center and the Women's Education Department in the MOE. The relationship of these institutions to the overall Project structure and to component implementation is shown in Figure 1.

2.3 End of Project Status

At the end of the Project the following accomplishments will have been achieved: 1) the Central Statistical Department will use improved computational technology; 2) participating institutions will have improved technical and management skills in the production, analysis and application of data; 3) increased Information, Education and Communication programs supporting family health services; 4) greater effectiveness of service personnel in motivating couples to adopt and continue FH practices; 5) upgraded and expanded clinical family health services of the MOH; 6) personnel who are implementing family health programs will have improved skills in operations research; 7) family health programs will be guided by an effective operations research system; and 8) a contraceptive social marketing program will be tested.

2.4 Project Components

The Project Components are designed to serve four separate but mutually re-inforcing functions. Figure 2 shows, for each component, the functions, the outputs and services, and their linkages with each other. The Population Data and Policy Component will support family health by quantifying demographic conditons and facilitating the development of a policy framework for the delivery of services. The Information, Education, and Communication Component will provide information and explanation to the public concerning the role of family health services. The Clinical Family Health Services Component will deliver and administer services. Finally, the Operations Research Component will monitor, evaluate, and undertake special research for family health

Figure 1
PROPOSED ORGANIZATION STRUCTURE
FOR FAMILY HEALTH SERVICES PROJECT

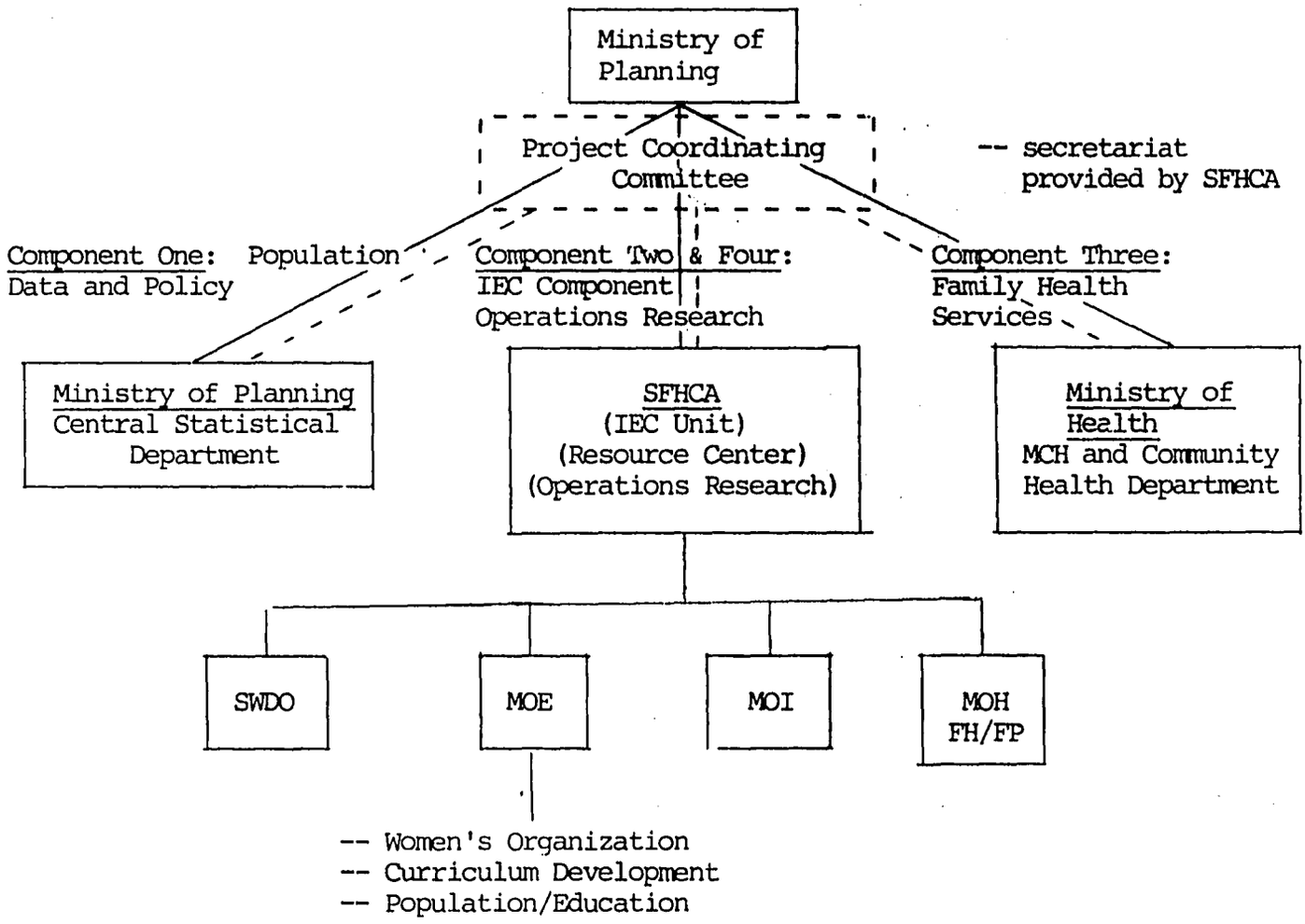

Figure 2

FAMILY HEALTH

Function:	Quantifies demographic conditions & promotes a policy framework for family health services	Supports services by providing information & explanation on the role of family health	Delivers services	Monitors & evaluates Services
Component:	Component One Population Data and Policy	Component Two Information, Education & Communication	Component Three Clinical Family Health Services	Component Four Operations Research
Outputs and services:	Demographic Data Analysis of Data Special studies Workshops to use data National POP conferences	IEC program data Resource Center Staff training Materials development	Health staff training Training Center/ Clinic Special services Management/Admin.	Operations research Uni Seminars on research methods Reports Family Health Survey Monitoring Social Marketing Progra
Linkages:	Of Component One With: Two - Provides data for public distribution Three - Quantifies the magnitude of demographic stats and trends; isolates problems which require the attention of FH Four - Provides data & policy standards against which programs can be evaluated	Of Component Two With: One - Provides feedback on public opinion to policy makers; provides case studies for specific data Three - Explains services to the public; produces educational materials for health facilities Four - Tests new approaches of supporting FH services & recommendations of the research unit	Of Component 3 With: One - Develops statistical data on health conditions; identifies technical solutions for policy consideration Two - Provides services which define IEC activities; identifies problems which IEC can try to overcome Four - Identifies areas for evaluation & special studies; source of information & data for in-depth studies	Of Component 4 With: One - Provides in-depth analysis of family health problems to answer policy questions & fill data gaps Two - Serves as a source to monitor & evaluate IEC programs Three - Serves as monitoring & evaluation service institution for FH programs & potential trainers

programs and services, including contraceptive social marketing. Together these four Components will enable the GSDR and other non-government institutions involved in family health to develop programs which will improve the quality of life for the Somali people.

2.41 Component One: Population Data and Policy

A. Component Sub-Goal:

The sub-goal of this component is to provide accurate and timely data and analyses to guide Somali policies and programs which improve the quality of life. Census, survey and service statistics data are necessary for assessing current conditions and for projecting future conditions of the population. The analyses of these data are essential for informed policies and effective programs since they: establish the current policy and program environment; enable evaluation of the impact of past policy and program initiatives; and provide a basis for formulating policies and designing programs which hasten progress toward national development goals.

B. Component Purpose:

The purpose of this component is to strengthen the capabilities of Somali institutions to collect, process, analyze and apply population data. Component activities will strengthen Somali institutions through: 1) transfer of computational technologies, enabling efficient data processing and analyses; and 2) training and technical assistance support, to improve local technical and management skills for producing, analyzing, and utilizing population data.

These capabilities will be developed over the life of the Project. The focus on institution building will produce both short-term and long-term benefits. In the short term, as these capabilities and skills are developed, project activities will meet immediate data and policy needs by assisting with the production, analysis, and finally the application of data. In the long-term, following completion of the Project's activities, Somali institutions will have improved technical, analytic, and management capabilities for continuing in the production and utilization of population data.

C. Summary of Outputs:

1. Upgraded Computer Hardward and Software

2. Population Census (Quick Counts and Sample Tabs)

3. Report on the Analysis of the 1980 Population Survey

4. Report on the Analysis of the 1982 Settlement Survey

5. Demographic Studies

6. Workshops on Data Analysis and Planning Techniques

7. National Population Conferences

D. Component Activities

The following activities will be undertaken to achieve the above-mentioned outputs. These activities will be integrated and coordinated with inputs from other donor agencies and AID centrally-funded projects. As shown in Figure 3, these inputs are especially critical to the accomplishment of outputs 1-4. How these activities and inputs will be managed is demonstrated in the implementation plans in Section 15.0.

1. Upgrading Computer Hardware and Software

The existing hardware and software equipment at the Central Statistics Department (CSD) of MONP is inadequate for efficient and timely data entry and processing for the upcoming 1986 National Population Census. The FHS Project will procure and install a computer hardware and software system suitable for the Somali census. Aside from census processing, this system will serve the Central Statistical Department's full data processing requirements for the next decade and thereby enable the CSD to carry out its function as the primary data collection and processing institution in Somalia. UNFPA will provide the paper and other materials required for the computer operation.

A series of standard tabulations are the final hard product of a Census. Performing the statistical calculations and producing the results in tabular form can be a time consuming undertaking. The FHS Project will install a standard census tabulation computer software system (CENTS4) and provide training to the CSD personnel in its use. This system automatically produces statistical cross tabulations in a format that can be published without manual preparation. A team of two Data Processors will install the system and conduct a three week course for Somali computer programmers. This tabulation system will also be extremely valuable in tabulating future census and survey data sets.

2. Census Sampling, Questionnaire, Data Processing Design, and Post-Enumeration Coverage

To ensure accurate and timely Census results, considerable preliminary design work is necessary. This includes preparing the sampling design, census design, questionnaire design, and data processing design. The FHS Project will provide technical assistance to the CSD and work closely with CSD staff in three critical design areas. A Mathematical Statistician will make recommendations concerning sample design (if a two stage design is adopted) and will design the sample on which preliminary tabulations will be run. A Survey Statistician will assist in the development of a tabulation plan and in the questionnaire design. Finally, a data processor will ensure that the questionnaire can be easily keyed and processed and recommend a computer software design for processing the Census data. Apart from ensuring a smoother Census operation, this technical assistance will strengthen the skills of CSD technicians to design future census and survey structures.

Post-enumeration coverage surveys are essential for determining the extent to which the Census has under or over-counted individuals and

Figure 3. INTERRELATIONSHIPS OF USAID FHS INPUTS AND OTHER INPUTS IN COMPONENT ONE

PLANNED OUTPUTS	FHS USAID INPUTS DESCRIPTION	INPUTS FROM OUTSIDE PROJECT RESOURCES	IMPORTANCE OF THESE OUTSIDE INPUTS TO PRODUCING OUTPUTS.[1]
COMPONENT NUMBER 1			
1. Upgraded computer hardware and software	Computer Maintenance of computer Training for operators Technical Assistance Software Package	UNFPA: Computer site preparation.	***
2. Population Census completed (Quick counts and preliminary tabs)	Technical Assistance (short-term) Local costs (Computer and related training)	UNFPA: Long-term Data processing advisor; Census Advisor; Cartography Advisor; vehicles, equipment, and supplies for use of the computer and making maps.	***
3. Report on the Analysis of the 1980 Population Survey	Short-term Technical Assistance	Demographic Data for Development Project will provide initial assistance in data processing and analysis.	***
4. Report on the Analysis of the 1982 Settlement Survey	Short-term Technical Assistance	Research Triangle Institute under the Integrated Population Development Planning Project will provide initial assistance for data processing and analysis.	***
5. Demographic Studies	Technical Assistance Local costs	Futures Group RAPID II Project for small-scale studies; these studies will be expanded versions of two which warrant more indepth study.	* Topics/studies could be defined without Futures Group support of earlier ones.
6. Workshops on Data Analysis and Planning Techniques	Short-term Technical Assistance Local costs	None.	N/A
7. National Population Conferences	Short-term Technical Assistance Local costs	None.	N/A

*** Very important; Useful

households. In Somalia, nomads are the largest segment of the population and the most difficult group to enumerate. Given the poor quality of demographic data presently available on the nomads, it is especially important to carefully examine the Census coverage for this group. The FHS Project will provide a Mathematical Statistician to assist in the design and field testing of a survey methodology suitable for estimating the Census coverage of the nomadic popultion. Since a sound methodology for a nomad coverage study has not been developed in the past, the assistance provided by the Project will be useful, not only in validating the Census data with respect to nomads, but also in providing a model for future census work both in Somalia and other parts of the world where the enumeration of nomadic populations poses similar problems.

3. Analysis of the 1980 Population Survey

In 1980, with United Nations assistance, the CSD conducted a national level demographic survey that covered approximately 8000 households in urban, rural and nomadic areas. Due to data processing delays, the information from the survey has only been partially computerized. The information is a rich and still timely source of data and can provide a fuller picture of the demographic characteristics of the Somali population. Under the AID centrally funded Demographic Data for Development Project, Westinghouse is planning to assist CSD in entering, processing and analyzing this survey by providing technical assistance and covering related local costs. The FHS Project will support the final stages of analysis, including report write-up with CSD and the presentation of findings to policy makers, planners and administrators. This activity is especially important because it will: (1) provide interim demographic information prior to the production of the 1986 Census; (2) more clearly identify gaps in demographic data, and (3) further develop CSD skills in survey processing and analysis.

4. Analysis of the 1982 Settlement Survey

In 1982, the Settlement Development Agency (SDA) conducted a socioeconomic survey with assistance from the University of North Carolina . (under subcontract with the AID centrally funded project Integrated Popultion Development Planning, IPDP) of approximately 2000 households in four nomadic settlement areas. Due to data entry problems, the infomation has yet to be computerized. The survey was designed to provide insight into the demographic, social and economic consequences of settlement schemes. Under the IPDP Project, the Research Triangle Institute has tentative plans to support the local costs for transferring the data for processing in the U.S. and provide technical assistance to the SDA for the analysis of the data . The FHS Project will support the final stages of the analysis and presentation of findings for this activity to GSDR officials and planners at the second National Population Seminar. This activity will provide useful information to the SDA for future settlement planning and help stregthen local skills in survey processing and analysis.

5. Demographic Studies

The FHS Project will provide support for local costs and outside technical assistance for two demographic research studies identified, selected and implemented over the life of the Project. Selection of these studies will be based on their relevance to Somali population and development issues.

their potential for increasing awareness of population issues. It is anticipated that these studies will be expanded versions of two of the small-scale studies presently being supported by the Futures Group under the AID centrally funded RAPID II Project.

6. Workshops on Data Analysis and Planning Techniques

Many of the activities conducted through this Project assist in collecting and analyzing data. These activities are especially valuable in Somalia, where data and analyses are scarce. Beyond establishing the current size and structure of the population, there is a need for using these data for projecting future population changes and for assessing their implications for sectoral development planning. The FHS Project will support two workshops with approximately 15 participants in each for strengthening the local development planning capabilities to utilize population data. Support will include short-term technical assistance solicited from a qualified centrally-funded contractor or recommended to the Mission and limited training materials which are not available locally. This activity will ensure that data produced under this Project are more fully utilized and incorporated into the development planning system.

7. National Population Conferences

Special population conferences provide useful forums for presenting findings from population research and planning activities to high-level government officials. These conferences raise awareness of population development links and allow researchers, planners and policy-makers to discuss patterns and implications of population growth. In 1981 the Ministry of Education organized a national Seminar on Population which brought together academicians, high level officials, and technical staff from the ministries to discuss population development issues in Somalia. A second National Population Conference is planned for December 1984. The FHS Project will support the local costs and short-term technical assistance, recruited locally or from a centrally-funded contractor for two additional conferences. With the participation of about 45 policy-makers in each conference, they will be useful for focusing attention on family health, population, and development issues and contribute to the ongoing policy dialogue on these issues.

E. Participants

The Central Statistics Department of the Ministry of National Planning will be the lead institution for the 1986 Census and for other data and policy activities. Additional participating institutions for the Census work include: Ministry of Education, Ministry of Local Government, Ministry of Defense, Ministry of Transportation, Ministry of Post, and Ministry of Telecommunications. Institutions which will participate in other data and policy activities include: Ministry of National Planning (Headquarters), Somali Family Health Care Association, Settlement Development Agency, Ministry of Education, and Ministry of Health.

F. Beneficiaries:

The immediate beneficiaries of this Project Component are the staff of the participating Somali institutions who will receive information, supporting

services and training related to population data and policy activities. Other direct beneficiaries will include the estimated 120 participants in the population conferences and workshops, and those who participate in the training conducted for the implementation of the Census. Indirect beneficiaries will include the users of population data such as GSDR planners and policy makers. The ultimate beneficiaries of the Component activities are the people of Somalia whose quality of life will be enhanced by more informed GSDR policies and effective programs.

G. Inputs:

1. USAID Contribution ($ 1,795,000)

a. Technical Assistance ($ 450,000) including: 15 person-months of short-term assistance in sampling, census questionnaire, and data processing design for the 1986 Census; 2 person-months short-term assistance in completing and presenting results from the 1980 Population Survey; 2 person-months short-term assistance in completing and presenting results from the 1982 Settlement Survey; 2 person-months short-term assistance in organizing and monitoring two National Population Conferences; two workshops on data analysis and planning techniques; and six person-months short-term research assistance for undertaking two demographic research studies.

b. Commodities ($ 1,150,000) including: computer hardware and software for data entry and processing for the 1986 Census and costs for maintenance and training for use of the computer.

c. Contingency ($ 195,000)

2. UNFPA Contribution for the 1986 Census ($ 967,000)

a. Technical Assistance including: 18 person-months of long-term assistance for a Census Advisor; 20 person-months long-term assistance for a Cartography Advisor; and 24 person months long-term assistance for a Data Processing Advisor.

b. Training overseas for three Somalis.

3. Government of Italy ($ 702,000)

a. Commodities including: the site preparation for the computer, vehicles, and supplies.

4. GSDR Contribution ($ 4,535,000)

a. In-Kind Contribution including: salaries, rent, equipment, and services required for Census training and enumeration.

b. Cash Contribution including: per diems for supervisors and enumerators for the 1986 Census, fuel and maintenance for vehicles; local costs for completing and presenting results from the Population and Settlement Surveys; local costs for conducting two demographic studies; local costs for two

training workshops on data analysis and planning techniques; and local costs for conducting two National Population Conferences.

2.42 Component Two: Information, Education, and Communication

A. Component Sub-Goal:

The sub-goal of this Component is to support family health programs and services with information, education, and communication activities which are conducive to positive changes in the family health behavior of Somali couples. At the present time, many people do not understand the importance of family health programs, especially family planning, to the health of mothers and their children. Information, education, and communicaiton services will be used to explain the benefits of family health services and support a continuing dialogue between family health workers and the communities on family health issues.

B. Component Purpose:

The purpose of this Component is to increase the operational capability and effectiveness of the institutions involved in the delivery of family health information, education, communications and other related services. IEC is a principal support system for family health services. The activities of this Component will improve the IEC skills, facilities, and coordination of the various Somali institutions which have IEC programs related to family health and population. The impact of these activities will be improved understanding, acceptance, and practice of family health methods.

C. Summary of Outputs:

1. IEC Baseline Data Report

2. Annual Workplans which Integrate Family Health IEC Activities

3. IEC Unit and Resource Center Established

4. Trained IEC Staff and Family Health Personnel

5. Family Health Curriculum and Classroom Materials Developed

6. Implementation of IEC Programs Increased

D. Component Activities:

The following activities will be undertaken to achieve the above outputs. Coordination of these activities is extremely important, both between institutions participating in this Project and with other IEC organizations, to assure that IEC messages are complementary and that recipients are not overwhelmed with information and demands on their time.

Coordination is the responsibility of the IEC Unit of the SFHCA and the IEC Technical Committee composed of representatives of these institutions:

SFHCA; the Health Education Program and the Family Health/Family Planning Division of the Ministry of Health; the Women's Education Department, Curriculum Development Center, and Population Education Project of the Ministry of Education; the Somali Women's Democratic Organization; and the Ministry of Information and National Guidance. Further details on how this coordination will be accomplished are presented in Sections 4.42.D.2-3 and 13.4.

1. IEC Baseline Report

Family health programs and IEC support services are still a recent development in Somalia. With the ground broken by the MOH family health services, the collection and analysis of information on current IEC activities which relate to family health is critical for planning for their development. The Population Communication Services Project (PCS) will provide short-term technical assistance to guide the collection of three types of information: (1) information on the personnel resources of the IEC institutions, including staffing levels, training, and present utilization; (2) information on the material resources of these institutions, such as media production equipment, supplies, and distribution systems; and (3) information on the social environment in which the IEC programs must operate, including, additional information on the social, economic, and demographic characteristics of communities, cultural beliefs, informal communication channels, and family health attitudes and practices. The final product of this activity will be a report which will not only benefit family health activities, but be useful for other Somali IEC institutions and programs.

2. Strategy and Annual Plans which Integrate IEC Activities

The importance of coordinating IEC activities has already been emphasized. A Strategy which integrates the IEC activities of the various institutions will be an important mechanism for achieving this coordination. This Strategy will be used as a basis for preparing four annual plans which amend and update the original blueprint. The initial Strategy will be developed by representatives of local institutions from the information contained in the IEC Baseline Report. It will include for each year: (1) the target groups by geographical areas, ages, and sex; (2) IEC methods to be used and tested; and (3) the general activities of each institution. Every year, representatives of the local institutions will convene to review and revise the overall Strategy in light of the achievements and lessons learned from the preceding year. Specifically, these reviews will result in annual workplans in which all IEC activities related to family health are identified, requirements for materials and resources are highlighted, and the plans for joint IEC ventures between institutions are reported. The development of an overall Strategy and subsequent Annual Plans, besides making IEC activities more effective, can also economize on scarce personnel and financial resources available to these local institutions.

3. Establishment of an IEC Unit and Resource Center

Beyond the Strategy and Annual Plans there is a need to develop the capacity of local IEC institutions to create inter-institutional linkages on a day-to-day basis. To accomplish this, an IEC Unit and Resource Center will be established in the Somali Family Health Care Association. The IEC Unit will contain three staff members: a Director, a Resource Center Manager, and a Training

Officer. The Director will be responsible for managing the activities of the Unit and liaising with all other IEC institutions. The Resource Center Manager will be responsible for developing and producing IEC materials and managing the Resource Center. The Training Officer will plan and implement in-country training programs for IEC personnel.

The IEC Unit will serve a number of useful functions. First, the Unit will produce and distribute guidelines for field testing IEC materials and approaches. The Unit will also assist the other IEC institutions during the actual field testing. Second, the Unit will collaborate with the Operations Research Unit to establish a monitoring system for IEC activities. Besides tracking activities, the monitoring system will be designed to provide information on community attitudes and the general responses of the public to family health messages. The information collected by the monitoring system will be disseminated through a newsletter produced by the Unit. Third, the IEC Unit will organize meetings and seminars to address issues and problems related to family health IEC activities.

The Resource Center will provide information, materials and equipment which can be used by all IEC institutions participating in the Project. The following resources will be made available: (1) documents produced by the Project and related agencies; (2) films, slides, and other visual aid materials; and (3) equipment such as slide projectors, film projectors, and electrical generators. The Resource Center will employ staff to maintain and repair the equipment and manage the library materials.

The FHS Project will assist in the establishment of the IEC Unit and Resource Center through the provision of short-term technical assistance in organizing the Unit, the provision and placement of a long-term IEC Advisor in the Unit, and through the provision of the needed commodities.

4. Training of IEC Staff and Family Health Personnel

Personnel working in family health programs and the participating agencies have had little training. Acting on the recommendations of the IEC Baseline Report and the advice of the IEC Unit and Advisor, the Project will support 46 person-months of short-term overseas training and study tours. In-country short-term courses will provide the necessary training for over 600 people to improve the effectiveness of the IEC staff and, more generally, the IEC skills of all personnel providing IEC support to family health services. The training will be conducted by the senior IEC staff of the agencies and the IEC Unit. These staff will prepare training materials, manuals, and visual aids to guide the training delivery and assure quality control. (See Annex 15.2(D) for more detailed training plans.) On-the-job training will also be provided by the long and short-term advisors.

5. Curriculum and Classroom Materials

The nation's classrooms provide an excellent forum for introducing basic family health concepts within the framework of other academic studies. The Project will support a short-term technical Advisor, equipment, vehicle, and local currency to the Curriculum Development Center (CDC) in the Ministry

of Education. The CDC, assisted by the Advisor, will draft a family health curriculum and support materials for each year (class) of intermediate and secondary school. The draft curriculum and materials will be pre-tested, revised, produced and used in selected areas of the country. Over the Project period, 50 sets of classroom materials will be produced for each class.

6. Implementation of IEC Programs

Important measures of the effectiveness of IEC programs are: (1) the production and presentation of IEC materials (2) the implementation of IEC programs; and more importantly, (3) the number of people who are introduced to and educated about family health. Even though baseline information on existing IEC programs is incomplete, and the overall strategy for IEC is to be defined only after the Baseline Report is prepared, it is possible to assume that certain activities will be undertaken and to establish some initial targets, which can be readjusted when the report is released. These targets include: (1) the production of 100,000 leaflets, 3 slide sets, 15,000 pamphlets, 30,000 posters and two weekly radio features related to family health in Somalia; (2) the conduct of 1000 group sessions in family health for various audiences and the conduct of 25 community events implemented by local groups; and (3) over the life of the Project, 75% of the couples in urban and rural, settled areas (approximately 50% of all Somali couples) will be introduced to family health and family health services.

E. Participants:

The Somali Family Health Care Association will be the lead institution in the implementation of IEC activities. It is selected because of its central role among family health service institutions. Other key participants are: the Curriculum Development Center, MOE; the Women's Education Department, MOE; the Family Health/Family Planning Division and the Health Education Program, MOH; the Somali Women's Democratic Organization; and the Ministry of Information and National Guidance. Headquarters Staff will initiate the activities while the regional and district staff will participate in later implementation phases.

F. Beneficiaries:

The immediate beneficiaries of the IEC Component activities are the staff of the IEC institutions participating in the Project. These will include the 600 trainees, the three new hires, and the management staff of the SFHCA. Indirect beneficiaries will include personnel working with equipment and materials provided under the Project and those individuals and/or agencies which utilize the products or services of the participating IEC institutions. The ultimate beneficiaries of the IEC Component are the Somali couples who, as a result of IEC activities, adopt family health practices and receive benefits in the form of better health.

G. Inputs

1. USAID Contribution: ($ 2,695,000)

a. Technical Assistance ($ 1,770,000) including: 48 person-months of a long-term IEC Advisor; 7 person months of short-term assistance for IEC

Consultants; 24 person-months for a Curriculum Development Advisor.

b. Training ($ 190,000) including: 34 person-months of short-term training and 12 person-months of study tours.

c. Commodities ($ 440,000) including: audio-visual equipment, vehicles, office equipment and supplies.

d. Contingency ($ 295,000)

2. GSDR Contribtuion ($ 3,025,000) including: salaries for staff specially hired for the Project, salary supplements, materials, equipment, per diems and travel for training, and other associated costs for the education activities.

2.43 Component Three: Clinical Family Health Services

A. Component Sub-Goal:

The sub-goal of this Component is to upgrade clinical family health services and thereby improve the quality of life for the Somali people. Clinical family health services are important because they: (1) allow couples to adequately space their children so that the mothers and children can regain and maintain their health before another child is conceived; (2) promote good reproductive health so that couples can conceive when they desire; and (3) protect the health of those mothers who for medical reasons, should not have more children. Healthy mothers, children, and families enable the society to pursue higher economic, social, and psychic goals and thus improve the quality of life.

B. Component Purpose:

The purpose of this Component is to strengthen the capabilities of selected Somali institutions to plan, implement, and evaluate clinical family health services. Component activities will strengthen Somali institutions by upgrading the skills of technicians, developing management systems, providing commodity support, and improving family health facilities.

The principal focus of this Component will be to extend and upgrade family health services provided through the Ministry of Health. As the family health services are being integrated into already established services, for which staff and facilities are already available, the principal needs for upgrading are in the training of the staff in the delivery of the services and the provision of the necessary commodities. Supervision will also be integrated, with the corresponding need to train the supervisory staff as well. At the end of the Project period, 8% of married women of reproductive age in the urban and rural, settled areas will be users of family health methods (as compared with the estimated less than 1% who are presently using family health methods). This Component will resolve some of the existing problems constraining the delivery of family health services such as the lack of logistical support and adequate training. In the longer term, this Component provides the foundation and direction for future expansion of family health services.

C. Summary of Outputs

1. Improved and Expanded Cadre of Family Health Trainers, In-Service and Pre-Service Training Programs.

2. Family Health MCH Training Site Established

3. Voluntary Surgical Contraception, Infertility, and Sexually Transmitted Disease Services Established

4. Improved Management Systems and Facilities for Family Health Services

5. Expansion of Family Health Services

D. Component Activities:

The activities of this Component will require on-going coordination with: (1) the delivery of other health services of the Ministry of Health; (2) the USAID Rural Health Care Project; (3) other donor efforts, especially UNICEF and WHO/UNFPA; and (4) AID centrally-funded projects. The structure and process of this coordination are discussed in the Technical Analysis, Section 13.1. The following activities will be included in this Component.

1. Upgrading and Expansion of the Cadre of Family Health Trainers, In-Service, and Pre-Service Training Programs

A critical element in improving family health services is the effective training of the physicians, nurses and other medical staff, who are responsible for delivering these services, to the appropriate levels of competency. This component will support short-term training and technical assistance to upgrade the cadre of Family Health trainers and strengthen their skills in curriculum and materials development and competency-based training approaches. Similar to the Family Health Initiatives Project, trainers will receive advanced clinical training in Zimbabwe and other countries. Selected trainers will attend training skills courses in the U.S. Short-term technical assistance will be used to develop curricula and training materials and to prepare modules for the use of PHC staff for the training of TBAs and CHWs in family health. The long-term Training and Management Advisor will develop systems for planning training programs, providing logistical support, monitoring courses and instituting competency-based testing procedures, and reporting accomplishments. Further, short-term technical assistance will be provided to Benaadir Hospital to strengthen the training skills of the physicians who conduct the training for physicians and medical students under JHPIEGO sponsorship. INTRAH or its follow-on project contractor will provide limited support to the Project, primarily through periodic assessments and for specific inputs requested by the long-term advisor.

In addition to training the family health trainers, this component will support direct training for staff who are to provide family health services. This support will normally cover local costs for per diem, travel, and trainers stipends, as well as the production and reproduction costs of training materials.

Audio-visual aids and materials will also be provided for the training. Up to 10 courses per year are planned in such areas as basic family health skills, clinical skills (including IUD insertion) and refresher training for MCH and hospital nurses and nurse-tutors. Training of trainers programs will be given selected MCH nurses, nurse-tutors from the Schools of Nursing, and for Tutors and Coordinators from the Primary Health Care Program. MCH supervisors and Primary Health Care coordinators will receive training in family health management and supervision. (For more details on courses and numbers to be trained, see Section 15.3.) These training courses will be conducted by Somali trainers whose training capabilities will be strengthened through Project-sponsored training and technical assistance.

2. Preparation and Establishment of a Family Health and MCH Training Site

To date most training in clinical family health services like IUD insertion has been located overseas. This situation seriously restricts the numbers of Somalis who can participate in these types of training both because of the high costs and inherent logistical difficulties associated with overseas training. This Component will establish a Training Site/Model Clinic in Mogadishu where training in contraceptive service delivery, IUD insertion, and other family health services can be provided in the familiar setting of an MCH Clinic. The Training Site will also serve as a demonstration of how high quality MCH and family health services can be provided by trained nurses. Specific activities will include: (1) modest renovations of the site; (2) provision of equipment and supplies; (3) short-term training; and (4) short-term technical assistance to provide guidance to the Clinic, train staff, and design training courses.

3. Establishment of Special Family Health Services

The services for Voluntary Surgical Contraception, Infertility and Sexually Transmitted Diseases each respond to specific needs in Somalia. VSC provides an alternative to a couple who cannot or prefer not to use other methods of family health, particularly for those cases where a woman's health would be endangered by another pregnancy or where the couple has completed their family. Likewise, while there is little information on the prevalence of infertility, many women request assistance to become pregnant. The incidence of sexually-transmitted diseases is high and may be an important factor contributing to reported infertility problems.

This Component will support the establishment of these services in three Regional/Specialty Hospitals: Kismayo, Mogadishu, and Hargeisa. Specific activities will include: (1) support for short-term overseas training for physicians; (2) provision of the necessary equipment and supplies for these services; (3) short-term technical assistance to provide consultations in the development of protocols and procedures to ensure these services are of the highest quality; and (4) training for nurses and other technical staff needed to support these special services. The funding for the physician training will be provided by the Association for Voluntary Sterilization, JHPEIGO and this Project.

4. Development of Facilities and Management Systems

The Family Health/Family Planning Division of the Ministry of Health has encountered problems in establishing the facilities and management systems which are necessary to support their work. This Component will provide support for: the upgrading of the Division's facilities, developing a personnel management structure and supervision system, improving the logistics and service information system, installing a financial accounting system, and establishing a medical review system to assure quality control.

Specific activities which will be undertaken to upgrade the physical facilities include: (1) minor renovation of the FH/FP Division's offices and storerooms at the Post-Basic School of Nursing; (2) provision of basic office equipment and supplies; and (3) upgrading the warehouse used for storing contraceptive supplies.

Activities which will contribute to the development of a personnel management structure and supervisory system include: (1) short-term technical assistance to evaluate the FH/FP Division's management structure and its adequacy for effective operations of the Division at central and field levels, recommend roles and responsiblities of the different units and staff, and develop a work program for the Division; and (2) follow-up of the recommendations by the long-term Training and Management Advisor.

An effective service delivery program depends upon a regular supply of contraceptives and information on acceptors and users. This Component will support three activities to ensure supply and information systems are operating properly: (1) short-term technical assistance from the Center for Disease Control will be provided to review the present supply and service statistics systems and make recommendations on how they can be improved; (2) a revised manual (which includes sets of forms for managing supplies and reporting users) will be prepared, translated into Somali, and disseminated to family health personnel through training courses; and (3) periodically testing of contraceptive supplies will be performed.

Specific activities which will support the installation of financial accounting systems include: (1) the continuation of short-term technical assistance started under FHIP to monitor the financial management and accounting system at regular six month intervals; (2) short-term training for personnel involved in financial management and accounting of family health activities; and (3) oversight of the financial systems by the long term Management and Training Advisor.

A medical review system is critical to assure that the services provided meet accepted medical standards and AID requirements for informed consent and free choice. Such review is particularly important when non-physicians are dispensing drugs and services are provided which are still controversial. The long-term advisor will assist the FH Division in setting up an appropriate system.

5. Expansion of Family Health Services

Presently, family health services are being provided at 31 MCH centers and 9 hospitals. Through the efforts of the Family Health Services Component and other parts of the FHS Project, these services will be significantly improved and expanded to include at least 60 MCH centers and 20 hospitals.

When the PHC Program starts training their staff, family health services will expand even further. Beyond the support which has already been outlined above, it will be necessary to provide additional logistical support to the FH/FP Division. The specific support activities which are anticipated include: (1) provision of contraceptive supplies; (2) purchase and delivery of clinical equipment and supplies; (3) provision of vehicles for moving supervisory staff and delivering supplies; and (4) technical assistance to assess the adequacy of the services being provided and to suggest ways to improve them.

E. Participants:

The Family Health/Family Planning Division of the Ministry of Health will be the lead institution for the implementation of this Component. It will be assisted by other related units in the Ministry of Health, including: Benaadir Hospital; the Health Education Program; the Primary Health Division; the Maternal Child Health Division; and the Department of Medical Supplies.

F. Beneficiaries:

The immediate beneficiaries of this Component are the staff of the FH/FP Division and other institutions who will receive training, supervision, and financial support. Secondary beneficiaries include those people who receive the family health services - primarily women and children. Ultimate beneficiaries are the Somali families whose lives are improved as a result of better health.

G. Inputs:

1. USAID Contribution ($ 4,000,000)

a. Technical Assistance ($ 1,040,000) including: 36 person-months of long-term technical assistance and 20 person-months of short-term TA.

b. Training ($ 195,000) including: 26 person-months of short-term training in the U.S. and 28 person months in third country institutions.

c. Commodities ($ 2,330,000) including: training materials and supplies, clinical supplies and laboratory equipment, contraceptives, vehicles and typewriters.

d. Contingency ($ 435,000)

2. GSDR Contribution ($ 1,930,000) including: travel and per diem for training programs and supervision, salary supplements, costs for materials, renovation and costs associated with service delivery activities.

2.44 Component Four: Operations Research

A. Component Sub-Goal:

The sub-goal of this Component is to monitor, evaluate and guide the

operations of family health programs which improve the quality of life for the Somali people. Operations research is a continuous process of program information feedback, assessment, experimentation, and adjustment. It provides program designers and managers with the information needed to improve present service delivery procedures and to plan future activities. Hence operations research work will contribute to effective and efficient programs serving the family health needs of Somalis.

B. Component Purpose:

The purpose of this Component is to strengthen the capabilities of Somali institutions involved in family health to evaluate program implementation, investigate and identify the most effective service delivery approaches, and assist in planning program implementation, including contraceptive social marketing. Component activities will strengthen Somali institutions by establishing a coordinated and comprehensive operations research system, by improving skills of program management staff in operations research methods, and by establishing a structure and skilled personnel for contraceptive social marketing.

In the short-term, operations research efforts will provide the means to adjust and refine various methods of developing and extending family health services. Ultimately, this Component will improve staff skills and establish organizational procedures, which will enable local institutions to systematically evaluate and guide Somali family health programs.

C. Summary of Outputs:

1. Operations Research Unit Established

2. Seminar on Operations Research Methods

3. Operations Research Reports

4. Report on Family Health Survey

5. Program Monitoring Systems

6. Social Marketing Program for Contraceptives

D. Component Activities

The following Component activities will be undertaken over the life of the Project to produce the above outputs. These activities will rely, in part, on coordination and collaboration with AID centrally-funded projects. This Component will be initiated during the second year of the Project.

1. Establishment of an Operations Research Unit

An Operations Research Unit will be established in the Somali Family Health Care Association to assist and support the research requirements of the local family health institutions. The Unit will include a Research Associate who will have a long-term Operations Research Advisor as a counter-

part. (See Section 16.0.) In addition to the activities described below, this Unit will coordinate and assist monitoring and evaluation activities for the Project and maintain on-going communications with appropriate personnel in the participating institutions. An OR Technical Group made up of evaluation and management representatives of the institutions will conduct quarterly meetings to complement these coordinating functions.

2. Training in Operations Research

Key to the central purpose of the overall Project i.e., strengthening the capabilities of Somali institutions, is the development of local skills in operations research methods. These skills are important for the effective and efficient operation of IEC, service delivery, and social marketing programs. The Project will support a two-week, in-country training seminar in operations research methods. The seminar will be conducted by two operations research specialists. Participants will include operations research and management counterparts, and the local counterparts to each of the long-term advisors provided by the Project. Seminar topics will include: problem identification, research objectives and hypotheses, study design and implementation, and research analysis.

3. Focused Studies of Program Operations

It is likely that special problems in program operation or questions of the effectiveness of new approaches will arise over the course of the Project's implementation. Among the anticipated areas of investigation are: approaches to recovering delivery costs by charging fees for services or payment for contraceptives; strategies for extending services to rural areas such as community-based distribution by TBAs or SWDO volunteers; and approaches to encourage community involvement and support of family health IEC and services.

These problems and questions will require special focused operations research studies. Three large-scale studies and other small-scale studies are anticipated at this stage. (See Technical Analysis, Section 13.1.) One short-term operations research advisor will be assigned to each large-scale study. The exact focus and timing of these studies will be determined by the Operations Research Unit in consultation with USAID and the Technical Group. Proposals for these research studies will be developed by the agencies with the assistance and guidance of the OR Unit and reviewed by the Technical Group. Implementation will be supervised by the Unit but undertaken by the staff of the institutions. Lessons learned through these research activities will be directly applicable to family health services in Somalia and may also have useful applications in other contexts and for other community-based services.

4. Family Health Survey and Evaluation

In 1983, under AID's centrally-funded Contraceptive Prevalence Survey Project, Westinghouse collaborated with the Ministry of Health and the Central Statistical Department, in conducting a survey of 3000 married women aged 15-49 living in five urban areas. The Family Health Survey covered a

broad range of family health topics. It provided baseline parameters against which later survey results can be compared to yield estimates of program impact and effectiveness. The FHS Project will support with technical assistance and local costs, a second Family Health Survey and an analysis of family health changes occuring between the two surveys. The survey will be conducted in the fourth year of the Project with the technical guidance of the centrally-funded Demographic and Family Health Surveys Project.

5. IEC and Service Delivery Monitoring Systems

In addition to special studies and surveys, it is essential for a comprehensive operations research program to monitor the day-to-day operations of IEC and service delivery systems. Such routine information systems enable program evaluators to: (1) identify successful operations which may merit additional resources or replication elsewhere; and (2) locate problem areas which might be quickly remedied or require closer evaluation. This information can also be utilized as program impact indicators for country-wide cost-effectiveness research. The FHS Project will provide assistance to the various family health institutions for establishing and developing service monitoring systems. This assistance will be provided by the long-term Operations Research Advisor and the local counterpart. The service monitoring systems will be simple so as not to be excessively burdensome to service providers. Nevertheless, these systems will be extremely useful for operations research work over the life of the Project and be valuable to Somali institutions thereafter for ongoing planning and management purposes.

6. Contraceptive Social Marketing Program

The FHS Project will provide support for the establishment of a contraceptive social marketing program in order to assess its acceptance and effectiveness in expanding the number of locations where people can obtain contraceptives. A CSM Unit will be established with the following Somali staff: a Director, a Marketing Manager, an Office and Finance Manager, and field and office support staff. This Unit will be guided by an Advisory Board made up of representatives of the key family health institutions as well as the pharmaceutical organization and other business interests. This Unit will have responsibility for: conducting market tests for prices, brand names, and packaging and promotional materials design; arranging for the production of the packaging and promotional materials outside of Somalia; set up the system for packing the countraceptives in-country; and launch product sales and maintain distribution channels directly to retailers. The CSM program is targeting the 350 pharmacies for condoms and pills and 750 other retail outlets for condoms in the six urban areas of Somalia: Hargeisa, Berbera, Burao, Mogadishu, Baidoa, and Kismayo. The country will be treated as two divisions, north and south, and serviced by two teams, one in the North and one in Mogadishu.

Project support for CSM will include: short-term, periodic technical assistance to help set up the program and conduct the needed small-scale research studies; study tours for the managerial staff; commodity support for contraceptives, vehicles, and office equipment; purchase of materials (paper and cardboard) for the packaging and promotion and their printing outside of

Somalia; and local currency support for staff salaries, packing costs (piece rate for the packers), fuel and vehicle maintenance, local travel and office expenses. Experience in other countries indicates that the following might be accomplished during the first year: sales of 1 million condoms and 120,000 cycles of pills.

E. Participants:

The Somali Family Health Care Associaton will be the coordinating institution for operations research activities. Operations research skills will be developed and activities will be undertaken in all IEC and service delivery institutions, including: Ministry of Health, Ministry of Education, and Somali Women's Democratic Organization. The Family Health Survey will be undertaken through the Ministry of Health with technical assistance from the Central Statistical Department of the Ministry of National Planning for the sample design and data collection and processing.

F. Beneficiaries:

The immediate beneficiaries of activities supported under this Component are the staff of the participating institutions who will receive training and financial support. The secondary beneficiaries are the IEC and service delivery managers who will have accurate, timely information and analyses on which to base decisions on program approach and resource allocations. The ultimate beneficiaries are theusers of family health services; Somali couples, mothers, and children who will benefit from more effective and efficient family health programs.

G. Inputs:

1. USAID Contribution: ($ 1,610,000)

a. Technical Assistance ($ 1,040,000) including: 24 person-months long-term assistance for an Operations Research Advisor; 3 person-months short-term assistance in evaluation service delivery operations; and 13 person-months short-term assistance in social marketing; 2 person-months short-term trainer assistance in operations research methods; 4 person-months research monitoring assistance; 1 person-month for focus group supervision; 1 person-month assistance in data processing; 1 person-month in sampling design; and 4 person-months to support Project evaluations.

b. Training ($ 15,000) including: study tours for the operations research associate and managers of the contraceptive social marketing program.

c. Commodities ($ 380,000) including: vehicles and the raw materials for the packaging and promotion of the CSM program.

d. Contingency ($ 175,000)

2. GSDR Contribution ($ 810,000) including: salaries for the staff of the OR and CSM Units, travel and per diems, packing for the contraceptives, and related costs.

3.0 COST ESTIMATES AND FINANCIAL PLAN

3.1 Total Costs of the Family Health Services Project

The total cost of this Project is estimated at approximately $22.6 million over the life of the Project. The total includes a $10.1 AID grant, $10.3 contribution from GSDR, the provision of over $600,000 in support from AID centrally-funded contracts, and over $1.6 million from UNFPA and the Government of Italy.

Figures 4-8 present the major budget allocations for the AID Grant and GSDR contribution. Figure 4 shows the FHS Project costs by component and, for the AID Grant, the specific allocations by the type of input, e.g. technical assistance and training, and for the GSDR contribution, the allocations (given in dollar amounts) for each institution. The expenditures by year of the AID Grant are presented in Figure 5, and Figure 6 shows the methods of implementaion and financing for the various inputs under the Grant. The detailed figures and breakdowns for expenditures under the Grant are provided for reference in Section 18.0 and can be related to the implementation schedules in Section 15.0. Finally, Figure 7 gives an overview of the GSDR contribution to Project costs by major budget categories and by year. Details of these allocations by component and by institution are available for reference in Section 19.

All costs shown in Figures 4-8 and in Sections 18 and 19 are based on 1984 prices and are considered reasonable and firm. The AID Grant was calculated using an inflation factor of 6% per annum for the technical assistance and an inflation factor of 10% for participant training. The costs for the commodities include a procurement and shipping charge of 42% and an inflation factor of 7%. GSDR costs include a 5% inflation factor for the categories of personnel, training and conferences, fuel, communicaitons, and vehicle maintenance. An inflationary factor of 25% was used in calculating the amounts for materials and supplies as well as equipment. To insure adequate budgetary flexibility, the budget for the AID Grant includes a 12% contingency and the budget for the GSDR contribution a 15% contingency.

The calculations of the costs to other donors for their inputs and for the inputs of centrally-funded AID support are based on figures provided to the Design Team; where specific budget figures were not available, levels of effort were estimated and costs calculated using standard costs figures.

3.2 Analysis of Financial Inputs.

3.21 AID Grant Financial Arrangements and Procurement

A. Obligation Schedule

The obligation schedule given below shows the monetary requirements by fiscal year to meet the implementation actions as shown in Section 15. Requirements for FY 84 were kept within the OYB limits of $1.6 million. The requirement for FY 1985 includes the funds required for the first two years of funding for the technical assistance contract. The remaining requirements

Figure 4

AID GRANT

FHS Project Costs by Component
(000)

	Component I	Comonent II	Component III	Component IV	Total
Technical Assistance	450	1,770	1,040	1,040	4,300
Long Term	-	1,070	680	485	2,235
Short Term	410	660	320	520	1,910
FSU	40	40	40	35	155
Training	-	190	195	15	400
Commodities	1,150	440	2,330	380	4,300
Sub-Total	1,600	2,400	3,565	1,435	9,000
Contingency	195	295	435	175	1,100
TOTAL	1,795	2,695	4,000	1,610	10,100

GSDR Contribution (in US $)

MONP	4,530	CDC	610	MOH	1,945	OR/SMP	820	10,300
		WED	1,445					
		SFHCA	330					
		SWDO	620					
			3,005					

Project Total------ 20,400

Figure 5

AID GRANT

FHS PROJECT COSTS BY YEAR

(000)

	FY84	FY85	FY86	FY87	FY88	FY89	TOTALS
Technical Assistance	75	922	1,039	1,211	938	115	4,300
Long Term	-	340	505	735	555	100	2,235
Short Term	75	550	500	440	345	-	1,910
Field Support Unit (FSU)	-	32	34	36	38	15	155
Training	55	250	80	15	-	-	400
Commodities	1,250	770	578	515	582	605	4,300
Sub-total-	1,380	1,942	1,697	1,741	1,520	720	9,000
Contingency	170	240	210	205	190	85	1,100
TOTALS	1,550	2,182	1,907	1,946	1,710	805	10,100

Figure 6

Methods of Implementation and Financing

Implementation	Financing	Approx. Amount (U.S. $000) 1/
Technical Assistance		
Direct AID Contract (L/T & S/T)	Direct reimbursement	$ 3,650
PASA	Direct reimbursement	305
AID/W Centrally funded contract to which project will contribute	Direct reimbursement	370
Direct AID contract (Eval, Mgmnt, Financial & Coord. Specialist)	Direct reimbursement	325
Logistical support from Field Support Unit (FSU)	AID PSC & PO	170
Training		
Direct Placement (early, short term)	Direct payment	110
Direct AID Contract	Direct reimbursement	350
Commodities		
Supply contracts, PSA's and direct PO's (Mission initiated PIO/C's for component 1-4)	Direct reimbursement Bank L/Com, Direct L/Com	1,925
Direct AID contract (films, supplies, equip. in component 3)	Direct reimbursement	530
GSA (Mission initiated for contraceptives)	Direct reimbursement	2,083
Direct AID Contract (packaging materials for component 4)	Direct reimbursement	282
		$ 10,100

1/ all figures include contingency factor

Figure 7

GSDR PROJECT COSTS BY CATEGORY
($000)

	CY84	CY85	CY86	CY87	CY88	CY89	TOTALS
Personnel	41	467	500	273	264	214	$1,759
Materials	35	218	99	59	67	56	534
Equipment	155	-	-	-	-	-	155
Fuel	20	150	286	53	57	53	619
Vehicle M'tnce	1	55	60	35	36	30	217
Bldg. Renovation	-	19	-	-	-	-	19
Special Travel	9	26	66	-	-	-	101
FSU Costs	53	116	49	-	-	-	218
Printing	3	43	48	1	1	-	96
Communications	-	7	7	7	8	6	35
Family Health Svy II	-	-	-	-	112	-	112
Travel & Trans.	32	1,672	1,694	170	195	169	3,932
Training and Conf.	-	145	210	259	314	272	1,200
	$349	$2,918	$3,019	$857	$1,054	$800	$8,997
Contingency	52	438	448	128	158	79	1,303
TOTALS	$401	$3,356	$3,467	$985	$1,212	$879	$10,300

Figure 8

Contraceptive Needs and Costs by Year and Type

	FY84	FY85	FY86	FY87	FY88	FY89	Total Qty.
Condoms @ .05	-	993,240 ($49,662)	2,705,800 ($135,290)	3,265,632 ($163,282)	3,885,152 ($194,258)	4,212,304 ($210,615)	15,062,128
Pills @ .21	-	-	552,610 ($116,048)	679,497 ($142,694)	747,831 ($157,057)	726,321 ($152,527)	2,706,319
IUDs @ .71	-	-	1,017 ($722)	4,701 ($3,338)	5,255 ($3,731)	5,807 ($4,123)	16,780
Jelly @ .50	4,690 ($2,345)	8,300 ($4,150)	11,070 ($5,535)	11,755 ($5,878)	13,135 ($6,568)	14,521 ($7,261)	63,471
Applicators @ .36	4,690 ($1,688)	-	-	-	-	-	4,690
IUD Kits @ $143.00	100 ($14,300)						100
	$18,333	$53,812	$257,535	$315,192	361,614	$374,526	

for the contract are shown for FY 1986. A detailed breakdown of the allocations/requirements for funding are provided in the obligation schedule in Section 18.0.

FY 84	F Y 85	FY 86	FY 87	FY 88	Total
1,600	3,400	3,000	1,400	700	10,100

B. Technical Assistance

As seen in Figure 6, AID will finance a major part of the technical assistance requirements through a direct AID contract; this contract will cover 9 years of long-term technical assistance and 68 months of short-term. The remaining short-term technical assistance will be financed through three mechanisms: (1) a PASA arrangement for technical assistance form the Center for Disease Control and from the U.S. Bureau of the Census; (2) direct AID contracts for the services of selected specialists (for coordination, for management structures, for financial accounting, and for evaluation); and (3) direct contributions to centrally-funded AID contracts for specific services needed for this Project. The contributions to centrally-funded contracts will cover 14 person-months of short-term assistance for demographic surveys and conferences in FY 85 and 86 and 7 person-months of technical assistance for the Family Health Survey in FY 87 and total $372 thousand. The direct contracts will provide for 18 person-months of assistance at a cost of $327 thousand. Figure 6 also includes funding for the Field Support Unit which will provide logistical support forthe long-term advisors; these services will be procured through purchase orders and personal services contracts.

C. Training

Ninety person-months of short-term training and study tours to third countries will be provided to the Project-related staff of the GSDR institutions participating in the Project. USAID will initiate short-term training programs for 22 person-months. All remaining short-term training and study tours will be arranged by the contractor.

D. Commodities

The ~~large~~ portion of the commodities will be procured by the Mission through the issuance of purchase orders, procurement service agents, and direct supply contracts. During 1984, the Mission will initiate the procurement of the computer, project vehicles, and a part of the audio-visual equipment and materials to be used for Component 2. Procurement of the contraceptives for Component 3 (and for the social marketing program in Component 4) will be managed by the Mission through GSA. Figure 9 presents the contraceptive procurement schedule by quantity and cost.

3.22 GSDR Contribution.

A breakdown of the budget by category of cost for the GSDR contribution is presented in Figure 8. Section 19.0 contains the detailed breakdowns by project component, agency and year.

Personnel costs include the payment of salary supplements and, for the organizations which will be established under the Project, salaries. These organizations include the Information, Education, and Communication Unit and the Operations Research Unit to be established under the Somali Family Health Care Association, and the Social Marketing Unit which will come under the SFHCA umbrella.

Materials include those to be used in thepreparation of educational and promotional brochures and pamphlets, posters, announcements, questionnaires, handbooks, etc. These are particularly important to the activities of the SWDO, Ministry of Health, WED, CDC and the Social Marketing Unit, all of which will conduct training and other outreach activities under the Project.

Equipment consists primarily of locally made and available office furniture to be used in the newly established institutions as well as those on-going agencies which are expanding their physical plants for Project purposes.

Costs for fuel are calculated at $616 thousand and are high due to the IEC and outreach activities planned for the participating organizations, training and conference activities to be conducted by the MOH, and for the conduct of the census by the Ministry of National Planning.

The Project will use the existing vehicle maintenance facility of the Rural Health Delivery Project for the service and repair of its vehicles, which will be the same as those presently being serviced by the garage. Spare parts will be ordered to supplement those already available and the mechanics will be familiar with the vehicles. Estimated cost for the maintenance and repair of the vehicles is $3000 per vehicle per year. These costs are apportioned among the agencies which will be receiving the vehicles for Project use.

Building renovation includes the repair and modest renovation of office space to be allocated to the Family Health/Family Planning Division of the Ministry of Health and selected modest renovations of an MCH center in Mogadishu to permit its use as a training site for clinical training and IUD insertion.

Special travel costs include those which will be necessary for implementing the census and its follow-up activities. The figures for hiring and guides and camels are estimates based on the number of watering holes which will need to be covered for the census of the nomads.

The FSU is included in the Shillings budget to cover the costs of housing, maintenance, utilities, and security for the long-term advisors to be provided under the contract. These costs are also apportioned among the participating institutions.

Printing covers the costs involved for preparation of materials for the Social Marketing program, as well as conferences, data analysis and conference activities of the MONP, and other promotional materials. Communications includes the mail and telex fees estimated for the entire life of the Project.

The Family Health Survey is a special activity to be conducted under Component 4 during CY 88. It will require payment for interviewers, coding, data analysis, and travel.

The travel category includes a large component for the 1986 Census activities of the MONP. Travel also include supervision and outreach activities of the other participating agencies.

Training and conferences includes the costs of travel and per diem to be paid to the trainers and participants in the wide variety of training courses and seminars to be provided under the Project.

3.23 Other USAID Funding

Inputs will also be provided by selected centrally-funded contractors. These are listed below with estimates of their inputs in level of effort and dollar amounts.

Project/Contractor	Level of Effort	Dollar Amount
Demographic Data for Development	3 person-months of TA	47,000
RAPID II	3 technicians over 2 month period, etc.	115,000
INPLAN	3 person-months of TA	85,000
Population Communication Services (PCS)	4 person-months of TA	56,000
Family Planning International Assistance	3 person-months of TA	46,000
JHPIEGO and Association for Voluntary Sterilization (AVS)	Training for up to 15 staff for 2 months per person	100,000
INTRAH	3 technicians for 2 person-months each	83,000
	and training for up to 10 staff for 2 months per person	68,000
TOTAL		600,000

3.24 Other Donors

The major contributions of other donors to this Project will be in the census component, The United Nations Fund for Population Activities has taken the lead in supporting the census effort and soliciting contributions of other donors. The UNFPA will provide long-term training to selected staff of the MONP, three long-term advisors to the MONP in overall census management, census cartography, and data processing, funding for incidental costs,

including paper and other supplies, and some vehicles. (The UNFPA has also provided support for the census under a project geared to assist the GSDR in preparation for the census.) The total estimated costs of the UNFPA contribution are: $ 967,000

The Government of Italy through the UNFPA will also provide support to the census. They will give vehicles, prepare the site for the installation of the computer, support office space, and purchase cartographic equipment. Total contribution is estimated at: $ 702,000

4.0 IMPLEMENTATION PLAN

The Implementaion Plan for this Project provides a framework for executing the proposed component activities in a coordinated and mutually reinforcing manner. Three factors are critical to the success of this Plan: (1) the efficient operations of three separate executing agencies, (2) an effective coordinating structure, and (3) a U.S. Private Contractor qualified to provide technical assistance and procurement support.

4.1 Overall Project Implemenation Responsibilities

The Ministry of National Planning will have the overall responsibility for the implementation of the Project. The Ministry of Foreign Affairs will authorize the Grant Agreement and approve all substantive Project modifications. The Ministry of National Planning will administer the Project Coordinating Committee.

Three institutions: the Central Statistical Department of the Ministry of National Planning, the Family Health/Family Planning Division of the Ministry of Health, and the Somali Family Health Care Association will have executive responsibilities for implementing the Project. The Central Statistical Department will be responsible for implementing the Population Data and Policy Component. The Family Health/Family Planning Division will implement the Family Health Services Component. The SFHCA will have the overall responsibility for implementing the IEC and Operations Research Components. The Ministry of Foreign Affairs and the MONP will delegate selected financial and management authority to the executing agencies to ensure the smooth implementation of the Project.

4.2 The Coordinating Structure

Somali institutions receiving Project assistance include: the Somali Family Health Care Association; the Central Statistical Department; the Family Health/Planning Division; the Somali Women's Democratic Organization; the Ministry of Education's Curriculum Development Center, the Population Education Department and the Women's Education Department; and the Ministry of Information and National Guidance.

A Project Coordinating Committee will be established which includes representation from each of these institutions and USAID. The function of the Coordinating Committee is to provide a forum for discussing the progress, problems, and issues related to Project activities. The Committee will meet four times a year. The MONP will Chair the Committee and the SFHCA will provide the Secretariat. The Secretariat will be responsible for setting agendas and recording the proceedings of Committee Meetings. Decisions of the Committee will be acted upon by the Chairman under the authority of the Director General, MONP. Special technical assistance will be provided to this Committee for setting it up and its on-going operations. (See Section 4.4.)

In addition, the Secretariat will: (1) serve as a clearinghouse for information related to Project activities; (2) identify, investigate and bring to the attention of the Committee the general issues which constrain the development of family health services and population policies in Somalia; (3) recommend methods of integrating the activities of the various institutions involved in family health services and population related activities.

4.3 Project Contractor

The shortage of skilled personnel within the GSDR precludes the possibility of using a Host Country contracting mode. (See Administrative Analysis, Section 13.4.) Instead, a Direct AID Contract, competitively selected, will be used to hire a Project Contractor. The Contractor will be responsible for providing technical assistance, procuring commodities, and supporting participant training. The Design Team recommends that selection of highly qualified long-term advisors and prior overseas experience in providing family health services, and procurement of commodities, especially in Africa, be given highest priority in the selection of the Project Contractor.

The USAID Mission, with the assistance of the GSDR, will prepare a Request For Proposals (RFP). Once the Project Paper is approved and funds obligated, USAID will forward the RFP to AID Washington for advertisement. The Mission has requested that the selection and contracting of the Project Contractor be undertaken by USAID Somalia with the assistance of the Regional Contracting Officer (REDSO/ESA). Bidders will forward separate technical and price proposals directly to the USAID/Somalia office. The selection Committee will be composed of the Regional Contracting Officer, the Project Officer, the Project Manager, and two GSDR officials.

4.4 Technical Assistance

The Project provides 220 person-months of technical assistance. Forty person-months of this technical assistance will be managed by USAID in support be selected activities under the Population Data and Policy component and for

the IEC and Clinical Family Health Services components, as well as the overall project management and coordination prior to the contractor's arrival in-country. The U.S. Bureau of the Census will provide 15 person-months of short-term technical assistance under a PASA arrangement. The remaining 180 months will be provided by the Project contractor, including 108 person-months of long-term assistance and 72 person-months of short-term assistance.

The USAID/Somalia Field Support Unit will be responsible for providing housing, utilities, and guard services for the Project's long-term technical assistance personnel.

4.5 Procurement

A substantial portion of the procurement needs of the Project will be met up front through Mission-initiated procurement actions. Key items will be the mainframe computer, vehicles, and some audio-visual equipment. The Mission will also manage the procurement through GSA of all of the contraceptives required over the life of the Project. The Project Contractor will be requested to procure all of the remaining commodities, as indicated in the Procurement Plan (See Section 14.0.) as a separate part of the overall contract. The Contractor will be required to purchase, ship and insure Project commodities as per the procurement schedule. The Contractor will provide a quarterly report on its procurement activities to the USAID Controller and Project Officer with copies to MONP. The Mission's Field Support Unit will be responsible for clearing and receiving the commodities in Somalia. The FSU will be supplied with local funds from the Generated Shillings Account, equivalent to 5% of the total cost of the commodities for arranging warehouse space, local purchases, hiring local employees, and assisting in the inventorying of end use of the commodities.

4.6 Disbursement of Funds

Foreign exchange costs will be provided from the Project. Budgeted local costs will be provided from the Shillings Account generated by the Commodity Import Program and the PL 480 Program. Allocation of funds for the Project will be made according to the Project Financial Plan and Obligation Schedule. (See Sections 3.0 and 18.0.)

Disbursement of foreign exchange will be made by the Contractor on a reimburseable basis by USAID/Somalia. The Contractor will receive funds as established in the contract and provide regular reports to the USAID Somalia Controller and the Project Officer. Disbursement by USAID will be executed through the regular disbursement instruments and recorded by the Mission Controller.

Overall agreement to finance identified local costs for the Project from the CIPL Shillings account will be established between the GSDR and the Mission prior to the release of funds from USAID. Disbursement of funds from the CIPL Account to the executing agencies of the Project will follow standard procedures. The executing agency will prepare an annual budget which fore-

casts the levels of local currency which will be needed for project implementation in the following year. These budgets will be submitted to the Ministry of Finance by the executing agencies. The MOF will prepare an overall budget which will be reviewed and approved by USAID before it is sent to Parliament for its approval. The MOF will then prepare a disbursement schedule which again is approved by USAID before funds are released. Financial monitoring and controls are provided by the MOF/CIPL Audit Section.

The allocation and phasing of local costs are presented in the Financial Plan (See Sections 3.0 and 19.0).

4.7 Project Implementation Schedule

An overall project Implementation Schedule is presented on the next page.

4.8. Implementation Plans for Project Components

Implementation plans for each of the four components are provided in the Annexes. (See Section 15.0.) The phasing of the activities of each component and their relationships to each other are presented in the Implementation Scheme at the end of Section 15.0.

5.0 MONITORING PLAN

The following Monitoring Plan has been established to accurately track the progress in implementing the Family Health Services Project. This Plan identifies the persons responsible for monitoring the Project, describes the type of information which will be required, and proposes ways in which this information can be collected.

5.1 AID Management System

The USAID Population Officer, who will serve full-time as the Project Manager, will have the overall responsibility for monitoring the Family Health Services Project.

The activities to be carried out under AID Project management, which represent the Project Manager's responsibilities for the Project, are listed in Table 4.1 of Section 4.0 and also presented in the Implementation Schedule for AID management in Section 15.0.

As shown in the Implementation Schedule in Section 15.0, the initial monitoring work will focus on the Conditions Precedent and Covenants in the Project Grant Agreement. After signing the Grant Agreement, a Project Implementation Letter will be sent to the GSDR Ministry of Foreign Affairs (MOFA). When the Condition Precedents to disbursement are satisfied, a Project Implementation Letter, cleared by Regional Legal Advisor, will be passed to the MONP, MOH and SFHCA. This will constitute the approval for the disbursement of funds

Table 4.1. FAMILY HEALTH SERVICES PROJECT IMPLEMENTATION SCHEDULE

MONTH	ACTIVITY	RESPONSIBLE OFFICER
	PROJECT DEVELOPMENT	
1	Final PP Draft Submitted.	Population Advisor
1	Project Authorized.	Mission Director
	FINAL NEGOTIATION	
	Draft ProAg and PIL No.1 to Grantee	
1	Negotiation of ProAg and PIL	
1	Grant Agreement Signed	Mission Director/GSDR
1	Funds Obligated	Controller
1	AID/Washington Advised	Pop Advisor/Director
1	Press Release	Pop Advisor
1	Project Manager Designated	Mission Director
2	Conditions Precedent Met	Population Advisor/GSDR
	Condition Precedent No.1 Condition Precedent No.2 Condition Precedent No.3 (Project Coordinating Committee formed)	
	CONTRACTOR SELECTION	
1	USAID Finalizes RFP	Population Advisor
1	USAID Forwards RFP to AID/W	Population Advisor
2	AID/W Publishes RFP	AID/W
4	Bidders Submit Proposals	Bidders
5	Contractor Selected	Committee
6	Contract Signed	Contractor/USAID
6	In-country Logistics Support Arranged	Pop Advisor/FSU
8	Long-term IEC Advisor and Long-term Training and Management Systems Advisors Arrive In-Country.	Contractor

MONTH	ACTIVITY	RESPONSIBLE OFFICER
	SHORT-TERM ADVISORS (COMPONENT No. 1) (see section 15.0 for more detailed schedule).	
1	USAID Prepares PASA for BUCEN Assistance to Cenuse	Population Advisor
On-going (see sec. 15.0)	USAID Identifies TA Needs	Population Advisor
On-going	USAID Prepares Scopes of Work	Population Advisor
As needed (see sec. 15.0)	USAID Prepares PIO/T for Add-on to Centrally-funded Contractors or Individual Consultants	Population Advsior
As needed	USAID Arranges Logistics	Population Advisor
As needed	USAID Monitors Performance	Population Advisor
	SHORT-TERM ADVISORS (OTHER COMPONENTS) (see section 15. 0 for more detailed schedule).	
On-going	Contractor Identifies TA Needs	Contractor
On-going	Contractor Prepares Scopes of Work	Contractor
As needed	Scopes of Work Approved	GSDR/USAID
As needed	Contractor Arranges Logistics	Contractor
On-going	Contractor Monitors TA Performance	Contractor
on-going	Contractor Reports to USAID on TA	Contractor
	PROCUREMENT OF COMMODITIES	
1	USAID Prepares Specs. for First Round of Commodities	Population Advisor/FSU
2	USAID Prepares PIO/C's for First Round of Commodities	Population Advisor/FSU
4,6,8,10	USAID Monitors PIO/C's Status	Population Advisor/FSU
12	Commodities Arrive and are Cleared	FSU
As needed	USAID Prepares PIO/C's for Contraceptive Procurement (see section 15.0 for schedule)	Population Advisor/FSU

MONTH	ACTIVITY	RESPONSIBLE OFFICER
As needed	USAID Monitors Contraceptive Procurements	Population Advisor
As needed	Contraceptives Arrive and are cleared	FSU
See Procurement Plan	Contractor Prepares Specs.	Contractor
	Contractor Orders Commodities	Contractor
	Contractor Monitors Orders	Contractor
	Commodities Arrive and are Cleared	FSU
	PARTICIPANT TRAINING	
7-8	Organizations Identify Trainees	Population Advisor/GSDR
8-9	USAID Prepares PIO/P's	Population Advisor
9-10	Logistics Arranged	Population Advisor
11-14	Participants Leave	Population Advisor
12-15	Participants Return	
On-going	Organizations/Contractor Identify Trainess	GSDR/Contractor
On-going	Contractor Arranges Courses	Contractor
On-going	Participants Leave	Contractor
On-going	Participants Return	
	IMPLEMENTATION PLANNING	
9,18,30.42	Contractor Prepares Workplans	Contractor
10,19,31,43	Review of WP with USAID/GSDR	Contractor/USAID/GSDR
11,20,32,44	Contractor Submits Final Workplan	Contractor/GSDR/USAID

MONTH	ACTIVITY	RESPONSIBLE OFFICER
	MANAGEMENT AND EVALUATIONS	
Every Quarter (Mar, Jun, Sept, and Dec)	Contractor Submits Reports	Contractor
Every Quarter (Apr, Jul, Oct, and Jan)	Project Coordinating Committee Meeting	GSDR
24	First Evaluation	Population Advisor/REDSO/ AID/W
48	Second Evaluation	Population Advisor/Selected Consultants
50	Preparations Start for Follow-on Project	Population Advisor
60	PACD	

for specific components where Conditions Precedent have been met. The USAID Project Manager will, over the life of the Project, follow Project implementation to ensure that Project activities comply with the agreed upon Covenants and other AID policies, procedures and regulations.

Much of the Mission's monitoring attention will be focused on the Project Contractor. The Contractor will prepare an Annual Work Plan which will be consistent with the overall implementation plan for the Project; in it will be detailed how the major tasks will be accomplished, set deadlines and time periods within which these tasks are to be accomplished, identify the responsible parties for implementing the tasks, and quantify task inputs and outputs. This plan will be used to assess progress and identify problems with implementation. The Contractor will submit quarterly reports specifying the levels of Project inputs which were provided (e.g. person-months of technical assistance), tasks which were completed and the significant outputs which were achieved. With regard to inputs, the reports will supply details on the status of technical assistance, training, commodity procurement, and financial disbursement. For the outputs the Contractor will identify those achieved for the Project as a whole and for the components for which they have responsibility (i.e. IEC, Clinical Family Health Services, and Operations Research).

Activities for which the Contractor is not responsible, such as the census and various centrally-funded activities, will be monitored directly by the Project Manager. Short-term advisors will submit work plans and trip reports which identify accomplishments, specify problems, and present plans for any follow-up actions required. Table 5.1 presents the centrally-funded and PASA inputs with the corresponding time frame. Table 4.1, the Implementation Schedule for the FHS Project, and Table 5.1 together constitute the management responsibilities of the Project Manager.

Under Component 1, the Project Manager will be responsible for preparing the documents for the PASA arrangement with the Bureau of Census for technical assistance and arrange for their lodging in Mogadishu. The BUCEN staff will be responsible for all other logistical arrangements and for maintaining contact with the Mission regarding progress and problems. The Project Manager will also monitor the activities of the Centrally-funded contractors who will assist in the analysis of the 1980 Survey of Population and the 1982 Settlement Survey, and with the representatives of these contractors, develop the scopes of work of the portions of their work to be funded by the Project. The Project Manager will also initiate the PIO/Ts for the technical assistance to be provided in the execution of the demographic studies, the workshops and conferences of this component.

Under Components 2 and 3, the Project Manager will be responsibile for arranging for the technical assistance needed for starting the IEC Unit and conducting the baseline surveys and for assisting the Ministry of Health to develop its own workplans and management structure, revise its logistical systems, and improve its financial systems. These actions are shown in the Implementation Plan in Section 15.0.

Procurement will be divided between the USAID Mission and the Project Contractor; the monitoring system will be designed accordingly. (See Section

Table 5.1. Centrally Funded/Mission Managed Project Inputs

Month	Activity	Source/Funding Mechanism
	TECHNICAL ASSISTANCE	
1, 3, 5, 8, 15, 21, 24, 30	Assistance to the 1986 Somali Census	BUCEN/PASA
2, 3, 4, 6	Analysis and report for 1980 Survey of Population	Demographic Data for Development (Central and FHS)
3, 5, 6	Settlement Survey Analysis and report	INPLAN contractor (Central and FHS)
1, 2	Planning for IEC Unit	FPIA
3, 4, 5	Conduct of IEC inventories and survey	Population Communication Services
2	Definition of FH/FP Divisions structure and staff roles and responsibilities	To be determined.
3, 6	Review/revision of logistical and service information systems.	Center for Disease Control
10, 15	Demographic Surveys	To be determined.
28, 42	Population Conferences	To be determined.
34, 38	Workshops on data use in planning	DDD/INPLAN - FHS Project
33-47	Conduct of Second Family Health Survey	Demographic and Family Health Survey contractor

14.) The USAID Field Support Unit assisted by the Project Manager will be responsible for USAID procurement and the required documentation will be deposited in the Mission. The monitoring of the Contractors procurement will be the responsibility of the Project Manager. The Project Manager will utilize the Quarterly Procurement Reports which will include the specifications for the commodities which have been ordered, their source and origin, cost and delivery dates. The Project Manager will also rely on site visits, trip reports and evaluations to monitor the procurement under the Project. The scheduling of major procurement actions which are the responsibility of the Project Manager are shown in Section 15.0.

The Project Manager will also monitor the participant training provided under the Project. For the IEC, Clinical Family Health and Operations Research Components, the Project Contractor will keep records of all training provided by the Project and include this information in quarterly reports. Likewise, BUCEN will provide information on its training programs and trainees in its reports. Additional information on the Project's training activities will be obtained from visiting training sites, observing training sessions and examining training materials.

Other actions for which the Project Manager will be responsible include: assistance to the participating agencies in preparing their first budgets for the CIPL Unit (before the contractor arrives in-country); arranging for the scheduled evaluations; and maintaining contacts and liaising with all of the participating agencies.

The availability of funding for project implementaiton will be monitored by the USAID/Somalia Controller. The Controller will review the quarterly reports of the Contractor and expenses incurred by the Mission to ensure that expenditure levels are within the limits of the approved fiscal authority.

Semi-annual reports will be prepared by the Project Manager for the Mission Director and AID/W. These reports will follow the standard format established by AID/Africa Bureau.

A chronological filing and record keeping system for the Project will be established at USAID/Somalia to facilitate Project monitoring.

5.2 GSDR Monitoring System

The FHS Project Coordinating Committee will serve as the principal mechanism for the GSDR to monitor Project implementation. As the Secretariat to the Committee, the SFHCA will request from the executing agencies and organizations quarterly progress reports, prepared according to a standard format. These reports will be assembled, duplicated, and distributed to the Committee members before their quarterly meeting. In addition to the review of this quarterly report, the Committee will provide the opportunity for the participating institutions and USAID to discuss problems, resource allocations, proposed Project modifications and other issues arising from the implementation process. Minutes of the meetings will be documented; these and the reports presented to the Committee will constitute a valuable resource for overall Project monitoring.

At the sub-project level, the Operations Research Unit will be involved in strengthening and, in some cases, creating, monitoring systems for local institutions involved in family health activities. The long-term advisor and the Somali counterparts will be responsible for developing and integrating these systems so that they can be utilized for Project monitoring.

6.0 SUMMARY OF ANALYSES

6.1 Summary of Technical Analyses

The four separate components require different technical considerations. The summary of each component analysis is treated below:

A. Component One: Population Data and Policy

The Project's data and policy assistance is one element in a broad population program. This component supports data gathering and evaluative research necessary for government leaders to: (1) establish the current size, distribution and needs of the population; and (2) plan programs and formulate policies which address population and population-related problems. Data on Somali population are scant and of questionable quality. Local skills and facilities for production and utilization of data are not well developed. Despite these limitations, a few GSDR leaders are beginning to recognize the value of population data and the need for policies which incorporate population information.

The FHS Project responds to requests by the GSDR to provide technical assistance, training and research aimed at data production, analyses and applications for planning and policy-making. The largest amount of resources will be provided to data collection and tabulation activities, because of the poor quality of existing data. In the later years of the Project, as data sets are built up, assistance will be provided to utilize this information for planning and policy making purposes.

Problems which require special attention include: (1) Census mapping activities; (2) enumeration of nomads; (3) CSD management; (4) coordination among different GSDR institutions; (5) data processing support from UNFPA; and (6) logistical problems associated with implementing the Census.

B. Component Two: IEC

Information, education and communication (IEC) covers the broad spectrum of media and other communication channels by which individuals learn about innovations. The introduction of an innovation, such as family health services, can be facilitated through a well planned IEC program designed to encourage its adoption. The FHS Project provides the assistance for developing family health-related IEC programs.

Somalis learn of innovations through the radio, printed materials, their friends, community leaders and local officials. The most critical variables in obtaining people's early acceptance of family health programs depend

upon: (1) their perceptions of the credibility of the persons or medium presenting family health information; (2) the consistency of the information with their values and traditional way of behavior; and (3) the personality characteristics of the individual.

To provide family health information to as many couples as possible, the Project is supporting a multi-institutional, multi-media approach for developing IEC programs. The criteria which are being used to select IEC activities for the Project include: (1) participating institutions must have adequate outreach into the urban and settled rural areas and a demonstrated interest in family health; (2) IEC methods must be easy to use, readily available, relatively maintenance free and appropriate to the message they are sending. The development of grassroots activities in IEC will assure that the messages are presented in a framework and language familiar to the people.

Potential problems which require ongoing consideration include: (1) lack of coordination among the IEC agencies and activities; (2) potential maintenance problems with equipment; (3) potential delays in production of materials; and (4) the need to reach men as well as women.

C. Component Three: Clinical Family Health Services

Clincial family health services are just getting established in Somalia. The Project assistance is directed to areas of greatest perceived need: (1) the development of a more effective logistical and management systems; and (2) improved training capabilities and expanded family health training activities for health workers.

Family health services will continue to be developed within the Maternal Child Health Program and increasingly through Primary Health Programs. This strategy is preferred because MCH services are established in all districts and regions and in some regions already include family health services. The development of family health services within the Primary Health Care system will proceed more slowly, primarily through training and information programs, since this system is also getting started.

Problems which are anticipated include: (1) quality control of family health services; (2) recurrent costs for services; (3) maintenance of equipment; (4) coordination with MCH and PCH program; and (5) maintaining a positive policy environment.

D. Component Four: Operations Research

Operations Research is an especially important part of the Family Health Services Project. Since family health services have only recently started in Somalia, pilot testing of delivery approaches and early monitoring of activities, including social marketing, will be crucial to the Project's success. The results will be instrumental in designing a broader-based, refined follow-on Project.

The establishment of a separate Operations Research Unit at the SFHCA is designed to assure coordination among all of the implementing agencies and

to assure that OR will be built into the activities of these institutions, as their staff will need to be actively involved with the implementing of all OR studies. Proposals for all studies will be required to ascertain the objectives, utility and costs of each and to assess which ones are most appropriate. Specific implementation plans for the large-scale and small-scale studies will assist in monitoring their implementation and assessing the staffing and other requirements for the institutions to be involved. The second Family Health Survey will build on the experience of the first, and be expanded to encompass all of Somalia, and perhaps men.

Potential problems are relegation of this component to be of less importance than the others and the maintenance of communication links among the participating institutions.

The Contraceptive Social Marketing Program will meet a demand for contraceptives from people who, for various reasons, prefer not to use the government health services. The well-established retail network of pharmacies and other outlets in the six major urban areas can be used to meet this demand. The possibility of using a private entrepreneur for managing the program was explored and rejected because the few private entrepreneurs are overcommitted to other business enterprises. Placing the CSM Unit under the SFHCA with a director hired to manage it has the advantages of providing the Unit with ready advocates and a legitimate, approved organizational relationship. Anticipated problems which will require attention throughout the Project, include developing its self-sufficiency, retaining its independence (of government), and maintaining a positive environment for the program.

6.2 Summary of Economic Analysis

A conventional cost-benefit economic evaluation for Somalia is impractical due to limited family planning experience and data constraints. Likewise, it is inappropriate since the program is being promoted by GSDR officials as a health measure and not expressly for reducing fertility. The economic analysis, then, dispenses with a formal cost-benefit evaluation and instead provides a cursory assessment of population conditions and economic development prospects for Somalia.

At the macroeconomic level, recent experience shows Somalia's national population growth rates to be as high as national production growth rates so there has been no real improvement in GNP per capita. The current annual rate of population is estimated to be 3.1 percent. Such a rapid growth rate has important implications for future requirements of that population in terms of food, housing, education, health and employment. There is good reason to expect population growth to actually increase in coming years. For real per capita national development to take place, rates of national production growth will have to be stepped up to even higher rates.

At the microeconomic level, it has been argued that rapid population growth actually contributes to per capita national production growth. This argument breaks down, however, for many less developed countries in two ways. First, as is true in Somalia, natural land resources are often ill-suited to support

a rapidly expanding population. Second, en hancement of human and material capital is made difficult by rapid population growth. The short-term burden represented by six to eight child families often means diverting family income from investment (which is needed for modernizing production processes) and from education (which is needed for improving human skills) to meet more immediate food and health requirements of family members. This short-term burden of children is translated in the long-term to continued traditional production techniques and largely unskilled laborers.

Adoption of smaller family size norms enable families to devote greater resources to more productive technologies and to better educate their children. There is evidence that a segment of the population of Somalia (those educated and urbanized, employed in the modern sector) have adopted these norms already. As this segment is likely to grow, it is important to establish family health programs which will enable these couples to freely choose the timing and number of their children.

6.3 Summary of Social Analysis

A. Introduction

The data available on relevant social and demographic characteristics are very limited and most of the studies which have been done are geared towards women and the urban and rural, settled communities. The FHS Project will address these deficiencies by providing funds and technical assistance to conduct studies useful for planning and revising programs for IEC and family health services delivery. Thus, the assertions in this analysis are drawn from rough interpretations and are subject to further refinement.

B. Context

1. Child Spacing and Health

The poor health status of Somali mothers and children are evidenced in the high rates of maternal and child mortality and morbidity. Thus high fertility norms are reinforced as couples attempt to compensate for the high infant mortality by having many children so that adequate numbers will survive to assist the family and ultimately their parents when they reach old age. Lack of access to family health services and the poor understanding of the negative effects of closely spaced births also contribute to high levels of fertility. However, there is evidence to suggest that Somalis have practiced some forms of child spacing to ensure healthy mothers and children.

2. Organization and Decision-Making

The Somali people share a common nomadic heritage, language and oral tradition. They have preserved a high degree of cultural, social and linguistic unity over the centuries. Lineage and clan membership assign each Somali a place in society, and lineage groups still compete for the scarce resources of water and grazing areas. Although close to 100 percent of Somalis adhere to the Muslim faith, they are divided in their interpretations of the

Quran, following one of the four brotherhoods, each defined by the teachings of a different sheikh.

The socio-economic divisions of nomad, settled and urban are somewhat misleading as many families are simultaneously occupied in at least two or even all three sectors. Many farmers and city dwellers actually become nomads during the rainy seasons and nomads may "settle" in urban areas during the dry periods. Thus contacts between the urban and settled and nomadic populations are frequent and ties of urban Somalis to rural and nomadic relatives remain strong. Household may form extended management units which may be geographically dispersed, encompassing even those family members who have gone to work in the Gulf States.

Marriage and the role of women must be seen in the context of the high value placed on family, clan and lineage. The purpose of marriage is primarily to produce children to strengthen and increase the numbers of the father's lineage. These factors place strong pressures on individuals to have many children.

3. Social Changes and Population Growth

Most of the evidence indicates that Somalia's high rate of population growth is likely to accelerate in the near term as a result of the following: (1) improved health services, which will effect a decrease in infant mortality; (2) a decline in breastfeeding (with a decrease in the contraceptive effect of this practice); (3) a decline in traditional practices which serve to limit fertility; (4) the increase in fertility which has accompanied the achievement of primary education by large numbers of women in other countries; (5) increases in fertility anticipated as more nomads are settled. Further, as noted above, Somalis adhere to high fertility norms and are under pressure to produce many children. Thus, fertility is not likely to drop, except among certain sub-groups, i.e. those in the urban areas, even if family health services are made available, as the numbers of family health users are likely to grow very slowly.

C. Beneficiaries and Benefit Flow

1. Direct, Indirect and Ultimate Beneficiaries

The direct beneficiaries of the Project components are the personnel of the Somali family health institutions, many of them women, who will receive training and advice to enable them to manage program activities, deliver services and collect, analyze and use data for planning, programming and policy development. Indirect beneficiaries will be the users of new data and the IEC materials developed with Project support. The ultimate beneficiaries are those Somalis who will benefit from improved and expanded services and health information.

2. Benefit Flow: Data Collection and Use

The Project will support the analysis of useful, previously collected data and will support the collection and analysis of new data sets to

fill some of the many data gaps which exist in Somalia. This means that significant benefits of the Project will flow indirectly -- first, to the individuals and institutions responsible for data collection and use, then to service delivery institutions and finally to the individuals who benefit from the services.

D. Feasibility and Impact

1. Political, Social and Ideological Factors

The social feasibility of establishing broad child spacing services appears to be positive in light of (1) the evidence of governmental support, particularly by the Somali Women's Democratic Organization and in the establishment of the Somali Family Health Care Association in 1983, and (2) the evidence of growing demand for contraceptives, mainly derived from informal anecdotal surveys and accounts from those presently providing family health services.

Another factor affecting the feasibility of expanding these services is the likelihood of on-going public support for child spacing and access to contraceptives. This will depend on opinions held by the society's traditional leaders and by male family heads, and those opinions are likely to be affected by how the program is presented. If it is presented as birth spacing to improve family health and well-being and as something which is within human influence and beneficial, then it could be seen as fully within social and religious tradition. As Somalis value the opinions and teachings of religious leaders, it will be especially important to foster their support.

2. Concerns

To facilitate acceptance of family health, all of those involved will need to do the following:

a. Maintain a positive policy environment.

b. Promote public understanding through appropriate educational materials and messages.

c. Study male attitudes and the means to get their support.

In its emphasis on capacity-building, data generation and the strengthening of services in urban (and more settled, rural) areas, the Project is taking a sound approach to a sensitive area by (1) building Somali capacity to deal with family health problems on their own, (2) helping to insure that programs are designed and refined on the basis of current information and (3) supporting the delivery of services first to segments of the population which are most likely to be receptive to Project-supported innovations.

3. Impact

This Project looks to develop institutions which will not only be able to sustain activities, but also replicate or adapt delivery systems in the

areas of the country which remain underserved. Furthermore, the kin networks mentioned above may serve to disseminate information and new attitudes to the more isolated, rural areas and to nomads.

6.4 Summary of Financial Analysis

The purpose of the Family Health Services Project is to strengthen institutions in order that family health activities and practices may be promoted and eventually accepted by Somali families. The four components of the Project will achieve that goal and provide the basis for extending the family health services following the five-year Project period. Thus, financial costs and benefits of the Project cannot appropriately be measured by conventional methods using costs per current user and projected contraceptive prevalence rates. While the Project does include the distribution of contraceptives, at this point in time, this is ancillary to the central purpose of the Project and its costs are likely to exceed those of other established family planning programs.

The estimates of monetary inputs for the various project activities can be used to derive such measures as cost per trainee; however, these will not be useful in comparing this program to those in other countries (See above) or to similar programs in Somalia. Somalia has, at present, little, if any, of the information needed to make such comparisons. Likewise, the costs of training the teachers, midwives and other staff can be computed, but the results of their training in changed practices and their effects on behavior are impossible to predict.

Given that this Project represents the beginning of the delivery of family health services in Somalia in a coordinated fashion, it is not possible to anticipate and take action to assure that the GSDR will be able to assume responsibility for the recurrent costs of the Project. At start-up, all Projects are relatively more expensive; further, this Project will actively consider and assess different ways of providing family health services, e.g. through contraceptive social marketing as well as through other means. As noted in the Description of Component 4, Section 2.44, one of the important areas for investigation in the Operations Research studies will be the issue of recurrent costs and the Project will look for ways to minimize these costs. This is yet another reason for supporting the close coordination not only of the organizations involved in family health activities, but also those who are providing services to similar groups of people.

The development of financial management skills and capability will be an area of emphasis in the Project training and technical assistance. Those institutions which are presently involved in family health activities have not yet demonstrated their competence to manage and account for funds. The other organizations, just joining in the delivery of family health services, still have no track record in financial accounting, but must be assumed to require assistance in order to adhere to the requirements of the GSDR and AID in accounting for local currency expenditures. A first step in providing this help was a four-day workshop in financial management and accounting conducted in May 1984 by a consultant with the active collaboration of the CIPI Unit.

Additional assistance will be provided by means of similar workshops and direct technical assistance from external consultants and from the CIPL Unit.

6.5 Summary of Administrative Analysis

The lead institutions of the four Project components are as follows: for Component 1, Population Data and Policy, the Central Statistics Department of the Ministry of National Planning; for Components 2 and 4, Information, Education and Communication (IEC) and Operations Research (OR), the Somali Family Health Care Association; and for Component 3, Clinical Family Health Services, the Family Health/Family Planning Division of the Ministry of Health. Other government institutions will participate in each component. The coordination of the Project overall will be handled by the Project Coordinating Committee, to be formed under the direction of the Ministry of National Planning.

The major activity under Component 1 is the 1986 Census of Population, which presents a formidable technical and management challenge to the Central Statistics Department. Inputs of technical assistance from the FHS Project and from the UNFPA are being provided to CSD to help meet this challenge and to develop CSD's capabilities for future, similar endeavors. The assistance includes: from UNFPA, three long-term advisors in cartography, census design and management, and data processing; from USAID, short-term advisors for census and questionnaire design and data processing system design. These advisors will assist not only in their particular technical areas but will also address related planning and other management needs. Under other funding (non-FHS Project), USAID is also funding two training programs for census planning. UNFPA is providing funds for two accountants to manage the large budgets of both the GSDR and generated shillings to be used for the census. USAID will support the maintenance of the computer to be purchased under the Project by providing training for the CSD staff and a maintenance contract with the computer company/supplier. Annual plans and quarterly reporting will be instituted to monitor progress and identify any problems early.

The Somali Family Health Care Association is a newly-established and, as yet, untested organization. The membership of its Board, however, includes representatives of all the organizations and most of the people interested and involved in family health; it therefore has a unique position among Somali institutions with potential for a strong role in coordinating all Somali family health activities. The FHS Project will provide substantial support to the Association to help it realize this potential. In addition to providing local currency funding for a larger building and for hiring full-time staff for the IEC and OR Units, the Project will offer short-term training and long-term technical assistance. The advisors will assist the SFHCA to set up the IEC and OR Units; develop the needed management skills in planning, monitoring, coordination, documentation, and evaluation; strengthen its financial management capabilities; and develop its logistics management for vehicles and the A/V equipment. The IEC and OR Technical Groups will complement the coordination functions of the Units. These groups will approve joint work plans and monitor progress. The advisors will assist the Units in planning the meetings for these groups and in making them as productive as possible.

The Family Health/Family Planning Division was created in 1981 by the Ministry of Health to implement family health services. It is under the Department of Maternal Child Health and Community Health Services. Since its founding, the Division has grown rapidly to its present size of 28. It plans to reorganize and expand further. Its staff is eager and enthusiastic, but their previous training in nursing and family health clinical skills has not provided them with the skills they need for management of a program which will be more than doubling in size over the next 5 years. Present problems with financial and logistics management, planning and documentation, and overall organization will be addressed during Project implementation with a three-year Training and Management Systems Advisor and short-term consultation in financial management, logistics and service statistics, and evaluation. Other deficiencies will also be addressed so as to assure an effective management capability; vehicles will be provided so that scheduled activities can be implemented in time and office space will be renovated so that the staff have suitable working conditions.

The problems of the other, participating institutions are similar to those described above for the lead institutions. Technical assistance will be used to strengthen their technical and administrative capabilities.

The Project Coordinating Committee will be initiated by the Ministry of National Planning and supported by the SFHCA as the Secretariat. Membership will include representatives from all of the participating institutions in the FHS Project and will, therefore, closely parallel the SFHCA Board. While the Committee will not have direct responsibility for preparing budgets and other, operational management functions, it will play an important managerial role in planning overall Project activities, assessing Project progress towards established targets and goals, identifying problems and solutions, and acting on any issues affecting Project implementation. This Committee is a new forum and its members have little training or experience with similar institutions. The Project, therefore, has provided for periodic technical assistance to the Committee and the Secretariat; the first visit will occur early in Project implementation, when a consultant will work for 2-3 months assisting the staff and the Committee draw up the terms of reference, outline their roles and responsibilities, and draft any documents needed for their on-going operations. Then, every year the advisor will return for up to 3 months to follow up on the functioning of the Committee and the Secretariat and to assist in resolving any problems.

7.0 CONDITIONS PRECEDENT AND COVENANTS

7.1 Source and Origin of Goods and Services

Commodities financed by AID under the Project shall have their source and origin in the United States, the Cooperating Country or any other Code 941 country, except as AID may otherwise agree in writing. Except for ocean shipping, the suppliers of commodities or services shall have the United States, the Cooperating Country, or other Geographic Code 941 countries as their place of nationality, except as AID may otherwise agree in writing.

Ocean shipping financed by AID under the Project shall, except as AID may otherwise agree in writing be financed on flag vessels of the United States.

7.2 Conditions Precedent to Disbursement

7.21 First Disbursement:

Prior to any disbursement of funds or to the issuance of any commitment documents under the Grant, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish A.I.D. in form and substance satisfactory to A.I.D.:

A. An opinion of counsel acceptable to AID that the agreement has been dully authorized and/or satisfied by, and executed on behalf of the Grantee and that constitutes a valid and legally binding obligation of the Grantee in accordance with all of its terms.

B. A statement of the names and titles,of the persons who will act as the representatives of the Cooperating Country, together with a speciman signature of each person specified in such statement.

C. A statement indicating that the GSP Committee has reviewed the annual local currency requirements for the Project and that such requirements will be included in the annual budget programming document.

D. Evidence that the Project Coordinating Committee has been established and the names, titles and functions of the persons who will serve on this Committee.

E. A letter from th Ministry of Finance confirming that personnel and commodities financed by A.I.D. under the Grant shall be exempt from all GSDR taxes and duties, including taxes on fuel purchased with Project funds.

7.22 Additional Disbursements:

Prior to any disbursements or the issuance of any commitment documents for the Population Data and Policy Component, the Cooperating Country shall except as the Parties may otherwise agree in writing, furnish A.I.D. in a form and substance satisfactory to A.I.D.:

A. A written service contract from a manufacturer's service representative for the regular maintenance of the GSDR computer equipment purchased by the Project.

B. An implementation schedule and financing plan for the 1986 National Population Census.

C. A written contract with a firm to complete the site preparation for the GSDR computer equipment purchased by the Project.

D. Evidence that the following positions for the 1986 National Population Census have been funded by non-USAID funding sources: (1) Census Advisor; Census Cartographer; (3) Data Processing Advisor.

Prior to any disbursement or to the issuance of any commitment documents for the Information, Education and Communications Component, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in a form and substance satisfactory to A.I.D.:

A. Evidence that suitable counterparts are available to serve in the Information, Education and Communications Unit.

Prior to any disbursement for activities 4 and 6 of the Information, Education and Communication Component, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D.:

A. An overall IEC strategy specifying the role and function of each participating organization and the first annual work plan identifying the specific activities and schedules of each organization.

Prior to any disbursement or to the issuance of any commitment documents for the Operations Research Component, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in a form and substance satisfactory to A.I.D.:

A. Evidence that suitable counterparts are available to serve in the Operations Research Unit in the Somali Family Health Care Association.

Prior to any disbursement for the implementation of any research study under Activity 3 of the Operations Research Component, the Cooperating Country shall, except as the Parties may otherwise agree in writing, furnish to A.I.D. in form and substance satisfactory to A.I.D., a written proposal for any such research study, that has been approved by the OR Technical Group.

8.0 EVALUATION PLAN

Evaluations are particularly important for the Project in view of the relatively recent introduction of family health services in Somalia. When programs are just starting, they are likely to need on-going guidance and direction. Moreover, since these programs are being implemented by a number of different institutions, regular reviews will help identify program gaps and overlaps and thereby contribute to a more coordinated and comprehensive program effort.

Beyond measuring the impact of the Project's activities, evaluations will also be used to develop better management and supervision practices. Evaluations provide the Mission and Government with extra resources and expertise to thoroughly review Project activities and discuss their findings with project managers. Often this process will cause project managers to re-examine their approaches and make adjustments which improve both the effectiveness of individual activities and the Project as a whole.

For these reasons, two types of Project evaluations will be used: External Evaluations and Internal Evaluations.

8.1 External Evaluation Plans

Two major evaluations are scheduled for month 24 and month 44 in the 60 month cycle of the Project; in addition, an evaluation will be conducted at the end of the first year to assess progress and identify any overriding problems. The first major evaluation will examine implementation progress and recommend adjustments to improve the performance and overall effectiveness of the Project. The second evaluation, will serve two purposes: (1) to review the implementation of the Project, much as in the first evaluation; and (2) in light of the findings, to consider the design of a follow-on project.

The first evaluation will last six weeks. The composition of the first evaluation team will include representatives from USAID/Somalia, GSDR, REDSO/ESA, and other consultants where necessary. This Team would be expected to review the administration and management of the Project; the implementation accomplishments in light of the outputs and levels of effort established in the PP; the participation of the GSDR; coordination between the implementing organizations; the ramifications of external and unplanned events on Project implementation; and alternative methods which could be adopted to achieve the specified targets of the Project.

The second Project evaluation will last eight weeks. It will complement and expand upon the previous evaluation providing an overall assessment of the Family Health Services Project. The membership of the evaluation team will include at least two experts not previously involved with Project implementation. This evaluation will thoroughly review the Project's achievements as compared to the results which were expected four years earlier.

8.2 Internal Project Evaluation Plans

The Operations Research Component builds continuous evaluation capabilities into the Project. During the life of the Project the Operations Research Unit will undertake formal, three month evaluations of both the IEC Component and the Clinical Services Component. (See Technical Analysis) Ongoing evaluation and assessments of other Project activities are also planned by the Unit. In addition to providing evaluation services the Unit will hold seminars, workshops and informal meetings with program managers to discuss research results and their implications for program operations.

A number of Project activities will provide baseline data and other types of information which will be used for both internal and external Project evaluations. The 1986 National Population Census is the largest of these activities. In addition, analyses on the 1980 Population Survey and the 1982 Settlement Survey and the two additional research studies will provide critical demographic parameters and socio-economic information which will be used to guide other Project activities. A baseline survey of IEC personnel, resources and programs is also provided by the Project to guide IEC activities. Lastly, the Project will support a second Family Health Survey to compare the findings with the earlier 1983 Family Health Survey. This comparison will

provide, among other things, a guage of changes in public awareness of family health services and prevalence of contracpetive use. Each Project Component is designed and funded to disseminate the information it collects to further facilitate internatl review and evaluation efforts.

FAMILY HEALTH SERVICES PROJECT

(649-0131)

PROJECT PAPER ANNEXES

SECTION 9 ANNEX 1

OFFICIAL FILE

ACTION COPY

MAR 3 . 1984

Action taken: Taken under advisement; response to para 4 being prepared.
No action necessary:
MN 3/4/84
(Initials) (Date)

NNNNVV ESB192BRA373
PP RUQMDI
DE RUEHC #2771/01 0622222
ZNR UUUUU ZZH
P R 022102Z MAR 84
FM SECSTATE WASHDC
TO RUQMDI/AMEMBASSY MOGADISHU PRIORITY 3414
INFO RUEHNR/AMEMBASSY NAIROBI 4939
BT
UNCLAS SECTION 01 OF 02 STATE 062771

AIDAC, NAIROBI FOR REDSO

E.O. 12356: N/A
TAGS:
SUBJECT: ECPR FOR FAMILY HEALTH SERVICES PID (649-0131)

1. SUMMARY: THE ECPR FOR THE SUBJECT PID WAS HELD FEBRUARY 7, 1984 UNDER THE CHAIRMANSHIP OF DAA/AFR, GLENN PATTERSON. THE ECPR APPROVED THE PID CONTINGENT UPON THE PREPARATION OF AN ACCEPTABLE PROJECT DESCRIPTION WHICH CLEARLY DEMONSTRATED THE STRATEGY AND LOGIC OF INITIAL DESIGN AND AN ILLUSTRATIVE BUDGET CONSISTENT WITH THIS DESCRIPTION WHICH SHOWS HOW PROJECT RESOURCES ARE PROPOSED TO BE ASSIGNED. THIS HAS NOW BEEN ACCOMPLISHED, AND THE SECTIONS IN QUESTION WERE CIRCULATED FOR CLEARANCE WITH THIS CABLE. FINAL DESIGN SHOULD PROCEED ON SCHEDULE.

2. THE ISSUE: ONE ISSUE ONLY WAS IDENTIFIED BY THE ISSUES REVIEW FOR RESOLUTION BY THE ECPR. THIS WAS THE LACK OF DESCRIPTION IN THE PID AS TO WHAT THE PROJECT WOULD ACTUALLY DO AND WHAT PROJECT RESOURCES WOULD

ACTUALLY BUY. WHILE THE PID EFFECTIVELY DESCRIBED THE SOCIO-CULTURAL SETTING AND THE TARGET GROUP AND LAID OUT A COMPREHENSIVE SET OF OBJECTIVES FOR THE PROJECT, NOWHERE WAS THERE A DESCRIPTION OF ACTIVITIES DESIGNED TO ACHIEVE THE OBJECTIVES IN TERMS OF RESOURCES TO BE ASSIGNED TO THE FOUR INSTITUTIONS OVER THE THREE-YEAR LIFE OF THE PROJECT. LACKING THESE ELEMENTS, THE BASIS FOR THE COMPOSITION, COST AND TIMEFRAME OF THE PROJECT COULD NOT BE UNDERSTOOD AND APPROVED. WITH THIS IN MIND, THE ISSUES REVIEW REQUESTED D/DIR. NELSON TO PROVIDE A DETAILED VERBAL DESCRIPTION OF THE MISSING ELEMENTS INCLUDING PROJECT STRATEGY FOR THE BENEFIT OF THE ECPR. THIS WAS DONE AND THE PID APPROVED ON THIS BASIS, PROVIDED THAT THE PID ITSELF BE REVISED TO INCORPORATE THE ADDITIONAL MATERIAL. THIS HAS NOW ALSO BEEN ACCOMPLISHED, AND THIS CABLE INDICATES FINAL APPROVAL.

3. DESIGN GUIDANCE QUESTIONS:

A. PROJECT STRATEGY, INSTITUTIONAL RELATIONSHIPS AND CAPABILITY AND THE NEED FOR ARTFUL DESIGN: ACCORDING TO THE AMPLIFIED PROJECT DESCRIPTION, THE NEWLY FORMED SOMALIA FAMILY HEALTH CARE ASSOCIATION (SFHCA) WILL SERVE AS THE PRINCIPAL COORDINATING VEHICLE FOR THE PROJECT GIVEN ITS UNIQUE ACCESS TO THE OTHER MAJOR ORGANIZATIONS ENGAGED IN FAMILY PLANNING ACTIVITIES THROUGH QUOTE INTERLOCKING DIRECTORATES UNQUOTE. THE PRESENT INSTITUTIONAL CAPACITY OF SFHCA TO PERFORM THIS PIVOTAL ROLE AND MEASURES NEEDED TO UPGRADE ITS CAPACITY SUFFICIENTLY SHOULD BE CAREFULLY ANALYZED AND DETAILED IN FINAL DESIGN, IN ADDITION TO THE COORDINATION MECHANISM ITSELF. FURTHER, THE USAID SHOULD RETAIN A CERTAIN MINIMUM FLEXIBILITY, IN EFFECT A FALLBACK CAPABILITY, TO REDIRECT OR SHIFT PROJECT MANAGEMENT/COORDINATION FUNCTIONS TO THE MINISTRY OF HEALTH OR ANOTHER AGENCY IF THE NEED ARISES, I.E., IF IT TURNS OUT THAT SFHCA (A NEW AND UNTESTED ORGANIZATION) IS NOT VIABLE INSTITUTIONALLY OR CANNOT, FOR WHATEVER REASON, SERVE IN THE ENVISIONED ROLE. FOR THIS REASON IT WOULD PROBABLY BE BEST TO UTILIZE A DIRECT AID CONTRACT MECHANISM. IN GENERAL, THE LAST WORD ON DECISION MAKING WITH RESPECT TO ALLOCATION AND UTILIZATION OF PROJECT RESOURCES SHOULD BE RETAINED BY THE USAID ONE WAY OR ANOTHER. FURTHER, INSTITUTIONAL

RELATIONSHIPS WITHIN THE FRAMEWORK OF THE PROJECT SHOULD BE CAREFULLY ANALYZED DURING FINAL DESIGN TO ASSURE THAT CONTEMPLATED COLLABORATION WILL, IN FACT, TAKE PLACE ON THE BASIS OF THE INFORMAL HIGH LEVEL CONNECTIONS MENTIONED. FINALLY, AS THE PROJECT'S PRINCIPAL SERVICE DELIVERY COMPONENT WILL PROBABLY BE PRIMARILY THROUGH THE MINISTRY OF HEALTH (MOH) DELIVERY SYSTEM, THE ADEQUACY OF EXISTING MOH SERVICES SHOULD BE ASSESSED AND A DETERMINATION MADE AS TO WHETHER THE PROJECT SHOULD ALSO CONSIDER UPGRADING MOH SERVICE CAPABILITY IF THERE IS A NEED TO DO SO. THERE WAS SOME CONCERN THAT INTEGRATION OF A NEW SERVICE INTO A POORLY FUNCTIONING EXISTING SERVICE WOULD COMPROMISE THE EFFECTIVENESS OF NEW FP ELEMENTS.

THE THREE YEAR TIMEFRAME OF THE PROJECT WAS UNREALISTIC AND THAT A MINIMUM OF FOUR YEARS WOULD BE NECESSARY FOR FULL IMPLEMENTATION. THE ECPR DID NOT ATTEMPT TO PUT A LIMIT ON THE TERM OF THE PROJECT, BUT URGED THAT THIS BE BASED ON THE DEVELOPMENT OF A REALISTIC IMPLEMENTATION PLAN. AS THE PROJECT IS EXPERIMENTAL, HOWEVER, AND IS PROBABLY ONLY THE FIRST PHASE OF A LONG TERM SCENARIO, NORMAL PRUDENCE WOULD DICTATE A MAXIMUM LOP OF FIVE YEARS. FINAL DESIGN SHOULD ALSO LOOK AT THE PHASING QUESTION AND DETAIL A LONGER TERM PLANNING FRAMEWORK TO THE EXTENT POSSIBLE WHILE INCORPORATING AN EVALUATION/DESIGN/PLANNING COMPONENT LEADING TO A

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TO RUQMDI/AMEMBASSY MOGADISHU PRIORITY 3415
INFO RUEHNR/AMEMBASSY NAIROBI 4940
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SUBSEQUENT PHASE (C BELOW) IF THIS, IN FACT, IS INTENDED.

C. DATA COLLECTION AND EVALUATION. IN LINE WITH THE ROLLING DESIGN CONCEPT MENTIONED BY THE PID, AN ONGOING DATA COLLECTION, ANALYSIS AND REPORTING SYSTEM SHOULD BE DESIGNED DURING PP DEVELOPMENT WHICH WILL MEASURE PROGRESS ACHIEVED BY THE PROJECT ON THE BASIS OF BENCHMARKS COVERING TECHNICAL, ECONOMIC, INSTITUTIONAL, SOCIAL AND OTHER OUTPUTS TO SERVE AS CONCRETE AND VERIFIABLE INDICATORS FOR EVALUATION PURPOSES. INITIAL BASELINE DATA SHOULD ALSO BE COLLECTED AGAINST WHICH THE REAL IMPACT OF THE PROJECT IN TERMS OF ITS GOAL AND PURPOSE STRUCTURE CAN BE MEASURED IN THE FUTURE. AS MENTIONED, THE PLAN SHOULD FURTHER PROVIDE FOR EVALUATION AND DESIGN WORK LEADING TO A PHASE II FOLLOW-ON EFFORT.

D. OPERATIONS RESEARCH ELEMENT: THE OPERATIONS RESEARCH ELEMENT OF THE PROJECT WAS NOT DESCRIBED IN THE PID. OF SPECIAL INTEREST IS POSSIBLE EXPERIMENTATION WITH USER FEES FOR SERVICES AND SUPPLIES. CRITERIA AND THE PROCESS FOR SELECTION AND FUNDING OF OPERATIONS RESEARCH EFFORTS AND PILOT OR EXPERIMENTAL INITIATIVES SHOULD BE DEVELOPED AND DETAILED IN THE PP. TO THE EXTENT THAT THIS APPLIES TO THE PROJECT AS A WHOLE, THE SAME GUIDANCE SHOULD BE OBSERVED.

E. POLICY DIALOGUE: IT IS UNDERSTOOD THAT FAMILY PLANNING HAS NOWBECOME ACCEPTED AS A CONCEPT IN THE SOMALI LEXICON THANKS TO THE PRESIDENT'S WIFE AND OTHERS OF STATURE ON THE BOARD OF DIRECTORS OF THE FAMILY HEALTH CARE ASSOCIATION, AND THAT OVERALL RECEPTIVITY AND AWARENESS IN SOMALIA HAS PROGRESSED TO A REMARKABLE DEGREE IN THE LAST FEW YEARS THANKS IN PART TO AID CENTRALLY FUNDED ACTIVITIES. IT IS ALSO UNDERSTOOD THAT THIS PROJECT WILL ATTEMPT NO NEW MAJOR POLICY INITIATIVES. NEVERTHELESS, TO THE EXTENT POSSIBLE, THE PP SHOULD SPELL OUT THE POLICY ENVIRONMENT AND HOW EXISTING PROGRESS WILL BE FURTHERED LITTLE BY LITTLE THROUGH DIALOGUE AND SUPPORTING MEASURES UNDER THIS

PROJECT AND OTHERS, I.E., RAPID II, DDD, IPDP.

F. POSSIBLE USE OF SOMALI WOMEN'S DEMOCRATIC ORAGNIZATION (SWADO) AS DELIVERY VEHICLE: ALTHOUGH THE PID INDICATES THAT SWDO IS PRIMARILY DEDICATED TO INFORMATION AND PROMOTIONAL ACTIVITY, FINAL DESIGN SHOULD ALSO ASSESS ITS POTENTIAL FOR SERVING AS A DELIVERY MECHANISM FOR SERVICES AND POSSIBLY CONTRACEPTIVES (PILLS AND CONDOMS).

4. D/DIR. NELSON WILL HANDCARRY REVISED PID. PLEASE ADVISE LATEST ESTIMATE FOR PP DEVELOPMENT, AUTHORIZATION AND OBLIGATION. THANKS. SHULTZ
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OFFICE	INFO	ACTION
DIR		
[illegible]		
[illegible]	✓	
[illegible]	✓	
[illegible]		
RD/RA		✓
SMO		
C N		
MGT		
AGR		

LOGICAL FRAMEWORK
FAMILY HEALTH SERVICES

NARRATIVE SUMMARY	OBJECTIVE VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
OGRAM GOAL:	MEASURES OF GOAL ACHIEVEMENT:		
TO IMPROVE THE QUALITY OF LIFE FOR THE SOMALI PEOPLE	IMPROVED MATERNAL AND CHILD HEALTH CARE	SSDR HEALTH STATISTICS	FAMILY HEALTH SERVICES WILL BE ABLE TO GENERATE INFORMATION, AWARENESS, & PROGRAMS TO IMPROVE HEALTH OF MOTHERS & CHILDREN
	IMPROVED POPULATION DATA	CENSUS DATA & OTHER REPORTS FROM HEALTH FACILITIES	
PROJECT PURPOSE:			
TO STRENGTHEN THE CAPABILITIES OF SOMALI INSTITUTIONS TO PROMOTE, SUPPORT, COORDINATE, & SUSTAIN FAMILY HEALTH PROGRAMS	- CENTRAL STATISTICS DEPT HAS IMPROVED COMPUTATIONAL TECHNOLOGY - FH INSTITUTIONS HAVE IMPROVED TECHNICAL & MANAGEMENT SKILLS TO PRODUCE ANALYZE & APPLY FH & POPULATION DATA - INCREASED IEC PROGRAMS SUPPORTING FH SERVICES - FH SERVICES PERSONNEL HAVE GREATER EFFECTIVENESS TO MOTIVATE COUPLES TO ADOPT FH PRACTICES - CLINICAL FAMILY HEALTH SERVICES OF MOH WILL BE UPGRADED & EXTENDED - PERSONNEL WHO ARE IMPLEMENTING FH PROGRAMS WILL HAVE IMPROVED KNOWLEDGE & SKILLS RELATED TO OPERATIONS RESEARCH - FH PROGRAMS WILL BE GUIDED BY AN EFFECTIVE OPERATIONS RESEARCH PROGRAM	SSDR REPORTS FIELD VISITS EVALUATIONS	SSDR WILL CONTINUE TO PROVIDE POLICY SUPPORT, PERSONNEL, & FINANCE TO THE FAMILY HEALTH PROGRAMS OF SOMALI INSTITUTIONS AND ORGANIZATIONS
SUB-PURPOSE: A) TO STRENGTHEN CAPABILITIES OF SOMALI INSTITUTIONS TO COLLECT, PROCESS, ANALYZE, & APPLY POPULATION DATA B) TO INCREASE THE OPERATIONAL CAPABILITY & EFFECTIVENESS OF INSTITUTIONS INVOLVED IN THE DELIVERY OF FH IEC SERVICES C) TO STRENGTHEN THE CAPABILITIES OF SOMALI INSTITUTIONS TO PLAN, IMPLEMENT & EVALUATE CLINICAL FAMILY HEALTH SERVICES D) TO STRENGTHEN THE CAPABILITIES OF LOCAL INSTITUTIONS TO EVALUATE FH PROGRAM IMPLEMENTATION, INVESTIGATE & IDENTIFY THE MOST EFFECTIVE DELIVERY APPROACES, AND TO ASSIST IN PLANNING IMPLEMENTATION			
OUTPUTS:			
- UPGRADED COMPUTER HARDWARE AND SOFTWARE	- ONE SYSTEM OPERATING	SITE VISIT	COMPUTER SITE PREPARED MAINTENANCE PROVIDED
- POPULATION CENSUS	- POPULATION COUNTS FOR ALL PERSONS & POP TABULATIONS FOR 10% OF POPULATION	REVIEW CENSUS DATA	SSDR PROVIDES PERSONNEL & ARRANGES ADDITIONAL FUNDING FOR CENSUS ACTIVITIES
- REPORT OF ANALYSIS OF 1980 POP SURVEY	- ONE REPORT	REVIEW REPORT	UNFPA PROVIDES ADVISORS
- DEMOGRAPHIC STUDIES	- TWO STUDIES	REVIEW STUDIES	SSDR APPROVES RESEARCH
- WORKSHOPS ON DATA ANALYSIS AND PLANNING TECHNIQUES	- FOUR WORKSHOPS	REVIEW RECORDS OF WORKSHOPS & CONFERENCES	SSDR ENDORSES RESEARCH DATA FOR DISSEMINATION
- NATIONAL POPULATION CONFERENCES	- TWO CONFERENCES	REVIEW REPORT	
- IEC BASELINE DATA REPORT	- ONE REPORT	REVIEW PLANS	FH INSTITUTIONS COOPERATE
- ANNUAL WORKPLANS WHICH INTEGRATE FH IEC ACTIVITIES	- ONE WORKPLAN & FOUR ANNUAL PLANS	SITE VISITS	SFCA ESTABLISHES UNIT & PROVIDES COUNTERPARTS
- ESTABLISHMENT OF IEC UNIT & RESOURCE CENTER	- ONE UNIT AND ONE CENTER	REVIEW TRAINING RECORDS	TRAINEES AVAILABLE
- TRAINED IEC STAFF & FAMILY HEALTH PERSONNEL	- 585 PEOPLE TRAINED	EXAMINE MATERIALS	
- FAMILY HEALTH CURRICULUM & CLASSROOM MATERIALS DEVELOPED	- 100 SETS AUDIO-VISUAL MATERIALS & ONE FAMILY HEALTH CURRICULUM	"	
- IMPLEMENTATION ACTIVITIES INCREASED	- 100,000 PAMPHLETS, 30,000 POSTERS, 2 SETS OF SLIDES, 2 WEEKLY RADIO FEATURES	"	
- IMPROVED CADRE OF FH TRAINERS, IN-SERVICE, & PRE-SERVICE PROGRAMS	- 20 TRAINERS, 30 NURSE TUTORS, & 680 PERSONNEL TRAINED	REVIEW TRAINING RECORDS	TRAINEES AVAILABLE
- FH MATERNAL CHILD HEALTH TRAINING CENTER ESTABLISHED	- ONE CENTER OPERATING	SITE VISIT	MOH PROVIDES BLDG
- SPECIAL FH SERVICES ESTABLISHED	- 3 HOSPITALS PROVIDE VOLUNTARY STERILIZATION, INFERTILITY SERVICES, AND SEXUALLY TRANSMITTED DISEASE SERVICES	SITE VISITS	MOH CONTINUES SUPPORT FOR SERVICES
- MANAGEMENT SYSTEMS FOR CLINICAL FH SERVICES	- MANAGEMENT SYSTEM IN PLACE	EXAMINE SYSTEMS	SSDR PROVIDES PERSONNEL & FINANCING
- EXPANSION OF FAMILY HEALTH SERVICES	- 60 MCH CENTERS & 20 HOSPITALS PROVIDING FH SERVICES	SITE VISITS	SFCA ESTABLISHES UNIT & PROVIDES COUNTERPARTS
- OPERATIONS RESEARCH UNIT ESTABLISHED	- ONE UNIT OPERATING	SITE VISIT	ALL FH INST.S COOPERATE
- SEMINARS ON OPERATIONS RESEARCH METHODS	- ONE SEMINAR	REVIEW RECORDS	
- OPERATIONS RESEARCH REPORTS	- THREE REPORTS	REVIEW REPORTS	SSDR ENDORSES RESEARCH
- FAMILY HEALTH SURVEY	- ONE SURVEY REPORT	REVIEW SURVEY	
- MONITORING SYSTEMS FOR FH PROGRAMS ESTABLISHED	- FIVE PROGRAM MONITORING SYSTEMS	REVIEW SYSTEMS	
INPUTS:			
1. TECHNICAL ASSISTANCE: (LT) IEC ADVISOR TRAINING & MANAGEMENT ADVISOR OPERATIONS RESEARCH ADVISOR	---PERSON YEARS LT/TA ---PERSON YEARS ST/TA	USAID RECORDS SSDR RECORDS	SSDR WILL BE ABLE TO EFFECTIVELY UTILIZE INPUTS
(ST)	---PERSON MONTHS OVERSEAS TRAINING		USAID WILL CONTINUE TO PROVIDE FUNDING TO SSDR
2. TRAINING: OVERSEAS TRAINING IN-COUNTRY TRAINING	---PERSON MONTHS IN-COUNTRY TRAINING	SEE BUDGET	BOTH SSDR & USAID AGREE TO CONTINUE THE PROJECT
3. COMMODITIES: COMPUTER & EQUIPMENT IEC MATERIALS & EQUIPMENT CONTRACEPTIVES	---(SEE PROCUREMENT LIST)		
4. RESEARCH: POPULATION DATA & POLICY OPERATIONS RESEARCH	---REPORTS		
5. CONSTRUCTION: BUILDING RENOVATION			

Best Available Document

PROJECT ASSISTANCE

Revised for FY 84 2/21/84

5C(1) - COUNTRY CHECKLIST

Listed below are statutory criteria applicable generally to FAA funds, and criteria applicable to individual fund sources: Development Assistance and Economic Support Fund.

A. GENERAL CRITERIA FOR COUNTRY ELIGIBILITY

1. FAA Sec. 481; FY 1984 Continuing Resolution. Has it been determined or certified to the Congress by the President that the government of the recipient country has failed to take adequate measures or steps to prevent narcotic and psychotropic drugs or other controlled substances (as listed in the schedules in section 202 of the Comprehensive Drug Abuse and Prevention Control Act of 1971) which are cultivated, produced or, processed illicitly, in whole or in part, in such country or transported through such country, from being sold illegally within the jurisdiction of such country to United States Government personnel or their dependents or from entering the United States unlawfully? NO

2. FAA Sec. 620(c). If assistance is to a government, is the government liable as debtor or unconditional guarantor on any debt to a U.S. citizen for goods or services furnished or ordered where (a) such citizen has exhausted available legal remedies and (b) the debt is not denied or contested by such government? NO

3.	FAA Sec. 620(e)(1). If assistance is to a government, has it (including government agencies or subdivisions) taken any action which has the effect of nationalizing, expropriating, or otherwise seizing ownership or control of property of U.S. citizens or entities beneficially owned by them without taking steps to discharge its obligations toward such citizens or entities?	NO
4.	FAA Sec. 532(c), 620(a), 620(f), 620D; FY 1982 Appropriation Act Secs. 512 and 513. Is recipient country a Communist country?	NO
	Will assistance be provided to Angola, Cambodia, Cuba, Laos, Vietnam, Syria, Libya, Iraq, or South Yemen?	NO
	Will assistance be provided to Afghanistan or Mozambique without a waiver?	NO
5.	ISDCA of 1981 Secs. 724, 727, 728 and 730. For specific restrictions on assistance to Nicaragua, see Sec. 724 of the ISDCA of 1981. For specific restrictions on assistance to El Salvador, see Secs. 727, 728 and 730 of the ISDCA of 1981.	N/A
6.	FAA Sec. 620(j). Has the country permitted, or failed to take adequate measures to prevent, the damage or destruction by mob action of U.S. property?	No. See January 6, 1984 memorandum signed by the administrator taking into consideration various provisions of the Foreign Assistance Act of 1961, as amended, prior to approval of the FY 84 OYB, for this item and items 7, 8, 10, 12 and 16 below.

7.	FAA Sec. 620(l). Has the country failed to enter into an agreement with OPIC?	No
8.	FAA Sec. 620(o); Fishermen's Protective Act of 1967, as amended, Sec. 5. (a) Has the country seized, or imposed any penalty or sanction against, any U.S. fishing activities in international waters? (b) If so, has any deduction required by the fishermen's Protective Act been made?	NO
9.	FAA Sec. 620(q); FY 1982 Appropriation Act Sec. 517. (a) Has the government of the recipient country been in default for more than six months on interest or principal of any AID loan to the country?	NO
	(b) Has the country been in default for more than one year on interest or principal on any U.S. loan under a program for which the appropriation bill appropriates funds?	NO
10.	FAA Sec. 620(s). If contemplated assistance is development loan or from Economic Support Fund, has the Administrator taken into account the amount of foreign exchange or other resources which the country has spent on military equipment? Reference may be made to the annual "Taking into Consideration" memo:	N/A

This approval by the Administrator of the Operational Year Budget can be the basis for an affirmative answer during the fiscal year unless significant changes in circumstances occur.)	
11. FAA Sec. 620(t). Has the country severed diplomatic relations with the United States? If so, have they been resumed and have new bilateral assistance agreements been negotiated and entered into since such resumption?	NO
12. FAA Sec. 620(u). What is the payment status of the country's U.N. obligations? If the country is in arrears, were such arrearages taken into account by the AID Administrator in determining the current AID Operational Year Budget?	Taken into account by the Administrator on January 6, 1984, at time of approval of FY 84 OYB
13. FAA Sec. 620A; FY 1982 Appropriation Act Sec. 520. Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed an act of international terrorism?	NO
Has the country aided or abetted, by granting sanctuary from prosecution to, any individual or group which has committed a war crime?	NO

14.	FAA Sec 666. Does the country object, on the basis of race, religion, national origin or sex, to the presence of any officer or employee of the U.S. who is present in such country to carry out economic development programs under the FAA?	NO
15.	FAA Sec. 669, 670. Has the country, after August 3, 1977, delivered or received nuclear enrichment or reprocessing equipment, materials, or technology, without specified arrangements or safeguards? Has it transferred a nuclear explosive device to a non-nuclear weapon state, or if such a state, either received or detonated a nuclear explosive device, after August 3, 1977? (FAA Sec. 620E permits a special waiver of Sec. 669 for Pakistan).	NO NO
16.	ISDCA of 1981 Sec. 720. Was the country represented at the Meeting of Ministers of Foreign Affairs and Heads of Delegations of the Non-Aligned Countries to the 36th General Session of the General Assembly of the U.N. of Sept. 25 and 28, 1981, and failed to disassociate itself from the communique issued? If so, has the President taken it into account?	Taken into account by the Administrator on January 6, 1984 at time of approval of FY 84 OYB
17.	ISDCA of 1981 Sec. 721. See special requirements for assistance to Haiti.	N/A

18. FY 84 Continuing Resolution. Has the recipient country been detemined by the President to have engaged in a consistent pattern of opposition to the foreign policy of the United States.	NO

B. FUNDING SOURCE CRITERIA FOR COUNTRY ELIGIBILITY

1. Development Assistance Country Criteria

a. FAA Sec. 116. Has the Department of State determined that this government has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, can it be demonstrated that contemplated assistance will directly benefit the needy?	No. Taken into account by the Administrator on Jan. 6, 1984 at time of approval of FY 84 OYB.

2. Economic Support Fund Country Criteria

a. FAA Sec. 502B. Has it been determined that the country has engaged in a consistent pattern of gross violations of internationally recognized human rights? If so, has the country made such significant improvements in its human rights record that furnishing such assistance is in the national interest?	N/A
b. ISDCA of 1981, Sec. 725(b). If ESF is to be furnished to Argentina, has the President certified that (1) the Govt. of Argentina has made significant progress in human rights; and (2) the provision of such assistance is in the national interests of the U.S.?	N/A

c. ISDCA of 1981, Sec. 726(b). N/A
If ESF assistance is to be furnished to Chile, has the President certified that (1) the Govt. of Chile has made significant progress in human rights; (2) it is in the national interest of the U.S.; and (3) the Govt. of Chile is not aiding international terrorism and has taken steps to bring to justice those indicted in connection with the murder of Orlando Letelier?

5C(2) PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This section is divided into two parts. Part A. includes criteria applicable to all projects. Part B. applies to projects funded from specific sources only: B.1. applies to all projects funded with Development Assistance Funds, B.2. applies to projects funded with Development Assistance loans, and B.3. applies to projects funded from ESF.

CROSS REFERENCES: IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT?

A. GENERAL CRITERIA FOR PROJECT

1. FY 1982 Appropriation Act Sec. 523; FAA Sec. 634A; Sec. 653(b); Second CR FY 83, Sec. 101(b)(1).

(a) Describe how authorizing and appropriations committees of Senate and House have been or will be notified concerning the project;	(Filed by Mission)
(b) is assistance within (Operational Year Budget) country or international organization allocation reported to Congress (or not more than $1 million over that amount)?	YES
(c) If the proposed assistance is a new country program or will exceed or cause the total assistance level for the country to exceed assistance amounts provided to such country in FY 83, has a notification been provided to Congress?	NO

(d) If the proposed assistance is from the $85 million in ESF funds transferred to AID under the Second CR for FY 83 for "economic development assistance projects", has the notification required by Sec. 101(b)(1) of the Second CR for FY 83 been made?	N/A
2. FAA Sec. 611(a)(1). Prior to obligation in excess of $100,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance and (b) a reasonably firm estimate of the cost to the U.S. of the assistance?	The Regional Legal Advisor has determined that plans and cost estimates are adequate to satisfy Section 611(a)(1).
3. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance?	N/A
4. FAA Sec. 611(b); FY 1982 Appropriation Act Sec. 501. If for water or water-related land resource construction, has project met the standards and criteria as set forth in the Principles and Standards for Planning Water and Related Land Resources, dated October 25, 1973?	N/A
5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and all U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's	N/A

	capability effectively to maintain and utilize the project?	
6.	FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs.	NO
7.	FAA Sec. 601(a). Information and conclusions whether project will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; and (c) encourage development and use of cooperatives, and credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions.	The Project will investigate private sector distribution channels for contraceptives, and where feasible support pilot distribution programs.
8.	FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise).	The commodities and contractor will be from the U.S.
9.	FAA Sec. 612(b), 636(h); FY 1982 Appropriation Act Sec. 507. Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and othe services,	The GSDR will contribute SoSh._____ roughly _____% of total costs. There are no U.S. owned local currencies.

	and foreign currencies owned by the U.S. are utilized in lieu of dollars.	
10.	FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release?	NO
11.	FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise?	YES
12.	FY 1982 Appropriation Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. producers of the same, similar or competing commodity?	N/A
13.	FAA 118(c) and (d). Does the project comply with the environmental procedures set forth in AID Regulation 16?. Does the project or program take into consideration the problem of the destruction of tropical forests?	Yes. A categorical exclusion has been granted.
14.	FAA 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (dollars or local currency generated there from)?	N/A

15.	FAA Sec. 128; Second CR FY 83, Sec. 101(b)(2). Has an attempt been made to finance productive facilities, goods, and services which will expeditiously and directly benefit those living in absolute poverty under the standards adopted by the World Bank?	YES
16.	FY 84 Continuing Resolution. Is comparable American private enterprise funding available for the proposed project?	NO
17.	FY 84 Continuing Resolution. Has full consideration been given at each stage of project design to the involvement of small minority (including women-owned businesses) enterprises, historically black colleges and universities and minority PVO's?	YES

FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

a. FAA Sec. 102(b), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives,	This project will be aimed at Somali couples, more especially women, to provide family planning information and services which will improve the health of mothers and children.

especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?	
b. FAA Sec. 103, 103A, 104, 105, 106. Does the project fit the criteria for the type of funds (functional account) being used?	YES
c. FAA Sec. 107. Is emphasis on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)?	N/A
d. FAA Sec. 110(a). Will the recipient country provide at least 25% of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)?	YES

e. FAA Sec. 110(b). Will grant capital assistance be disbursed for project over more than 3 years? If so, has justification satisfactory to Congress been made, and efforts for other financing, or is the recipient country "relatively least developed"?	NO
f. FAA Sec. 122(b). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth?	Indirect benefits will be obtained as a result of lower long term population growth.
g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civil education and training in skills required for effective participation in government processes essential to self-government.	The project stems from a direct request of GSDR for such a project. The project design has been a collaborative effort between USAID, GSDR, and several Somali non-Government organizations. Likewise, the project is specifically designed to strengthen Somali Family Planning Institution.

FILE ANNEX 4

ACTION COPY -20-

ACTION: PROJ-Bagells

Action taken:

No action required

RECEIVED JUN 28 1984

Jamhuuriyadda Dimoqraadiga Soomaaliya

WASAARADDA QORSHEYNTA QAran

MUQDISHO (Somalia)

Somali Democratic Republic
Ministry of National Planning
P. O. Box 1742
MOGADISHO (Somalia)
Telex: 715 SPC MOGA

MINISTER
WASIIRKA

جمهورية الصومال الديمقراطية
وزارة التخطيط الوطني
ص. ب. ١٧٤٢
مقديشو - الصومال
تلكس ٧١٥

Tix/Ref : MNP/CSD/029/1753/84

84/722

Ujeeddo/Subject :

Mr. Louis Cohen
Director
USAID/Somalia.

Dear Mr. Cohen,

The Government of the Somali Democratic Republic (GSDR) requests financial assistance of approximately $10.1 million over a five-year period from the Government of the United States. The funds will finance the short-term training, technical assistance and selected commodities which will support the conduct of information and education programs, delivery of services, and research related to family health, as well as the implementation of various demographic studies and policy programs, including the conduct of the 1986 census of population.

The GSDR places a very high priority on the effective implementation of the 1986 census as a step to resolving critical deficiences in demographic data; with improved data, the GSDR can more effectively plan and guide policies reated to all development sections. In addition, the GSDR is concerned with the implementation of family health services as an integral part of maternal-child health and primary health care. Information, the delivery of services, and research into their effective operations all assure that Somali couples can utilize child-spacing practices for the benefit of the health of mothers and children.

It is our understanding that the cost to the GSDR during the duration of the project will be approximately 179.8 million Somali Shillings. Given the importance that we attach to the project, we intend to request this amount from the Ministry of Finance. We look forward to receiving a favorable response to our request in the near future.

Yours Sincerely,

Mohamed [illegible]

Minister of National Planning.

TELEPHONE: N 80384/7 ; طبسون : ٨٠٣٨٤/٧ — ٨٠٦٣٤

SECTION 13

ANNEX 5

PROJECT ANALYSES

13.1.(a) TECHNICAL ANALYSIS FOR THE POPULATION DATA AND POLICY COMPONENT

A. Justification

AID's population assistance program focuses on the provision of safe and effective family planning services, but is balanced with assistance in population data collection, analysis, program design, and policy development. This data and policy component supports the data gathering and evaluative research necessary for government leaders to: establish the current size, distribution, and condition of the population; project future growth, redistribution, and needs of the population; and plan programs and formulate policies which address population and population-related problems. Without knowledge of population characteristics and understanding of links between population growth, health conditions, and economic development, government planners and policy-makers may ignore or assign low priority to family health programs.

Data on the Somali population are scant. Of the limited data sources, most cover only urban, settled, or regional segments of the population and so are insufficient for comprehensive national assessments and for detailed planning purposes. Because of difficulties in surveying and enumerating refugee and nomadic groups, even the few national surveys and the 1975 Census are of questionable quality. Aside from the dearth of demographic and socioeconomic data, Somalia also has limited data collection, production, and analysis resources - in terms of: 1) infrastructure for planning, organizing, and carrying out data collection activities; 2) data entry and processing equipment and associated skills; and 3) analytic skills for assessing population data, incorporating data into development planning activities, and advising government leaders on appropriate policy and program initiatives to hasten achievement of national development goals.

Despite this scarcity of data, Somali Government leaders have begun to recognize problems associated with rapid population growth. The 1979-81 Three-Year Development Plan identified the development of human resources as a prerequisite for development and recommended the formulation of sound long-term population and manpower policies for optimal human resources development. The current 1982-86 Five-Year Development Plan recognizes rapid population growth as one of several factors contributing to foreseeable future employment and underemployment problems. Other factors include: 1) the increase in secondary school graduates coupled with the government's policy of guaranteeing employment to all graduates; 2) the limited absorptive capacity of the modern, non-agricultural sector; and 3) a perceived tapering off of employment opportunities in the oil-exporting states of the Near East. Yet, population links with other sectors (e.g., health, agriculture and nutri-

tion, environment and land use, housing and urban social services) are absent from these planning reports.

While Somalia does not have a formal policy regarding population growth and fertility as such, the government has, through a number of programs, demonstrated a commitment to family planning as a means for couples to space childbirths and thereby contribute to improved maternal and child health. The Ministry of Health has since 1978 included family planning as part of maternal and child health care; it has recently mandated that all primary health care (PHC) workers participate in family health training sessions and that family planning be incorporated into the PHC curriculum. The Somali Women's Democratic Organization (SWDO) has since 1975 carried out an effective campaign to acquaint women with their legal and cultural rights; SWDO has recently incorporated family health/family planning issues into its daily radio program and community discussion program. The Ministry of Education has integrated population and family health education into the primary and secondary school curriculum and supports an out-of-school outreach program which addresses family life and family health issues. In 1983, the National Parliament passed a decree to establish the country's first non-governmental Somali organization - the Somali Family Health Care Association - to undertake family health activities. The Somali Government has recently begun considering the establishment of a national policy-level commission, responsible for formulating MCH and population policies and ensuring the coordination of these with other government policies.

The Government of Somalia has recognized the health benefits associated with family health services and has responded by supporting educational and service delivery programs. Still, to continue development of these programs and to progress toward informed national population policies, a broader and more detailed data base is needed. The Government of Somalia is committed to information-based program development and policy formulation. The full data and policy requirements in Somalia include, then, training and technical assistance in the production of population data and training and technical assistance in the analysis and use of data in the policy-making, development planning and program design processes.

B. Strategy

The FHS project attempts to meet these requirements through a balanced technical assistance, training, and research support program aimed at data production, analyses, and applications for planning and policy-making.

The major data production undertaking is the 1986 Census. Census data will be extremely valuable for detailed analyses of the population, including: establishing the

size of the working population and its distribution by age, sex, education, location, and type of work; evaluating current and estimating future employment requirements; evaluating characteristics of existing housing and estimating future housing requirements; assessing current enrollments against number of school-age children and estimating future schooling requirements; and establishing the geographic distribution of the population by age and estimating medical and family health needs by geographic region. The Census activity does require considerable resources and is a time-consuming activity. By the end of project, the detailed tabulations for the total population will be incomplete, but total population counts and tabulations for ten percent of the population are expected to be prepared.

In the meantime, the FHS project will support a number of data collection and research activities, which will provide more timely, though less comprehensive and detailed information. The FHS project will support the completion of analyses of two important data sets. The 1980 Population Survey promises to provide more accurate estimates of fertility, mortality, and migration rates. That survey also contains the data on fertility and mortality of nomads - information which was not provided by the 1975 Census. The 1982 Settlements Survey contains useful information on quality of life and demographic characteristics of recently settled populations. Since nomad settlement schemes are planned to continue in the future, this information will be valuable for guiding the settlement program and estimating the demographic consequences of this program.

The FHS project will also support two demographic research undertakings. These two projects will expand upon small-scale studies conducted in preparation for the upcoming Second National Population Conference. The research subjects will be identified after that Conference, but may address one of the following topics: fertility-health relationships, population-natural resources relationships, nuptuality patterns, demography of resettlement, male attitudes toward child-spacing and family planning, results of unwanted fertility, determinants and consequences of urbanization, and employment drain to Near East States. These topics cover areas of special concern to Somalia and require focused research work. This work will help to highlight important population-development links.

The FHS project will provide the greatest resources to data collection and tabulation activities, which is practical since data resources are so poor in Somalia. Still, the project will provide limited assistance, in the later years of the project (as data become available) in the utilization of population data for planning and policy-making purposes. These include two workshops on utilizing demographic data in projecting future population growth and in estimating requirements for the growing population (including health, education, employment,

and food requirements). These workshops will help strengthen local skills in population-development planning. In addition, the project will support two additional National Population Conferences. These conferences will provide a mechanism for disseminating research findings and planning analysis results to a broad government and research audience and will help to raise awareness of population-development links.

C. Component Inputs

Planned FHS project inputs to support population data and policy activities are considerable. This commitment of resources, however, is necessary to ensure that: 1) accurate data are produced in a timely fashion and 2) local data production and analytic capabilities and skills are developed. These were two major shortcomings of the 1975 Census. Because of questionable enumeration methods employed in surveying the nomadic population and less than complete coverage of the settled population, the Census data are not of high quality. Due to computer deficiencies and data production delays, the final tabulations from the Census have still not been released. Finally, because most of the collection and processing work for the Census was handled by outside advisors, there are few local personnel who have developed skills in data collection and production procedures.

The FHS project, however, is providing short-term technical assistance in the early phases of census planning to ensure that proper steps are taken to provide fullest coverage of the Somali population and to ensure adequate questionnaire construction to provide useful information in a form easy to administer and computerize. The Project is also providing a mainframe computer and adequate maintenance to facilitate timely data entry and processing. The central purpose guiding FHS project activities is the development of local capabilities and skills for undertaking data collection and analysis work. In this regard, the Project provides technical assistance work which strengthens these local skills, through short-term and on-the-job training.

D. Special Problems

1. Cartography

Census field mapping activities have already begun in preparation for the 1986 Census. An important question-mark remains, however, over the conditions placed on using the base maps for the rural areas. The military's National Cartographic Directorate (NCD) has indicated that CSD is only allowed to borrow the maps, which essentially means that their usefulness is limited as they have to be returned in good condition. But updating maps in the field requires that they be drawn on, folded, cut up and joined together according to the chief compass limits of the administrative boundaries.

It is recommended that CSD seek higher authority, therefore, to enable the maps to be used in the field as necessary. The Somali Census has already been delayed one year and, as there are no cartographic equipment and materials available, even further delays could be incurred if tracings or photocopies have to be made of the 470 NCD base maps. A long-term advisor in cartography sponsored by the UNFPA will be responsible for assisting the Somalis in the acquisition of maps and their delineation for the census. It is hoped that his presence will reduce delays in cartographic work.

2. Special Problems with Nomads

The problem of how nomads can best be counted has been addressed by sample and survey technicians in the past, but has never been satisfactorily resolved. This is in part because of the difficulty of locating a mobile population during a short census-taking period. Also, since few countries have sizeable nomadic segments, few resources have been devoted to this problem.

Somalia does have a sizeable nomadic segment and so the 1986 Census must address this enumeration problem. The Somalis have been encouraged to update the list of waterpoints and to study nomadic migration patterns before the 1986 Census. They can do this without technical assistance. However, further research is required for determining the best way to establish nomadic migration patterns in the confines of a few census questions.

Even if the list of waterpoints is updated, the migration patterns are studied, and the field procedures are developed according to findings, the movement of nomads is dependent upon rainfall patterns during census field work. Unpredictable nomadic movement which can make accurate counting even more difficult.

3. Appropriate Counterparts

Although the Director of CSD, the Deputy Director, and some Section Heads have had over ten years of experience including the last census, their availability is limited due to other administrative responsibilities and service as counterparts in other survey projects. Furthermore, only one programmer has received long-term training abroad. The lack of trained programming staff is the most critical problem facing CSD in the technical aspect of census implementation.

It is recommended that CSD give the Census top priority. It has so promised, but too much emphasis cannot be given to this undertaking. It will be primarily the responsibility of the long-term advisors in census taking and data processing (sponsored by the UNFPA) to train CSD staff while on-the-job.

The limited technical assistance provided by USAID is insufficient to assure quality and timeliness of census implementation.

4. Collaboration and Support of Other Ministries

The 1975 Census was taken during a nationwide literacy campaign. Approximately 25,000 students and 5,000 teachers who had been living in the rural areas were made available for census enumeration (the exact number who actually conducted the enumeration is unknown). In fact, major field work implementation in the rural areas was controlled by the Central Committee for the Rural Development Campaign and not the Census Committees. There is a serious question concerning how effective the 1986 Census Committees will be and whether or not they can provide the support required for the census.

The importance of the Census Executive and Technical Committees has been brought to the attention of the Director of CSD during an Executive Level POPSTAN workshop given by the U.S. Census Bureau in February. They were advised by CSD that permission to set up the Committee has been requested from the President of GSDR. CSD hopes he will approve it soon and that work can begin in March. However, there is no way to guarantee the success of the Committees now.

5. Data Processing

Although the computer site will be prepared and the computer acquired with assistance from UNFPA and USAID, respectively, this alone cannot guarantee successful processing of census data. Some of the problems experienced with the NCR will no doubt plague the new computer because power outages and environmental factors are hard to control. Furthermore, experience in computer center management is limited and CSD has no systems analyst able to fully understand and utilize the new equipment. None of the programmers are experienced and only the Head of the Processing Section has received long-term training.

Although training in COBOL, Wang Systems, CENTS4, CONCOR and Systems Analysis and Design has been recommended, most of it is not presently covered in the assistance offered by UNFPA and USAID. If increased funding is not made available for these activities, the need for training must be filled primarily by the long-term data processing advisor funded by UNFPA. That individual will have to allocate time to provide formal training in the areas identified if institutional capacity is to be strengthened.

6. Logistical Support

Although both USAID and UNFPA are funding a significant proportion of the local costs of the Census, the major portion

of local costs must be supported by the GSDR. Among the most important of these are salaries and supplements for local staff, especially enumerators, supervisors, data entry staff, editors and coders.

It is extremely important that the Ministry of Education, and other Ministries which have staff in the field, provide release time for their students, teachers and other appropriate staff to carry out the field work. The present GSDR budget for the Census has no line item for enumerator salaries or supplements. The U.S. contribution will cover only enumerator per diems for a period of two weeks. Assuming 15,500 enumerators and supervisors are required for two weeks of training and two to three weeks of enumeration and their salaries are supplemented by So. Sh. 2,000 per month, this cost will be quite high. The same can be said for support of office staff, especially keyers for the duration of data entry which may take over two years. If the GSDR is unable to cover such costs, the Census cannot be implemented as planned, or if implemented, it will suffer from low morale and staff motivation due to lack of incentives.

The GSDR must be made fully cognizant of these obligations and must plan well in advance for the budget allocations necessary for taking and processing the Census.

13.1.(b) TECHNICAL ANALYSIS FOR THE IEC COMPONENT

A. Justification

Before a couple can choose to adopt or not to adopt a method of child spacing, they must know that they have such a choice and the advantages and disadvantages to them of choosing one option or another. Evidence from the Family Health Survey (in which only about 2% of the women interviewed reported using any child-spacing method and about 20-40% had any knowledge of modern methods) suggests that for most Somalis utilizing a family health service and using a method are new, innovative behaviors.

Sociologists have described the process of acceptance of a new behavior as consisting of five critical stages: 1) awareness (the person's introduction to a new idea or practice); 2) interest (the stage at which she/he actively seeks more information); 3) evaluation (the stage of assessment in relation to her/his beliefs, experience, and other criteria); 4) trial (a limited time phase of experiment); and finally, 5) acceptance or adoption. The duration of this process will depend upon personality factors of the individual, how the innovation itself is presented (as consistent with present values and experience or not), and who presents the innovation. At the societal level, you can describe the following sequence: first the "innovators" or "early adopters", i.e., those who respond more quickly and positively to new ideas or radical concepts; then, the "early majority" who help legitimize the process; then, the "late majority" who consolidate it; and finally, the "laggards" who are the last to accept the change.

IEC has a role to play in all stages of the adoption process and can be critical in reducing the time for adoption to take place. IEC helps to inform the "innovators" and attract the members of the "early and late majorities". Within IEC are included all of the possible communication media, i.e. everything from radio to one-to-one, face-to-face discussion. The different media and channels have their own strengths and limitations in supporting this adoption process; some do better at different stages than others.

IEC is critical to informing Somali couples about the options family health presents to them. Most family health IEC activity is presently conducted through the MCH Centers of the Ministry of Health, though effective, the staff can reach only a limited audience. Expanding the institutions and strengthening the program will increase the numbers of couples reached and improve the knowledge (awareness) and (ultimately) adoption of family health practices.

B. Component Strategy

The selection of a multiple-institutional, multi-media, coordinated strategy for IEC is dictated by the needs and realities of the Somali environment. People in Somalia learn of innovations through a variety of channels: radio, printed materials, their friends, teachers, political leaders, and visitors -- to name just a few sources. Of particular importance is the continuing strength of the oral tradition; story-tellers and poets are highly regarded. The influence of these channels and their messages on the behavior of an individual will depend on their credibility to the person; some people regard the advice of teachers highly, others prefer to follow the advice of friends or relatives.

To reach as many couples as possible and affect their behavior, the FHS project must use a variety of institutions reaching different audiences in Somali communities. The selection of the institutions was influenced by the extent of their outreach into urban and rural, settled areas and their interest in becoming involved in family health IEC. A variety of media or communication channels must also be used; the selections made so far are based on considerations of what is appropriate and available in communities to be reached. In this society, radio is a particularly effective medium for communicating and achieving awareness of family health and its importance. Group discussions, presentations, and the like are also popular and often used; they have been quite effective, given the anecdotal evidence available, in promoting use of family health methods. Posters, films, slide shows have not yet been tested for family health education. It is assumed that they will be popular, given the popularity of these media for communicating other messages. One-on-one, word of mouth transmission of messages is known to be effective in most cultures, and the evidence indicates that this will be the case in Somalia. The use of all of these media and the results will be assessed during project implementation.

Given the objectives, the plan to use a number of institutions and media is necessary; at the same time, it is important that the messages that people receive from the different sources are consistent and mutually reinforcing. This requires close coordination of all those who are involved in this program and agreement on what and how IEC will be done. The SFHCA IEC Unit was chosen as the most appropriate coordinating body as it is a relatively neutral entity with representation on its board from all of the concerned governmental agencies. Neither the Ministry of Health, nor the Ministry of Education, nor the SWDO can make a similar claim.

The formulation of the messages to be used and their adaptation into the various media will be done on the basis of the information gathered on attitudes towards family health and related characteristics in the baseline study for this component. The

messages must convey how the practice of family health reinforces accepted values and practices. If this innovation is closely aligned with accepted values and practices the evaluation stage of the adoption process can be speeded up. To align family health with traditions and accepted values, the IEC staff must present the concepts of family health in a framework familiar to the people in the audience, in their words, and in ways in which they are comfortable. Although this can be studied and applied by IEC-trained staff, the Project will aim to develop grassroots activities. This approach is drawn from experience in other countries when people at the local level present the innovative ideas to their own people, the communications is generally more effective and adoption facilitated.

Among the staff in the implementing institutions, the present levels of knowledge and skills about information, education and communication and about family health are low. There is no advanced education or training available in Somalia related to IEC. The Somali film agency and radio station have some trained staff, but their levels of skills and effectiveness have not been assessed. The staff of the Ministry of Health, FH/FP Division have received some training in low-cost media and visual aids production but these have been very simple and for their own personal use. Thus, a whole cadre of persons skilled in IEC remains to be developed. In addition, no systems presently exist for developing an integrated IEC program for any field as is envisioned for this project. Each agency has its own means of dissemination of information and materials, with short-comings in each. The specific problems likely to be encountered are not yet evident, but will have to be dealt with in the process of program implementation.

C. Component Inputs

The inputs for this component include short-term training and study tours for the IEC staff; one long-term advisor and months of short-term advisors for specific technical areas of IEC implementation; commodities which consist primarily of audio-visual equipment and materials; and vehicles for fieldwork of the implementing agencies. These inputs have been carefully selected so as to develop the cadre of IEC specialists required for effective implementation of an IEC program. The placement and scopes of work of the advisors, as well as the selection and placement of the commodities support the development of the coordinating mechanism required for the integrated IEC approach.

These inputs will be complemented by those of other donors: UNFPA provides funding to the Ministry of Education's Population Education Project to implement selected IEC activities for MCH and family health; UNICEF is supporting the development of community and health education programs with emphasis on nutrition, immunization and other preventive health measures through the SWDO, MOH's Health Education Program and the Women's Education Department of the Ministry of Education.

D. Special Problems/Issues

1. Coordination of Efforts

Active, comprehensive coordination is a key to the implementation of IEC under this project. Coordination requires certain actions on the part of the involved parties: regular communications about activities and plans; willingness to come to agreement on a common goal and common products; willingness to compromise in order to develop common products; delegation to one party the right to take selected actions on behalf of the group. Ostensibly, by working together, the product of the whole becomes greater, and better, than the sum of the parts. However, experience indicates that participants in such ventures rarely see it from that perspective. Especially where resources are scarce and leaders and agencies under pressure to gain for themselves and for their staff, each organization is tempted to take as many of the resources as possible including the resources of prestige and power. Rather than work together, the leaders and staff try to demonstrate their superiority and influence, making the process of compromise long and difficult.

The Somali Family Health Care Association will play an important role in bringing the institutions together, facilitating their work and the development of joint plans and other products, and, possibly by mediating differences. The Director of the IEC Unit of the SFHCA must be selected on the basis of her/his skills in communicating effectively with the leadership and operational staff of the implementing agencies and her/his ability to gain the respect of the leaders.

To foster the needed coordination and avoid possible breakdowns in communications, the SFHCA will use the following approaches:

- Meetings of the Program Coordination Committee. As the review and policy committee for the project, the members will review all IEC plans and activities and will identify problem areas; policy issues will be discussed at this level.

- Meetings of the IEC Technical Group. This group, made up of the directors of IEC activities in each agency, will meet at least once every two months to share information on plans and activities; this group will formulate the joint workplan every year. A regular meeting time and place will be set and an agenda circulated before the meetings to achieve as high an attendance as possible of these leaders.

- Informal meetings with the Director of the IEC Unit. The IEC Director will meet at least once every month with the directors of the IEC activities in each agency. These meetings will be more informal with the agenda being only to share information and tea.

- Newsletter. The newsletter of the IEC Unit will provide another means of sharing information, and for granting prestige to agencies who are performing particularly well.

2. Maintenance and Upkeep of the Equipment

The record of maintenance of equipment of any mechanical nature in Somalia is not reassuring. The project will purchase equipment which is as easy as possible to maintain. The project has also planned for and provided resources for training staff in the upkeep and repair of equipment and in its proper use.

3. Translation/Printing of Materials

For the advisors to provide their technical review of the materials and contribute to the improvement of program quality and effectiveness, some translation will be needed. If the materials are developed in Somali (highly perferred) then translation will be needed from Somali to English. If materials are developed in English, then translation to Somali is necessary. To avoid delays that such translations often impose on projects, the project proposes to take the following actions:

- Provide the Somali counterpart staff with English training (through USIS or other means); this will enable the Somali staff to serve as on-the-spot translators and to better check the translations of others. It will also help them prepare for their participation in short-term training programs and study tours.

- Develop an on-going relationship with someone competent in translation so that this individual develops the vocabulary necessary for accurate and speedy translation.

Printing of materials is also a major bottleneck in the production of materials. The project will provide an offset press as one means to avoid such delays. Project plans will also be made to take inevitable delays into account.

4. Reaching Men

Although women are often the first acceptors of family planning and are often the actual users, in Somali society, men play a major role in making decisions for the welfare of the family and in relation to personal, sexual matters. If a woman's husband does not want her to use a family health method, then she will either follow his direction and not use or use a method surrepticiously, possibly leading to other problems and conflicts between the couple. An important audience for IEC activities and an important group to reach and educate about the role of family health are the men.

The institutions being tapped for participation in the IEC component, however, largely direct their efforts to adult women. Family Life Education Centers, the Orientation Centers, and MCH Centers cater to a female audience and orient their messages to concerns of women.

The Somali Family Health Care Association and the Ministry of Information and National Guidance will take the lead in assuring that programs and materials are prepared and implemented for male audiences. These will include radio features, pamphlets, and posters, and group sessions in Ministries, other institutions at the central and local level, and through activities generated at the local level.

13.1.(c) TECHNICAL ANALYSIS FOR THE CLINICAL FAMILY HEALTH SERVICES COMPONENT

A. Justification

Improvement of the quality of life depends in large part on the improvement of the health status of all Somalis, particularly mothers and children, the most vulnerable groups. An important action to assure the good health of mothers and children is spacing of pregnancies at least 2-3 years apart; to allow the mother and her new child to regain their health. To space births the couple must either avoid intercourse or use some method of family health. Traditionally, in Somali society, in polygamous marriages the man would leave the one wife for up to two years following the birth of a child. While this is still practiced in some communities, these traditional ways are being practiced less as urbanization and concomitant cultural changes take place. Thus, the need to practice and use family health methods for child-spacing is becoming greater.

The provision of comprehensive family health services is central to the purpose of the Project. These services provide information to couples which helps them select the most appropriate method for child-spacing, provides them with the method they choose, instructs them in its use, and follows up to assure there have been no side effects. The Project's intent to strengthen the capabilities of the institutions to manage and support clinical services will permit improvements in the quality of services and expansion to more people in more geographical areas.

B. Component Strategy

The selection of the Maternal Child Health Center System as the most appropriate in which to integrate family health services was made with the full realization of its limitations, and only when the limitations of other alternatives were seen as greater. The strengths of the MCH are described below. To date, the MCH System has the most well-developed structure for the delivery of health services in Somalia, with over 89 centers in the regions and districts. More are being constructed. While some of these centers are not fully operational nor fully staffed, other donors, such as WHO/UNFPA and UNICEF are providing support for construction and renovation, hiring of staff, and supplying equipment. MCH services are heavily preventive and oriented to the urban areas. At this time, this urban orientation is an advantage for family health services as urban couples are more likely to accept family health methods. Another important reason for integration of family health into MCH has already started: family health services are being implemented in the MCH centers of 5 regions and they are accepted as a legitimate part of MCH. Although accomplishments in acceptance rates and usage are modest, over 30 MCH centers are now providing some family health services.

An alternative health system considered for developing family health services was the primary health care system. While PHC is to become the national system into which all other health systems are to be integrated, there are still many steps to be completed before it will be fully functional as a national system. The thrust of this program is to provide services to rural communities, through trained community health workers (CHWs) and traditional birth attendants (TBAs). The communities are asked to select and support (financially and in-kind) the CHWs; the program provides the training and supplies. For cases they cannot treat, the CHWs refer patients to Primary Health Care Units (PHCUs) located in district centers. USAID, UNICEF, and Caritas are among the donors providing support to the PHC system; each donor has assisted the development of the program in separate regions with some variations in each. To date there is no unified system for PHC services.

Other alternatives to the health systems described above were considered and rejected as being either too costly or risky, as other candidate institutions are still hesitant about becoming involved with the family health program, and particularly in the delivery of family health services. One alternative, the development of a separate system of free-standing family health clinics, possibly under the Somali Family Care Association, would be very expensive and, at present, inappropriate in the context of Somalia, where family health is acceptable only as a part of a health delivery package. Approaches using the network of the SWDO's Orientation Centers or the Ministry of Education's Family Life Education Centers may be tested under the Operations Research component, but these institutions are not prepared to become involved in service delivery at present. The possibility of using commercial retail sales outlets will also be tested under the Operations Reserach component.

Experience in delivering family health services through MCH has resulted in the identification of a number of problems; these problems have formed the basis of the selection of purpose indicators and outputs for this component, as the project will attempt to alleviate these problems and avoid others experienced in similar programs in other countries. Although correcting these weaknesses does not guarantee an effective field program, it does increase its likelihood. The most serious weaknesses are these: inadequate financial management; inadequate management of the supplies and equipment; limited service information; extremely limited documentation of plans and activities/accomplishments; sporadic supervision and personnel management. While some of these problems have been aggravated by lack of transport and timely financial support, a major reason is the lack of procedures and systems. (Problems of transport will be addressed in Section 4 below.)

An additional concern is the adequacy of the service structure of MCH for reaching the couples most in need of services

An additional concern is the adequacy of the service structure of MCH for reaching the couples most in need of services and providing follow-up. In those centers visited by outside observers, there seemed to be no method for case-finding, e.g., for identifying women at risk and who need antenatal care, or for identifying those patients needing follow-up. There was also wide divergence in the level of activity related to family health services; in some clinics the nurses seem to "promote" family health, in others they do not. Because of this concern, the Project plans a short-term consultation by an expert in service delivery to review the structure and assess its strengths and weaknesses, and to make recommendations on how they can be improved.

C. Implementation Strategy

The approach to implementation for the clinical family health services component of the Project is primarily to continue with the implementation of family health services started two and one half years ago, with efforts directed to consolidating progress and improving the services being delivered. Over the five years service sites will expand (more than double) but at a rate which will allow the FH/FP Division to closely monitor and supervise the staff and facilities. The selection of regions and districts where family health services will be incorporated into MCH and Primary Health Care will be closely coordinated within the Ministry of Health. The proposed expansion plan is presented in Table 13.1.1.

One major change from previous activities will be the delivery of health education. While the Ministry of Health will continue its important role in the delivery of health education about family health, it will, under the FHS project, coordinate its activities with the IEC component, namely the IEC Unit of the SFHCA, and the other implementing agencies. No major change is anticipated in the types of IEC activities undertaken; however, the Ministry of Health would share in the development and production of IEC materials with the other agencies.

The primary mechanism for expanding and upgrading family health services (and IEC) is through training of staff. As noted in the Implementation Plan (See Section 15.0.), training programs will cover a variety of topics; over the five year project period, all staff working in family health will receive some type of training. For training to adequately support this responsibility in program implementation, it must be well-designed and delivered. Further, once training is completed, then the staff must receive adequate logistical and supervisory support. All of these are areas of project emphasis.

D. Component Inputs

The inputs are directly related and compatable with the strategy and outputs defined. Technical assistance is the

TABLE 13.1.1: PROPOSED MCH CENTERS AND HOSPITALS OFFERING FAMILY HEALTH SERVICES
By Region and by Year - 1982-1988 (PAGE 1/2)

	1982		1983		1984		1985	
	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers
Benadir	2	12	2					
Northwest			2	4		3		2
Lower Juba				1	1	1		
Togdheer			1	1		1		
Middle Shebelli			1	2		1		
Lower Shebelli			1	6				
Gedo							1	1
Bakool								
Hiraan							1	2
Gal Goduud								1
Mudug								
Nugaal							1	1
Bari								1
Saraag								
Middle Juba								
Bay			1	5				

PROPOSED MCH CENTERS AND HOSPITALS OFFERING FAMILY HEALTH SERVICES
By Region and by Year - 1982-1988 (PAGE 2)

	1986		1987		1988	
	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers
Benadir						
Northwest						
Lower Juba		1				
Togdheer		1				
Middle Shebelli						
Lower Shebelli						
Gedo		1		1		
Bakool	1	1		1		
Hiraan		1				
Gal Goduud	1	1				
Mudug	1	1		1		
Nugaal				1		
Bari			1	1		
Saraag		1	1	1		
Middle Juba	1	1				
Bay						
	4	9	2	7		
Hospitals = 20		54		60		
MCH Centers = 60						

heaviest component and is consistent with the need to provide skills in doing the jobs within the Somali context. The technical assistance and short-term training are to be targeted to the specific needs mentioned above. The long-term advisor will work with all of the management systems, including training.

Other inputs are directed to fill specific gaps. The renovation of the office space and the MCH Center for a training site will permit the Central Office staff to work in an environment in which the needed systems can be implemented. Contraceptives and clinical equipment will be purchased so that effective and high quality services can be provided. An important input is vehicles which will support the logistics and supervision systems.

E. Implementation Problems

There are a number of problems which are anticipated in the implementation of this component of the project. Specific actions to avoid these problems are explained under each.

1. Maintenance of the Quality of Service

As the services expand into more MCH centers and PHC service sites, the possibility increases for the quality of services to slip. To meet USAID guidelines and generally accepted standards of care in family health services, the project must take steps to assure that patients who participate are fully informed about the benefits and hazards of all the family health methods available, that they make a choice without any coercion, and that they be treated with dignity and confidentiality. A first step is establishing the standards by which this project will assess the quality of care as in the development of the model MCH center to be used as the training site for IUD insertion training. In conjunction with its development, the director of the medical services unit of the FH/FP Division, with consultation of the Director, Deputy Director, and the Director of Community Health Services, will develop written standards for care. These standards will be incorporated into the training for MCH nurses and for the procedures and training for the supervisors.

The Director of the Medical Services Unit will also establish a review committee, with membership from the Division and other parts of the Ministry of Health and University. This committee will review the guidelines and periodically visit MCH centers to assess whether these guidelines are being followed. They will review the reports of the supervisors to assess adherence to the guidelines in those facilities they cannot personally visit.

Family health services will also be provided through three hospitals and will extend into new services, infertility services, voluntary surgical contraception, and services for the

treatment of sexually transmitted diseases. Protocols and procedures will be written for these services with the assistance of the short-term advisor. This advisor will also recommend the most appropriate review process and body to assure that the protocols are followed.

2. On-going Support for the Family Health Services: Recurrent Costs

This project is providing almost complete financing for the delivery of these services. The Operations Research component of the project will be critical in examining the issue of recurrent costs; under the OR component, studies will be undertaken to assess whether and how much people will be willing to pay for family health services and/or contraceptives. Various payment mechanisms will be reviewed and assessed, and be of particular concern in the preparation for the pilot programs in community-based distribution of contraceptives through the TBAs and/or through the political leaders of the SWDO.

The project also anticipates reducing the level of recurrent costs by integrating these services with the regular services of MCH and PHC and by closely coordinating inputs at all levels (See 4 below.)

3. Maintenance of Vehicles

The survival record of vehicles provided to the Ministry of Health is not positive. Various reasons are given for the number of vehicles now not functioning: lack of spare parts, poor maintenance, and unskilled mechanics. The project proposes to add five vehicles to the Family Health/Family Planning program of the Ministry. To make sure that these vehicles will operate and continue to operate the following actions will be taken: purchase of sufficient numbers of spare parts; training for the drivers in how to drive the vehicles properly and in ascertaining when they need to take them for maintenance; and training for the mechanics. The project will contribute to the development and maintenance of the vehicle garage of the Ministry of Health initiated under the Rural Health Project of USAID. The garage will provide these services to the project: routine maintenance and periodic checks of all mechanical systems; preventive maintenance; repair of vehicles as possible.

4. Coordination of Efforts with PHC and MCH

Both the MCH program and the Primary Health Care program are presently providing health services to the people of Somalia. While the MCH program is primarily concentrated in the more urban areas of the districts and regions, the two programs are directing their efforts to preventive health measures and to treating the most common health problems; they are both trying to reach the people in greatest need and direct their attention

to those most vulnerable: mothers and children. Family health is to be integrated into these systems.

To provide these services, common systems and support are required: transport, supervision, records, supplies, to name a few. With resources of the Ministry of Health limited and the needs great, the programs must do as much as possible to coordinate their efforts. This means planning trips, so that supervisors can travel in the same vehicles; planning distribution of drugs and other commodities; arranging training programs jointly, so that the same staff are not being asked to go to different training programs at the same time or to training programs so closely spaced that services cannot be provided in the centers.

The project proposes to structure coordination by conducting meetings at minimum on a monthly basis with the principals of these programs, the Director of Community Health and MCH, the Director of Primary Health Care, and the Director of Family Health/Family Planning. The purpose of these meetings is to discuss plans and problems and to share information and accomplishments. Reinforcing this coordination activity will be meetings of the long-term advisor with the Director of Community Health and MCH on a monthly basis, and informal meetings with the Director of Primary Health Care and other donor agencies, such as WHO and UNFPA. Further coordination of activities will be accomplished through the Project Coordination Committee in which all project activities will be discussed in light of the activities of other ministries and agencies.

5. Maintaining a Positive Policy Environment

The Ministry of Health has provided strong support to the development of family health services, within the context of MCH and Primary Health Care services. Reproductive health issues are given considerable importance, among them the control of sexually-transmitted diseases, infertility, and female circumcision. Nonetheless, questions persist as to the need for family health services in a country with a relatively small population and low desnity for total land area. Most observers agree that family health has been able to expand because it has been presented in the context of health and because efforts have been fairly low-key and directed entirely by the Somalis themselves. The expansion of the project, the renovation of separate office space, and the arrival of a contingent of expatriate experts will bring greater exposure to the program and expose it to more misunderstanding, rumors and potential backlash.

Several approaches will be used to mitigate these possibilities. First, in the policy area, studies will be implemented which will demonstrate more explicitly for Somalia the relationship of child-spacing to health, and thereby the importance of family health for the health of Somali women and children.

These findings will be more widely disseminated through the IEC component and the workshops proposed under the policy area. Second, the IEC component will be developed with the cultural context and just these concerns in mind; expansion will be done step-by-step, and each phase will be evaluated to assess response and to identify needed changes. Third, Somalis will decide on the annual work plans, what will be done, where, and when (that is, how quickly to expand and what should be done). More Somalis will be trained to take leadership roles in the program. Advocacy of the program will be reinforced by the programs of the Somali Family Health Care Association. Fourth, the program, through its monitoring and planning system to be developed under the project, will keep all important officials and concerned parties informed as to what is being done in the delivery of family health services. This will be important to get any negative reactions early; to learn of any problems so that action can be taken before they become major ones.

The leadership of the project will determine to what extent regular meetings should be held to inform the high officials of the government about project activities. It is anticipated that the newly legislated Council for the Care of Mothers and Children wil monitor project activities and give policy advice when appropriate. The project leadership will need to keep the members of this council informed through such reports as mentioned above.

13.1.(d) TECHNICAL ANALYSIS FOR THE OPERATIONS RESEARCH COMPONENT 1/

A. Justification

Key to any effective service delivery program is an innovative, informed, and responsive management system. Operations research activities are critical to the functioning of such a management system. A comprehensive and effective operations research program has three elements: 1) testing alternative approaches to service delivery and identifying the most practical approach; 2) establishing an ongoing monitoring system which identifies successful operations and isolates problem areas; and 3) undertaking formal research projects which establish the impact of service delivery inputs and uncover sources of service delivery problems. The availability of this sort of operational information in a timely fashion enables program managers to adopt service delivery approaches which have been tested and recommended, to replicate service delivery approaches which have been demonstrated to be effective in a given context, and to redesign ineffective operations according to guidance provided by formal operations research projects.

Operations research is an important element in any service delivery program, but is an especially important part of the FHS Project. This is because family health services have only recently been introduced in Somalia and effective delivery approaches have yet to be identified. The Somali Government has been supportive of family planning methods as a preventive health measure for infants and mothers. Family planning services have been provided through the Ministry of Health's Maternal/Child Health Centers and population education has been incorporated into shcool curricula by the Ministry of Education. There is evidence that Somalis are willing to adopt family planning and that a small segment of the population is currently using family planning methods. Still, the institutions providing these services have been slow in establishing services in urban areas and relatively unsuccessful in extending services to rural areas. They have offered only a limited mix of family planning method alternatives. These institutions are also poorly equipped to answer the many questions that are raised by users and potential users about maternal-child health measures, child-spacing, family planning, and alternative contraceptive methods. Hence, much service delivery development is required and there is a pressing need for testing alternative approaches, establishing a workable monitoring system, and estimating program impact and solving operational problems.

Operations research also plays an important part in the FHS Project, insofar as the Project prepares the way for a finer-tuned and broader-based follow-on project. In drawing up the five-year FHS Project, the Design Team adopted a ten-year horizon for longer-range planning. The FHS Project comes at a very early stage in program development and so the Project will be imple-

1/ Note: The Technical Analysis for the Contraceptive Social Marketing Program in 13.1(e).

menting new types of services and entering new areas in Somalia. Evaluating these new services, testing alternative delivery approaches, and redesigning delivery programs will be an ongoing exercise, pivotal in the evolution of family health services. This continuous operations research work will contribute to a lengthened and broadened experience in Somali family health which will be instrumental for the design of a refined and expanded follow-on project.

The Operations Research Component is critical, then for the effective management and operation of service delivery programs. It is especially critical to the success of this Project, since family health services are just beginning in Somalia and since this Project is intended to set the stage for a follow-on project.

B. Strategy

The FHS Project will provide a balanced program of operations research aimed at testing alternative service delivery approaches, establishing ongoing monitoring systems, and undertaking formal, focused operations research projects. Project activities will be phased in a way which corresponds to the natural progression of program development.

The selection of a strategy in which Operations Research will be closely coordinated with all of the implementing agencies and rely on their staff for the implementation of its studies was made only after other alternatives were reviewed and assessed as too costly and duplicative. The integrated approach yields these benefits: maintaining ongoing responsibility for the conduct of evaluation or with the operations agencies; providing them with the training and experience in the implementation of these studies and learning the need to build them into their regular activities; and providing a mechanism for the sharing of information and results among the various institutions.

By developing a Unit, the FHS Project also assures itself that these research activities will be considered and incorporated into the work plans for the project as a whole. The Unit becomes a means for ongoing "lobbying" for OR as well as ongoing, regular assistance in the implementation of studies.

By locating this Unit at the Somali Family Health Care Association, the FHS Project chose a neutral organization with a particular interest in the results of these studies for the promotion of family health services in Somalia. It will be in a unique position to promote those approaches identified as particularly successful in Somalia. Beyond this Project, the SFHCA can use th skills gained and related resources to continue experimentation and testing of family health service delivery mechanisms.

The Operations Research methodologies to be employed will be those deemed appropriate by experts in the field.

By requiring the institutions to submit proposals for the smaller and large-scale studies allows the OR Unit and Technical Group to: 1) compare studies and select those of greatest potential utility; 2) make sure that the study has been well thought through; 3) determine the resources required for its implementation; and 4) assess the implications for other activities ongoing in that institution. At the same time, the preparation of such proposals assures that the institution has carefully considered its interest and commitment to the study.

The second Family Health Survey requires separate consideration. The Project will endeavor to use the lessons gained in the first in this one. Final decisions will be made to design and structure in the third year of the Project. Among the recommendations is that the scope of the second round should be enlarged to cover a minimum of 4,000 ever-married women 15-49, living in urban areas as well as villages throughout the country. Given the difficulties of obtaining reliable probability samples of nomadic households and the virtual impossibility of interviewing women using the customary waterpoint approach, some alternative method is indicated. One approach would be to administer the questionnaire to a relatively small (200-500) number of women in selected groups of temporary nomadic encampments. Another approach would be to abandon the questionnaire in favor of a more anthropological method of gathering data, such as discussion groups. Before either approach is adopted, it should be discussed with Somali researchers and pretested.

In order to maximize the comparative value of the survey, the questionnaire should be modelled on the one used in the first round with the following exceptions: a) a shorter questionnaire would improve respondent cooperation, reduce the length of interviewer training and simplify data processing. Possible deletions might be questions on vaccinations of children, husband's attitudes towards family planning and female circumcision, weaning of the last child, and some of the questions on source of method for users; b) because there is some doubt as to whether the questions on knowledge of specific contraceptive methods were fully understood by respondents in the first survey, special care should be given in the second survey to ensuring accurate Somali translations of these terms. Consideration should be given to including short descriptions of each method in the questionnaire as is done, for example, in World Fertility Surveys (e.g. "there is something which a man can put over his penis before having intercourse in order to avoid pregnancy. This is called a condom or rubber. Have you ever heard of this?"); c) depending on the types of IEC activities introduced in the new project, this section should be expanded. Final determination of the questionnaire will depend on a full analysis of data from the first round.

Prior to developing the questionnaire, consideration should be given to conducting focus group discussions. Focus groups

have long been used by marketing research agencies to gather data on attitudes and to refine questionnaires for subsequent sample surveys. This approach has more recently been applied in demographic research in developing countries (e.g. Mexico and Thailand) and has been found to provide a richer data source than can be collected in structured individual interviews, although, since the method does not rely on a probability sample of respondents, it should not be considered as a substitute for a survey, but instead as an adjunct. Focus groups may be particularly suitable in Somalia, where group discussion is an integral part of the traditional culture.

Consideration should also be given to collecting information from men. This could be accomplished either through focus groups or by implementing a small survey. The Westinghouse Contraceptive Prevalence Survey Project has developed a male questionnaire and has conducted male surveys in several countries in conjunction with female surveys. Experience has shown that surveys of male and female respondents are more efficiently implemented in separate stages of fieldwork. In order to keep inputs at a minimum, a male survey in Somalia should utilize a short questionnaire and should cover a sample of only 1000-1500 respondents.

c. Inputs

Project inputs have been designed to enable the development of a complete, comprehensive OR program. Most important is the long-term operations research advisor who will guide all OR activities. This individual will provide important technical design assistance as well as planning, implementation and analytic support to the Unit, Technical Group, and individual institutions.

The long-term advisor will be assisted by three short-term advisors who will provide assistance to the three major studies planned. In addition, the IEC and Training and Management Systems Advisors will reinforce OR activities, particularly in the area of evaluation and monitoring systems, in their respective components and counterpart instituituions.

The second Family Health Survey will be timed so that its findings on changing family health behavior can be used in the second evaluation of the Project. This activity will be carried out by the contractor for the AID centrally-funded Demographic and Family Health Surveys Project through a Mission add-on to that contract. That contractor will collaborate with the long-term advisor, the Somali Research Associate, and their counterparts in evaluative/management units of relevant institutions in designing the survey instrument. The OR Unit will take the lead, however, in advising and coordinating the survey work of the Ministry of Health and Central Statistics Department.

The Somali Research Associate will participate in a study tour to similar projects already successfully implemented, most

likely in Asia. This experience will provide him/her with information on what should be done or be avoided to initiate such studies and what has been gained from them.

The FAS Project will support the Unit for all local costs for its operation and the studies it undertakes. Vehicles for field work will be supplied by the participating agencies from those already provided by the Project.

D. Special Problems/Issues

1. Reinforcing the Importance of This Component

Although considerable resources are being provided to this component, it still receives less than any of the others and starts later than the other components. It will be very tempting to relegate OR to a less than equal position among the components. Besides, OR will be asking questions that many in the Project, especially around the third year, when it will start, probably will not want asked, or answered.

To avoid this eventuality, USAID and the SFHCA will need to directly assist and insist in the selection of an appropriate candidate as the Research Associate and the contractor will need to retain a dynamic well-qualified person as the long-term OR advisor. The formation of the Unit and the Technical Group will also mitigate against losing this component in the shuffle.

2. Maintaining Communication Links

The implementation of OR activities and the utilization of the findings depends on ongoing effective communications with the concerned agencies. By assigning responsibility for ongoing coordination to the Unit and structuring the Technical Group, two means have been provided to assure communication takes place.

13.1.(e) TECHNICAL ANALYSIS - CONTRACEPTIVE SOCIAL MARKETING

A. Justification

Contraceptive Social Marketing (CSM) makes use of the established networks of retail outlets to make contraceptives readily available to people at a price affordable to the vast majority. Experience in many other countries has shown that many potential users of contraceptives prefer not to patronize government health facilities, for various reasons, be it inconvenience, waiting time, large numbers of people, poor services, or just not knowing about the service. Many people prefer to pay something for the convenience of having a source of supply near by. In fact, some observers would argue that charging for contraceptives increases their value and importance, and therefore, their attractiveness; in addition, it is argued, that when people pay for contraceptives, they are much more likely to actually use them.

There is reason to believe that this experience is applicable to Somalia. Although contraceptive use is still low, less than 1% even in the urban areas, pharmacies report steady sales of contraceptive pills. In a recent, informal survey of pharmacies in Mogadishu, 14 of the 15 visited had stocks of contraceptive pills and were retailing them for So.Sh. 20-40 per cycle. All confirmed that the take-off from the shelf had been steady. Physicians, now permitted to set up their own private practices and clinics, report a steady business for private, fee-for-service health care and an increasing demand for family health services, including requests for contraceptives.

In Somalia, moreover, the retail network is well-established and very active. Most outlets purchase direct and effect sales direct to consumers. The main categories of outlets are: general stores; textiles and crockery; book stores and stationery; pharmacies; hardware; and liquor and beverage stores. Pharmacies and trade outlets can add contraceptives as one other product line.

There are few, if any other constraints for social marketing. There are no known legal constraints; duty is not paid on contraceptive imports. As evidenced in conversations with officials at the Ministries of Health and Education and with the governmental pharmaceutical corporation (ASPIMA), the government's attitude is positive. While cultural and religions attitudes towards CSM specifically have not been probed, most Somalis concur that if the program is directed towards the health and economic benefits of child-spacing and towards married couples, it will be acceptable.

B. Strategy

The selection of the CSM strategy, i.e. to establish an independent unit under the SFHCA with a director hired to manage the program, was done only after careful consideration of two other

alternatives, the first using a government-sponsored enterprise and the second using a wholly private entrepreneur. The first was rejected because the CSM program would not have had the flexibility required and would be subject to the same problems as the present programs already operating. Moreover, the purpose of CSM is to establish an alternative to government channels, which can serve the private sector.

Using a private entrepreneur was an attractive but ultimately impractical alternative. First, there are few private entrepreneurs in Somalia. Second, their involvement in the private sector trade is enormous and so diversified that they are unlikely to devote the necessary attention to the program. Thus, although they profess a desire to be associated with a program of utility to the country, investments of time and commitment are also required, and difficult to obtain.

The advantages of developing a unit with a director specifically hired for the program and associated with the SFHCA are: 1) its acceptance by the government is more likely; 2) the Somalis already active in family health are all associated with the SFHCA and can give their support to the program; and 3) the Unit can devote its entire energies to the program.

The selection of the six urban areas and the pharmacies and selected retail outlets as the targets for the program was dictated by assumptions of where contraceptive demand presently exists (i.e. among urban, more educated people) and who would have disposable income to spend on contraceptives. Moreover, the program must limit its geographic scope in the beginning to assure that an adequate distribution/supply network is developed.

C. Inputs

The Project will provide the support needed to set up the CSM Unit and maintain its operations for four years. This assistance includes: technical assistance, i.e. on-the-job training for the staff in the conduct of small-scale research studies and marketing tests, set up of packing, distribution, and promotion systems, and overall organizational management; contraceptives, packaging and promotional materials, offfice equipment, and vehicles; study tours to observe how similar programs in other countries operate; and local cost support for the salaries, travel, per diem, and packing costs.

D. Potential Problems/Issues

1. Becoming Self-Supporting

The CSM Unit's sales should generate enough return so that over time it can become self-supporting (except for the costs of the contraceptives-USAID would continue to provide the Unit with free contraceptives). Under the Project, USAID will subsidize all Unit costs; all surplus sales revenue, after mar-

gins to retailers are met, will be placed in a separate account to accumulate over the project period. After funding ends, these funds are to be used as the capital to continue the program. Whether these funds will be sufficient after four years, and whether there will be sufficient funds generated to continue to pay the staff, travel, etc. is a question. Moreover, the Unit will also require access to foreign exchange to replace vehicles and produce the packaging and promotional materials outside of the country.

To address this issue, several kinds of assistance will be given: technical assistance to be provided to the Unit in the third and fourth years of the project to assist in answering this question; OR studies will examine the CSM program in comparison to others in terms of cost-effectiveness; and the evaluations scheduled for the Project as a whole, will also assess this program and make recommendations regarding future support of the Unit and its potential for independent existance.

2. Retaining Independence

Experience in other countries, for example Nepal, indicates that governments frequently want to take control of programs which are innovative and successful. The CSM Unit will be an unusual enterprise in Somalia and a tempting target. However, it is anticipated that the placement of the Unit under the SFHCA and its linkages with an Advisory Board made up, in part, of government officials, will permit the Unit to retain its ability to act independently.

3. Maintaining a Positive Environment for CSM

The environment for family health is still sensitive; the present family health activities appear to be accepted in part because they are low-key and within the context of health services. The development and distribution of packaging and promotional materials and the increase in the number of outlets for contraceptives will increase the potential for misconceptions and charges of immorality, etc.

All program materials must be designed with these sensitivities in mind; further, the advisory board should assist by setting appropriate guidelines and policies for the program. The Board and SFHCA will be important forces for addressing criticisms and advocating the program.

13.2. ECONOMIC ANALYSIS

A. Background: The Methodology

Conventionally, eocnomic analyses undertaken for family planning projects are based on a weighing of the benefits derived from a slower growing population against the costs of providing a level of family planning services to achieve that slower growth. In short, cost-benefit analyses estimate the number of couple-years contraceptive protection provided by the level and mix of contraceptive products distributed through project-supported family planning programs. Based, then, on an assumed ratio of births averted to couple-years protection, the total number of births averted through project inputs is computed. The current value of social savings derived per averted birth is estimated by calculating the discounted present value of the marginal individual's lifetime stream of expenditures (including food, housing, education, and health) minus lifetime stream of income from productive activities. The total savings (in present value terms) from project-supported family planning inputs is then calculated and compared against total costs (in present value terms) of the project to establish the internal rate of return.

Such an analysis for Somalia is complicated by two factors. First, the lack of adequate data makes a cost-benefit analysis impractical. Since the FHS Project virtually initiates a family planning program for Somalia, the rate of acceptance of family planning and the mix of preferred methods is difficult to estimate with any precision. Further, the benefits derived from an averted birth in Somalia is a presumptuous calculation, given the poor data on household consumption, on national and local expenditures, on education, health, and social services, on size and age distribution of the base population, and on labor productivity. Any computation of an internal rate of return to Project inputs, then, would be highly speculative.

Second, the particular focus of the FHS Project makes a cost-benefit analysis inappropriate. Actual family planning service delivery constitutes only a part of Project activities. A sizeable portion of Project inputs will support population census and survey data collection and analysis (an important activity for population policy and planning given the poor condition of data in Somalia). Since family planning is just getting underway in Somalia, considerable resources are being devoted to pilot studies and operations research activities to develop an effecient and effective distribution system. But even the service delivery portion of the Project may not be suited for a conventional cost-benefit analysis. This is because the Somali Government is promoting family planning for the purpose of child-spacing and its associated benefits for maternal and child health; it is further presumed that a large segment of current users and potential future users of services under this project will adopt family planning for this health

purpose. The immediate impact of Project activities will likely be improved health, with a smaller, secondary impact on reducing effective rates of fertility.

Yet, activities supported under the FHS Project are appropriate given the demographic conditions in Somalia and indispensible to the timely achievement of an effective family planning program. They develop the program infrastructure for ongoing family planning distribution beyond the term of this Project when services will continue to be utilized to maintain maternal and child health and will be utilized to a greater extent to limit the number of childbirths. The present economic analysis will dispense with a formal cost-benefit evaluation and will instead provide a cursory assessment of population conditions and economic development prospects for Somalia.

B. Macroeconomic Issues

Real national economic development is most simply measured by a "ledger sheet" comparison of the rate at which national production is growing. This comparison of growth rates is in effect an evaluation of changes in Gross National Product (GNP) per capita. Improvement in national development is spurred by efforts to increase the rate of production growth, efforts to decrease the rate of population growth, or some combination of these efforts. Economic indicators for Somalia suggest that GNP per capita has not increased and may have actually declined over the past twenty years. Hence, Somalia has been stationary (or perhaps retrogressing) over this period in economic development progress. Gains in national production have been matched or outpaced by gains in national population.

The current annual rate of population growth in Somalia is estimated to be 2.6 percent. This translates to a length of time of 27 years in which the population will double in size. Such a rapid growth rate has important implications for future requirements of that population in terms of food, housing, education, health, and employment needs. Prospects for this growth rate being reduced in the near future are not promising. In fact, there is good reason to expect this growth rate to increase in coming years - perhaps to 3.0 - 3.4 percent. This translates to doubling times of 20 - 23 years. Such an increased pace of population growth would further complicate efforts to feed, house, educate, and productively employ the population.

The reasons underlying expected increases in Somalia's population growth rate relate to changing patterns of mortality and fertility. Mortality rates are extremely high in Somalia -- especially among children and mothers. The crude death rate is estimated to be 21 per 1000 people. of 1000 childbirths, 170 are estimated to result in infant death and 11 to result in maternal deaths. These mortality rates are among the highest

in the world. Through various means of health intervention (including improvements in primary health care services, health-related education, water and waste management, agricultural output, and food transport and storage systems) these mortality rates may be brought down quite quickly and achieved in the absence of like strides in national production development. Hence, the crude death rate (and infant and maternal mortality rates) may well fall dramatically in the coming years.

Lowered incidence of mortality will have some direct influence on raising fertility. This is because more women will be surviving into and through childbearing years and so will be contributing to national fertility levels. Aside from this link, there are other reasons to suspect fertility levels to increase. With improved nutrition and health, (including abandonment of female circumcision practices and control of venereal disease) the incidence of infertility among Somali women is likely to be reduced. Also, with the settlement of nomads and modernization taking place among settled populations, traditional fertility regulation and polygamous marriage practices are likely to break down, contributing to higher fertility. Hence, the crude birth rate (which is estimated to be 46 per 1000 people and about on a par with Africa as a whole) may well increase slightly in the coming years.

The combination of significant mortality declines and slight fertility increase will lead to higher rates of national population growth in the future. For real per capita national development to take place, rates of national production growth will have to be stepped up to even higher rates. The rate of population growth can be slowed, however, through programs providing safe and effective methods of family planning to those couples wishing to space or limit childbirths.

C. Microeconomic Issues

Of course, the macroeconomic "ledger sheet" comparison of national production growth rates and national population growth rates ignores important links between these growth rates. The national population, in addition to being benefactors of national productive output, are the generators of that very output. It has been argued that rapid population growth contributes to per capita national production growth. This argument breaks down, however, for most less developed countries in two ways. First, in many of these countries, the ability of natural land resources to support a rapidly expanding population is limited. This is certainly true in Somalia where much land is very marginal and water is in short supply through much of the year. Expansion of the agricultural sector, then, faces major constraints.

Second, in many of these countries, enhancement of human and material capital is made difficult by rapid population growth.

The short-term consumptive burden posed by large new additions to a population (in terms of food, health, and education requirements) are counterbalanced by their long-term productive contributions. However, in many instances the short-term burden of children is considerable and has major long-term consequences. The short-term burden represented by six to eight child families often means diverting family income from investment (which is needed for modernizing production processes) and from education (which is needed for modernizing human skills) to meet more immediate food and health requirements of family members. This short-term burden is translated in the long-term, not by modern, capitalized production and skilled laborers with large numbers of innovators, but to continued traditional production techniques and largely unskilled laborers with few trained to contribute to technological innovation.

Adoption of smaller family size norms, on the other hand, enable families to devote greater resources to more productive technologies and to better educate their children. In this way a more moderate rate of population growth can contribute to more productive labor. While the entire Somali population cannot be expected to adopt smaller family norms overnight, there is evidence that a segment of the population (those who are better educated, reside in urban areas, and employed in more modern economic sectors) has adopted these norms already. As the nation develops, it is likely that this segment will continue to grow. It is important, then, to establish family planning programs which enable couples to freely choose the timing and number of children.

13.3 SOCIAL ANALYSIS

A. Introduction

Data on social and demographic characteristics relevant to this analysis are few. While some anthropological studies have investigated attitudes and practices related to health and disease, none of them have concentrated specifically on child-bearing, sexual practices, or decision-making within the family regarding children. The AID-funded Family Health Survey, conducted in 1983, was the first sample survey intended to assess attitudes towards family size, child-bearing, awareness of and use of contracteption, etc. Almost all of the studies, including the Family Health Survey, have been geared towards women. There is very little information available which systematically attempts to assess men's attitudes.

Thus, most of the assertions made in this analysis are drawn from rough interpretations and are subject to refinement. They apply primarily to the urban and more settled rural portion of the population. The FHS project will address just such deficiencies by providing funding and technical assistance to conduct demographic, socio-economic and operations research studies which will yield information about

the knowledge, attitudes and practices of Somali men and women concerning family health and family size. Results of these studies will be utilized in planning specific activities, particularly IEC and family health service delivery, and in adjusting plans to deal with particular problems encountered during implementation. The evaluation cycle and preparation of annual workplans will help to incorporate these results into the on-going program.

B. Context

1. Child Spacing and Health

The major health problems of Somali mothers and children result from the high prevalence of three, interrelated factors: malnutrition, infectious diseases, and unregulated fertility.[1] There is a high rate of maternal mortality and morbidity, and an especially high rate of anemia during the fertile years. In some cases, customary practices leave mothers and children highly vulnerable to infection, e.g. that of reducing, sometimes drastically, the intake of food during the third trimester of pregnancy, in the belief that smaller babies will result in an easier delivery. However, problems also result from lack of health facilities: one estimate is

that national health services are out of reach for 85 to 90 percent of the rural population. Lack of adequate water and sanitation facilities and food shortages are other factors contributing to Somalia's health problems.

Best available estimates[2] of demographic parameters demonstrate the effects of unregulated fertility in the context of high mortality: a crude birth rate of 46 per 1000; a crude death rate of 20 per 100; an infant mortality rate of 170 per 1000; a total fertility rate of 6.1 children per woman; natural rate of increase of 2.6 percent per annum; and a life expectancy at birth of 43 years. Based on preliminary results of the Family Health Survey, the proportion of married women of reproductive age using modern methods of contraception is less than one percent. Of urban women aged 15 to 49, twenty to forty percent have heard of family planning and 10 to 15 percent of them know of a source of contraceptives.

Although studies of the determinants of fertility are lacking for Somalia, the general social framework for this Project can be described on the basis of population surveys to date, the anthropological literature, and comparisons with demographic patterns and change in other sub-saharan African countries.

As elsewhere in Africa, a synergistic relationship between high infant mortality and high fertility characterizes Somalia. Aware of the high likelihood of childhood deaths, couples try to have many children in order that adequate numbers will survive. Very high fertility, in large part, follows from the lack of alternate options, as health services (including child spacing) are inaccessible for most of the population. Most studies to date suggest poor understanding of the linkages between infant and maternal morbidity, and closely spaced births.

Somalia's social, economic and political context is one in which large families are valued. As in most agriculturely based, developing countries, the value of children derives from their role in providing economic support, through their labor on family enterprises, when young, and their contributions to their parents and family when older. Children start being productive from about the age of seven. (In the more settled areas, where education is available, parents tend to send their children to primary school. Approximately one third of primary enrollment is girls. Dropout rate is high.) Data are not available to permit more precision about the need for children's labor in the household,

and this gap will remain until there is further study of household and extended family economic strategies.

However, the value placed on large families does not necessarily preclude the practice of spacing of births, to ensure healthy mothers and children. Evidence for traditional spacing practices is, unfortunately, only anecdotal for Somalia, but some observers have referred to practices such as prolonged breastfeeding, and separation of husband and wife after childbirth (especially in polygynous households, when the husband would move away to another wife). Whether or not parents saw these practices in terms of their health benefits is not understood; there is some evidence that Somalis view the first two years of life as very precarious, and that an important way to strengthen the child is through breastfeeding throughout that period.

2. Organization and Decision Making

The Somali people share a common nomadic heritage and a common language and oral tradition. They are ethnically one of the most homogeneous in Africa, with five major clan families deriving language and culture from similar Cushitic

origins, and having a 98 percent (or more) adherence to Sunni Islamic beliefs. Traditional norms stress the dominance of the individual within a strong egalitarian (although male-dominated) framework. Traditional organizational structures provide for communal decision making at various levels within an extended family and clan grouping.

Despite their frequent movement and geographic dispersion, Somalis have preserved a high degree of cultural, social and linguistic unity over the centuries. Clan membership provides a system for assigning each Somali a place in society and a network of relatives to a call upon for support no matter where one may travel. However, there are important economic and social variations, which correspond, in part, to differences in physical environment, and in part to differences in local social and political institutions.

A fundamental principle of social and political division is the lineage based on patrilineal descent. The lineage groups are led by a Council of Elders - all men - a policy-making body chaired by a headman. Although inter-lineage competition and warfare have been reduced, and numbers alone are not as important now as they were in the

past, mutual support among lineage members persists, and elders remain strong leaders.

In religious life, there are four major brotherhoods, each formed from the following of a particular Sheikh. Religious leaders, looked to for inspiration, are seen as mediators between people and God. They may be accorded great personal loyalty, and followers tend to give strict obedience to their teachings. Controversies arise when religious leaders differ in their interpretation of the teachings of the Quran.

Identification of a Somali family as either nomad, settled or urban is somewhat artificial, as many families are simultaneously engaged in at least two, or perhaps three, sectors. Of the approximately 5 million Somalis living in the Republic, about ten percent are estimated to be refugees. Of those remaining, it is generally agreed that about 50 percent of the population are primarily nomads, about 20 percent are primarily involved in settled agriclture, and another 20 percent are urban dwellers engaged in non-agricultural occupations. Many farmers and city dwellers actually become nomads for part of the year, following a cyclical pattern: during the dry seasons, when the herds are gathered at watering

points, some of the nomadic population may shift to urban centers to earn supplementary income, or to stay with their relatives working there. With the rains, these temporary migrants then return to their herds. The urban population may expand by 20 to 50 percent during the dry seasons. Many "nomads" keep houses in urban, settled areas. Thus, there are frequent contacts between the urban and settled populations and the nomadic population, and through these contacts both groups are affected. No matter how long one stays in urban centers, ties with rural relatives remain strong.

Households are often grouped together in larger, extended family management units. The same organizational form facilitates responses to agricultural and non-agricultural opportunities. Extended families may constitute a single unit with regard to pooling of risk or investment, with rural members linked economically to kin in town and overseas. Internal and external migration -- there are an estimated 140,000 Somalis, primarily male, working abroad -- should be seen in this context. Most Somalis in the Gulf identify with, and remain an important part of their families within Somalia. Male family heads often make critical decisions e.g. with reference to starting a new enterprise, moving a child closer

to a school, or employment, in the context of the wider (and to the outsider', far-flung) unit.

It is in the context of the high value placed on family, clan and lineage that the role of marriage should be seen. Marriage is essential and its purpose is to produce children to strengthen and increase the father's lineage. Traditionally, women's roles are defined in terms of caring for their children.

3. Social Change and Population Growth

For a number of reasons, it is likely that Somalia's high rate of population growth may accelerate in the near term, unless modern contraceptives are made available to couples.

First, if better health care services (and water and sanitation) are provided, the infant mortality rate may decline, and more children will survive. This is likely to happen in urban areas and more densely settled rural areas first, where services can be most easily expanded.

Second, it has been suggested that the duration of breastfeeding is declining throughout the country, and that it

is lower in urban areas than rural areas. One figure cited is a current practice of 6-12 months in urban areas and 12-15 months in rural areas. Given the contraceptive effect of prolonged lactation, and the near absence of modern contraceptives, the result is likely to be a shortening of the birth interval, and higher fertility.

Third, if other traditional practices (for example polygamy) which served to limit fertility are declining in prevalence, in Somalia as they have elsewhere, this will contribute to higher fertility.

Fourth, it has been noted that elsewhere (e.g. in Kenya), women's fertility increases with achievement of primary education -- perhaps because of better health or sanitation practices. This may apply to Somalia as well.

Fifth, some analysts believe that nomadic fertility is lower than that of the more settled population as a result of nutritional shortages among women, and perhaps a strong tradition of child-spacing. Wherever nomads settle, or begin to assume habits of the settled population, fertility among this substantial group of the population may rise.

Thus, in the absence of strong national institutions, trained people, and facilities to support provision of family health services, Somalia faces the possiblity of a rise in fertility and higher rates of population growth. The extent to which this may be the case is poorly understood, as a result of the lack of data, and this is one research topic of key importance to planning.

Fertility is not likely to drop significantly in the short term among the majority of Somalis, however, even if services are available. For most Somalis the strong values attached to large families and family networks are likely to preclude the use of contraception to limit family size. Family size limitation may be the option chosen by pockets of the population: where women have employment outside the home and other economic interests; where wives are relatively highly educated; in urban areas where large numbers of children are seen more as an economic burden than as a source of family labor. Thus, among certain sub-groups, probably first in urban areas, family size may decline somewhat as women and men begin to redefine their roles, and those of their children in family support.

C. Beneficiaries and Benefit Flow

1. Direct, Indirect and Ultimate Beneficiaries

The direct beneficiaries of project components are the personnel of Somali family health institutions, a large portion of which are women. The Family Health /Family Planning Division of the MOH and the Somali Family Health Care Association with particularly benefit, as well as other institutions with information and education. Also benefitting will be staff of the Central Statistical Department, Ministry of Planning.

Civil servants will receive training and advice to enable them to manage program components; deliver services in reproductive or family health; and collect, analyze and use appropriate data for planning and programming. Project inputs will also assist them through providing better facilities in which to conduct their work.

By project component, direct beneficiaries will be:

Population Data and Policy: About 60 staff of the Central Statistical Department, who will receive new analytical

skills and have access to greatly improved data processing facilities.

Information, Education and Communication: About 600 staff (600 trainees, 3 new hires) of Somalia's leading information institutions, and the management staff of the SFHCA, all of whose skills in reaching the Somali population with appropriate health messages will be increased.

Clinical Family Health Services: About 200 staff of the FH/FP Division and other institutions, who will receive training, supervision, and financial support. The MOH will have a strengthened training capability, including a cadre of family health trainers.

Operations Research: About 50 staff of participating institutions, especially the SFHCA, whose capacity to conduct monitoring, research and evaluation activities, and assist IEC and service delivery managers in the application of findings to program development and improvement, will be strengthened.

Indirect beneficiaries will be the users of new data -- GSDR planners, leaders, policy makers and program managers in the areas of national policy, health services, and

education. Persons utilizing IEC materials developed with Project support will also benefit indirectly.

The ultimate beneficiaries of Project support are those Somalis who will benefit from improved and expanded services and health information. Benefits will be in the form of improved health of mothers and children, and improved family well-being. It is estimated that 8 percent of married women of reproductive age will be users of modern child spacing methods, through services made available (or strengthened) in 60 MCH Centers and 20 regional/specialty hospitals. During the Project life most of those receiving services will be urban residents or will live in settled rural areas.

2. Benefit Flow: Data Collection and Use

Without an improved data base, national planning for Somalia's population and health sectors will not be possible, and program inefficiencies (e.g. misplaced services, inappropriate service delivery approaches) will hamper improvements in family health over the long-term. Without better knowledge of population characteristics and of population-health and population-development linkages, planners

may continue to give low priority to population and family health. Further, effective approaches to service delivery have yet to be identified: this can be done through operations research, review of service statistics, and surveys (for example, the IEC Baseline Survey).

In Somalia, data gaps run the gamut from basic demographic parameters, to knowledge and attitudes toward child spacing and family planning, to reliable service statistics. The Project's strong emphases on improving skills and institutional capabilities in identification of data gaps; data collection, processing and analysis; and data applications to planning and decision making, are necessary if Project benefits to the Somali population are to be maximized over the long term. This implies that significant benefits of the Project will flow indirectly -- first, to the individuals and institutions responsible for data collection and use, then to service delivery institutions, and finally to the individuals who benefit from services.

As noted in the text, relevant data are scant, and most cover only urban, settled, or regional segments of the population. There are few completely analyzed surveys (the

Demographic Survey of Benadir, Bay and Lower Shebelle, published December 1981, is one exception). Most surveys have not been fully processed or analyzed, including the 1980 Survey of Population (covering 7500 households in urban, rural and nomadic areas), the 1982 Labor Force Survey, and the 1983 Family Health Survey (of 3000 ever-married women in 5 urban areas). The 1975 Census is only partially analyzed and is of questionable quality.

The Project will support the analysis of useful, previously collected data bases, and will support collection and analysis of new data sets. This will permit establishment of current conditions, assessment of program impacts, and an ongoing basis for formulation and refinement of policies and programs.

More specifically, by component:

Population Data and Policy: In order to permit the quantification of demographic and socioeconomic parameters and trends, the project will support the 1986 Census of Population (along with other donors); interim analysis of the 1980 Survey of Population and the 1982 Settlement Survey (the latter

will provide data on the demographic, economic and social consequences of settlement); and special studies of population - development linkages (topics are not yet decided, but likely ones include male attitudes, and health effects of family size differences).

Information, Education and Communications: The planned IEC Baseline Study will provide important, new information on the social environment (including communications channels, formal and informal, and family health attitudes, beliefs and practices) in which education programs must operate.

Clinical Family Health Services: Support to this component will include development of an improved service statistics system. Among other things, this will permit documentation of usage, and differentials in usage, and service delivery problems.

Operations Research: This component will test alternate approaches to service delivery, and provide feedback necessary to improve services. The second Family Health Survey will measure changes in attitudes and knowledge on family health topics and in contraceptive use. Focussed studies will address cost recovery (fees/payment), extension of services to rural

areas and ways to encourage community involvement in service delivery. Market tests will be conducted to establish an appropriate contraceptive social marketing program. Also included under this component is monitoring of service delivery.

D. Feasibility and Impact

1. Political, Social and Ideological Factors

The social feasibility of establishing broad child spacing services should be examined in terms of: evidence of governmental support; evidence of demand for services; and likelihood of ongoing popular support for child spacing and for population access to contraceptives.

The National Five-Year Development Plan (1982-1986) recognizes population growth as one factor contributing to the nation's development problems, and (although actual coverage is minimal) family planning information and methods have been officially included in MCH services since 1978. The establishment in 1983 of the Somali Family Health Care Association (although a non-governmental organization, it was established by government decree) is perhaps the most significant indicator of government support.

An important share of the credit for official support for expanding child spacing services in Somalia should go to Somali women's leaders, especially those who hold positions in the government, and in the Party, where they form a significiant proportion of regional and district secretariats. Support by the Somali Women's Democratic Organization has been critical, as the organization is one of three branches of the Party, is powerful in national policy formulation, and has an extensive network of regional, district and village committees which can mobilize women in campaigns related to social welfare.

Consultants' reports[3] cite indications of women's interest in using contraceptives, if they were made available, particularly among those women who are better educated or who live in urban areas. An unofficial survey of pharmacies revealed that 14 out of 15 had stocks of oral contraceptives, retailing for between Sh 20 and Sh 40 per cycle; shopkeepers all confirmed that the takeoff from the shelf had been steady. An important indirect indicator of unmet demand, statistics on hospitalized complications of abortion, have not been compiled, but discussions with medical staff suggest the figures may be significant. In reporting on meetings with nurse and

nurse-midwife trainees, consultants noted [4] that many nurses, initially reserved and uninformed about family planning, had become strongly supportive and indicated that "people are now beginning to ask for family planning at clinics."

Popular support will depend on opinions held by the society's traditional leaders, and by male family heads. It might appear to an outside observer that family planning runs counter to tradition, but (as has been shown in other Islamic societies) this is not necessarily the case. Support for limitation of births is likely to be opposed, but support for birth spacing, with the purpose to improve family health and well being, could be seen as fully consistent with tradition.

Somalis perceive that the number of children which a woman bears is something decided by God. A government program which attempted to alter this belief might be considered an attack on religion, and therefore opposed. However, a program which worked within the context of such a belief (this depends on <u>how</u> information is presented, as the program is not intended to change family size or family size norms) would probably be viewed favorably. Further some scholars of Somali culture[5]

note that the fatalism often ascribed to Somalis as Muslims -- that outcomes of situations should be left up to God -- does not preclude purposeful human action. When Somalis see that particular things are within the domain of human influence, they believe that people should not be complacent, but rather should do their part and take action to ensure a good outcome. In terms of maternal and child health, this means introducing specific practices which can be seen, through experience, to be beneficial.

It will be important to secure the positive involvement of religous leaders, who otherwise could see a new health practice as threatening to their power, or to the role of religion in life. This is especially true with reference to women's health and reproduction. And their resistance could have major repurcussions:

> "if the Sheikhs want to make an issue of something concerning women, it is likely that they can rally the men of the community to their side if it touches so directly on the local interpretation of religion as does health" (Thomas 1982)

As Somalis especially value the opinions and teachings of their religious leaders, it will be especially important that they support family health.

2. Concerns

Child spacing practices are most likely to be an acceptable and appropriate innovation if, during implementation, the following, facilitating steps are taken. Most of these steps indicate areas of emphasis within the context of planned activities.

a. Maintain a Positive Policy Environment. Staff of participating institutions, especially those involved in activities under the first project component, should realize that potential for misunderstanding is ever-present on subjects related to family health, and attempt to preclude it through open dialogue and discussion of issues with government and traditional leaders.

b. Promote Public Understanding Through Appropriate Educational Materials and Messages. The IEC Baseline study will be critical to the design of suitable material, as will

feedback from other sources (e.g. nurses). Child spacing through modern contraceptives use is an innovation in Somali culture and one which, given the Somali context, could be seen as threatening to valued traditions. Misunderstanding can be avoided if messages are based on an understanding of local interpretation and are styled to be consistent with deeply held values. Any promotion of a change in the value of children is likely to be opposed.

c. Male Attitudes and Support. Because of the male role in the family, it will be difficult for women to adopt family health innovation without their husbands' support. Male attitudes are one of the most important factors which will affect acceptability of project innovations -- but these are to date very poorly understood. Special studies should focus on the topic.

By emphasizing capacity-building, data generation and strengthening of services in urban (and more settled rural) areas, the Project is taking a sound approach to a sensitive area by (1) building Somali capacity to deal with family health problems on their own, (2) helping to ensure that programs are designed and refined on the basis of current information, and

(3) support of service delivery first among segments of the population which are most likely to be receptive to project innovations.

3. Impact

This five-year Project looks to a longer time frame in which institutions strengthened during Project life will not only be able to sustain activities, but replicate, or adapt, delivery systems in areas of the country which remain underserved. Some activities supported under the project, especially though the Operations Research component, will address directly the constraints to expansion of services to more isolated rural areas, and to nomads. Acceptable new information, or attitudes toward new practices which are seen to be beneficial, may spread through the kin networks which characterize Somali society and link urban to rural, nomad to farmer, and geographic area to geographic area.

1] UNICEF. 1983. Children and Women in Somalia. Summary of Situation Analysis. Mogadishu.

2] Based on analysis in: Cross, Anne R. 1984. "Population and Family Planning Research in Somalia: Report to USAID", Mogadishu, Westinghouse Social Services, International.

3] For example, see: Louis, Terry. 1984. "The Potential for a Contraceptive Social marketing Project in Somalia." Report to USAID, Mogadishu.

4] Murphy, Catherine, and Beth Henke. 1983. Trip Report No. 160 - Somalia. INTRAH.

5] See Thomas, Abby. 1982. Bringing Somali Nomads into the Primary Health Care Program, and Training Nomad Community Health Workers. II. Anthropological Considerations. Medical Service Consultants, Inc. (MSCI).

13.4. ADMINISTRATIVE ANALYSIS

A. Introduction

The Family Health Services Project will work with eight different Somali organizations in the implementation of the four project components, with one organization taking the lead for each, as shown below:

Component 1: Population Data and Policy - Lead Institution: Central Statistics Department of the Ministry of National Planning. Other cooperating institutions include: Somali Family Health Care Association and the Ministry of Education (Population or Planning Department).

Component 2: Information Education and Communication - Lead Institution: Somali Family Health Care Association. Cooperating Institutions: Somali Women's Deomcratic Organization; the Curriculum Development Center, Women's Education Department, and Population Education Program of the Ministry of Education; the Ministry of Information and National Guidance; and the Family Health/Family Planning Division and Health Education Program of the Ministry of Health.

Component 3: Clinical Family Health Services - Lead Institution: Family Health/Family Planning Division of the Ministry of Health. Cooperating institutions: Benaadire Hospital (Ministry of Health).

Component 4: Operations Research - Lead Institution: Somali Family Health Care Association. Other cooperating institutions: see Component 2 and 3 above.

In the implementation of this project, these organizations must operate separately to carry out those activities for which they have sole responsibility; they must also, in varying degrees, depending on the component and the specific activities, work together. All of the organizations will coordinate their activities through the Project Coordinating Committee, which will oversee all project activities.

This analysis assesses the capabilities of the lead institutions in detail, summarizes the capabilities of the cooperating institutions, and specifies how the Project will strengthen their administrative capabilities,an important purpose for the Project. The final section address the proposed structure for overall coordination of the Project Coordinating Committee.

B. Central Statistics Department, Ministry of National Planning

The Central Statistics Department (CSD) is responsible for the implementation of all the activities under project Component 1, Population Data and Policy. This component encompasses a wide

variety of activities including some which would be a challenge to managerial capacities in any setting. The planning and execution of the 1986 National Census is SCD's responsibility; to be successful, CSD must gain the collaboration of many different ministries and organize their efforts. In addition, CSD will have responsibility for managing the completion of several other analyses, conduct of conferences, and the planning and implementation of several additional demographic studies. One or more of these activities CSD may choose to delegate to another institution, such as the Somali Family Health Care Association or the National Academy of Sciences and Arts.

1. Organization and Staffing

The Ministry of Planning is directed by a Minister, Vice Minister, and Director General (DG), who is responsible for operational oversight of the Ministry. The Director of the Central Department of Statistics reports to the Director General of the Ministry. All official letters and documents are signed by the DG.

The Central Statistics Department has a staff of approximately 60 people organized into six sections. (See Appendix A for details on the structure and staffing of each of the sections.)

Specific needs for staffing are discussed in Appendix A. The CSD will require additional staff in order to plan and process the census, indicating: more programmers, operators, data entry operators, as well as staff to train and manage the planning for enumeration, the enumeration itself, and the organization of the questionnaires and their transmittal to the CSD in Mogadishu.

The technical staff of CSD frequently leave, as they can find more lucrative positions outside of Somalia. Thus, some turnover of the trained staff is likely; however, because of overtime pay and interest in the training and experience, it is anticipated that during the course of the census itself, this will be relatively low.

With the hiring and training of more staff in 1984 and 1985, and with appropriate technical assistance and on-the-job training, it is anticipated that the CSD will be able to technically manage the census and other data analysis activities required under this component.

2. Management Capability

a. General

More than any other skill, the census requires strong management capability. Among the specific management skills required are planning, scheduling, recruiting and selecting staff,

ongoing coordination, monitoring of activities, budgeting and disbursing of funds, and supervision. The CSD will need to manage the inputs of at least 6 different ministries; the Census Committee, which will take primary responsibility for this coordination, will rely on CSD for implementation.

At present, CSD does not appear to have the experience or required skills to manage such a complex undertaking. While many of the staff were involved in the 1975 Census, none were in positions of directing the census efforts. Moreover, the 1975 Census was able to make use of another parallel management structure, the Central Committee for the Rural Development Campaigns for Literacy and Health. The 25,000 students and 5,000 teachers teaching in the rural areas during the campaign were loaned to the census for the enumeration activity. In 1986, there will be no such parallel structure; CSD will have to make and maintain the linkages needed to get access to potential enumerators, such as teachers and nurses, and other support required from other ministries.

This key deficiency will be addressed through the provision of technical assistance to the CSD; UNFPA is providing funding and will recruit a long-term Census Advisor, who is expected to arrive in Somalia in late 1984 and stay for two years. This person will assist the CSD in organizing and managing the overall census activity. In addition, other assistance is being provided which will support the management of the census: UNFPA is providing an advisor to assist in census planning for five months in 1984; USAID/BUCEN are providing two training programs, one in census planning and the other in technical preparation for the census; UNFPA and USAID are providing other technical experts who will also advise in planning and management of their respective activities, the UNFPA in cartography and USAID in design and data processing. In sum, these advisors, both in the work they do and in the advice and training they provide, will enable the CSD to manage the census activity.

b. Financial Management

CSD will not be required to manage any of the hard currency contributions to the census or other demographic studies, as these will all come through the provision of commodities, technical advisors, and long-term and short-term training programs. The CSD will be required to manage a large budget of shillings from GSDR and CIPL, both of which have requirements for budgeting and accounting which must be met. At present CSD does not have the capability to manage such large budgets and account for such large expenditures.

The UNFPA has agreed to provide funding to hire two local accountants for accounts for the conduct of the Family Health Survey.

Problems with the accounting and management of funds include lack of knowledge and skills in basic accounting procedures; lack of understanding of the relationship of expenditures to budget line items; lack of understanding of the need to provide a "paper trail" for all expenditures; lack of ability to keep files and receipts in order.

With such problems still plaguing this project, two things were clear: that the Ministry of Health would not be able at this time to manage a USAID contract; and ongoing assistance was required to assure that accounts are properly kept for this project. This assistance is beginning with the development of procedures and training by a financial management consultant under the Family Health Initiatives Project in April-May, 1984. It is planned that this same consultant return at six-month intervals during the first two years of project implementation. (When he returns under this project, the scope of work will also include financial accounting guidance to the other implementing agencies.)

c. Logistics Management: Vehicle Maintenance and Commodity Management

Vehicles for the preparatory work (principally mapping) and enumeration for the census are being supplied by UNFPA. Although USAID is not providing vehicles and, therefore, is not directly concerned with their upkeep and maintenance, activities do require transport support. If transport fails, then the activities are delayed, and everybody is affected.

The vehicles being provided are Landrovers and Campagnolas. The Landrovers in particular are known to be sturdy and spare parts and maintenance are fairly easy to obtain. USAID will provide funds through local currency support to assure preventive maintenance of the vehicles. In addition, USAID will institute in CSD a systematic procedure for recording vehicle use, maintenance, and repairs.

USAID is providing a large, expensive computer system to CSD. Its maintenance and the maintenance of its operating environment are critical to its proper operation and utilization. While USAID is not responsible for the site preparation for the computer, (this is being funded and contracted for by the Italian Government), it will closely monitor the renovations and installation of auxiliary equipment. The computer supplier will be responsible for the installation of the computer itself. To avoid the failures of the previous mainframe computer system at the CSD, several steps are being taken. First, an auxiliary power source is being included with the site preparation. Second, the computer supplier is being asked to establish a service outlet in Mogadishu with technical staffing capable of servicing their mainframe computer. Third, USAID will be supporting the operations of the computer by providing foreign currency support for

the maintenance contract with the supplier for the three years of the census data processing as well as training on the computer for the CSD staff.

d. Monitoring, Documentation, Reporting

As for all implementing agencies, CSD will be asked to submit reports to USAID on the implementation of its project-related activities. Each year CSD will update its workplan for review by the Project Coordination Committee. Quarterly reports will be submitted to the Project Coordination Committee and reviewed by its members, and recommendations will then be made for future planning and activities. At present, CSD does not report to USAID; the director, however, writes English well and has been responsive in preparing required documentation. This is not expected to be a problem.

In addition to these reports, USAID will also receive progress and trip reports from the short-term technical advisors to be provided from BUCEN. These reports will permit the Mission to monitor progress and identify any potential problems.

e. Other Management Concerns

While a major concern is the overall management of the census effort, an equally important one is the management/coordination required among the donors. CSD has proposed a formal mechanism for coordinating the inputs of UNFPA, the Italian Government, and USAID, the primary donors. Such a mechanism will be difficult to implement on a regular basis, as UNFPA does not have a resident representative in Modadishu. This particular concern has been communicated to UNFPA by both USAID and CSD. To date, no response has come from UNFPA.

In the absence of a formal, ongoing mechanism for coordination, USAID has requested written commitments from UNFPA regarding what USAID considers critical inputs, namely the long-term data processing advisor and the long-term census advisor. These are formalized as conditions precedent to any disbursement of funds for Component 1. These advisors will, in effect, "represent" UNFPA on a day-to-day basis throughout the census effort. They are in the best position to assure that activities are being implemented on schedule and that any needs are brought to the attention of the respective donors agencies. We have asked that the verbal agreement that the long-term data processing advisor be hired by BUCEN be affirmed in writing.

C. Somali Family Health Care Association

The Somali Family Health Care Association is responsible for the coordination and selected implementation of the activities under Component 2, the Information, Education and Communication for Family Health Services, and for the implementation as well

as coordination of activities under Component 4, the Operations Research for the project. Both of these components will require ongoing contacts with a variety of Somali institutions, the generation and management of joint activities, and the fostering of good relations. The SFHCA is in a pivotal role and its staff will affect the success of these efforts.

1. Background of the SFHCA

The founding of the SFHCA in 1983-84 was the result of three to four years of discussions and planning. Somalis interested and supportive of family planning, the Somali Women's Democratic Organization and others approached the Internatonal Planned Parenthood Federation and discussed the formulation of such an association and requirements for affiliation. Somalis attended a number of international conferences sponsored by IPPF and discussed the organizing efforts further.

In August 1983, the plans were put in the form of a Parliamentary Decree which was approved; in January 1984, the President signed the document which established the association.

2. Structure and Organization

The SFHCA is a private, non-governmental institution (one of few in Somalia) which will solicit members and associate members from the society at large. The members and associate members will make up the Membership Assembly which will, in turn, select the Management Board, composed of seven members. Until the Association has established its membership, called its first assembly meeting, and formally elects its board, the designated Board will manage the Association and establish its policies. The present Board is made up of representatives of the Somali institutions with direct concern with family health: the Ministry of Health, the Ministry of Education, the Women's Organization, the Ministry of National Planning, the Faculty of Medicine, and the Ministry of Local Government.

The officers of the Association are presently these people:

President:	Dr. Mohamed Warsame Ali (Director of Benaadir Hospital)
Vice President:	Mrs. Hawa Haji Egal
Secretary General:	Dr. Rukiya Mohamed Seif (Director of the Family Health/Family Planning Division of the Ministry of Health
Executive Director:	Dr. Raqiya Haji Duale (Vice President of the Somali Women's Democratic Organization)

The Executive Director is the only paid staff of the officers.

At present, the SFHCA has five staff members as follows:

Executive Director:	Dr. Raquiya Haji Duale
Program Officer:	Ms. Asli Aden Ashkir
Information Officer:	Mr. Abdi Rahman
Secretary:	Mr. Sheikh Mohamed Sheikh
Accountant:	To be determined.

Primary support for the Association's start-up is from IPPF; IPPF is also providing substantial technical assistance and short-term training to the staff. The SFHCA has been accepted as an associate member of the federation, its 118th in the world. At present, the Association has no units or other divisions.

All of the officers of the Association retain their commitments to their other, full-time positions in government agencies. Thus, they can only devote limited time and energy to its activities. The SFHCA's history is too short to have staff turnover; but they have had difficulty in recruiting competent staff for its positions.

3. Project Management

The SFHCA is, in effect, an untested organization. While its officers are highly regarded in their respective fields and organizations, they have not worked together in such an enterprise before. Moreover, the establishment of such an organization is highly unusual in Somalia and there is little experience here to guide them; the leaders cannot go to other similar organizations for suggestions or moral support.

The work of these project components will be under the overall guidance of the Executive Director and the respective heads of the units to be established, namely, the IEC Unit and the Operations Research Unit. The heads of these units, and, in the case of the IEC Unit, the staff, have yet to be recruited. The reputation of the Executive Director and her performance in a similar capacity in SWDO indicate that she will delegate responsibility to her staff as long as they demonstrate competence and interest in their work. A formidable challenge is the freeing up of her time from other demands and responsibilities, to provide the guidance and supervision needed.

As noted earlier, the heads of the involved units have not been selected. These, clearly, will be key people and it will be very important to select competent, confident people. They will have the time and commitment to work on these assignments.

To address the needs which exist in the SFHCA to carry out their responsibilities in these components, the FHS project has proposed a number of actions. First, the long-term IEC advisor will provide assistance in the establishment and management of the IEC Unit. The Operations Research Advisor will take the same role for his/her unit. Second, before these advisors arrive, the project will engage a short-term advisor to assist the Association in setting up the IEC Unit and establishing its terms of reference and the job descriptions for the staff; this same advisor will assist the SFHCA in recruiting and selecting the key staff members of the unit. (Another advisor will assist the unit in carrying out three studies needed before an IEC plan can be developed.) Third, the IEC Unit staff will receive short-term training for both their technical roles and their management responsibilities. Fourth, other short-term advisors will assist the Unit in developing its capabilities in selected management functions, such as evaluation.

The problem of limited time of the Executive Director will thus be addressed by developing the capabilities of the staff and backing them up with advisors so that she can confidently delegate a major portion of the day-to-day operational responsibilities to them.

4. Financial Management

The SFHCA will be required to manage a substantial budget for the disbursement of shillings for salary supplements, rent, per diem and other local expenditures for the two components. For the funds provided under the FHS project, the Association will be required to adhere to the guidelines set by the CIPL Unit. They will also receive funds from the International Planned Parenthood Federation and from their own membership. These will require separate accounting systems and procedures, and thus will present the Association with somewhat more complicated financial management arrangements than the other institutions.

At present, the SFHCA has no capability to manage these accounts. The accountant originally hired was deemed unsuitable, so they are presently recruiting another. To address this problem, the FHS project is undertaking several actions. First, a financial management consultant will, before the project starts, assess the particular needs for the financial accounting of the Association and recommend technical assistance/training inputs. These inputs will be provided by CIPL, which will train the accountants and other staff to meet their requirements; by IPPF which will provide training and technical assistance to meet their requirements; and by a short-term financial advisor who will return to Somalia three times during the first two years of the project period to assure that the accounting systems of all the participating agencies are fulfilling the requirements and needs of the project. The Association has also asked for assistance from the Mission in interviewing prospective candidates for

the accountant position, to assure that the person they choose has the potential for strong accounting skills. The project will also provide calculators for use in financial management.

5. Logistics Management: Vehicle Maintenance and Commodity Management

Under the FHS Project, the SFHCA will receive vehicles and audiovisual hardware and software. The Association is also proposing that RAPID II provide them with a microcomputer to use for RAPID-type computer modeling demonstrations as well as word processing and other support activities.

The SFHCA has no proven capability to maintain or manage such commodities. This may be a strength rather than a weakness, as the project then has the opportunity to train staff from the start in proper maintenance and foster an approach to commodities which reinforces the idea of preventive maintenance and care in use.

The development of the needed capability will be done in several stages. First, the equipment and vehicles are being selected for their ease of use and maintenance. Second, for the audiovisual equipment, the long-term advisor will assist in preparing an appropriate storage area, recruiting and selecting the staff person who will have overall responsibility for the equipment, and training him/her in the do's and don't's of its use. The long-term advisor will also assist in recruiting and selecting a staff member that will serve as the technician for the maintenance of the A/V equipment and arranging for the training of this person. Third, the A/V technician will train all staff who will use the equipment in how to use it properly and in basic maintenance. Procedures will be developed for control over the use of the A/V equipment and for its maintenance.

The SFHCA vehicles will be serviced in the garage run by the Ministry of Health. Procedures will be developed jointly with the garage manager and the designated staff from each participating agency with US-made vehicles for regular maintenance work and vehicle use control. These steps will bring the misuse of vehicles to a minimum. Training will also be arranged for the drivers to assure that they know how to drive the vehicles correctly and can recognize when the vehicles require maintenance.

Provision for adequate site preparation and training in use and maintenance of the microcomputer will be the responsibility of the RAPID II Project, with USAID monitoring assistance.

6. Facilities for Project Management

The house presently rented by the Somali Family Health Care Association is too small to accommodate the needed staff and commodities for this project. Since the project proposes adding

at least five Somali staff members, space must be provided for the IEC Resource Center. Office space will also be needed by the IEC Advisor, the Operation Research Advisor, their Administrative Aide, secretary, and short-term advisory staff. Ideally the Association will be able to host meetings of the Project Coordinating Committee and other joint activities of the implementing agencies.

To resolve this problem, the project will provide the SFHCA with funds from local currency to rent a building with adequate space to meet these needs. Modest repairs and office equipment and furniture will also be provided to assure an appropriate working environment.

7. Monitoring, Documentation and Reporting

The SFHCA will have primary responsibility for collecting together periodic reports and documenting the activities undertaken in the two components. The specific formats to be used for reports and the materials to be developed under the two components will be determined with the consultation of the long-term technical advisors. To date, the SFHCA has no track record or experience with such requirements.

To develop the organization's capabilities in this area, the long-term advisors will provide technical assistance and ongoing guidance. In addition, a short-term advisor for IEC will assist in the development of an evaluation system for the IEC activities and assist the Unit in its installation. The long-term advisor will follow up its implementation.

8. Other Management Concerns

The implementation of both the IEC and the Operations Research components will require ongoing coordination with the cooperating agencies. The SFHCA will play the lead role in effecting this coordination. Coordination will be done through regular meetings of the IEC Technical Committee (IECTC), made up of the directors of the IEC-related programs in the participating institutions. These meetings will be held quarterly, and one will be devoted to the review of the annual workplan (prepared by the IEC Unit). In addition to these formal mechanisms of the IECTC, the IEC Unit will work through one or more technical groups for the implementation of joint activities; these technical groups will be composed of officers of the agencies with particular skills or assignments pertinent to the activity. For example, there may be a materials production technical committee, to develop guidelines, models, and procedures for the review of all IEC materials to be produced under the project. Another mechanism for coordination will be the preparation of the overall IEC strategy and the joint workplans. During the meetings to develop

these documents, the IEC institutions will share ideas and make decisions about the roles and responsibilities of their respective agencies.

The coordination approach relies on meetings; experience to date indicates that it is very difficult to get people together for such meetings, especially the directors of programs and agencies. The project will take all actions possible to make this approach effective: 1) meetings with the directors are being kept to a minimum, i.e. four times per year; 2) the advisors will assist the counterpart staff in planning for the meeetings well in advance and arranging times and places as conveniently as possible; 3) the advisors will assist their counterparts in running productive meetings which take as little time as possible. In addition, logistics support, for telephone, transport, and meeting sites is being provided.

. Family Health/Family Planning Division, Ministry of Health

The Family Health/Family Planning Division of the Ministry of Health is responsible for the implementation of all activities under project Component 3, the Clinical Family Health Services. Among the activities are training, supervision, management of logistics, and maintaining information on contraceptive usage and acceptance. Health education will continue under the FH/FP Division but will be coordinated with the overall project IEC efforts, as has been described in the IEC portion of the paper. Although the staff to provide the clinical family health services work under other divisions of the Ministry, such as the Maternal Child Health Division and Primary Health Care Division, they will be supervised for their activities in family health by staff of the FH/FP Division. The FH/FP Division will also utilize the supervisory staff of the other divisions to assist in the supervision of the family health activities in the field.

1. Background of the FH/FP Division

The Family Health/Family Planning Division was created by the Ministry of Health in 1981 and placed under the Department of Maternal Child Health and Community Health. In this department are all other health services directed towards the rural and urban populations, i.e. MCH, Primary Health Care (PHC), Expanded Program of Immunization, and School Health. The Division has been the responsible institution for implementing activities under the USAID-funded Family Health Initiatives Project. It has also received support from the Project for International Training in Health (INTRAH), for the training of staff from Westinghouse Health Systems, for the conduct of a Family Health Survey and from Johns Hopkins Program for International Training in Gynecology and Obstetrics (JHPIEGO), for the training of doctors and nurses.

In the last three years, the Division has implemented the following activities:

- o Training. Short-term courses for nurses, primarily from MCH centers, in Clinical and Non-clinical Contraceptive Technology, Management and Supervision, and Preparation and Use of Visual Aids. Training has been conducted to train the trainers in training methods and cirriculum design.

- o Health Education. Conducted education sessions for ministries and other groups, political and other leaders, and for women at the Orientation Centers of the SWDO. Prepared radio programs on family health. Developed cloth posters and other visual aids related to family health.

- o Logistics/Service Statistics. Developed and implemented a system for distribution of commodities and collection of service statistics.

Family Health services are now being provided in 31 MCH Centers in five regions and nine hospitals, primarily in Benaadire regions.

2. Structure and Organization

The Family Health/ Family Planning Division is one of the divisions of the MCH and Community Health Department. Its staff are employees of the Ministry of Health and as such are subject to the regulations governing this ministry. The Division is led by a Director and Deputy Director, Dr. Rukiya Mohamed Seif and Dr. Asha Haji Mohamed, respectively, both physicians. The Division staff of 28 is presently divided into four units: the Training, Health Education, Medical Supply and Logistics and MCH. Each Unit has a director and assistant; some units have additional staff. Many of the staff play interchangable roles -- those whose primary responsibilities in logistics also serve as trainers and supervisors; the trainers often help with logistics.

The Division is presently considering a reorganization and expansion to 34 staff at headquarters and the addition of 21 staff in the regions. The headquarters staff would be divided into four units as follows: Training, Health Education, Administrative, and Medical Services. The staffing for each of these are presented in the Chart on page .

Given that the Division is only three years old and had no staff at the beginning, the staff has expanded rapidly. The staff are primarily nurses with little administrative experience. Many are taking on new responsibilities for which they have had little training or experience. The Director and Deputy Director and the Head of the Training Unit have received short-term train-

FAMILY HEALTH/FAMILY PLANNING DIVISION

Director

Deputy Director

Training Unit

Head

Assistant

Health Education Unit

Head

Assistant

Administrative Unit

* Head

Accountant

Cashier

* Transport Officer

* Protocol Officer

* Research/ Evaluation Officer

* Messenger

* Storekeeper

* Clearance Officer

Drivers (10)

Cleaners (2)

Medical Services Unit

* Head (Physician)

General Services Officers (2)

Drugs

Equipment

Distributors (2)

Statisticians (2)

* proposed new positions

ing courses in some aspects of management. As noted above, there has been only limited technical assistance in the management of commodities and service information. While systems for each were developed, neither is working as anticipated and further training and orientation are needed to have them work effectively.

The Division will face many demands in the next five years of activities under the project. Its staff must have very clear ideas of their roles and responsibilities and the capabilities and interest to carry them out. While the interest is there, the Division needs to revise its own organizational structure and clarify the roles and responsibilities of the staff. As noted above, many of its activities are conducted through other Divisions of the department, so close coordination with these divisions will be critical to efficient and effective implementation of the program. Further, the staff must gain the skills and knowledge they need to effectively perform their responsibilities.

The Family Health/Family Planning Division will receive assistance under this project so that it can successfully fulfill its activities under this project and in the future. During the first months of the project, a short-term advisor will work with the staff of the Division to assess their planned organizational structure and make any needed modifications to assure that it is suitable to their needs. He/she will then work with the different units and the Division as a whole to clarify the roles and responsibilities of the Division, the units, and then the staff in the units. This will provide the basis for more specific assessments of training needs of these staff.

The long-term Training and Management Systems Advisor will primarily work with the division and the unit heads to develop their skills in planning and management of their particular areas of responsibility. He/she will also assist in establishing ongoing coordination links with the other divisions and the department. These will include regular monthly meetings with the Director of the department and the Directors of the Divisions of MCH and Primary Health Care. The inputs of the Training and Management Systems Advisor will be complemented by assistance from other, short-term advisors in specific areas of management and training. In addition to the on-the-job training and study tours in general management and their specific areas of responsibility.

3. Project Management

The Family Health Initiatives Project, which is managed by the Division, started in 1981 and has been expanding its staff and range of activities. As any similar organization, it has felt its growing pains, changing from what was, in effect, the one person show of its director, to a division with four units and 28 staff. As the program expands further, responsibilities for the management of the different functions will have to be

delegated; staff will have to take on responsibilities for implementation and act on their own. Thus, periodic reporting systems and meetings will have to be started and institutionalized so that communications among the staff are maintained.

While the Division has prepared overall plans each year and budgets for the use of local currency, these are not prepared in a systematic manner and require many revisions and adjustments. Regular monitoring and documentation of activities is also not done in a systematic manner. Supervision of field activities is conducted on an ad hoc basis.

Some of these management deficiencies can be ascribed to problems with transport; it is difficult to develop a systematic supervision schedule if you do not have vehicles to get the supervisory staff to the sites. Others can be attributed to problems in working in overcrowded or unsuitable office space, delays in releasing budgets for local costs, and problems with support staff, such as secretaries and accountants. An additional factor, however, is the limited skills and experience of the staff in management.

The FHS Project will address each of these deficiencies so that the FH/FP Division will have an effective management capability. Vehicles will be provided to assure that scheduled activities can be implemented in time. Office space will be renovated so that the staff will have suitable working conditions. Technical assistance in financial management will be continued so that accounting and, therefore, budgets will be completed in a timely manner. (See next section for more details on the specific problems and assistance planned).

4. Financial Management

The Family Health/Fmaily Planning Division has been responsible for the management of the shillings-generated funds budgeted to it by the CIPL Unit and the Ministry of Finance. In 1983, the FH/FP Division received a total of So.Sh. 2,774,800.00. This amount was to be spent for salary supplements, health education activities, training courses, and the like. In January 1983 the CIPL Unit performed an audit of the accounts for these funds. While the audit report has not been made public and is therefore not available for comments in this analysis, the auditors were dissatisfied with the accounting for the funds and made strong recommendations for major changes in the accounting procedures. This judgement was also reached by the auditors who reviewed the accounts for the INTRAH training project and by staff of Westinghouse who reviewed the accounts for the conduct of the Family Health Survey.

Problems with the accounting and management of funds include: lack of knowledge and skills in basic accounting procedures; lack of understanding of the relationship of expenditures

to budget line items; lack of understanding of the need to provide a "paper trail" for all expenditures; lack of ability to keep files and receipts in order.

With such problems still plaguing this project, two things were made clear: that the Ministry of Health would not be able at this time to manage a USAID contract; and ongoing assistance was required to assure that accounts are kept properly for this project. This assistance is beginning with the development of procedures and training by a financial management consultant under the Family Health Initiatives Project in April-May, 1984. It is planned that this same consultant return at six-month intervals during the first two years of project implementation. (When he returns under this project, the scope of work will also include financial accounting guidance to the other implementing agencies.)

5. Logistics Management: Vehicle Maintenance and Commodity Management

a. Vehicles

Under the funding from the Family Health Initiatives Project, the Family Health/Family Planning Division received four vehicles, two of which were turned over to the Rural Health Project as repayment for the loan of two Suburbans from that project during the early days of project implementation. Of the four vehicles, only one is still in working order. The Division has used the garage supported by the Rural Health Project in the Ministry of Health for maintenance and repairs.

There are reasons for the present unfortunate status of the vehicles. Repairs are not done on the vehicles in a timely manner due to lack of spare parts (no spare parts were ordered when the vehicles were ordered) and because no clear-cut arrangement was made for the Family Health Initiatives Project to contribute to the upkeep of the garage. Also drivers and mechanics are not highly skilled in care, maintenance and upkeep.

Five new vehicles are scheduled for procurement for the FH/FP Division. To assure that they are maintained in good working order, the following steps are being implemented: a written arrangement is being made with the Ministry of Health garage for the maintenance and repair of the vehicles, with a contribution allocated in the budget; training is to be conducted for the drivers so that they know how to properly drive the vehicles and watch for problems and due dates for preventive maintenance. In addition, the drivers will be required to maintain a log book for noting destination, kilometers driven, any problems, etc.

b. Other Commodities

In the beginning the major problem was a shortage of contraceptives; once this was resolved, there was a shortage of

needed equipment, such as IUD insertion kits and gloves. Now there are ample supplies of contraceptives and needed equipment. By August 1982, twelve MCH centers and hospitals had received contraceptive supplies. Each organization was intitially given 100 cycles of pills, 100 condoms, and 20 IUDs. In December 1983, 30 MCH centers and 9 hospitals were reported to be providing family health services. Even though there were four full-time staff members at headquarters responsible for distributing supplies and collecting statistics.

Several problems still plague the logistics system. There are delays in receiving the shipping documents which are required in order to clear things from the port. Once cleared, they are placed in various warehouses where their placement is haphazard and does not permit ready access for taking of inventories or following the rules of "first in, first out". No record is kept in the central office as to what contraceptives are where. While the contraceptives are logged in to the warehouse, they do not appear to be logged out. When the contraceptives are distributed, a form is filled out at headquarters that the commodities have been taken and by whom. However, these are never collated or used to assess the quantities which have been distributed and to calculate what is left. At the clinics, the nurses fill in forms when they receive the contraceptives, but they do not keep track of what goes out nor do they have a regular system for requesting more supplies. There are forms, but there is still no system which is useful for the Central office and the clinics to keep track of what they have and when they need to order more.

To address these problems, the Family Health Services project will provide a short-term technical assistance from the Centers for Disease Control to review the present design for logistics, make recommendations for its revision, develop a simple procedures book with forms for operating the revised system, and assist in arranging the warehouse space so that the contraceptives can be more easily managed. (The project will provide local currency support for the building of shelves for the warehouse.) The consultant will also supervise the testing of the contraceptives presently in-country to insure that they are in good condition. During a second consultation, the advisor will train the staff who are involved in the logistics system and will prepare training modules and materials on logistics management for the family health in-service training courses for MCH nurses. Follow-up guidance on the implementation of the system will be done by the long-term Training and Mangaement Systems Advisor.

6. Facilities for Project Management

The Family Health/Family Planning Division is currently in temporary office space at the Ministry of Health; the staff has access to three-four rooms. Many of the staff have no desks, cabinets or other facilities they need to work. There is no

telephone. These conditions hinder the development of a good work environment and management systems. To address this problem, the project will provide local currency support to the renovation of office space at the Post-Basic School of Nursing, and the provision of basic office furniture. This space will permit each staff member to have his/her own desk and working space.

7. Monitoring, Documentation and Reporting

The service statistics system was developed under the Family Health Initiatives project with the idea of making the calculation of the number of active users of family health methods relatively easy. However, many of the staff do not understand how to maintain the records and manage the system. Each MCH Center is supposed to prepare monthly reports; centers in Mogadishu are sending these reports to headquarters only for the centers in Mogadishu. Therefore, the headquarters staff do not have any way of knowing what is being done by the different centers, or of assessing their performance except during field visits. When the reports are received in the Central Office, no one is analyzing the data so as to draw any conclusions about project performance or to identify the need for corrective action.

Beyond the reports of acceptors and users, the Family Health/Family Planning Division does not keep systematic records of its other activities. Training is an exception, but even the training courses are not reported on a systematic and regular basis.

To develop better, more systematic documentation of all levels of activities in the Division, assistance will be provided to the staff in the following areas: revision of the present client record system (to be done with CDC assistance in conjunction with revision of the logistics system); preparation of training for implementation of the revised record system; preparation of reporting formats for clinic activities and performance and scheduling for transmittal of these reports to the central office; preparation of reporting procedures for other activities of the Division. These procedures may include the development of a monthly report and more comprehensive quarterly report. The quarterly report would be submitted as part of the reporting to USAID for the FHS project. The specific reporting needs of the special family health services and training courses will be addressed with the guidance of the long-term advisor.

E. Somali Women's Democratic Organization; the Curriculum Development Center; Women's Education Department**

1. Organization/Staffing

** The Ministry of Information and National Guidance and the Population Education Program will provide technical guidance to the participating agencies and receive limited support from the project.

The SWDO, CDC and WED will be implementing agencies for the IEC and OR components of the FHS Project. In each organization, the family health activities will be implemented by a specially designated group made up of regular employees of the agency. Each group will have a leader who will report directly to the Director of the organization. There will be up to six staff members working in each group. In each of these organizations, family health teaching/education is a new field; however, the agencies have had substantial experience in implementing programs in other fields.

In the absence of a formal survey of manpower capabilities in these agencies, planning for the technical assistance and participant training support has been based on the perceptions of the directors of these agencies -- they perceive a lack of knowledge about family health; limited skills in planning, developing and implementing non-formal and formal education programs and materials; and limited skills in the management of such efforts on a national scale. The specific needs of the staff will be assessed during the first months of the FHS Project during the manpower resources survey.

2. Management

These organizations will face problems with the planning, organization, and implementation of the IEC and OR activities planned for the project and with specific management functions, such as accounting and vehicle maintenance. Assistance will be provided to address these problems and to build their capabilities to manage such projects in the future. First, they will all participate in the IEC and OR Technical Groups which will plan activities on an annual basis, participate in joint activities, and in joint training programs. Selected staff will participate in training programs and study tours overseas. In addition, technical assistance will be provided by the long-term IEC and OR advisors and short-term advisors, including the advisor in financial management and the advisors in evaluation to these organizations to assure their competency in these critical areas. Vehicle maintenance and A/V equipment maintenance assistance will be provided under Component 3 and Component 2, respectively.

3. Other Management Concerns

The leaders of each of these organizations are very busy; each has a list of at least 3-4 other jobs. Their time will be very limited for providing guidance to the family health groups under them. Given this limitation, each organization must delegate to the group authority for making day-to-day decisions. In turn, the project must help by strengthening the capabilities of the group members to manage and implement activities and for coordinating activities within their own organizations. Short-term training and technical assistance will be of particular importance to them.

F. Project Coordinating Committee

The Project Coordinating Committee will have responsibility for planning overall project activities, assessing project progress towards stated goals and targets, identifying problems and solutions, and acting on any issues which affect project implementation. The Committee will be formed by the Ministry of National Planning; the Director General will send an official letter requesting appropriate representatives to each of the agencies participation in the Project: the Somali Family Health Care Association; the Ministry of Health, Family Health/Family Planning Division; the Ministry of National Planning, Central Statistical Department; the Somali Women's Democratic Organization; the Women's Education Department and Curriculum Development Center of the Ministry of Education; and the Ministry of Information and National Guidance. It is anticipated that the membership of the Committee will closely parallel the membership of the present Board of the Somali Family Health Care Association.

The structure of the Committee will include a chairperson and rapporteur, the representative of the Ministry of National Planning is expected to chair the Committee. If the membership of the Committee is similar to that of the SFHCA board, then they are among the most experienced administrators involved in family health and educational activities in Somalia. Nonetheless, many of them have had relatively little training in management and little experience in working on such a coordinating body. The structure, the mechanics of the operations of such a committee, and their roles and responsibilities in relation to the Committee and the project will have to be clearly defined and agreed to by all the parties.

This committee will not have direct responsibility for preparing budgets or accounting for funds, managing the logistics of commodities or transport, or documentation and reporting. In fact, they will be the recipients of such reports from the implementing agencies. Since many of the members of the Committee will also be overseeing the activities under their units, they will, in those roles, become intimately involved with such problems. In the Committee they will be called upon to jointly deal with problems and identify solutions.

The staff of the SFHCA will serve as the Secretariat for the Committee. They will prepare documents, arrange meeting times and locations, prepare agendas, keep minutes and submit reports. If this Committee does not work well, then project activities will not be coordinated and duplicaiton of efforts will inevitably occur. Further, without such a forum there will be no means to discuss problems, and implement project-wide solutions. Since this Committee will be convened specifically for this project, and the members have had little experience in such organizations, the project has provided for

periodic technical assistance to assist it develop its structure and implement its responsibilities. The first technical assistance visit will require approximately 2-3 months during which the advisor will assist the staff of the SFHCA and the participating organizations draw up the terms of reference of the Committee, outline its roles and responsibilities, any other guidelines or documents needed to assure its legal and appropriate functioning, and plans for the activities of the Secretariat. The advisor will also assist in the conduct of the first meeting of the Committee. Then, every year, the advisor will return for 2-3 months to follow-up on the functioning of the Committee and Secretariat and assist in resolving any problems. In addition to this advisor, all of the other long-term advisors will provide support to the Project Coordinating Committee as needed.

APPENDIX A

CENTRAL DEPARTMENT OF STATISTICS

INSTITUTIONAL ANALYSIS

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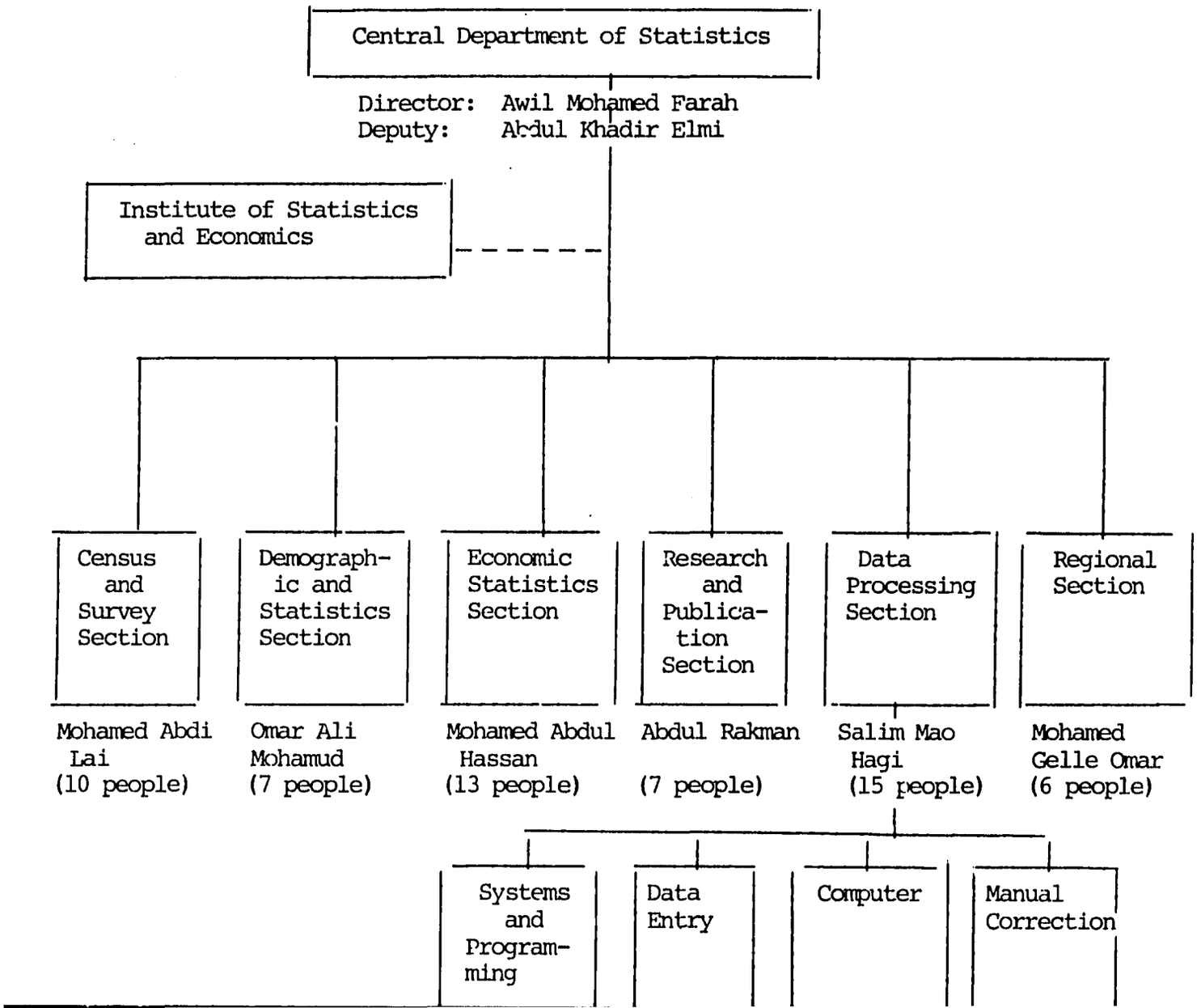
APPENDIX A

CENTRAL DEPARTMENT OF STATISTICS
INSTITUTIONAL ANALYSIS

I ORGANIZATION AND STAFFING

The Central Statistics Department (CSD) of the Ministry of National Planning has a small staff of approximately 60 people organized in six sections: Census and Surveys (10), Demographic and Social Statistics (7), Economic Statistics (13), Research and Publication (7), Data Processing (15), and Regional Section (6). The Institute of Statistics and Economics with part-time teachers is also under the direction of CSD.



The Director, Deputy Director and all of the Section Heads have worked at CSD for at least 10 years and took part in the work of the last census; at least five of them were Regional or District directors of census operations.

In the Census and Survey Section, six people were trained in the Institute of Statistics and Economics and two were trained for one year at the U.S. Bureau of the Census with a specialization in cartography.

In the Regional Section, the Head is a graduate in economics and received a one-year diploma from Kuwait. Two of the staff are graduates of the Institute and one of the graduates took a 3-month course in demography at the U.S. Bureau of the Census. Two others have little formal education but have been working with CSD for 15 years.

The Demographic Section has one graduate from the Institute who is analyzing data from the last census with assistance from a long-term UN advisor in demography.

The training and experience of the data processors is reviewed in Section III C.

II IMPLEMENTATION OF THE 1975 CENSUS OF POPULATION AND HOUSING

A. Data Collection[1]

1. Geographic Definitions Used For Fieldwork

Urban settled - all district capitals and towns or villages with 1500 people or more.

Village - a community with a name which has been settled for at least six months.

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[1] Major portions of this section are based on information provided in "Population of Somalia, An Analysis of 1975 Census" by Mohammed Abyal, UN Advisor in Demography which will be published shortly.

Rural settled - all settled populations engaged in agriculture, fishing and commerce.

Nomad population - people who do not have a permanent place of abode and whose main occupation is raising livestock.

2. Questionnaire Content

Three questionnaires were used in the 1975 Census; one each for:

(1) urban and rural settled areas;

(2) nomads; and,

(3) institutions.

The questionnaire for the urban and rural settled areas was as follows:

1.	Name		
2.	Relationships to household head		
3.	Sex		
4.	Age		
5.	Place of birth		
6.	Place of usual residence		
7.	Literacy		
8.	Educational attainment		
9.	Marital status		
10.	Children born alive	(2)	(3)
11.	Children still living	(2)	(3)
12.	Births last 12 months	(2)	(3)
13.	Deaths last 12 months	(2)	(3)
14.	Type of economic activity	(2)	
15.	Occupation	(2)	
16.	Industry	(2)	
17.	Livestock		(3)

All items with a (2) to the right were dropped from the questionnaire for nomads. All items with a (3) to the right were dropped from the questionnaire for institutions.

According to the Swedish data processing advisor for the Census, items 9, 13, 14, 15, 16 and 17 had high error rates; items 7 and 8 had low rates.

3. Management

Although CSD was in charge of the 1975 Census, the Census Committee set up in 1973 did not function well and the major functions and duties of the Census were taken up by the Central Committee for the Rural Development Campaigns for Literacy and Health.

4. Fieldwork

The Campaign had 25,000 students and 5,000 teachers teaching in the rural areas. These were loaned to the Census for enumeration. The actual number who took part in census enumeration is unknown.

The urban enumerators were students in boarding schools and in National Service Training. Except for Mogadishu they were not paid for their work.

CSD provided technical advice and training for enumeration. Supervisors and trainers were trained for 4 months ending December 1974. Enumerators were trained in January of 1975.

A complete list of all waterpoints was prepared before the Census and updated twice, the last time in December of 1974. Waterpoints are listed according to the name of the nearest village. They are classified as very important (serving 20 or more households), important (10-20 households), and ordinary (serving less than 10 households).

Enumeration District (ED) maps were prepared for only 27 of the 64 districts. However, cities with 15,000 or more inhabitants had sketched maps showing the basic network of streets, boundaries of major subdivisions, outstanding buildings and names of major landmarks. Unfortunately the ED maps for Mogadishu were not finished in time for the Census and were largely ignored during enumeration.

Several drought conditions in 1975 upset the distribution of populations:

1) Nomads moved from drought stricken areas to neighboring places inside and outside the borders;
2) Many nomads were in relief camps in towns and rural areas;
3) Many nomads retreated to inaccessible areas;
4) It rained unexpectedly in January, causing population shifts across borders to the south and southwest;
5) Due to the rain in January nomads did not go to known dry-season waterpoints; and,
6) Animals were too weak to get to waterpoints.

5. Evaluation

The census counts were so suspect that they were withheld in 1975 but later released in response to UN requests. There was no coverage evaluation, but a recount done in Mogadishu for food distribution shortly after the Census showed a population 20% higher than the census count. Estimates from the 1980 Survey of Population and the 1980/81 Demographic Survey differ from that of the Population Census.[2] Official tables from the 1975 Census have not yet been published.

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[2] For further information on demographic data refer to "Population and Family Planning Research in Somalia" by Anne Cross, Report prepared for USAID/Mogadishu, March 1984.

B. 1975 Census Processing

One questionnaire for urban and settled rural and a second for nomads were processed on an NCR Century 101. The institutional questionnaire was manually processed. Due to the delayed installation of the NCR in June 1977, processing did not begin until July 1977. Data entry of 650,000 questionnaires took 2 ½ years with 22 operators (including supervisors) working two 5-hour shifts, six days a week using Mohawk key-to-tape machines. Verification began the first month at 100%, after which a 10% sample was taken which was soon stopped altogether due to problems with the Mohawk equipment.

There was a high rate of absenteeism necessitating considerable overtime.

Assistance was given by computer expert Bertil S. Georgson for 2 years, 1975-77. He developed 5 programs for editing the questionnaires and 5 to produce 18 of the 31 base tables. Georgson left one month after the computer was installed and was able to edit one region with partially tested programs. Georgson began with 5 CSD programmers, 3 of whom left the country and 2 others changed from data processing to economics. His staff included:

1 EDP Manager

1 Deputy EDP Manager

1 Computer Operator

1 Librarian

4 Coders for correcting and updating

22 Data Entry Operators

0 Programmers

The Computer Operator was the only one who could learn to run the

programs. No one was available to further debug and test the programs.

Marla P. Rao, a U.N. senior data processing advisor, arrived April 1979, leaving a 20 month period after Georgson's departure in which there was no data processing expertise. At this point, 47% of the data had been edited with the partially working programs and he decided not to change the programs for the remainder of the data editing and/or re-edit the 47%. In September 1979, a U.N. associate advisor in computer techniques, Erik Valeratn, arrived. He assisted Mr. Rao and also taught a COBOL course following Rao's course in Introductory Computer Concepts.

Editing continued for a total of 2 years. Several districts were not edited and those which were resulted in errors in 20% of the records processed. Corrections were done manually. Since the questionnaires were not batched and checked-in appropriately using control counts and control lists, the loose questionnaires were difficult to locate and corrections were not complete. Under Rao's supervision, tabulation programs were developed for remaining tables while a few were done by hand. Preliminary tables were available by Spring 1980.

Besides the 20-month gap in data processing expertise, other problems which delayed the census processing were: inadequate site preparatuon & environmental control of temperature, humidity and dust, power outages, inadequate service from NCR, a 6-month halt to census operations followed by the war.

Much of the aforementioned along with many instances in which processing controls were lacking resulted in poor quality. Five percent of the records collected disappeared somewhere in the production. Ten thousand forms used for coding had columns missing. Since correction was not done by going back to questionnaires in many cases, one-half of the final tapes

were not error free resulting in inconsistencies in the final tables.

III IMPLEMENTATION OF THE 1986 CENSUS

A. Data Collection

1. Administration

A letter has been sent to the President of the GSDR by the Director of CSD requesting permission to form the Executive Census Committees. The Executive Census Committee will be made up of the Directors General of the following Ministries:

1) Planning
2) Defense
3) Local Government
4) Education
5) Information
6) Health
7) Transport
8) Post and Telecommunications
9) Police Force

The Technical Committee will be made up of the Deputies from these Ministries. The Chairs will come from the Ministry of National Planning.

The Director of CSD has already set up a Steering Committee in CSD which has met to discuss technical issues in census implementation.

2. Technical Assistance

The U.S. Bureau of the Census gave a two-week Executive Level POPSTAN workshop on census implementation in February and will give a 4-week Technical Level Workshop in May or June. These workshops cover all aspects of census implementation.

An Egyptian advisor is giving six months of assistance in census planning and is in the process of updating and expanding the original UN draft schedule.

The long-term UN census advisor is not due to arrive until November of 1984, the cartography advisor is due in June of 1984 and the arrival date of the data processing advisor is unknown.

3. Number of Enumerators and Supervisors

The estimated number of enumerators and supervisors required for the 1986 Census ranges from 12,000 to 15,500 depending upon the base numbers used in the calculation. If the population is estimated as high as 6,133,805 the number is 15,500. If a lower population count is used the number required is less.

For example:	4,089,203	1975 estimate
	x 1.5	(3% growth rate)
	6,133,805	
	x .4	urban and settled
	2,453,522	
	÷ 5	urban household size
	490,705	
	÷ 100	questionnaires per enumerator
	4,907	enumerators for urban areas
	6,133,805	
	x .6	nomad
	3,680,283	
	÷ 5.6	nomad household size
	657,193	
	÷ 60	questionnaires per enumerator
	10,953	enumerators for nomadic areas

4. Maps for Enumerators

In order to carry out the fieldwork enumeration districts must be delineated, the number and location of waterholes in the dry season (3,000 in February) must be updated and the nomadic patterns must be studied.

Base maps developed with Russian assistance are available with scales of 1:200,000 and 1:100,000. They also indicate important waterpoints. Unfortunately they are 8 years old and must be updated.

With the assistance of District Officials it should be possible to update the list of waterholes from the last census with no foreign assistance. However, delineating ED's and studying nomadic migration patterns will require technical assistance which should be covered by the UN program.

5. Office Editing

To date little thought has been given to office check-in and editing requirements. Specifications should be written for edit programs and manuals should be written to explain how errors are resolved by office staff.

6. Schedule of 1986 Census Activities

The schedule of activities for the 1986 Census was drafted for the UNFPA project and updated in January of 1984. The updated schedule is attached to ~~this~~ the main report. (Attachment D) (An Egyptian advisor is expanding the schedule to show more detail. Unfortunately, it is being done in Arabic.)

The schedule appears adequate with respect to most items, however, sections on data processing are very cursory and leave out many important functions such as development of specifications. These sections (specifically item 11 and Section IV) should be completely revised.

B. Institutional Capacity of CSD in Computer Processing

The EDP Center of the CSD is headed by Salim Mao Hagi. Acting in his place is Hassan Abukar H. Hassan. The Center is divided into four sections: Systems and Programming, Data Entry, Operations and Manual Correction. There are 5 manual editors, 4 data entry operators, 3 computer operators and 5 programmers. One programmer doubles as data entry supervisor and two double as operators. The programmers began working with CSD between 1973 and 1978. Two of these helped with the processing of the 1975 Census. In 1979, two studied COBOL and FORTRAN at the University of Maryland with 8 hours of lecture a week. Three others (U.N. fellows) attended Control Data Institute (CDI) for 6 months in 1981 for a self-study program in COBOL and FORTRAN. This was very difficult in a second language and not very effective. A few days of classes at NCR in Dayton, Ohio followed CDI studies. All 5 programmers studied 2 years at the Institute of Statistics and Applied Economics.

Although they have studied COBOL which will be needed for census processing, due to operational difficulties of the computer and its environment, they have had little opportunity to apply their training. Samples were reviewed of the most recent programs which date back to early 1983, but for one produced in 1980. One programmer has written nothing outside of class excercises. For the most part, they were very simple and unstructured. In other words, they have a long way to go. It would be more appropriate to refer to the 4 programmers as trainees.

The Head of the EDP Center, Salim Mao Hagi, is studying one year on a fellowship at the U.S. Census Bureau and will return to CDS September 1984.

The UN senior data processing advisor Marla Rao left this post March 1984. Dhahira Azer Iaam, UN long-term associate data processing advisor and FORTRAN programmer, will return from maternity leave May 1, 1984 for 4 months to process data from the 1980/81 Population Survey and write programs for the 1982 Labour Force Survey. She will not be able to contribute to the census data processing effort. Carla Priciotto, a newly-contracted UN associate data processing advisor and statistical programmer/analyst, will be here several months ahead of her supervisor, the UN senior data processing advisor. Abdel Salam Sultan, a statistician contracted by GSDR from the Arab League has prepared a census plan which includes data processing but neglects programmer training and program development.

The current equipment is the NCR 101 which processed the 1975 Census. In 1982-83, the NCR was down for 10½ months with one instance of 7 consecutive months. The manufacturer has not produced spare parts for this model for several years. The support has been so poor that the only maintenance contracted for at this time is on-call maintenance at $2k/call. CSD continues to have problems in maintaining the computer environment. For example, CSD had no power for a full month in 1983 and has frequent outages of lesser strength.

MNP has attempted to process a number of surveys using the computer. For the most part, they have not been processed and must be either transported out of the country to be processed or done by hand.

1. <u>1986 Census Processing</u>

Staff needed: 25 keyers and 2 supervisors, 3 operators, 3 new programmers. The new programmers will be secondary school graduates. Their aptitude for programming should be tested before they are trained by Salim Mao in introductory computer concepts and programming design and logic. Appropriate incentives should be paid to programmers and operators. Incentives for data

entry should be based on records keyed and error rate.

Equipment: WANG VS/100, etc. The general perception at MNP is that the new computer will solve all problems. Vendor support may be from Nairobi from which there are only two flights/week to Mogadishu. Local support from one engineer and one trained backup is recommended. Installation should be as soon as possible to allow for training, program development and testing and pre-testing. A supply of spare parts should be ordered.

Site: There should be sufficient air conditioning, humidity control, UPS ~~ups~~, generator, dedicated circuits where needed, line conditioners (the generator is not smooth power), lighting, termite control (it's used for storage now) and spare parts for all equipment.

Advisors: The long term data processing advisor should be contracted by the U.S. Census Bureau before the computer is installed. The associate data processing advisors should have relevant data processing background and be contracted so they will have direction from the senior advisor.

Training: The POPSTAN 4-week workshop should be attended by all programmers (although one will be in Sweden for 2 months of training). Carla Picciotto should be postponed until the senior advisor arrives. If this is not possible, she will need to attend POPSTAN to be able to make a contribution to the census this year. All programmers except Salim Mao need to study COBOL, preferably using a WANG VS system. With the inexperienced staff, packaged software needs to be used wherever possible. All programmers should attend a CENTS4 workship. Programmers responsible for editing and correcting or migrations should attend a CONCOR workshop. With the aforementioned training, there will still be no experienced systems analyst. The 5 senior staff should attend a Systems Analysis and Design workshop. Because the turnover is high, two programmers need one-year

training comparable to that which Salim Mao has. Waberi and Hassan appear to have the aptitude. Hassan needs more English.

SECTION 14.0 PROCUREMENT SCHEDULE ANNEX 6

14.0. PROCUREMENT SCHEDULE COMPONENT 1

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDS	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
C1-1	VS100			$ 119,885	1	$119,885	AID	MONP	FY 84	
C1-2	75 MEG Disk			16,800	3	50,400	AID	MONP	FY 84	
C1-3	Disk IOP			10,500	2	21,000	AID	MONP	FY 84	
C1-4	Tape Drive			19,600	2	39,200	AID	MONP	FY 84	
C1-5	Disk Switch Option			6,300	2	12,600	AID	MONP	FY 84	
C1-6	32K Serial W/S			3,853	7	26,970	AID	MONP	FY 84	
C1-7	Band Printer			18,553	2	37,105	AID	MONP	FY 84	
C1-8	Serial IOP			4,900	2	9,800	AID	MONP	FY 84	
C1-9	Tape IOP			4,900	2	9,800	AID	MONP	FY 84	
C1-10	Cobol Compiler			9,800	1	9,800	AID	MONP	FY 84	
C1-11	Fortran Compiler			9,800	1	9,800	AID	MONP	FY 84	
C1-12	Boxes of 10 Diskettes (6)			84	10	840	AID	MONP	FY 84	
C1-13	Packs 75MB Disks			665	10	6,650	AID	MONP	FY 84	
C1-14	Tapes			392	20	7,840	AID	MONP	FY 84	
C1-15	Printer Ribbons			20	24	480	AID	MONP	FY 84	
C1-16	Print Band			1,120	2	2,240	AID	MONP	FY 84	
C1-17	Additional 32 K Serial Workstations				8	30,822	AID	MONP	FY 84	
C1-18	Cables	2000 ft coil		700	1	700	AID	MONP	FY 84	
C1-19	Connectors	2 x 350-2-74 TNC		12.50	50	625	AID	MONP	FY 84	
		2 x 350-2-74 BNC		12.50	50	625	AID	MONP	FY 84	

PROCUREMENT SCHEDULE COMPONENT II

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDED	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
VEHICLES										
C2-1	Vehicle	4 x 4	AMC, Jeep	$ 16,000	5	$ 80,000	AID	1 SWDO; 2 WED; 1 CDC; 1 SFHCA	FY 1984	
C2-2	Spare parts	Standard kit		2,000	5	10,000	AID		FY 1984	
		Fitting as AV mobile unit		2,000x	5	10,000	AID		FY 1984	
AV EQUIPMENT										
C2-3	Offset Press	70 x 50 cm.		20,000x	1	20,000x	Cont.	Som.Prtg.Agency	FY 1985	
C2-4	Reprographic Unit			3,000x	3	9,000x	Cont.	SFHCA, H/ED, MOH, SWDO - 1 ea.	FY 1985	
C2-5	Film Projector	16 mm, Elmo, model 16-CL Xenon AV (with public address capability), 240V	Nelson C. White Co. 82 AV Cat. p. 7	2,650	10	26,500	Cont.		FY 1985	Kismayo Hargeisa Mogadishu Baidoa
C2-6	Aluminum Carrying Case	Elmo, AP 605	- do -	130	10	1,300	Cont.	- do -	FY 1985	
C2-7	Speakers	Elmo, FS-1000, two-way (set of two (2556	- do -	200	10	2,000	Cont.	- do -	FY 1985	
C2-8	Projection Screen	Da-Lite, portable/tripod, Picture King, 96 x 96 in.	- do - p. 18	310	10	3,100	Cont.	- do -	FY 1985	
C2-9	Power Generator	For use in mobile unit to power film projectors		1,100x	10	11,000x	Cont.	- do -	FY 1985	
C2-10	Current Stabilizer	For use with projectors		1,200x	10	12,000x	Cont.	- do -	FY 1985	
C2-11	Public Address System	Powered from car battery or other		500x	10	5,000x	Cont.	SWDO	FY 1985	
C2-12	Tape Recorder	Professional model (possibly Uher 4000 LC, portable (w/case) & battery charger (Z124A1)		700	3	2,100	Cont.	Radio (MING), SFHCA, H/ED (1 ea.)	FY 1985	
C2-13	Cassette Recorder	Portable, battery-operated, w/mike & carrying case, address syst. output		120	15	1,800	Cont.	Oper. Units. All institutions	FY 1985	
C2-14	Slide Projector (electrical)	Elmo, Omigraphic 200, 35 mm	Nelson C. White Co. 83 Cat. p. 12	400x	4	1,600x	Cont.	SFHCA, H/ED, Film Agy., WED	FY 1985	

x-estimated

PROCUREMENT SCHEDULE COMPONENT II

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDS	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
C2-15	Lense for above	Elmo (4180), 70-120mm, f3.5 zoom	Nelson C. White Co. 83 Cat. p. 12	$ 130	4	$ 520	Cont.	SFHCA, H/ED, Film Agy., WED	FY 1985	
C2-16	Trays, for above	Elmo (for Omnigraphic 300)		20x	16	320x	Cont.	- do -	FY 1985	
C2-17	Telecontrol & Extension Cord	For above slide projector		30x	4	120x	Cont.	- do -	FY 1985	
C2-18	Slide Projector (kerosene)	With sturdy carrying case		80x	20	1,600x	Cont.	Oper. Units, All institutions	FY 1985	
C2-19	Photographic Camera	35mm, professional model with lenses & accessories flash, carrying case and tripod		900x	1	900x	Cont.	SFHCA	FY 1985	
C2-20	Photographic Camera	Automatic, 35mm w/carrying case (possibly Trip)		80x	10	1,600x	Cont.	Oper. units, All institutions	FY 1985	
C2-21	Flipchart Easel	All-purpose portable easel for 27 x 34 in. pads, easy clean, white surface panel		120x	20	2,400x	Cont.	- do -	FY 1985	
C2-22	Microphone, Headphones	For tape-recorder (Uher or equivalent)		200x	3	600x	Cont.	Radio (MING), SFHCA, H/ED, MOH	FY 1985	
OFFICE EQUIPMENT										
C2-23	Typewriters	Manual, long carrel, with tabulator		500x	3	1,500x	AID	SFHCA, WED, H/ED	FY 1984	
C2-24	Furniture	Filing cabinets, shelves & misc. (for documentation center/library) - suite of items				6,900x	AID	SFHCA	FY 1984	
C2-25	Air Conditioners	Large size		1,000x		6,000x	AID	SFHCA, H/ED	FY 1984	
SUPPLIES										
C2-26	Film Projector Lamps				50		Cont.	According to allocation of above equipment & identified needs (through SFHCA)	FY 1985	

x-estimated

PROCUREMENT SCHEDULE COMPONENT II

ITEM	NAME	SPECIFICATION	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDED	TOTAL COST ($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARK
C2-27	Film Proj. Exciter Lamps				30		Cont.		FY 85	
C2-28	Slide Projector Bulbs				20		Cont.		FY 85	
C2-29	Rechareable Ni/Cd Cells	For Uher or equiv tape recorder			6		Cont.		FY 85	
C2-30	Photo Film	Kodak 135-24 for: color prints			100		Cont.		FY 85	
		color slides			50		Cont.		FY 85	
		black & white			200		Cont.		FY 85	
C2-31	Audio Cassettes	C90 (TDK)			200		Cont.		FY 85	
C2-32	Audio Tape	5 in. reel			60		Cont.		FY 85	
C2-33	Splicing Tape	Red/green leader reels			20	$9,000				
C2-34	Flipchart Pad	27x 34 in			140	($4,000 FY 84)	AID		FY 84	
C2-35	Paper	Stock of various types, drawing typing, offset preparation & printing					AID		FY 84	
C2-36	Graphic Design Materials	Ink, markers, chinagraph, pencils, etc.					AID		FY 84	
C2-37	Films, 116mm, color	Motivational/educational/training on FH, 10-30 min ea. sets of 20 frames different FH themes: 4x5 sets			20		AID		FY 84	
C2-38	Publications Materials	Books, journals, prototype IEC materials on FH: Charts, models, etc.			20		Cont.		FY 85	

PROCUREMENT SCHEDULE COMPONENT III

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDS	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
C3-1	"Contraceptive Methods"	16mm film I OB-11-English	Milner Fenwick Timonium, MD	$ 600	1	$ 600	AID	SFHCA	6/84	
C3-2	"Contraceptive Methods"	16mm film I OB-12	"	600	1	600	AID	SFHCA	6/84	
C3-3	"The IUD"	16mm film English	"	600	1	600	AID	SFHCA	6/84	
C3-4	"Sexually Transmitted Diseases"	16mm film English	"	600	1	600	AID	SFHCA	6/84	
C3-5	To be selected	"	"	600	1	600	AID	SFHCA	6/84	
C3-6	"	"	"	600	1	600	AID	SFHCA	6/84	
C3-7	"	"	"	600	1	600	AID	SFHCA	6/84	
C3-8	"	"	"	600	1	600	AID	SFHCA	6/84	
C3-9	"	"	"	600	1	600	AID	SFHCA	6/84	
C3-10	"	"	"	600	1	600	AID	SFHCA	6/84	
C3-11	"	"	"	600	1	600	Contractor	SFHCA	85/86	
C3-12	"	"	"	600	1	600	"	SFHCA	85/86	
C3-13	"	"	"	600	1	600	"	SFHCA	85/86	
C3-14	"	"	"	600	1	600	"	SFHCA	85/86	
C3-15	"	"	"	600	1	600	"	SFHCA	85/86	
C3-16	"	"	"	600	1	600	"	SFHCA	85/86	
C3-17	"	"	"	600	1	600	"	SFHCA	85/86	
C3-18	"	"	"	600	1	600	"	SFHCA	85/86	
C3-19	"	"	"	600	1	600	"	SFHCA	85/86	
C3-20	"	"	"	600	1	600	"	SFHCA	85/86	
C3-21	"	"	"	600	1	600	"	SFHCA	85/86	
C3-22	"	"	"	600	1	600	"	SFHCA	85/86	
C3-23	"	"	"	600	1	600	"	SFHCA	85/86	
C3-24	"	"	"	600	1	600	"	SFHCA	85/86	
C3-25	"	"	"	600	1	600	"	SFHCA	85/86	
C3-26	"	"	"	600	1	600	"	SFHCA	85/86	

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDS	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
C3-27	To be selected	16 mm film English	Milner Fenwick Timonium, MD	$ 600	1	$ 600	Contractor	SFHCA	85/86	
C3-28	"	"	"	600	1	600	"	SFHCA	85/86	
C3-29	"	"	"	600	1	600	"	SFHCA	85/86	
C3-30	"	"	"	600	1	600	"	SFHCA	85/86	
C3-31	Teaching Model	"Ginny" 3 dim. life-sized pelvis	Trainex Corp. PO Box 116 Garden Grove, CA 92642	550	4	2,220	AID	MOH	1984	
C3-32	Teaching Model	"Lindy" 3 dim. portable doll	Omni Educ. PO Box 220 190 W. Main St. Somerville, NJ 08876	20	4	80	AID	MOH	1984	
C3-33	Giant Uterus	RBM 1	Cleveland Health Mus. 8911 Euclid Ave. Cleveland, Ohio 44106	35	4	140	AID	MOH	1984	
C3-34	IUD	RBM 3	"	35	4	140	AID	MOH	1984	
C3-35	Life Size Uterus	RBM 4	"	35	4	140	AID	MOH	1984	
C3-36	"Pathfinder Model"		Pathfinder Fund, Boston Massachusetts	150	4	600	AID	MOH	1984	
C3-37	Other Models					1,240	AID	MOH	1984	
C3-38	Aneroid Sphyg	(TYCOS) Cat. No. 1055	Camex Int'l	105.10	30	3,153	Contractor	MOH	1985	
C3-39	Stethoscope	(Medic) No. 3036	"	8.25	30	248	"	MOH	1985	
C3-40	H. Brace Exam Table	Cat. 2735	"	320	30	9,585	"	MOH	1985	
C3-41	Utility Stand	Cat. 1562	"	61	30	1,830	"	MOH	1985	
C3-42	Foot Stool	Cat. 1579	"	21	30	690	"	MOH	1985	
C3-43	Exam Lamp	Cat. 1570	"	64	30	1,920	"	MOH	1985	
C3-44	Power Converter	Cat. 9016	"	23	30	630	"	MOH	1985	

PROCUREMENT SCHEDULE COMPONENT III

ITEM	NAME	SPECIFICATIONS	SUGGESTED SOURCE	UNIT PRICE($)	QTY. NEEDS	TOTAL COST($)	PROCURED BY	DISTRIBUTION	DATE TO BE ORDERED	REMARKS
C3-45	Sterile Exam Gloves	Cat. 3711-S	Camex Int'l	$ .20	75,000	$ 15,000	Contractor	MOH	1985	
C3-46	Laboratory+Equipment for infertility, VSC and STD services					46,000	"	MOH	1985	
C3-47	Oral Contraceptives		GSA	.21	2,706,319	568,327	AID	MOH		
C3-48	Jelly		GSA	.50	58,781	29,391	AID	MOH		
C3-49	IUDs		GSA	.71	16,780	11,914	AID	MOH		
C3-50	Applicators		GSA	.36	4,690	1,688	AID	MOH		
C3-51	Condoms		GSA	.05	15,062,128	753,106	AID	MOH		
C3-52	IUD Kits		GSA	143	100	14,300	AID	MOH		
C3-53	Jeeps	4 x 4		16,000	9	144,000	AID	5 to MOH;	1984	
C3-54	Spare Parts			2,000	9	18,000	AID	4 to contract	1984	
								long-term personnel	1984	
C3-55	Typewriters		GSA	1,000	14	14,000	AID	MOH/contractors	1984	
C3-56	Typewriters		GSA	333	6	2,000	AID	MOH/contractors	1984	
C3-57	Books			20	250	5,000	AID and Cont.		1984 1985	

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Component IV

Item	Name	Specifications	Suggested Source	Unit Price	Quantity Needed	Total Cost	Procured By	Distri-bution	Date
C4-1	Vehicle	4 X 4	AMC Jeep	$16,000[x]	4	$64,000	AID	SFHCA (CSM)	1984
C4-2	Spare parts	Standard set	AMC Jeep	$ 2,000[x]	4	8,000	AID	SF HCA (CSM)	1984
C4-3	Packaging materials for contraceptives	FY 85 FY 86 FY 87				52,000[x] 59,000[x] 67,000[x]	Con-tractor	SFHCA	1985 /86

IMPLEMENTATION PLANS AND SCHEDULES

This section includes the implementation plans for each component with a schedule for important events and, where appropriate an overall calendar for development and extension of the programmed activities. At the end of the section, a timeline is presented showing the activities planned for each component, their anticipated shceduling, and where appropriate, their relationship to each other. The final chart/timeline, shows the actions required by USAID in relation to the implementation of the Project as a whole and to the four components. These timelines are to be used as guides for the Project Manager and advisors in the implementation of Project activities. Further elaboration of these plans will be done by the agencies responsible for each component (for example, a complete plan for the implementation of the census will be developed) and revised each calendar year.

15.1. PROJECT IMPLEMENTATION FOR POPULATION DATA AND POLICY COMPONENT

A. Management

The primary implementing institution for this component will be the Ministry of National Planning (MONP) which will be responsible for overseeing, if not actually carrying out, the various component activities. Most data collection, processing and analysis work will be undertaken by MONP's Central Statistics Department (CSD). Utilization of data for development planning work will be undertaken by various units within MONP, including CSD and Human Resources Planning Division. Institutions outside of MONP will also be involved in population data and policy activities, as appropriate.

The lead institution in the 1986Census is CSD, under the supervision of the Director of CSD, who will be assisted by his deputy. CSD has a staff of about 60 organized in six sections: Census and Surveys, Demographic and Social Statistics, Economic Statistics, Research and Publication, Data Processing, and Regional Statistics. The Institute of Statistics, with 9 part-time teachers, is also under the direction of CSD. Because the staff of CSD is so small and because expertise is spread across all six section, census activities will require substantial inputs from most of the CSD staff.

In addition to CSD inputs, this massive census undertaking will require the support and collaboration of other institutions, including: Ministry of Education, providing teachers and students for enumeration; Ministry of Local Government, providing guides and escorts for enumerators; Ministry of Defense and Police Force, providing security as required; Ministry of Information, providing pre-census publicity; and Ministries of Transportation, Post, and Telecommunications, providing logistical support. The work of these Ministries will be coordinated by an Executive Committee composed of the Directors General from each Ministry and guided by a Technical Committee made up of the Deputy Directors from each Ministry. Both committees will be chaired by the Director General of MONP.

The lead institution of the analysis of the 1986 Population Survey is CSD. The processing and analysis of the data will be carried out in collaboration with Westinghouse, under the AID centrally-funded Demographic Data for Development (DDD) project. The FHS project will support the final stages of the work, including report-writing and presentation at the second National Population Conference, where the survey findings and implications will be reviewed and discussed with representatives from other institutions.

The analysis of the 1982 Settlements will be under the Settlement Development Agency (SDA) under the direction of the General Manager. The processing and analysis of the data is

tentatively planned to be carried out in collaboration with Research Triangle Institute, under the AID centrally-funded Integrated Population Development Planning (IPDP) project. The FHS project will support the final stages of the work, including report-writing and presentation at the second National Population Conference.

The lead institution for coordinating the two demographic research studies to be supported under the FHS project will be the Somali Family Health Care Association (SFHCA) under the direction of the Secretary General. The two studies will probably be selected from the small-scale research studies presently being supported by the AID centrally-funded RAPID II Project, in collaboration with the Somali Family Health Care Association. These small studies cover a wide range of policy-relevant family health and population issues. At least two will warrant more in-depth research. The research itself will be undertaken by an appropriate Somali institution with technical assistance from RAPID II or other centrally-funded contractor or selected directly by the Mission.

The lead institution for the workshops on data use in planning will be MONP's Central Statistics Department and Human Resources Planning Division. These workshops will be undertaken with technical training assistance from AID centrally-funded projects: DDD and Integrated Population Development Planning II (INPLAN).

The two National Population Conferences will be managed by the Ministry of Education (MOE) in close collaboration with the SFHCA. The Planning Department of MOE organized the first National Population Conference scheduled for December 1984, with technical assistance from the University of North Carolina under the AID centrally-funded RAPID II project. Given its experience in organizing these conferences, it is expected that the Planning Department will again take primary coordinating responsibilities for these two conferences -- with some limited technical assistance.

B. Technical Assistance

Short-term technical assistance under the Population Data and Policy component will serve primarily an advisory role. Technical assistance for the various activities related to the 1986 Census will be provided by the U.S. Bureau of the Census (BUCEN) under a direct contract (PSSA) with USAID/Somalia. Technical assistance for the 1982 Settlement Survey will be provided by the INPLAN contractor (to be determined) through a mission add-on to the INPLAN contract. Technical assistance for the two demographic research studies and for the two National Population Conferences is tentatively expected from the University of North Carolina through a mission add-on to the RAPID II project.

C. Training

Three short-term, in-country training activities are planned under this component of the FHS project. Training in the use of the CENTS4 tabulation system will be provided by BUCEN to data processing staff in CSD. Trainees will be identified by the Director of CSD in collaboration with BUCEN. Training facilities will be provided by CSD. Training in methods for using demographic data in establishing population trends and projecting future growth and redistribution of population will be provided by Westinghouse to planners in MONP. Follow-up training on using demographic and economic data for planning analyses will be provided to the same group by the INPLAN contractor. For these two training activities, trainees will be identified by the Director General of MONP and training facilities will be provided by MONP.

D. Procurement of Commodities

The FHS project will provide CSD with mainframe computer hardware and software for processing the 1986 Census and paper required for printing questionnaires and manuals. USAID/Somalia management will be responsible for procuring this system, with technical assistance on required equipment components and specifications provided by BUCEN. The FHS project will also provide CSD with CENT S4 census tabulation software under the BUCEN technical assistance contract.

E. Disbursement of Funds

Primary responsibility for disbursing funds for local costs in component activities rests with the Ministry of National Planning. The Director General of MONP will identify an accounting unit/person who will establish a system of financial accounting compatible with CIPL disbursement procedures.

F. GSDR Logistical Support

Little logistical support will be required for short-term technical assistance and training activities provided under this component. For the 1986 Census, CSD will provide guides for field tests and field trips in conjunction with planning for the post-census coverage study of nomads. CSD will also provide classroom and supplies for CENTS4 workshop and for two workshops on data use in planning.

G. Implementation Schedule

The implementation schedules for component activities to take place in the 60 months of the FHS project, first for activities relating to the 1986 Census and then for remaining component activities, follow:

1986 Census

Month	Event	Provided by:
1	Sampling design support: 3-week TDY (Mathematical Statistician)	BUCEN
1	Census design support: 3-week TDY (Survey Statistician)	BUCEN
3	Questionnaire design support: 3-week TDY (Survey Statistician)	BUCEN
3	Data Processing system design: 3-week TDY (Data Processor)	BUCEN
5	Sampling design support: 3-week TDY (Mathematical Statistician)	BUCEN
8	Monitor pretest to evaluate census design: 3-week TDY (Mathematical Statistician)	BUCEN
12	Delivery of Computer	FSU/WANG
12 (or when computer arrives)	Arrival of long-term Data Processor	UNFPA
15	Installation and training in CENTS4: 4-week TDY (2 Data Processors)	BUCEN
21	Monitor field work for coverage study: 4-week TDY (Mathematical Statistician)	BUCEN
24	Document results of coverage study: 3-week TDY (Mathematical Statistician)	BUCEN
30	Assistance in processing quick counts and sample tabulations: 4-week TDY (Data Processor)	BUCEN
37	Quick count of census data completed	CSD
49	Tabulation of 10% census sample completed	CSD
49	Integrate sample back into major data base	CSD

Other Population Data and Policy Events

Month	Event	Provided by:
4	Population Survey Report: 3-week TDY (Survey Researcher)	Demographic Data for Development (DDD) /Westinghouse
7	Settlement Survey Report: 3-week TDY (Survey Researcher)	INPLAN Contractor
6	Second National Population Conference	RAPID II/UNC (Central Support)
6	Population Survey presentation: 2-week TDY (Survey Researcher)	DDD/Westinghouse
9	Settlement Survey presentation: 2-week TDY (Survey Researcher)	INPLAN Contractor
10	Assistance for demographic surveys: (2 Survey Researchers)	To be determined
17	Assistance for demographic surveys: 2-week TDY (2 Survey Researchers)	To be determined
28	Third National Population Conference: 2-week TDY (Survey Researcher)	To be determined
34	Workshop on data use in planning: 2-week TDY (2 Data Analysts)	DDD/Westinghouse
38	Workshop on data use in planning: 2-week TDY (2 Economic Planners)	INPLAN Contractor
44	Fourth National Population Conference: 2-week TDY (Survey Researcher/RAPID Modeler)	To be determined

15.2. PROJECT IMPLEMENTATION FOR THE IEC COMPONENT

A. Activities Prior to Arrival of the Contractor

A short-term advisor will be requested from Family Planning International Assistance to assist in the planning for the establishment of the IEC Unit and Resource Center in the SFHCA and the IEC Technical Committee. The Advisor will assist in the following: developing the scope of work (terms of reference) for the center, unit and committee and job descriptions for the staff; identify in the qualifications required of the staff and assist in the recruitment and selection of them; working with the director in establishing relationships with the implementing agencies and initiating liaison activities. This Advisor will also review training needs and recommend training programs for the IEC Unit staff.

During the first six months of the Project, USAID/Somalia will request the Population Communications Services Project of Johns Hopkins University to provide two short-term consultants for the implementation of the data-gathering efforts specified in Activity 1 under the Project Description. One advisor will be asked to conduct an inventory of all the material and human resources available in the related Somali Institutions for use in the family health IEC efforts. The report will be used for identifying the commodity and training needs of the implementing agencies.

The second short-term advisor will assist in the planning, collection, and analysis of data on relevant sociological characteristics. This advisor will conduct two workshops, one before the data collection in the field and the second after the field work. The workshops will be attended by selected staff from each of the implementing agencies for IEC. During the first workshop the participants will review the data already available, identify any gaps in the data, and plan how they will be attended by selected staff from each of the implementing agencies for IEC. During the first workshop the participants will review the data already available, identify any gaps in the data, and plan how they will collect additional data. The workshop participants will then go to the field, meet with local staff from their agencies, and gather the information they need. The second workshop will be used to review the information collected and draw conclusions about needs and appropriate IEC approaches.

B. Management

All participating agencies will be responsible for the implementation of the IEC activities for which they assume the direction . Responsibility of the coordinated management of the whole IEC program will reside with the IEC Unit of the SFHCA. The Director of the IEC Unit will be the key liaison with the other agencies and will be the key counterpart for the long-

term IEC Advisor. The Unit will exercise its functions for management and coordination by developing and implementing procedures for planning the IEC activities (on an annual basis) and drawing up related budgets, monitoring implementation, and sharing information and experiences. The Director of the IEC Unit will report to the Executive Director of the SFHCA who is, in turn, responsible for the family health project activities assigned to the association; therefore, the Executive Director of the SFHCA reports to the Family Health Services Project Coordinating Committee composed of the directors of the family health program components in the participating institutions.

The IEC Unit will also work through one or more technical groups for the implementation of joint activities. These technical groups will be composed of officers of the agencies with particular skills (or those who will develop particular skills) pertinent to the joint activity, i.e., pamphlet design, poster production, training program development. At least twice a year, the directors of the IEC-related programs in the institutions will meet to discuss progress made towards their objectives, problems, and to share experiences. One meeting will be devoted to planning the activities of the up-coming year.

C. Technical Assistance

The long-term IEC Advisor will perform somewhat different functions at different levels of the program. He/she will advise the management of all participating institutions on their respective IEC strategies and programs, provide guidance to the IEC Unit heads in each institution and train the staff.

At the Central level, at the IEC Unit of the SFHCA, the advisor will provide guidance in the development and execution of all management functions (planning, monitoring, liaison). He/she will assist in the administration of the resources provided under the project. He/she will identify needs for short-term IEC consultants, and coordinate and follow-up on their work.

For each institution, the IEC advisor will provide assistance and guidance in the implementation of their IEC activities, working with the IEC staff according to a schedule agreed upon and in accordance with the annual work plan. The advisor will help the staff develop their IEC programs, identify needs for materials, training, and the like, and assist them in supervising implementation; the IEC advisor will provide technical guidance in the implementation of joint, inter-institutional activities. He/she will work towards improving the design and utilization of effective IEC materials for family health and in developing innovative approaches suitable to the cultural environment of Somalia.

The scopes of work of four short-term IEC advisors have been developed, with the assumption that other needs will be identified and scopes of work specific to those developed at the particular time. The short-term advisors would include: an IEC production consultant to assess the production of printed and other materials and assist the project to improve them; an IEC evaluation consultant who would assist the staff in setting up the monitoring and evaluation procedures needed for the program; a medium-term consultant in the development of curricula for formal education in family health; and a consultant to train the staff in the repair and maintenance of the A/V equipment.

D. Training

The Project will support short-term training overseas and study tours for key personnel of the implementing agencies working with IEC, up to four per agency, and including the staff of the IEC Unit of the SFHCA. Staff to be sent for these training programs will be selected jointly by the IEC Unit, members of the IEC Technical Committee and the IEC long-term advisor. (Prior to arrival of the IEC advisor, USAID will fill in.) The short-term courses will be in planning and management of IEC, development of IEC programs, materials and media production, evaluation of IEC materials, and related skills areas. These trained staff will form the core group with whom the long-term IEC advisor and short-term technical advisors will work.

The Project will also support, through the provision of technical assistance, commodities, local currency contributions, training programs for many levels of staff in the implementing agencies. The long and short-term advisors will work with the staff of the IEC Unit of the SFHCA as the lead agency and other, selected staff in preparing a series of training programs and manuals geared to developing the IEC skills of all participating staff in the implementing agencies. The training will be skills-oriented as the programs will serve as opportunities to develop IEC programs and materials for implementation in the field. Table presents some of the topic areas, agencies to be involved, and numbers expected to be trained.

Table15.1. Proposed IEC Training Topics and Staff

Topics	Agency(ies)	Personnel to Be Trained	Approximate Numbers
Overview of IEC: Purpose, Methods, Materials	SFHCA WED SWDO MOH	Senior staff Regional staff District staff	100
Design of IEC Approahes /programs	SFHCA WED SWDO MOH	Senior staff Regional staff	25

Topics	Agency(ies)	Personnel to Be Trained	Approximate Numbers
Materials Design & Production	SFHCA WED SWDO MOH	Selected staff Central and Regional	10
Using IEC in the Community/Educational Activities for Community Groups	WED SWDO MOH	All staff working at local level	200
Use of IEC Materials /Techniques	SFHCA WED SWDO MOH	All staff working at the local level and who do any IEC	250

Under the leadership of the SFHCA, training will also be arranged for staff of the agencies to learn how to run the film and slide projectors. The long-term advisor will suggest the appropriate training for the staff at the SFHCA in the use and maintenance of the A/V equipment.

E. Procurement of Commodities and Services

The specific commodities to be procured for this component are presented in the Procurement Schedule, Annex and consist primarily of audio-visual equipment, software, and vehicles. Under the local currency budget, the project will provide for materials needed to produce the posters, pamphlets, manuals and other goods.

F. Disbursement of Funds

In addition to the assistance provided through the provision of commodities, technical assistance, and short-term training, for which no funds need to be disbursed except by USAID and the contractor, the IEC component will utilize local currency funding. Assistance will be provided to the SFHCA and the IEC implementing agencies to set up the proper budgeting and accounting systems for these funds. The long-term IEC advisor will assist the Director of the IEC Unit and the SFHCA accountant in preparing their budgets in a timely manner so as to assure timely receipt of the funds. The SFHCA accountant will be responsible for maintaining all required accounts and sending reports to the CIPL Unit.

G. GSDR Logistical Support

The GSDR will provide the following logistical support to this component: office space for staff working in each of the implementing agencies, except for the SFHCA; staffing, including secretarial support when needed for those agencies with

field activities; the field sites for conducting the IEC sessions and training programs; and communications support, when needed, to inform staff in the field of IEC up-coming activities.

H. Implementation Schedule

An overall calendar of major activities by the implementing agencies is presented in Table15.2. The schedule for project/contractor actions of the 60 months of the FHS Project follows:

TABLE 15.2 CALENDAR OF MAJOR ACTIVITIES BY IMPLEMENTING AGENCIES

	WED	SWDO	MOH	SFHCA	JOINT
YEAR 1	FH incorporated into teacher training curriculum	FH series for orientation centers developed	IEC workshops for staff in Area A developed	Resource Center organized. Training for staff of SWDO, WED, MOH planned & begun	Selection/elaboration of basic FH messages/themes. Preparation of charts, posters, 1 pamphlet, 1 radio series
YEAR 2	Teachers trained in Area A; FH program started in Area A. FH curriculum revised. Teachers trained in Area B & program started	Staff trained in Area A & FH series started in Area A; FH series revised. Staff trained in Area B & program begun	Workshops implemented & revised; implemented for staff in Area B	Workshops in IEC for high-level staff. Training for staff of SWDO, WED & MOH. Start newsletter	Elaboration of FH messages/themes. Preparation of posters, 1 slide set; radio drama series
YEAR 3	FH curriculum updated. Teachers trained in Area C. Refresher training for Area A	FH series updated. Staff trained in Area C & program started. Refresher training for Area A	IEC workshops updated & implemented for staff in Area C. Training of teachers in IEC	In-service IEC training for other agency staff. Community Action program developed. Newsletter	Elaboration of FH messages. Preparation of posters, pamphlets, radio series
YEAR 4	Teacher training in Area D. Refresher training for Area B. Community Action/IEC training for selected staff in Areas A and B	Staff trained in Area D, refresher training in Area B. Community Action/IEC training in Areas A and B. IEC for pilot area program	Training of MCH staff in Area D. Community Action/IEC training in Areas A & B. IEC for pilot program	Preparation of sample materials for Community Action/IEC program. Newsletter	Preparation of sample Community Action/IEC materials; 1 slide series; posters; pamphlets
YEAR 5	Refresher training in Areas C & D, with training in Community Action/IEC	Refresher training in Areas C & D with training in Community Action/IEC. Revision of IEC for pilot program	Refresher training as needed; Community Action/IEC training for staff in Areas C & D. Revision of IEC for pilot program	IEC workshops for Agency staff; refresher training series. Newsletter	Revision of messages. Radio series; posters; pamphlets

IMPLEMENTATION SCHEDULE:

INFORMATION EDUCATION, AND COMMUNICATION

Project Month	Description of Activity	Institution Responsible
-1	Preliminary arrangements for establishment of IEC Unit and IEC Technical Group.	SFHCA-All Institutions USAID
0	Signing of project arrangement.	USAID-GSDR
1	Short-term IEC Planning Consultant arrives; Final selection and appointment of Director of IEC Unit.	SFHCA with Consultant
	Establishment of IEC Unit and IEC Technical Group, and initial oriantation.	SFHCA
2	Development of functions/responsibilities/relationships for IEC Unit and IEC Technical Group.	IEC Consultant
	Assignment of initial tasks to IEC Unit. 1. IEC Preliminary Survey; 2. Manpower Survey; 3. Material Resources Survey; 4. Organization of Resource Center.	
3	Work on the three surveys and development of the Resource Center; Preliminary IEC Survey: existing data gathered and analyzed; field interviewers trained. Completion of Manpower and Material Resources Survey.	IEC Unit-All agencies consultants
4-5	IEC field survey under way; data coming in, analysis started/completed. Guidelines given on formulation of long-term IEC strategy from Preliminary Survey findings; Work starts on IEC Strategy/plan; preliminary work plan developed.	Consultant IEC Unit and Consultant IEC Consultant IEC Unit and Technical Group
8	Long-term IEC Advisor arrives; IEC Preliminary Survey analysis reviewed.	USAID/Contractor IEC Unit/Tech. Group & Advisor
	Long-term IEC Strategy drafted.	
9	Short-term Advisor in FH curriculum development (for CDC) arrives.	Contractor
	Coordinated IEC 1985 Work Programme/ Budget drafted and approved.	IEC Unit/IEC TG/IEC-AD Proj. Coord. Comm.

IEC Implementation Schedule, p.2

Project Month	Description of Activity	Institution Responsible
9-10	Orientation sessions for all staff/ planning for programs.	IEC Unit IEC-AD/All agencies
10-14	Design of basic IEC-FH materials (leaflets, posters/flip charts, displays, radio program);	IEC-AD/ ./MING
10-12	Preparation of programs for WED, SWDO, MOH, including training program for implementing staff.	IEC Unit, SWDO WED, MOH
12-14	Pretesting of basic IEC-FH materials of new design.	IEC Unit/agencies
13	Joint review of programs,	SWDO,WED,MOH Tech. Group SWDO/WED
14-15	Staff training in Area A for implementation. One program started.	IEC Unit, SWDO WED, MOH
15	CDC advisor leaves; overall plan for curriculum developed.	CDC/Advisor
16	End of year IEC Evaluation/Reprogramming process set in motion: formats distributed (to incorporate data from continuing assessment) and explained to Institutions' IEC managers in 2-day Evaluation/Programming Workshop.	IEC Unit and IEC Technical Group
	First commodities (film and slide projectors, recorders cameras and supplies) arrive and are distributed; orientation given on their use and maintenance arrangements made;	USAID/GSDR SFHCA/Contractor
	4WD vehicles arrive and are distributed.	USAID/GSDR IEC Unit
	Offset press arrives and is installed.	MING-Ptng. Ag.
17	IEC Evaluation/assessment reports in, compiled and analyzed;	IEC Unit
	IEC-Technical Group meeting on 1985 Work Programme; Coordinated 1986 IEC Work Programme/Budget drafted;	IEC-TG IEC Unit/IEC-AD
	1986 IEC Work Programme/Budget approved; IEC Programme implementation (on-going throughout the year). Monetary plan developed.	Proj.Coord. Comm. All

IEC Implementation Schedule, p.3

Project Month	Description of Activity	Institution Responsible
19	WED, SWDO, MOH continue training staff and implementing program.	WED, SWDO, MOH
20	Short-term IEC Production Consultant arrives, surveys and assesses design and production facilities.	Contractor/IEC Unit
21	CDC Advisor arrives.	CDC/Contractor
21	IEC Production Workshop(2Weeks) for design/production personnel, with emphasis on low-cost materials.	IEC Unit/IEC-Prod. Cons. MING-Ptng.Ag.
22-24	Design of new IEC printed materials as follow-up to Production Workshop.	IEC Unit/IEC-Prod. Cons. MING-Ptng.Ag.
25-26	Study tour to view innovative IEC programs	IEC Unit,SWDO WED,MOH
27	Workshop on innovative IEC approaches	IEC Unit,SWDO,WED MOH
28	Development and field application of innovative field approaches, as follow-up to Experimental Field Workshop; Production and distribution of pretested new IEC printed materials.	IEC Unit/IEC Cons. MING-Ptng Ag.
28	IEC 1986 Evaluation reports in, consolidated, analyzed and discussed.	IEC Unit/IEC-TG
29	Coordinated 1987 IEC Work Program/ Budget drafted; 1987 IEC Work Program/Budget approved.	IEC Unit/IEC-TG Proj. Coord. Comm.
30	IEC Program implementation (on-going throughout the year).	All
32	Short-term IEC Evaluation Consultant arrives, designs and organizes Project's Mid-term IEC Evaluation.	Contractor/Eval. Cons.
33	Mid-term IEC Evaluation implemented.	IEC Unit/Eval.Cons.

IEC Implementation Schedule, p.4

Project Month	Description of Activity	Institution Responsible
34	Mid-term IEC Evaluation analysis completed;	IEC Unit/IEC Eval. Cons.
35	IEC Evaluation findings reported and discussed;	IEC Unit/IEC-TG
36	IEC Strategy/Program reviewed, revsions recommended on basis of evaluation findings;	IEC-TG/IEC-AD
41	IEC 1987 Evaluation reports in, consolidated, analysed and discussed;	IEC Unit/IEC-TG
42	Coordinated 1988 IEC Work Prog/Budget drafted; 1988 IEC Work Prog-Budget approved.	IEC Unit/IEC-TG Proj. Coord.Com.
43	IEC Program implmentation (on-going throughout the year);	All
53	IEC 1988 Evaluation reports in, consolidated, analyzed and discussed;	IEC Unit/IEC-TG
	Procedure starts for possible project extension. (Conversely, for end-of-project evaluation)	USAID/GSDR
54	Coordinated 1989 IEC Work Prog/Budget drafted;	IEC Unit/IEC-TG
	1989 IEC Work Prog/Budget approved; IEC Advisor leaves.	Proj. Coord.Comm.
55	IEC Program implementation (on-going);	All
60	Project completion date.	USAID/GSDR

15.3. PROJECT IMPLEMENTATION FOR THE CLINICAL FAMILY HEALTH SERVICES COMPONENT

A. Management

The primary implementing institution for this Component is the Family Health/Family Planning Division of the Ministry of Health. The Division is managed by a Director with the assistance of a Deputy Director. The Central FH/FP Office is presently staffed by 28 professionals and assistants. The Division is considering expanding its staff and reorganizing into four divisions as shown in the attached organizational chart. In addition, the Division is considering adding 21 staff at the regional level.

While most of the staff are interested and eager, many still lack the skills they need to manage their units and fulfill their responsibilities in an expanding program. The Project will assist by providing short-term training and study tours to these staff in the particular areas of need. Of greater importance will be the provision of technical assistance directed towards strengthening their management systems and skills. Under this technical assistance, the Division will develop an annual work plan for the Division as a whole, made up of the component plans from each unit. The work plan will clarify the schedules of activities of each staff member. The field and central staff will meet at least once a year to discuss program plans and problems. On a weekly or bi-weekly basis, the central staff will meet to discuss problems and solutions.

The Division will also develop monitoring tools and procedures for the program and implement a regular, systematic system for supervision, service statistics, and logistics. An accounting and financial management system will be developed and implemented to assure that local funds are spent according to the budgets.

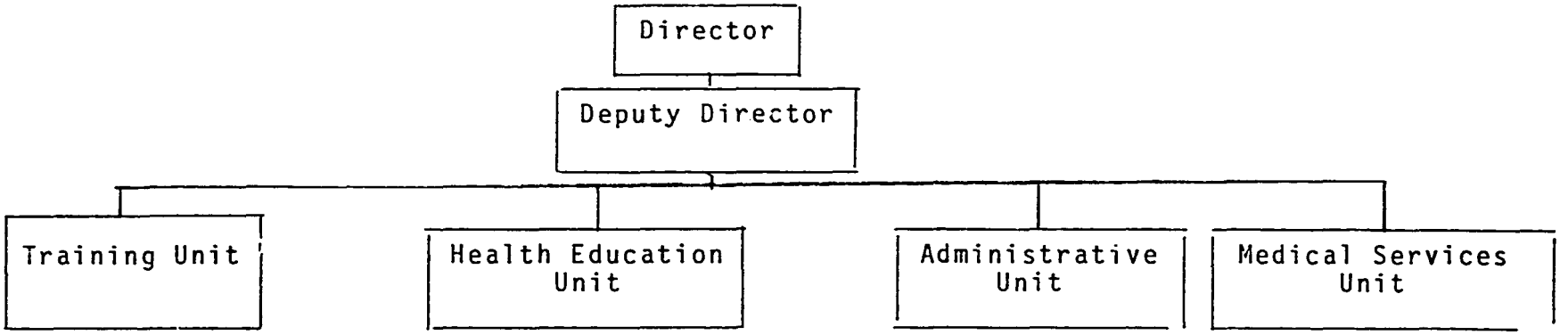
The Division Director will have responsibility for coordinating all activities for family health with those of MCH and primary health care. Regular meetings will be held with the Director of the Community Health Department and related division directors. The purpose of the meetings will be to discuss allocations of resources and use, particularly of vehicles, equipment and staff. Common problems should be discussed and solutions planned.

B. Technical Assistance

The emphasis of all technical assistance will be on the training of counterpart staff.

The long-term Training and Management Systems Advisor will be a counterpart to the Director of FH/FP. He/she will have an

FAMILY HEALTH/FAMILY PLANNING DIVISION



Training Unit

Head

Assistant

Health Education Unit

Head

Assistant

Administrative Unit

* Head

Accountant

Cashier

* Transport Officer

* Protocol Officer

* Research/ Evaluation Officer

* Messenger

* Storekeeper

* Clearance Officer

Drivers (10)

Cleaners (2)

Medical Services Unit

* Head (Physician)

General Services Officers (2)

Drugs

Equipment

Distributors (2)

Statisticians (2)

* proposed new positions

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office at the Ministry compound near the main offices of the division. The Advisor will work directly with the Director and Deputy Director; for specific tasks, other staff may work with him/her as counterparts.

The Advisor will be responsible for maintaining liaison with other donors to assure efficient use of resources and proper scheduling of short-term consultants. The Advisor will also conduct periodic, regular meetings with the Director of the MCH and Community Health Department to report on activities and maintain coordination.

The Advisor will be responsible for assisting the Division Director in identifying needs for short-term consultants and for scheduling their visits. Some needs have been anticipated, (see page) but these will need verification during the course of project implementation.

C. Training

Out of country training will include short-term training in the U.S. and third countries and study tours. The plan for these is presented in Annex , page . The training of physicians and nurses to deliver the new services in infertility, voluntary surgical contraception, and sexually transmitted diseases will be done primarily in third countries under the auspices of AVS and JHPIEGO.

A major emphasis of the project is on short-term training in-country with a wide variety of programs planned. No specific schedule has yet been developed; assistance in preparing these annual plans will be a task of the long-term advisor.

Preliminary estimates on numbers of trainees, courses, and activity level every year are presented below.

Course	Trainees	Number	Notes
Skills for Family Health (3-4 weeks)	MCH Nurses	130	20 Nurses/course
	Hospital Nurses	40	4 courses/year
	Nurse-Tutors	30	for 2½ years
	Total	200	
Clinical Skills (IUD Insertion) and Management (6 weeks)	MCH Nurses	100	Over a 4-year period, about 35/year
	Hospital Nurses	10	
	Nurse-Tutors	30	
	Total	140	
Refresher Training for Family Health (2 weeks)	MCH Nurses	180	25 trainees/course
	Hospital Nurses	40	4 courses/year
	Nurse-Tutors	30	
	Total	250	

Course	Trainees	Number	Notes
Training of Trainers in Family Health (including FH & Training Methods)	Nurse-Tutors	30	15 Trainees/course
	MCH Nurses	15	4 courses
	PHC Coordinators	15	
	Total	60	
Management and Supervision (with Family Health Review)	MCH Supervisors	15	2 courses/year
	PHC Coordinators	15	
	Total	30	

In any one year (e.g., Year 2) the following courses would be conducted:

Course	Number
Skills for Family Health	4
Clinical Skills (IUD Insertion)	2
Refresher in Family Health Skills	2
Training of Trainers	1
Management and Supervision	2
Total	10

In addition, the training staff will be developing training materials; updated curricula and curriculum modules for use by the PHC staff in training TBAs and CHWs.

Physician training will continue under the management of the project with financial assistance from JHPIEGO. Over the five-year period, the project expects to have accomplished the following:

Course	Number	Notes
Training of Physician Trainers	10	In small groups
Training of Physicians in Reproductive Health (3-week course, to include IUD insertion)	80	20 per course 1 course/year
Training of Medical Students in Reproductive Health (to include IUD insertion)	80	20 per course 1 course/year
Refresher training for Physicians (to include IUD insertion)	200	20 per course 2 courses/year

Banaadir Hospital will manage these course. Each year they will deliver the following:

Course	Number
Training of Physicians in Reproductive Health	1
Training of Medical Students in Reproductive Health	1
Refresher Training for Physicians	2
Total	4

D. Procurement of Commodities

The Procurement Plan for the commodities required for the clinical family health services is presented in Section 14. The FHS Project will provide vehicles, audio-visual equipment and materials for use in the training programs, and selected clinical equipment and materials; most of the afore-mentioned will be procured under PIO/Cs prepared by the Mission during the first six months of the Project Period. Contraceptives will be procured also under Mission PIO/Cs as needed (See Procurement Plan for timing of order for contraceptives.). All other procurement will be done under the Contract.

Other renovations will include the preparation of rooms at the Post-Basic School of Nursing as offices and training rooms, renovation of the bathrooms, and dormitory space for trainees. These will be modest in scale, but are important to permitting the FH/FP Division to conduct their work in a suitable environment. The renovations will be overseen by the AID Project Officer and Engineering Department.

F. Disbursement of Funds

The Family Health/Family Planning Division will be responsible for the disbursement of funds for local costs for this component of the project. The accounting system will be in accordance with the guidelines set by CIPL for managing these funds. This system is being set up under the Family Health Initiatives Project and will be monitored by the long-term advisor and through periodic visits by a short-term advisor in financial management.

G. GSDR Logistical Support

Timely, adequate GSDR logistical support is critical to this component. The GSDR will provide field transport, facilities for training, equipment and supplies, in conjunction with other health care programs, specifically Primary Health Care and MCH. Coordination of efforts will be needed to assure that the support is available when needed.

H. Implementation Schedule

Major activities for the Project period are presented in Implementation Schedule which follows. The schedule for expansion of Family Health Services to additional MCH Centers and hospitals is shown in Table 15.1.1.

TABLE 15.1.1 PROPOSED MCH CENTERS AND HOSPITALS OFFERING FAMILY HEALTH SERVICES
By Region and by Year - 1982-1988 (PAGE 1/2)

	1982		1983		1984		1985	
	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers
Benadir	2	12	2					
Northwest			2	4		3		2
Lower Juba				1	1	1		
Togdheer			1	1		1		
Middle Shebelli			1	2		1		
Lower Shebelli			1	6				
Gedo							1	1
Bakool								
Hiraan							1	2
Gal Goduud								1
Mudug								
Nugaal							1	1
Bari								1
Saraag								
Middle Juba								
Bay			1	5				

PROPOSED MCH CENTERS AND HOSPITALS OFFERING FAMILY HEALTH SERVICES
By Region and by Year - 1982-1988 (PAGE 2)

	1986		1987		1988	
	Hospitals	Centers	Hospitals	Centers	Hospitals	Centers
Benadir						
Northwest						
Lower Juba		1				
Togdheer		1				
Middle Shebelli						
Lower Shebelli						
Gedo		1		1		
Bakool	1	1		1		
Hiraan		1				
Gal Goduud	1	1				
Mudug	1	1		1		
Nugaal				1		
Bari			1	1		
Saraag		1	1	1		
Middle Juba	1	1				
Bay						
	4	9	2	7		
Hospitals = 20		54		60		
MCH Centers = 60						

IMPLEMENTATION SCHEDULE:

CLINICAL FAMILY HEALTH SERVICES

Month	Description of Activity	Institution Responsible
1	Advisor works with FH/FP staff on defining overall management structure of division and roles and responsibilities of units and staff.	USAID FH/FP Division
3	Advisor from Center from Disease Control (CDC) reviews and revises commodity distribution system and service information system.	USAID; CDC FH/FP Division
4	Renovations on office space start.	USAID; MOH
5	Financial Management Advisor reviews/ updates accounting procedures. Assists in preparation of 1985 budget and final accounts for 1984.	USAID; MOH
6	Report on 1984 Activities prepared. CDC Advisor returns; trains staff.	MOH
8	Long-term Training and Management Systems advisor arrives. Assists in preparing 1985 work plan.	USAID; Contractor FH/FP Division
10	ST Advisor assists Benaadir/trains physician trainers.	Contractor; MOH
12	ST Advisor assesses delivery system; makes recommendations and assists in planning implementation of them.	Contractor; FH/FP Division
12	ST Training Advisor assists in planning the set-up of MCH Model Clinic/ Training site.	Contractor; FH/FP Division
12	Renovations on clinic start. Preparation of clinical training program.	USAID; MOH

Implementation Schedule p.2

Month	Description of Activity	Institution Responsible
14	Curriculum/Materials dev. Advisor assist in preparing clinical and T of T training program.	Contractor FH/FP Division.
14 15-16	Equipment/materials for infertility, mini-laps and sexually transmitted diseases arrive. ST Advisor works with MOH to prepare protocols and set up service units.	Contractor; MOH
15	First clinical training program conducted.	FH/FP Div.
16	Training of Trainers for PHC.	FH/FP Div.
18	ST Advisor for TBA training assists in needs assessment and preparation of training program for TBA's and CHW's.	Contractor; FH/FP Div.
21	FH/FP Div. assist in training TBA's and CHW's.	FH/FP Div. PHC.
22	FH/FP prepare module for use by PHC in training TBA's and CHW's.	FH/FP Div.
26	Refresher training programs in FH developed.	FH/FP Div.
28	Refresher training started.	FH/FP Div.
30	Planning for Pilot TBA program initiated with OR.	FH/FP Div., SFHCA OR Unit.
36	Training plans for TBA/OR Program developed. ST Advisor assists.	FH/FP Div.; OR Unit of SFHCA.
38	TBA Pilot started.	FH/FP Div.; OR Unit of SFHCA.

15.4. PROJECT IMPLEMENATION FOR THE OPERATIONS RESEARCH COMPONENT

A. Management

The primary implementing institution for the Operations Research Component will be the Somali Family Health Care Association (SFHCA), under the direction of the Executive Director of SFHCA. An Operations Reserach Unit in the SFHCA will be established in the third year of the project. This unit will consist of a Somali Research Associate with the support of a long-term advisor. This unit will be responsible for carrying out principal research activities (including the development of program monitoring systems) in close collaboration with counterparts from evaluative/management units within relevant service delivery institutions including: Ministry of Health, Ministry of Education, and Somali Women's Democratic Organization. The unit will also collaborate and coordinate with long-term advisors and their operation units for the IEC and service delivery/training components of the FHS project. Since many operations research activities will focus on these two service components, close working relationships among the Somali staff and the long-term advisors will facilitate identification of service delivery problems and design of alternative service delivery approached and so contribute to the efficient and effective conduct of operations research work.

The Operations Research Unit will utilize the development of proposals for each of the OR activities as one management tool: as a detailed plan and commitment for the study by/with the participating agency(ies) and as a means of monitoring its implementation. Different requirements must be met for each of the three types of OR activities: 1) establishing an ongoing system of program monitoring; 2) testing alternative approaches to service delivery; and 3) identifying problem situations isolating the problem source, and program guidance to alleviate the problem. Proposals for monitoring systems should describe current monitoring system operations and their associated problems, review alternative approaches which have been successfully implemented in other similar contexts, and propose a new monitoring design. The new design should include a detailed plan for implementation and a means for evaluating the relative efficiency and effectiveness of the new design.

Proposals for testing alternative approaches to service delivery should describe current delivery operations, review alternative approaches which have been shown to be practical in other similar contexts, and propose an experimental methodology for comparing the alternative approaches. The discussion of methodology should include a detailed plan for research implementation and the quantitative/qualitative methods employed in comparing alternative approaches.

Proposals for research on operational problems should describe the problem situation (i.e., the discrepancy between actual and expected program performance), isolate a research question, discuss alternative explanation, review findings of past research on similar problems, and propose a research activity which will identify the problem's source. The discussion of the research activity should detail the plan for research implementation, describe the quantitative/qualitative methods employed in the research, and suggest how research results will contribute to the design of more effective program operations.

In reviewing operations research proposals, OR Technical Group should be certain that the proposal is comprehensive in these respects. Important considerations in the development of proposals and in their review are the following points:

1) The timeliness of the problem: Does it currently exist and will it likely persist?

2) The breadth of the problem: Does it affect a large segment of the population?

3) The depth of the problem: Does it warrant a major research undertaking?

4) The approach to the problem: Does the research design address the problem and its potential sources?

5) The solvability of the problem: Will the research likely uncover problem sources and aid in guiding program implementation?

The lead institution for the Second Family Health Survey is the Ministry of Health (MOH) under the direction of the Director General of MOH. The MOH will receive survey design and data production support from the Ministry of Planning's Central Statistics Department (CSD). The Survey activity will be carried out in collaboration with the contractor (to be determined) for the AID centrally-funded Demographic and Family Health Surveys project.

The lead institution for the contraceptive social marketing program is the Somali Family Health Care Association, which will monitor, through its OR Unit the CSM Unit. The CSM Unit will have an organizational structure as presented in Table The Director will be responsible for building a marketing and management team that can meet the program's objectives and manage the diverse set of activities required to implement the program. He/she will also be responsible for on-going contacts with the Advisory Board, and liaison with all family health-related institutions.

B. Technical Assistance

The long-term operations research advisor will serve advisory, coordinating, and supervisory functions. As an advisor, the individual will assist the Somali Research Associate to develop evaluative and operations research proposals which will be reviewed by OR Technical Group for approval. The advisor will collaborate and coordinate with counterpart evaluative/management units within relevant service delivery institutions in developing proposals and in implementing operations research activities. The Research Associate with the Advisor will supervise all approved operations research activities.

In addition to ongoing, small-scale activities, the OR Unit will initiate, coordinate, and supervise larger-scale operations research projects. The advisor will assist in the design of up to three of these projects for which short-term technical assistance will be available. The timing and workscope for short-term technical assistance will be developed by the advisor and Research Associate. These projects might focus on operations of IEC, service delivery, and social marketing programs. Again, the design for these larger-scale projects will be developed in collaboration with relevant service delivery institutions. The design will be presented in proposal form to the OR Technical Group for formal approval.

Short-term technical assistance in this component will serve advisory functions. This includes the short-term consultants for the three operations research projects and for the Second Family Health Survey. The long-term technical advisor and short-term consultants for operations research work and the social marketing program will be provided through the FHS contract. Short-term consultants for the Second Family Health Survey will be provided by the contractor for the Demographic and Family Health Surveys Project through a Mission add-on to that contract.

C. Training

Study tours are planned for the counterpart staff who will work with this component. One study tour will serve to orient the Research Associate to the various OR activities being undertaken in similar programs in Asia and Africa. Other study tours will orient the CSM staff to similar activities and their management in Sri Lanka, Bangladesh, and Egypt.

One short-term, in-country training activity on Operations Research and several training programs on family health/contraceptive marketing for the CSM staff are planned under this component of the FHS Project. Training in operations research methods and applications to family health programs will be provided by the FHS contractor to evaluative/management units of the relevant service delivery institutions, including: Ministry of Health, Ministry of Education, Somali Women's Democratic

Organization, and Somali Family Health Care Association. Trainees will be identified by the long-term operations research advisor in consultation with leaders of participating institutions. The CSM staff will be trained by the technical advisor and other local experts.

D. Procurement of Commodities

Commodities to be procured for this component include contraceptives (these are specified under Component 3), vehicles, office equipment, and raw materials for packaging and promotional materials. Training materials incidental to the operations research training seminar will be provided by the FHS contractor.

E. Disbursement of Funds

Primary responsibility for disbursing funds for local costs in component activities rests with the Somali Family Health Care Association. The Secretary General of SFHCA will identify an accounting unit/person who will establish a system of financial accounting compatible with CIPL disbursement procedures. The CSM Unit will manage its own accounts.

F. GSDR Logistical Support

Little logistical support will be required for technical assistance and training activities provided under this component. SFHCA will provide classroom and supplies for the operations research training seminar. For the second Family Health Survey, MOH will provide guides and interviewers.

G. Implementation Schedule

The implementation schedules for component activities to take place in the 60 months of the FHS project, the Operations Research Activities, the activities related to the Second Family Health Survey, and to the Social Marketing Program follow:

Contraceptive Social Marketing

Month	Event	Provided By
14	CSM Advisor arrives. Assists to set up CSM Unit; hire Director, Marketing Manager and Office and Finance Manager	Contractor
15	Activate Advisory Board; prepare marketing plan. Plan for testing of prices, brand names, packaging designs.	Advisor/ CSM Unit
16	Conduct tests.	CSM Unit/ Advisor
17	Decide on brand name and packaging (Advisor leaves)	CSM Unit/ Advisory Board
18-19	Produce packaging and promotional materials	CSM Unit (overseas)
20	Set up packing system. Recruit field staff. Advisor returns. Start packing of contraceptives. Train field staff.	CSM Unit Contractor CSM Unit
21	Launch sales in all urban areas simultaneously. Advisor leaves.	CSM Unit Advisor
24-25	Study tours for CSM staff.	Contractor
30	Advisor returns. Evaluation of CSM performance	OR Unit/ Contractor
31	Advisor leaves.	

Operations Research Activities (except Family Health Survey)

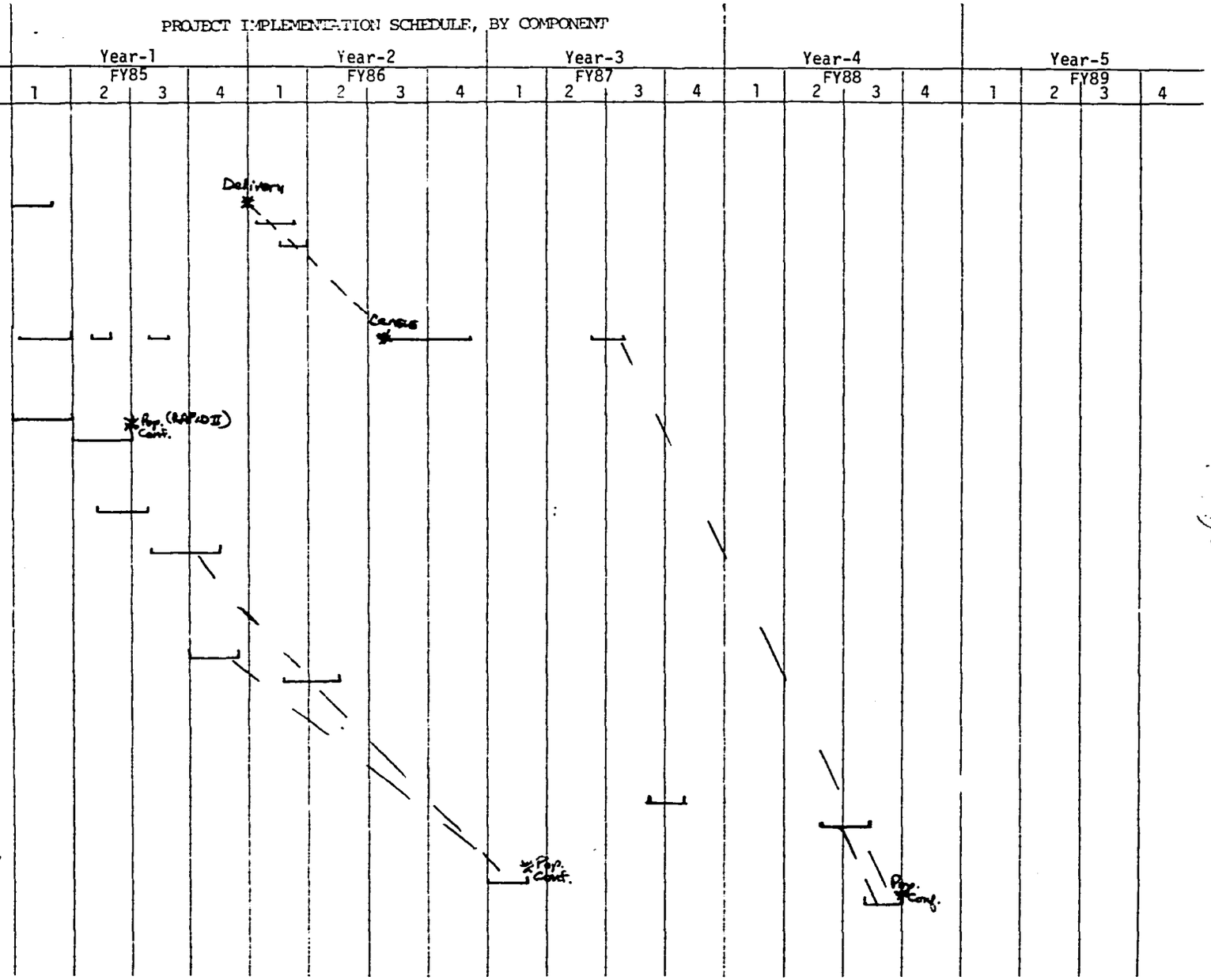
Month	Event	Provided By
25	Long-term advisor arrival: 24-month assignment (Operations Research Specialist)	FHS contractor
27	Counterpart associate hired: 34-month position	SFHCA
28	Operations research training: 3-week TDY (2 Operations Research Specialists)	FHS contractor
32	Operations research support, Project 1: 4-week TDY (Operations Research Specialist)	FHS contractor
35	Operations research support, Project 1: 4-week TDY (Operations Research Specialist)	FHS contractor
38	Operations research support, Project 2: 4-week TDY (Operations Research Specialist)	FHS contractor
41	Operations research support, Project 2: 4-week TDY (Operations Research Specialist)	FHS contractor
44	Operations research support, Project 3: 4-week TDY (Operations Research Specialist)	FHS contractor
47	Operations research support, Project 4: 4-week TDY (Operations Research Specialist)	FHS contractor

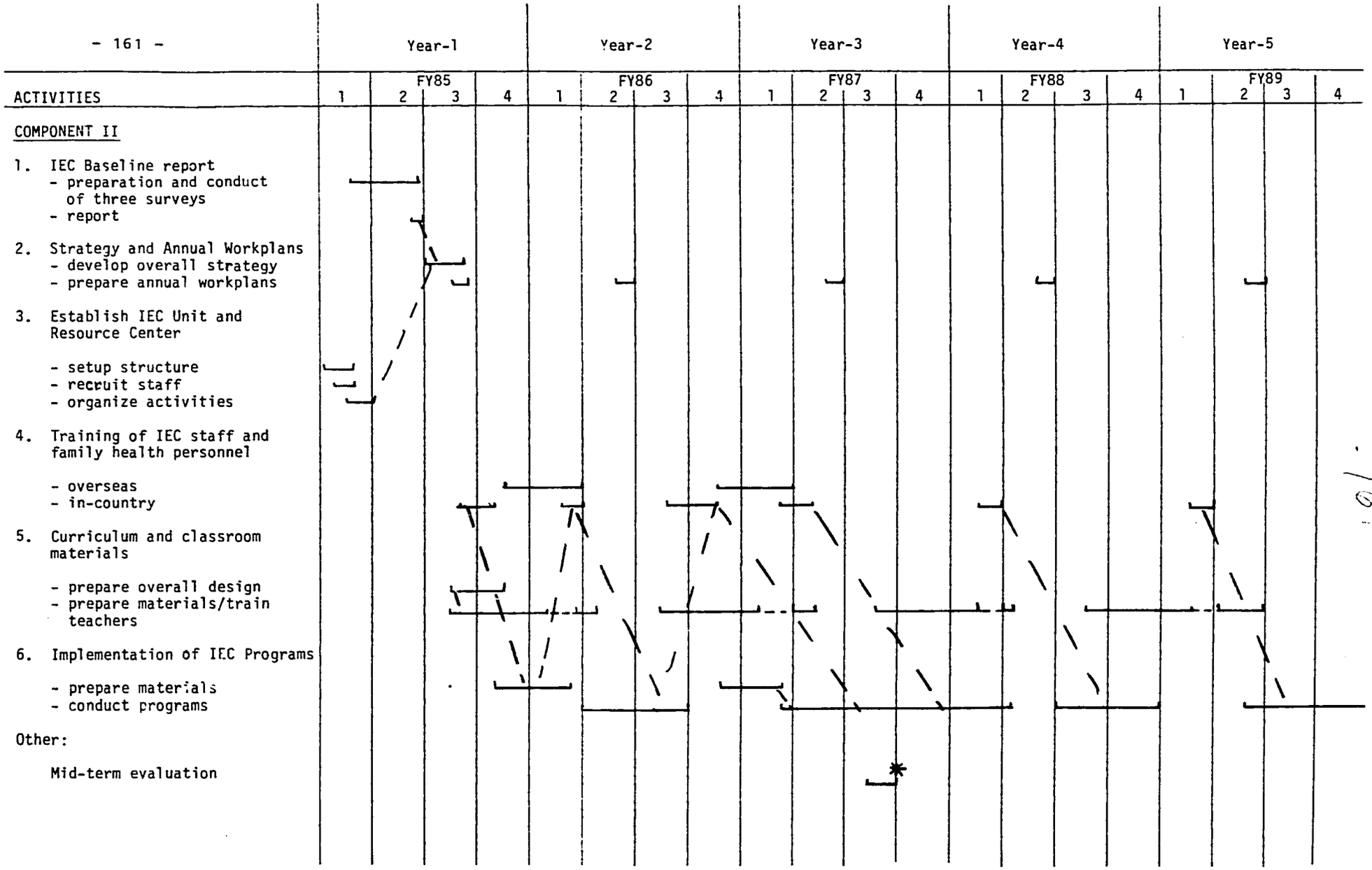
FHS Survey

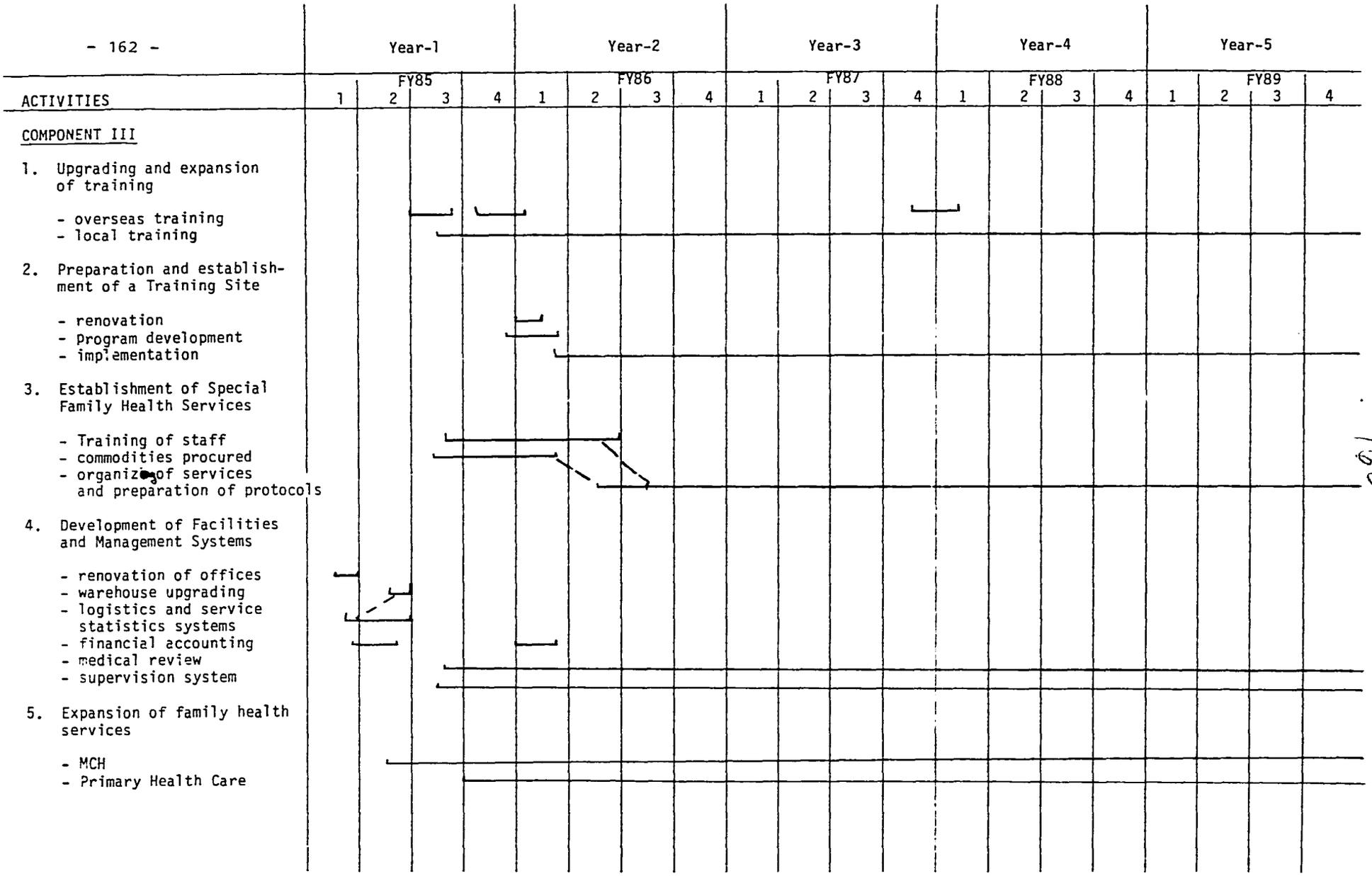
Month	Event	Provided By
33	Survey design support: 2-week TDY (Project Monitor)	DFHS contractor
35	Questionnaire design support: 4-week TDY (Focus Group Expert) 2-week TDY (Project Monitor)	DFHS contractor
37	Sampling design support: 3-week TDY (Sampling Statistician)	DFHS contractor
38	Pretest Support: 3-week TDY (Project Monitor)	DFHS contractor
41	Interviewer training and field-work inspection: 4-week TDY (Project Monitor)	DFHS contractor
43	Questionnaire coding and editing support: 2-week TDY (Project Monitor)	DFHS contractor
45	Computer editing support: 3-week TDY (Data Processor)	DFHS contractor
47	Data analysis support: 3-week TDY (Project Monitor)	DFHS contractor

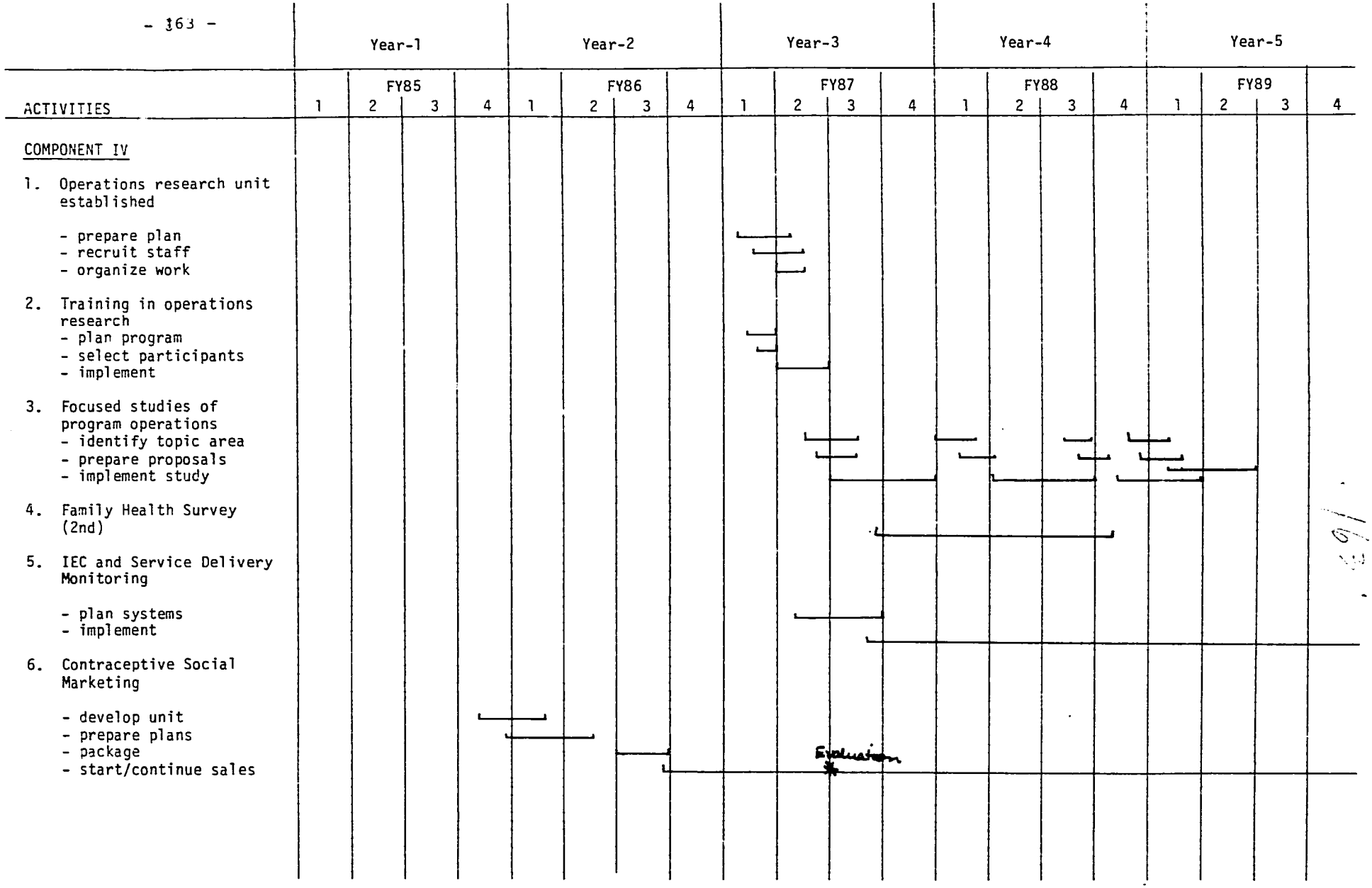
PROJECT IMPLEMENTATION SCHEDULE, BY COMPONENT

ACTIVITIES	Year-1 FY85 1	2	3	4	Year-2 FY86 1	2	3	4	Year-3 FY87 1	2	3	4	Year-4 FY88 1	2	3	4	Year-5 FY89 1	2	3	4
COMPONENT I																				
1. Upgrading computer hardware & software																				
- Computer procurement																				
- Computer training																				
- CENTS 4 Training																				
2. Census sampling, Questionnaire, Data Processing Design, and Post-enumeration coverage																				
- technical assistance																				
3. Analysis of 1980 Population Survey																				
- DDD assistance in analysis																				
- FHS/DDD reporting on results																				
4. Analysis of the 1982 Settlement Survey																				
- INPLAN assistance in analysis																				
- FHS/INPLAN reporting of results																				
5. Demographic Studies																				
- Technical assistance through Centrally-funded Contractor #1																				
#2																				
6. Workshops in Data Analysis and Planning																				
- Technical assistance through Centrally-funded Contractor #1																				
#2																				
7. National Pop. Conferences																				
- Tech. Asst. through Centrally funded contractor #1																				
#2																				



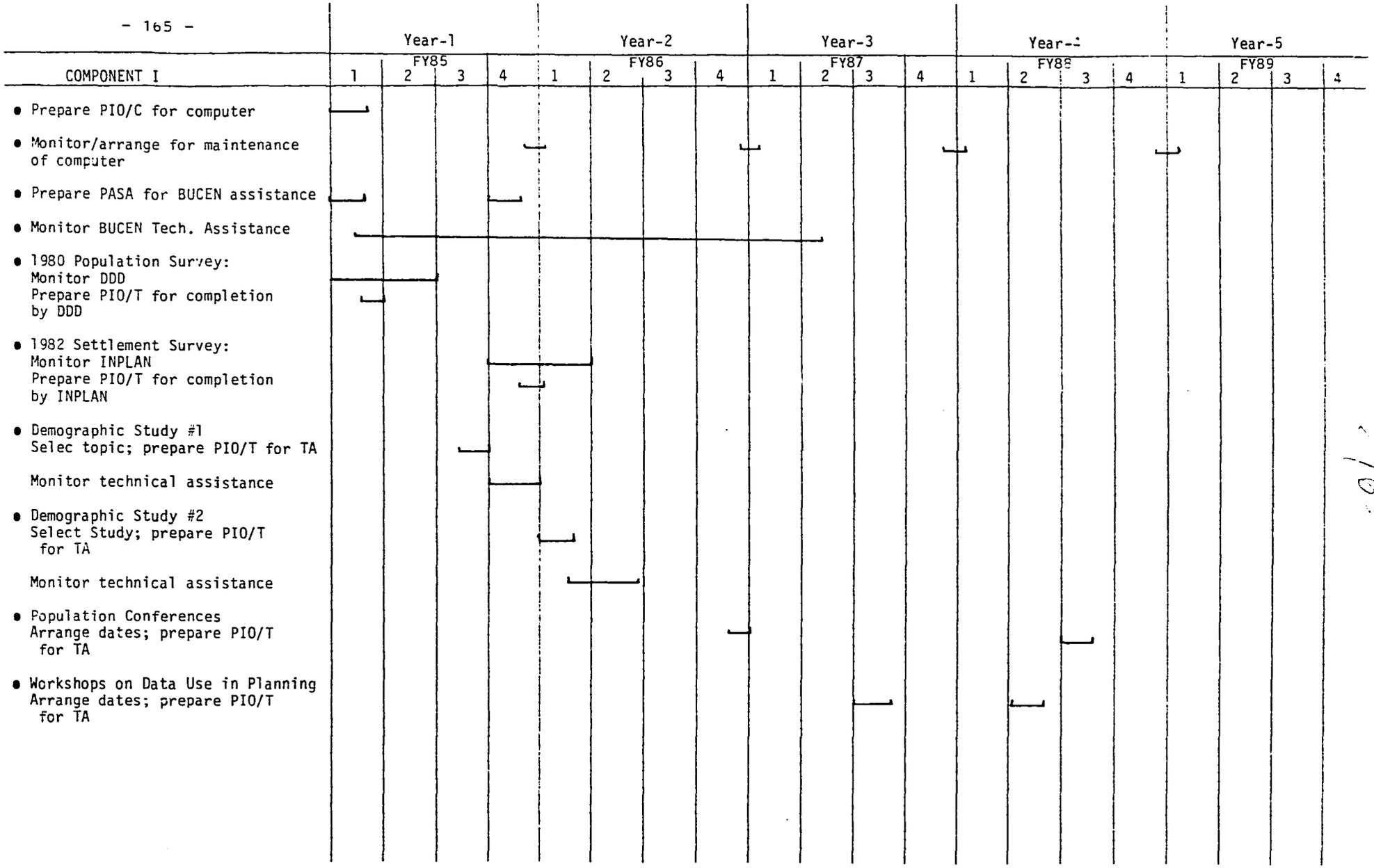

Year-1
Year-2
Year-3
Year-4
Year-5
FY85
FY86
FY87
FY88
FY89
ACTIVITIES
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
COMPONENT II
1. IEC Baseline report
- preparation and conduct of three surveys
- report
2. Strategy and Annual Workplans
- develop overall strategy
- prepare annual workplans
3. Establish IEC Unit and Resource Center
- setup structure
- recruit staff
- organize activities
4. Training of IEC staff and family health personnel
- overseas
- in-country
5. Curriculum and classroom materials
- prepare overall design
- prepare materials/train teachers
6. Implementation of IEC Programs
- prepare materials
- conduct programs
Other:
Mid-term evaluation


Year-1
Year-2
Year-3
Year-4
Year-5
FY85
FY86
FY87
FY88
FY89
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
ACTIVITIES
COMPONENT III
1. Upgrading and expansion of training
- overseas training
- local training
2. Preparation and establishment of a Training Site
- renovation
- program development
- implementation
3. Establishment of Special Family Health Services
- Training of staff
- commodities procured
- organizing of services and preparation of protocols
4. Development of Facilities and Management Systems
- renovation of offices
- warehouse upgrading
- logistics and service statistics systems
- financial accounting
- medical review
- supervision system
5. Expansion of family health services
- MCH
- Primary Health Care

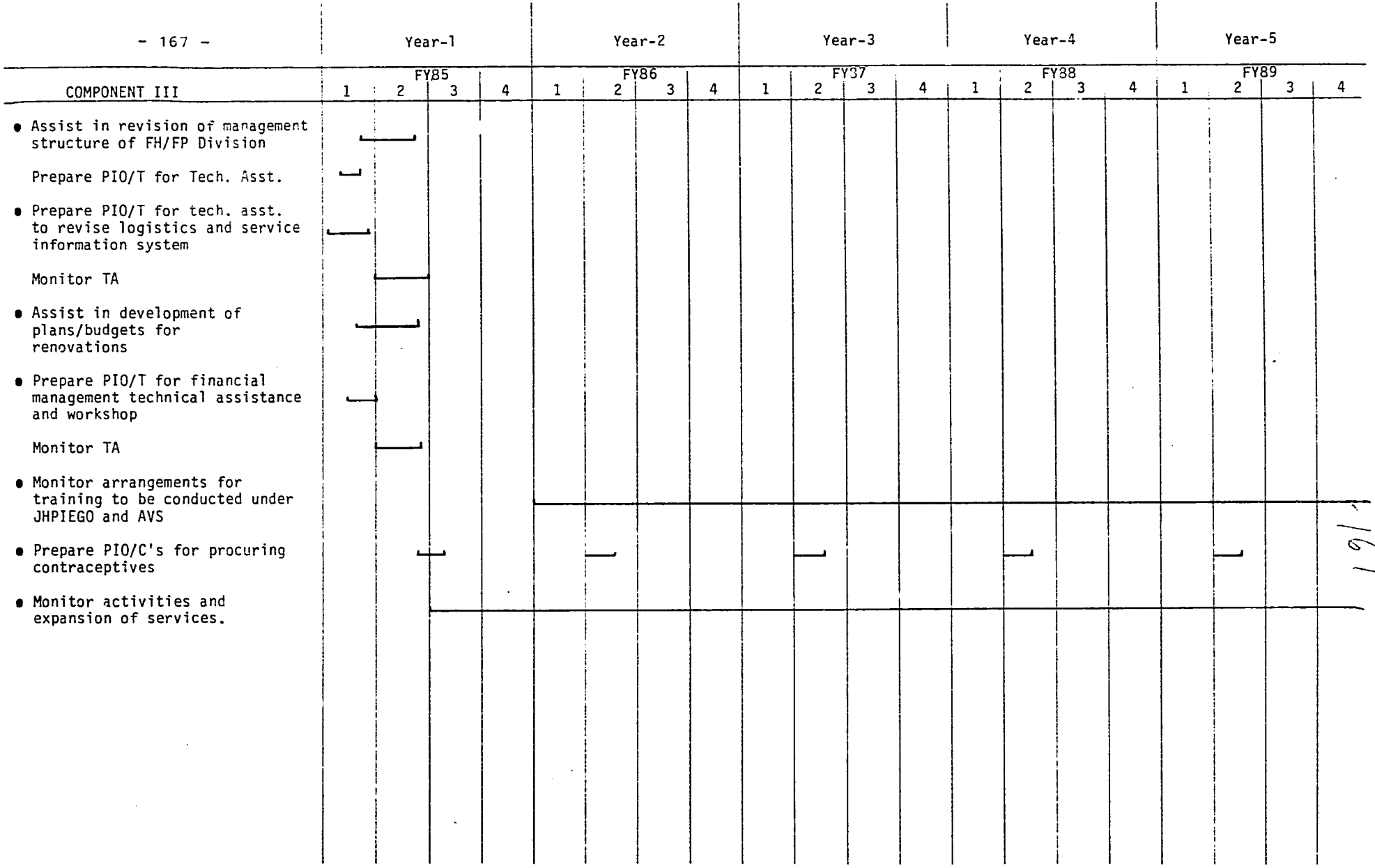

Year-1
Year-2
Year-3
Year-4
Year-5
FY85
FY86
FY87
FY88
FY89
ACTIVITIES
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
COMPONENT IV
1. Operations research unit established
- prepare plan
- recruit staff
- organize work
2. Training in operations research
- plan program
- select participants
- implement
3. Focused studies of program operations
- identify topic area
- prepare proposals
- implement study
4. Family Health Survey (2nd)
5. IEC and Service Delivery Monitoring
- plan systems
- implement
6. Contraceptive Social Marketing
- develop unit
- prepare plans
- package
- start/continue sales
Evaluation

USAID MANAGEMENT ACTIVITY SCHEDULE

ACTIVITIES UNDER USAID PROJECT MANAGEMENT	Year-1				Year-2				Year-3				Year-4				Year-5			
	FY85				FY86				FY87				FY88				FY89			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
OVERALL PROJECT																				
• Final Preparations for Project Implementation																				
- Assure that CP's are met																				
- ProAg signed																				
• Formation of Project Coordinating Comm. PIO/T for technical assistance																				
• RFP sent to AID/W; procedures to select contractor implemented																				
• Assist MOH regarding office renovation																				
• Logistics support of Contractor prepared																				
• Assist SFHCA in office move																				
• PIO/C's for initial batch of commodities prepared. (See Procurement list for those to be ordered first.)																				
• Assist in preparation of all CIPL budgets																				
• Contractor arrives in-country-assist in orientation																				
• Review Contractor plans and reports																				
• Preparations for 1st Eval.																				
• Preparations for 2nd Eval.																				


Year-1
Year-2
Year-3
Year-4
Year-5
FY85
FY86
FY87
FY88
FY89
COMPONENT I
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
• Prepare PIO/C for computer
• Monitor/arrange for maintenance of computer
• Prepare PASA for BUCEN assistance
• Monitor BUCEN Tech. Assistance
• 1980 Population Survey:
Monitor DDD
Prepare PIO/T for completion by DDD
• 1982 Settlement Survey:
Monitor INPLAN
Prepare PIO/T for completion by INPLAN
• Demographic Study #1
Selec topic; prepare PIO/T for TA
Monitor technical assistance
• Demographic Study #2
Select Study; prepare PIO/T for TA
Monitor technical assistance
• Population Conferences
Arrange dates; prepare PIO/T for TA
• Workshops on Data Use in Planning
Arrange dates; prepare PIO/T for TA

COMPONENT II	Year-1				Year-2				Year-3				Year-4				Year-5			
	FY85				FY86				FY87				FY88				FY89			
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
• Assist in set-up of IEC Unit																				
Prepare PIO/T for technical assistance																				
• Arrange logistics and prepare agencies for Population Communication Services Conduct of Baseline Surveys																				
• Assist in orientation of long-term advisor																				
Monitor development of Strategy and workplan																				
• Monitor activities of agencies (See Implementation Plan)																				


Year-1
Year-2
Year-3
Year-4
Year-5
FY85
FY86
FY37
FY38
FY89
COMPONENT III
1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4 1 2 3 4
• Assist in revision of management structure of FH/FP Division
Prepare PIO/T for Tech. Asst.
• Prepare PIO/T for tech. asst. to revise logistics and service information system
Monitor TA
• Assist in development of plans/budgets for renovations
• Prepare PIO/T for financial management technical assistance and workshop
Monitor TA
• Monitor arrangements for training to be conducted under JHPIEGO and AVS
• Prepare PIO/C's for procuring contraceptives
• Monitor activities and expansion of services.

COMPONENT IV	Year-1				Year-2				Year-3				Year-4				Year-5			
		FY85				FY86				FY87				FY88				FY89		
	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4	1	2	3	4
• Assist in orientation of long-term advisor																				
• Monitor preparations for and implementation of OR Study 1 OR Study 2 OR Study 3 OR Study 4																				
• Arrange for technical assistance for 2nd Family Health Survey PIO/T																				
Monitor implementation																				
• Social Marketing - assist in orientation of advisor																				
Monitor activities.																				

SECTION 16.0 SCOPES OF WORK FOR LONG-TERM AND SELECTED SHORT-TERM TECHNICAL ASSISTANCE

ANNEX 8

LONG-TERM INFORMATION, EDUCATION AND COMMUNICATIONS/ADVISOR

SCOPE OF WORK

A. Objectives.

The long-term advisor will be responsible for accomplishing the following:

- o the establishment of an IEC Unit and Resource Center at Somali Family Health Care Association
- o the development of on-going management procedures for planning, programming, monitoring, and evaluating the IEC activities of the IEC Unit and the cooperating agencies
- o upgrading of the design, pretesting, production and utilization of IEC materials for family health and the development of innovative approaches conducive to greater acceptance of family health in Somalia.

Insofar as the IEC Advisor is also the Chief of Party for the technical team in-country, he/she will also be responsible for the implementation of the other two components of the Project under the Contract: Clinical Family Health Services and Operations Research.

B. Outputs Required.

As Chief of Party, the IEC Advisor will be responsible for all plans and reports required of the Contractor; further, he/she will be responsible for assuring the timeliness and quality of all reports and related materials developed by long- and short-term technical advisors under the Contract.

For the IEC Component, the Advisor will be responsible for: completion of an Overall Strategy for IEC for Family Health in Somalia; preparation of Annual Workplans which encompass the objectives and activities of each cooperating agency as well as the joint activities; submission of Quarterly Reports on the progress and problems in the implementation of activities planned; all products (materials) to be developed for utilization in IEC activities: posters, pamphlets, radio programs, training manuals, guidelines on use of materials, and slide sets; and reports on the findings of evaluations (unless undertaken as a part of Operations Research).

C. Activities.

As the Chief of Party, the Advisor will undertake the following activities to meet his/her obligations in that role:

- o conduct periodic staff meeting of the long-term advisors and other contractor staff to plan and monitor contract work;

- o brief and de-brief all short-term advisors who work under the contracts;
- o prepare annual workplans and quarterly reports to be submitted to USAID and GSDR;
- o Take action to resolve any problems which come up in the implementation of the Project and bring those of importance to the attention of the USAID Project Monitor;
- o meet periodically with GSDR counterpart staff in the participating agencies (of the other two components);
- o supervise the office and contractor staff;
- o assist the Project Coordinating Committee in planning and conducting their quarterly meetings;
- o provide any other assistance which might be needed to coordinate and implement the activities of the participating agencies.

As the Advisor to IEC, he/she will undertake these activities to achieve the desired objectives/outputs:

- o meet periodically with all of the participating agencies to ascertain progress and problems with their implementation of IEC activities;
- o on a daily basis, work with the staff of the IEC Unit of the SFHCA, in planning, programming, monitoring, and evaluating the IEC activities;
- o assist in the planning and implementation of all meetings of the IEC Technical Group;
- o assist in the preparation of the IEC annual workplan;
- o work with the staff in the participating agencies according to a schedule agreed upon and in accordance with the annual work plan;
- o plan and conduct training programs for the staff of the IEC Unit and implementing agencies;
- o assist in the planning for and preparation of all IEC materials;
- o provide guidance and, where necessary, training to the staff of the various implementing agencies in their preparations for and implementation of their activities;

- o draw up specificatons for IEC equipment and materials to be ordered under the contract;
- o develop plans for the distribution of the IEC equipment and materials prior to their arrival in-country, and assist in carrying out these plans;
- o develop plans for modest evaluations of the materials and programs carried out under the Project;
- o identify needs for short-term consultants, prepare scopes of work and assist in the recuritment of all short-term IEC consultants under the contract;
- o with the Somali counterparts, identify appropriate candidates, specify their training needs, and arrange for short-term training and study tours;
- o train or assist in identifying a person qualified to train the staff in the use of IEC equipment and its maintenance;
- o develop plans with the IEC Unit for the regular maintenance of the IEC equipment;
- o assist in preparation of procedures for the management of the IEC Resource Center;
- o review all IEC activities and materials with USAID Project Monitor on at least a quarterly basis.

The Advisor, as a counterpart to the Somali staff in IEC, will work a 6-day week.

D. Responsibility/Relationships

As Chief of Party, the IEC Advisor will report directly to the USAID Project Monitor. The Advisor will also report on a regular basis and work with the following staff/groups as counterparts: the Executive Director of the SFHCA, as head of the Secretariat of the Project Coordinating Committee (PCC); the SFHCA staff who work with the PCC; the Chairperson of the Project Coordinating Committee; and the Committee as a whole. The Advisor will attend all meetings of the Project Coordinating Committee. He/she will supervise the Administrative Aide and other local-hire staff; he/she will supervise all short-term advisors to the Project.

The IEC Advisor, in his/her role with the IEC Unit, will work directly with the IEC Unit staff of the SFHCA; the director of the IEC Unit will serve as his/her chief counterpart. He/she will also collaborate with the IEC Technical Group and with the group's individual members in their capacities as heads of the IEC programs of the participating institutions. He/she will directly supervise and monitor the work of all short-term consultants who work in IEC.

E. Anticipated Problems or Constraints

The IEC Unit of the SFHCA is a new institution initiated for the purposes of this project; as such, it will be forging its relationships with the participating agencies and establishing lines of communication and responsibilities. Most of the participating agencies are new to the field of family health and have not previously worked closely together. While there are no known major personality conflicts, these may arise. The staff have presently limited skills in IEC, and some may have limited ability to communicate in English. Facilities for preparation and reproduction of materials are also very limited.

F. Qualifications Required/Desired

1. Required:

Education: Master's Degree or equivalent in Communications, Health Education or a Social Science discipline.

Experience: At least five years' experience in the development of IEC programs in family health or related field in at least two developing countries.

Specific Skills : Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to write clearly and speak using simple English; ability to wrok well on his/her own.

2. Desired:

Education: Doctoral level degree in Communications, Health Education, or related Social Science discipline.

Experience: Experience in a Muslim society and Africa.

Other : Knowledge of Somali, ARabic and/or Italian; skills in operation and maintenance of IEC equipment.

ADMINISTRATIVE AIDE

JOB DESCRIPTION

Summary

The Administrative Aide has a diverse set of responsibilities related to all aspects of the work of the contract. The AA will make all arrangements for the travel, per diem, and creature comforts for short-term advisors coming to Somalia and for short-term and study tour participants going from Somalia to the U.S. and third countries. The AA will prepare orders and monitor progress on the procurement of all commodities under the contract, including those for use by the counterpart agencies and the contractor; once received, the AA will inventory and distribute them as planned; for supplies and equipment under the control of the contractor, the AA will monitor maintenance needs and supplies so that reorders can be made in a timely manner. The AA will foster good relations with all counterpart agencies and USAID so as to keep informed and to keep them informed of pertinent events. The AA will be responsible for submitting all routine reports to GSDR and USAID in a timely manner; he/she will also be responsible for maintaining communications with the U.S.-based office of the contracting agency.

The Administrative Aide will report to the Information, Education, and Communications Advisor, the Chief of Party.

Specific Duties

The specific duties of the AA are these:

Short-Term Consultants:	Keep track of travel schedules
	Arrange for lodging and other creature comforts
	Arrange travel, internal and external
	Distribute per diem
Short-Term Training and Study Tours :	Monitor schedules
	Make travel arrangements
	Arrange for per diem and other payments
	Manage any correspondence and/or telecommunications required

	Request and file reports when they return from training
Commodity Procurement :	Identify needs for supplies and equipment
	Prepare orders and submit
	Complete all needed paperwork
	Monitor progress in filling and shipping orders
	On arrival, arrange for liberation from port and any needed storage
	Distribute to agencies or offices
	For contractors goods, monitor maintenance of vehicles and other hardware, paper and other office supplies.
Reporting and Paperwork:	Prepare drafts of all routine reports for review by team leader, in a timely manner
	Direct incoming correspondence to appropriate persons and manage responses as appropriate

The administrative aide will meet periodically and undertake other activities to foster good relations with the counterpart agencies.

Supervision:	Will supervise the secretary and other support staff

LONG-TERM TRAINING AND MANAGEMENT SYSTEMS ADVISOR

SCOPE OF WORK

A. Objectives

The long-term advisor will be responsible for accomplishing the following:

- o the development and implementation of management systems/procedures for: financial management; logistics (commodities management); service statistics; planning/scheduling/budgeting/monitoring; medical review and quality control; vehicle use; personnel management and supervision.
- o upgrading of the family health training staff (unit) within the Family Health/Family Planning Division and the expansion and upgrading of the programs and materials produced
- o the delivery of effective, high quality family health services.

B. Outputs Required

The Advisor will be responsible for: preparation of annual workplans which include the objectives and activities of the FH/FP Division and cooperating medical institutions (e.g. Benaadir Hospital); submission of Quarterly Reports on the progress and problems in the implementation of activities planned; all products developed for the implementation of the management systems mentioned under "Objectives" above, i.e. formats and descriptions of procedures to be followed; plans for training programs, curricula and training materials, and evaluation forms (competency-based tests and other assessment tools); reports on the findings of evaluations (unless undertaken as a part of Operations Research); and status reports for all participant training conducted under this Component.

C. Activities

The Advisor will undertake these activities to achieve the desired objectives/outputs:

- o work with the staff of the FH/FP Division and related implementing agencies/divisions in the Ministry of Health to develop an Annual workplan for family health services;
- o work with the Director and Deputy Director to assess and fine-tune the organizational structure and job descriptions of the Division;
- o work with the appropriate staff to monitor the personnel and supervision system, identify any problems, and implement solutions;

- o work with the appropriate staff to plan and implement the medical review and quality control procedures;
- o work with the appropriate staff to monitor the logistics and service statistics systems, identify any problems, and implement solutions;
- o work with the appropriate staff to monitor the financial management system, identify any problems and implement solutions;
- o work with the appropriate staff to implement a system for managing vehicle use;
- o work with the appropriate staff to plan and implement a system for planning/scheduling/budgeting and monitoring;
- o work with the staff of the Training Unit to plan and schedule training programs;
- o review all training materials and training designs and work with the Training Unit staff to make any revisions required to upgrade them;
- o assess the delivery of family health services (field trips) on a regular basis and recommend corrective action;
- o with Somali counterparts, identify training needs for staff recommend U.S. or third-country training programs, and arrange for their training;
- o identify technical assistance requirements, prepare scopes of work, and identify most suitable candidates to provide the assistance;
- o plan and conduct training programs for family health and other staff as needed to increase their management and other skills;
- o draw up specifications, as needed for clinical equipment and materials to be ordered under the contract;
- o develop plans for the distribution of the equipment prior to its arrival in-country, and assist in carrying out these plans;
- o coordinate all non-contract inputs to the clinical areas, e.g. from JHPIEGO and AVS;
- o review all clinical family health services activities and materials with the USAID Project Monitor on at least a quarterly basis.

The Advisor, as a counterpart to the Somali staff in Clinical Family Health Services, will work a 6-day week.

D. Responsibility/Relationships

The Training and Management Systems Advisor will report directly to the Chief of Party on the Contract, the long-term IEC Advisor. The Director of the Family Health/Family Planning Division of the Ministry of Health will be his/her chief counterpart; however, the advisor will also work closely with the Central Office and Regional staff who have responsibility for managing the various functions of the program and implementing family health services. He/she will directly supervise and monitor the work of all short-term consultants who work with the clinical family health services.

E. Anticipated Problems or Constraints

The Family Health/Family Planning Division was established in 1981 and has grown quickly in the last three years. Various problems have reduced the effectiveness and the fficiency of operations of the Division. Among these are limited vehicles, communications among the other health service divisions, inadequate office space, and lack of skills in basic management procedures for logistics, finances, filing, and the like.

F. Qualifications Required/Desired

1. Required:

Education:	Master's Degree in Health or Population Field or some related Management area. Complementary training in health/family planning or management.
Experience:	At least three years of work in developing countries in the development of training programs and trainers geared to competency-based training, and management capabilities in family health (family planning) programs. On-site, on-the-job training of counterpart staff in training and management skills.
Specific, Other Skills :	Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult working and living conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to write clearly speak using simple English; ability to write documents and procedural manuals; ability to work well on his/her own.

2. Desired:

Education:	Doctoral level degree in Health/Population, Management Sciences or Adult Education; M.D. R.N. degree **
Experience:	Two or more years working in African and/or Muslim countries; development of management and training systems for family health programs just being started and expanding fairly rapidly; development of family health programs delivered through government health services.
Other	Knowledge of Somali, Arabic, and/or Italian.

** Medical knowledge/skills highly desirable; however, not critical if short-term technical assistance used to provide needed inputs.

LONG-TERM OPERATIONS RESEARCH ADVISOR

SCOPE OF WORK

A. Objectives

The long-term advisor will be responsible for accomplishing the following:

- o the establishment of an Operations Research (OR) Unit at the Somali Family Health Care Association
- o the development of standard procedures for initiating, developing, planning, implementing and reporting operations research studies
- o development/installation of monitoring and evaluation systems for clinical family health services and IEC.

B. Outputs Required

The Advisor will be responsible for: the development of annual work plans for OR which will include the objectives and activities of each cooperating agency; submission of quarterly reports on the progress and problems encountered in the implementation of the activities planned; finalization of proposals for at least three large-scale studies and up to six small-scale studies; completion of the reports on the three large-scale studies and up to six small-scale studies; preparation of plans and related formats for the IEC and Clinical Family Health Services monitoring systems; preparation of the implementation plans and final report for the second Family Health Survey; plans for and report on training programs conducted on operations research.

C. Activities

The Advisor, as a counterpart to Somali staff in OR, will work a six-day week. He/she will undertake these activities to achieve the desired objectives/outputs:

- o develop cooperative relationships with the management and evaluation staff of each of the participating agencies;
- o conduct meetings with the OR Technical Group to lay out policy guidelines relating to OR activities and evaluation systems, prepare annual work plans, review progress and discuss problems and their solutions;
- o on a daily basis, work with the staff of the OR Unit in planning, programming, monitoring, and evaluating OR activities;

- o assist in the design and preparation of plans for all OR studies;
- o monitor the implementation of the OR studies;
- o analyze data and prepare reports from the OR studies;
- o assist the managers and other program staff to identify actions indicated by the results of the studies and to plan for their implementation;
- o identify training needs and prepare and conduct training workshops on operations research;
- o work with staff in the participating agencies according to the schedule agreed upon and in accordance with the annual work plan;
- o review proposals for operations research studies and make recommendations about their implementation;
- o prepare monitoring systems for the IEC and Clinical Family Health Services components;
- o identify needs for short-term consultants, prepare scopes of work, and assist in the recruitment of all short-term consultants for OR under the contract;
- o arrange for the study tour of the Somali OR counterpart;
- o review all OR activities and materials with the USAID Project Monitor on at least a quarterly basis.

D. Responsibility/Relationships

The advisor will report directly to the Chief of Party on the Contract, the long-term IEC Advisor. The Research Associate of the Operations Research Unit of the SFHCA will be his/her chief counterpart; the advisor will also collaborate with the OR Technical Group and with the group's individual members in their capacities as head of the evaluation/management units of the participating institutions. He/she will directly supervise and monitor the work of all short-term consultants who work with OR.

E. Anticipated Problems or Constraints

The OR Unit of the SFHCA is a new institution initiated for the purposes of this project; as such, relationships will have to be developed and lines of communication established with the institutions involved. The preceding experience with the IEC Unit will be helpful to the OR Unit in identifying successful and unsucessful approaches.

Operations Research and on-going monitoring and evaluation systems are new, particularly in the field of health and family health. The need and utility of these skills and activities will have to be demonstrated and the managers shown its value to their programs. Staff available and particularly staff with the desired skills are very limited.

F. Qualifications Required/Desired

1. Required

Education:	Master's Degree in Social Science or Health field; training in quantitative research methods.
Experience:	At least three years of work in developing countries in operations research, program evaluation, and program design; at least three years work with family planning and health programs.
Specific Other Skills:	Proven ability to work well with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to write clearly and speak using simple English; ability to work well on his/her own.

2. Desired

Education:	Doctoral level degree in Social or Health Statistics Sciences, or related discipline
Experience:	Two or more years working in African and/or Muslim country.
Other:	Knowledge of Somali, Arabic, and/or Italian. Skills in data processing, programming and computer use.

CURRICULUM DEVELOPMENT ADVISOR (SHORT-TERM)

SCOPE OF WORK

(The short-term advisor will come to Somalia for four six-month assignments during the life of the Project.)

A. Objectives

The Advisor will be responsible for accomplishing the following:

- o the development of curriculum outline for the teaching of family health and related health topics for Grades 1-12
- o the development of teaching materials for each grade level in family health and related health topics (materials include student texts, teacher guides, AV kits, and supplementary materials).
- o the preparation of materials for training the teachers responsible for teaching of family health in the schools
- o implementation of a pre-test for the materials prepared in selected regions of Somalia

B. Outputs Required

The Advisor will be responsible for the following: the preparation of a work plan at the beginning of each visit to Somalia (which is reviewed and agreed on by the CDC and contractor); submission of monthly reports on progress and problems encountered in implementing of planned activities; an overall outline (syllabus) of health education for all grades 1-12 in family health; materials for students and teachers; pre-test plan for the materials; reports on the pre-test results and recommendations for revision of the syllabus and materials.

C. Activities

The Advisor, as a counterpart to Somali staff at the Curriculum Development Center will work a six-day week.

He/she will undertake these activities to achieve the desired objectives/outputs:

- o assist in the formation of a health education curriculum unit within the Curriculum Development Center;
- o conduct a needs assessment for content/skills to be included in the curriculum for grades 1-12 (assessment should include study of the physical and other constraints encountered in the schools);

- o develop an overall strategy for the preparation of the curriculum and component materials and an overall work plan for the preparation of materials, testing, and revision;
- o provide orientation/training to the staff in the areas of family health and health topics;
- o arrange for needed inputs from Ministry of Health and other resources regarding family health and other health topics;
- o identify resources (materials) needs, and order;
- o draft detailed syllabus and materials for each grade;
- o review drafts periodically with CDC director and other officials within the Ministry of Education;
- o develop and maintain contacts with others engaged in health education (Somali and expatriate) formal and informal);
- o assist in organizing and conducting training of teachers in health education and use of prepared materials;
- o generally advise the Ministry on matters dealing with health education;
- o report on a monthly basis to the Chief of Party of the contractors.

D. Responsibility/Relationships

The Curriculum Development Advisor will report directly to the long-term IEC Advisor as this activity comes under the IEC Component. On a day-to-day basis the Advisor will work with the health education curriculum unit within CDC; however, a key counterpart will be the Director of the CDC, who will need to review all plans and products.

E. Anticipated Prob;lems/Constraints

The Curriculum Development Center is just moving to new space and embarking on a Curriculum Reform Project with the ambitious objectives of introducing a new curriculum in the primary and secondary schools and preparing new sets of materials for each subject in each grade. It can be anticipated that there will be delays and problems associated with such an undertaking. Physical facilities for duplicating and preparing materials are being upgraded, but still have limitations.

F. Qualifications Required/DEsired

1. Required

Education:	Master's Degree in Education, Health or related field.
Experience:	At least three years in the development of syllabi and materials for formal, primary and/or secondary shcools in health education; at least two years working in developing countries on similar or related project; conduct of at least three formal tests of materials for the formal education setting.
Specific Skills:	Proven ability to work with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; ability to write clearly and speak simple English; ability to work well on his/her own. skills in design/format of materials; skills in development of learning activities for children.

2. Desired

Education:	Doctoral degree in Education, Health or related field.
Experience:	Living and working in African and/or Muslim country; work with health education in rural and urban developing country setting.
Specific Skills:	Knowledge of Somali, Arabic and/or Italian.

- o assists the Somali counterpart managers to activate the Advisory Board for the CSM program;
- o assists the Somali counterpart managers in planning for the testing of prices, brand names, packaging designs, etc.
- o assists in the implementation of the tests;
- o assists in the analysis of the test results and the preparation of recommendations/plans to be reviewed by the Advisory Board;
- o assists in the planning of the production of the packaging materials;
- o assists in the arrangement for purchase of the materials needed for packaging and promotion;
- o assists in planning for the packing of the contraceptives in Somalia;
- o assists in implementation of the packing system and helps to start;
- o updates plans for sales launch;
- o participates in sales launch in six urban areas simultaneously;
- o assists staff in assessing effectiveness of sales launch and identifying ways to improve activities;
- o works with staff to identify additional areas of need for research and assistance from the Advisor;
- o develops scopes of work and schedule for return visits;
- o prepares reports for each visit;
- o develops plans for study tours by CSM managers and monitors arrangements;
- o debriefs managers on return from study tour;
- o develops and maintains relationship with others involved in similar ventures;
- o reports on a monthly basis and at the beginning and end of each visit to the Chief of Party of the contractor.

D. Responsibility/Relationships

The Contraceptive Social Marketing Advisor will report to the Chief of Party of the contractor, the long-term IEC Advisor. On

CONTRACEPTIVE SOCIAL MARKETING ADVISOR (SHORT-TERM)

SCOPE OF WORK

(The short-term advisor will come to Somalia for visits of 2-4 months during ther four years of the Project.)

A. Objectivs

The advisor will be responsible for accomplishing the following:

- o establishment of a Contraceptive Social Marketing Unit
- o preparation of a CSM strategy and implementation plan
- o implementation of an effective CSM program
- o integration of the CSM program/unit into the Somali Family Health Care Association.

B. Outputs Required

The Contraceptive Social Marketing Advisor will be responsible for the planning and setting up of the unit and all of the activities required for establishing an effective program, including small-scale studies and other marketing research. The Advisor will produce: at the beginning of each trip, a trip workplan with objectives, schedule, and planned outputs; at the end of each trip, a trip report specifying the outputs and outcomes of the trip, problems encountered, and future plans; for each small-scale study, a study design and report of the results; a strategy and implementation plan for the overall program; once implemented, annual reports on sales, projections, and discussion of problems and means to overcome them; and plans for the operation of the unit under the SFHCA.

C. Activities

The Advisor will undertake the following activities in order to achieve the outputs/objectives:

- o meet with Somali counterpart individuals and oragnizations to come to agreement on the form and structure for the Social Marketing Unit and program;
- o develop the terms of reference, job descriptions, and qualificiations for the positions in the Unit;
- o assist in the recruitment and selection of the managers for the Unit;
- o with the counterpart managers of the Unit, develop an overall strategy and workplan for the implementation of CSM;

a day-to-day basis the Admisor will work with the Contraceptive Social Marketing Unit under the Somali Family Health Care Association; therefore, a key counterpart will be the Executive Director of the SFHCA; other key counterparts will include the members of the Advisory Board.

E. Anticipated Problems/Constraints

The SFHCA is a new, untested organization. Therefore, the CSM Unit and the Advisor must be prepared to function somewhat independently, without relying on logistic and other support from the SFHCA. The concept of social marketing is also new in Somalia; as such, there may be some resistance to its activities. Promotion and advertisements must be developed with this constraint in mind.

F. Qualifications Required/Desired

1. Required

Education:	Master's Degree in Business, Marketing or related discipline.
Experience:	At least three years in the development and management of small business enterprises geared to marketing goods; at least three years in developing countries in similar or related projects; conduct of at least five tests of the type required for marketing contraceptives.
Specific Skills:	Proven ability to work with other people (counterparts and expatriates); ability to adapt easily to difficult living and working conditions; flexibility to adjust ways and means in order to meet selected objectives; skills in creative marketing; sensitivity to to the cultural mores of urban/rural societies; ability to write clearly and speak simple English; ability to wrok well on his/her own.

2. Desired

Education:	Doctoral level degree in Business, Marketing or related field.
Experience:	Living and working in African and/or Muslim country; work with contraceptive social marketing program in rural and urban developing country setting.
Specific Skills:	Knowledge of Somali, Arabic and/or Italian.

SPECIALIST IN THE DEVELOPMENT AND IMPLEMENTATION OF PROJECT COORDINATION MECHANISMS

SCOPE OF WORK

A. Objectives

By the end of the first consultation, the consultant will have accomplished the following:

- o preparation of job descriptions of all project staff related to overall project management and coordination;
- o set of guidelines, terms of reference, and specific structure and responsibilities of individual members of the Project Coordination Committee;
- o set of guidelines for the periodic reporting, monitoring and planning for the project as a whole;
- o identification of the follow-up technical assistance needs of the SFHCA staff in relation to their responsibilities in the coordination of the project;
- o increased knowledge on the part of the SFHCA and the PCC of their responsibilities in the Project.

The Objectives of subsequent visits of the advisor will be set at the end of each visit.

B. Activities

In order to achieve the objectives, the consultants will do the following:

- o review all project-related documents and interview involved parties to gain an historical perspective on the purpose and needs for the coordinating body;
- o develop an overall framework adequate for the coordination of the project;
- o identify the steps required in order to implement this framework and the timeframe within which they could be implemented;
- o define the role and responsibilities of the Project Coordinating Committee and the staff of the SFHCA within this framework;
- o develop the terms of reference, guidelines, and responsibilities of individuals in the Proejct Coordinating Committee;

- prepare the job descriptions of all project staff as they relate to their coordinating roles;
- meet with members of the PCC as needed to prepare for the first meeting;
- make preparations for the first meeting of the PCC, e.g. develop agenda, duplicate any materials required, send out notices;
- guide the conduct of the first meeting of the PCC;
- assist in identifying actions to be taken as a result of deliberations at first PCC meeting;
- assist in developing and documenting any other procedures needed as they relate to the overall framework for coordination, specifically, reporting requirements and overall planning;
- identify training and technical assistance needs of the staff with coordination responsibilities.

C. Counterpart Relationships

The Advisor will work wiht the Executive Director of the Somali Family Health Care Association as a counterpart. Other staff will serve as counterparts when so directed by the Executive Director.

D. Timing

The first consultation will require up to three months and will preferably be scheduled in the first three months of project start-up. Subsequent consultations are tentatively planned for two-month periods, twice each year.

E. Anticipated Problems|Constraints

The Project consists of a diverse set of activities and involves more than eight Somali institutions. These institutions have not worked together before and many are not familiar with family health. There are no known conflicts among the members of the Project Coordinating Committee but these could arise. This is a new form of organization in this setting. The members of the coordinating committee and the members of the Secretariat are busy people, with many other demands on their time. Problems have been encountered in the past in getting them together.

F. Qualifications Required|Desired

1. Required:

Education: Bachelors Degree

Experience: At least five years experience working with counterpart agencies in at least two other developing countries; at least two years organizing a new institution in a developing country.

Specific Skills : Proven ability to work well with counterpart staff of a variety of managerial levels; proven ability to organize a desparate group of people and help them work together; ability to write and speak clearly.

2. Desired:

Education: Masters level in Organization Development, Management, Health Administration or similar.

Experience: At least three years of working with family health institutions; at least 2-3 years of work in Africa and|or other Moslem country.

Other: Ability to speak or communicate in Arabic, Italian and|or Somali.

17.1 UNIT: INFORMATION, EDUCATION AND COMMUNICATIONS (IEC)

FUNCTION:

The functions of the unit are to: 1) develop an overall strategy and integrated workplan for IEC activities related to family health; 2) take a leadership role in those activities to be conducted jointly by institutions involved with IEC; 3) manage IEC resources for family health; 4) monitor and keep informed of all IEC activities; and 5) to implement its own assigned activities.

STAFFING:

The unit will have a 3-4 staff: a Director who will be responsible for on-going coordination of all IEC-related institutions, managing the work of the unit, and directing specific, assigned activities; a Training Officer, who will be responsible for the development and implementation of the IEC training programs to be conducted for and by the IEC components of the participating institutions; the Resource Center Manager, who will be responsible for the Resource Center and the design and production of all IEC materials developed by the IEC Unit or jointly by the institutions; an Audio-visual Technician, who will be responsible for the maintenance of the audio-visual equipment, making minor repairs, and for training all staff in the proper use and maintenance of the equipment. The staff position descriptions will be developed at the beginning of the project period; as the work load of the Unit increases and the functions these staff will perform become necessary, they will be filled.

OBJECTIVES:

The Objectives of the IEC Unit are:

1. To facilitate the preparation of an overall IEC strategy and annual workplans for the participating agencies.

2. To produce a newsletter on IEC activities on at least an annual basis.

3. To maintain regular contacts with all participating agencies and to keep informed of and inform others of all IEC activities.

4. To gudie the preparation of all IEC materials.

5. To facilitate and manage all joint training programs.

SUPERVISION:

The Unit will be located at the SFHCA and will be supervised by the SFHCA management, specifically the Executive Director. Plans

and reports of activities will be submitted to the Executive Director for approval and to the IEC Technical Group which will advise the Unit. The IEC Technical Group will be made up of representatives of all the participating agencies.

17.2 OPERATIONS RESEARCH UNIT

FUNCTION:

The function of the Unit is to improve the efficiency and effectiveness of family planning service programs by undertaking continuous operations research testing work, initiating workable program monitoring systems, and designing and overseeing larger-scale operations research projects.

STAFFING:

The Unit will be assembled at the start of the third year of Project activities. A long-term Operations Research Advisor will assist in setting up the Unit. A secretary will be hired upon the arrival of the advisor. During the first two months of Unit activities, the advisor will draw up a work-scope and qualifications summary for a Somali counterpart associate. The advisor will make a selection from among qualified candidates in consultation with SFHCA management. The Associate will direct the Unit and consult with the advisor on the various operations research activities; he/she will receive on-the-job training in operations research procedures.

OBJECTIVES:

The objectives of the Unit are: 1) to conduct continuous testing of alternative approaches to service delivery and identify the most efficient and effective approaches; 2) to establish and strengthen program monitoring systems which provide useful evaluative information; 3) to undertake three special operations research which address important problems in service delivery work. The Unit will design and implement operations research activities in collaboration with evaluative/management units in relevant institutions. The Unit will advise program management of its research findings and suggest adjustments in program operations to increase efficiency and effectiveness.

ADMINISTRATIVE SUPERVISION:

The Unit will be located in the SFHCA and will be supervised by SFHCA management. Proposals will be prepared for all operations research activities and submitted to SFHCA management for approval. Final reports on major research activities will be submitted to SFHCA management for review and distribution to participating institutions. The Unit will prepare semi-annual reports on completed work to date and project future work and submit them to SFHCA management for review and distribution.

SECTION 18 ANNEX 10

ANALYSES OF THE FOREIGN EXCHANGE GRANT AND OBLIGATION SCHEDULE

This Section contains the budget breakdowns for the foreign exchange grant given in summary in Section 3.0. Details are given for the long-term technical assistance, short-term technical assistance, and selected commodity procurement. Further details on the commodities are available in the Procurement Plan in Section 14.0.

TOTAL LT TA

ADVISORS/ YEAR	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89
I.E.C. Advisor		148,749	192,586	188,215	201,331	68,388
Training and Management Systems Advisor		148,749	192,584	188,215	64,556	
Operations Research Advisor			37,188	215,492	147,776	
		$330,278	$457,244	$629,120	$453,407	$68,388

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SHORT-TERM TECHNICAL ASSISTANCE-BUDGET BREAK-DOWNS

COMPONENT I	FY 84	FY 85	FY 86	FY 87	FY 88	TOTAL	
Sample Design 3 PM, 3 Trip	15,468	16,390	17,433			49,301	BUCEN
Census Design 2M, 2 Trip	15,468	16,390				31,858	BUCEN
Quest Design 1 PM		16,390				16,390	BUCEN
D.A. Design 2 PM		16,390	17,433			33,833	BUCEN
Cents-4 TRG 3 PM			38,246			38,246	BUCEN
Cov. Stdy 3 PM			38,246			38,246	BUCEN
POP Survey 2 MOS, 1 Trip	32,780					32,780	DDD/Wtg
Settlement Svy. 2 MO, 1 Trip		32,780				32,780	INPLAN
Demo. Survey 2 MO, 2 Trip		16,390	17,443			33,833	DDD/Wtg
Pop. Conference 2 MO, 2 Trip			17,443		19,870	37,313	CENTRAL
Data Use Workshop 2 MO x 2P=21 PM, 2T				68,996		68,996	DDD/Wtgh
	$30,936	$147,510	$146,264	$68,996	$19,870	$413,576	

COMPONENT II	FY 84	FY 85	FY 86	FY 87	FY 88			
Population Comm. Service 3 MOS, 1 Trip		43,704				Cent. CONTR.	Direct REIMB	43,704
Curriculum Development 24 MOS, (6 MOS p/a)		84,066	89,110	94,456	100,087	CONTR.		367,719
I.E.C. Prod. Advisor 3 MOS, 1 Trip		43,704				CONTR.		43,704
I.E.C. Eval. Advisor 2 MOS, 1 Trip			31,726			CONTR.		31,726
I.E.C. Comm. Action 2 MOS, 1 Trip				33,629		CONTR.		33,629
Coord Specialist 10 PM , 1 Trip	28,236	29,930	31,726	33,629	35,634	DIR CONTR.		159,155
	$28,236	$201,404	$152,562	$161,714	$135,721			$679,637

COMPONENT III	FY 84	FY 85	FY 86	FY 87			
Overall Management 1 MO, 1Trip	15,468				Direct AID Contract	Direct REIMB	$15,468
CDC Log Information 4 MOS, 3Trip		46,326	(17,380)		RSSA/PASA	Direct REIMB Travel & Per Diem	$63,701
Financial Advisor 3 MOS, 2Trip		29,930	17,380		Direct AID Contract	Direct REIMB	$47,310
Physicians TOT 2 MOS, 1Trip		29,930			Contractor		$29,930
Delivery Systems Assessment 2 MOS, 1Trip		29,930			Contractor		$29,930
Advisor IUD On-Site 4 MOS, 2Trip		29,930	31,726		Contractor		$61,656
Advisor on STD. VSC Intern Protocols 2 MOS			31,726		Contractor		$31,726
TBA TRG (Non-Lit) 3 MOS			31,726	18,422	Contractor		$50,148
	$15,468	$166,046	$129,938	$ 18,422			$329,876

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S/T TA

COMPONENT IV	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	6% FUNDING
2 OR Training 2 Mos, 2 Trips				30,936			$36,845 CONTR
3 IEC Research 3 Mos, 2 Trips				38,246		+7305	$45,551 CONTR
3 Reasearch To Be DET 3 Mos, 2 Trips				19,123	19.123	+3652+5010	$46,908 CONTR
13 Social Marketing 13 Mos.		41,000	66,540	28,236	38,246	+2460,8224, 5393,10,020	$200,119 CONTR
FHS Supvr/Mont 4 Mos, 2 Trips				28,236	28.236	+5393,7398	$69.263 CENTR. CONT.
Focus Group Exp. 1 Month, 2 Trips				15,468		+2954	$18,422 "
Sampling Stat 1 Month, 1 Trip				15,468		+2954	$18,422 "
Data Processing 1 Month, 1 Trip					15,468	+4053	$19,522
Evaluation 4 Mos, 2 Trips					56,470	+14,795	$71,265 Mission Funded PIOT
		$41,000	66,540	175,713	157,543		526,317

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Section 18. Funding for Short-term Training

Component 2. IEC SHORT TERM TRAINING

+ STUDY TOURS

FY 1985	6 Persons @ 2 Month U.S. Training in Communications and Planning. (Cornell Univ.)		
	6 Persons x $4,200 (1st WEEK)	$ 25,200	
	6 x 7 x 575	24,150	
			49,350
FY 1985	1 Person (FROM CDC) to attend Formal Education 2 Months U.S. Program		
	1 Person x $4,200 (1st WEEK)	$ 4,200	
	1 x 7 x 575	4,025	
			8,225
FY 1986	10 Persons to attend U.S. Training over 2 Month Period		
	10 Persons x $4,200 (1st WEEK)	$ 42,000	
	10 x 7 x 575	40,250	
			82,250
FY 1986	6 Persons- Study Tours to THAILAND, MALAYSIA or other countries over 2 Months		
	6 Persons x $4,000 (1st MO)	$ 24,000	
	6 x 2800	16,800	
			40,800
			$180,625
		+ 10%----	18,063
		Total:	198,688

Component 3. CLINICAL FAMILY HEALTH TRAINING

FY 1985	8 Persons trained in Zimbabwe, Kenya, Tanzania over 2 Months Period		
	8 x $4,000 (1st Month)	$ 32,000	
	8 x $2,000 (2nd Month)	16,000	
			48,000
FY 1985	2 Persons for Training in U.S. at Connecticut over 3 Months.		
	2 x $4,200 (FIRST WEEK)	$ 8,400	
	2 x 11 weeks at $575 p/w	12,650	
			21,050
FY 1986	4 Persons for 2 Month Training in STD/LAPS 3rd Country		
	4 x 4,000 (FIRST MONTH)	$ 16,000	
	4 x 2000 (2nd Month)	8,000	
			24,000
FY 1986	12 Persons for 2 Months U.S. and Third country Training in Logistical Services and General Management		
	6 Persons x $4,200 (FIRST WEEK U.S.)	$ 49,350	
	6 x 7 x 575		
	6 Persons x $4,000 (First MO. 3rd C.)	40,800	
			90,150
			$ 183,200
		+ 10%	18,320
			$ 201,520

COMPONENT IV: OPERATIONS RESEARCH and SOCIAL MARKETING TRAINING

FY 1985	3 Persons for Study Tours to Southeast Asia and African countries		
	3 x $4,000 (1st MO.)	$ 12,000	
	3 x $ 500 (5th WEEK)	1,500	
			$ 13,500

	$ 13,500
+ 10%	1,350
	14,850

Section 18

Funding for Commodities

COMPONENT I	FY-84	FY-85	FY-86	FY-87	FY-88	FY-89
Computer & Parts	396,040					
Paper & Supplies	75,000					
Maintenance Items 1-9		71,320	71,320	71,320	71,320	71,320
2 Compilers		960	960	960	960	960
Instruction		35,000				
	471,040	107,280	72,280	72,280	72,280	72,280
+ 42% Shipping	197,837	+7% infl. 7,510	+	+	+	+
	668,877	114,790	82,752	88,544	94,742	101,374

482,202

1,151,079

CONTRACEPTIVES

EXPECTED CONSUMPTION, BY YEAR, BY METHOD

	1984	1985	1986	1987	1988	1989	1990
ORALS MCH	50,349	151,021	251,693	352,365	402,714	453,050	719,128
CSM			122,000	+ 144,000	215,738	251,695	
IUD's	533	1,660	2,776	3,872	4,425	4,979	5,531
CONDOMS MCH	119,520	358,416	597,456	836,352	955,8[illegible]	1,075,392	
CSM			1,000,000	1,500,000	2,000,000	2,500,000	
JELLY	1,380	4,145	6,915	9,685	11,065	12,445	13,829

ANALYSIS OF THE GSDR CONTRIBUTION

Table 19.1. GSDR Contribution by Cost Catagory, Agency and Calendar Year. Cost in Somali Shillings (Dollars)

Category/Agency	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Totals
PERSONNEL							
SWDO	37,200	156,240	164,530	172,596	181,512	137,876	849,954
MOH	374,400	1,627,710	1,730,620	1,837,930	1,946,240	1,509,563	9,026,463
CDC		420,000	440,000	460,000	480,000	374,500	2,174,500
WED		548,730	570,060	1,154,490	1,362,920	1,218,313	4,854,513
Social Marketing		860,520	900,240				1,760,760
SFHCA	123,900	540,540	566,280	592,820	618,560	483,375	2,925,475
MONP (Census)	168,000	3,922,800	4,276,240	526,240			8,893,280
MONP (Financial)	14,400						14,400
MONP (DEM Res)		34,650	36,300				70,950
	717,900	8,111,190	8,684,270	4,744,076	4,589,232	3,723,627	30,570,295
	($41,306)	($466,697)	($499,670)	($272,962)	($264,052)	($214,248)	($1,758,935)
MATERIALS							
SWDO	54,688	262,500	306,250	350,000	393,750	328,125	1,695,313
MOH		2,106,275					2,106,275
WED		481,250	577,500	673,750	770,000	649,688	3,152,188
Social Marketing		706,488	814,416				1,520,904
SFHCA	541,946						541,946
MONP (Census)		212,500					212,500
MONP (POP Conf)				5,750	6,250		12,000
MONP (Fin Anal)	10,000						10,000
MONP (DEM Res)		12,500	15,000				27,500
	606,634	3,781,513	1,713,166	1,029,500	1,170,000	777,813	9,278,626
	($34,904)	($217,578)	($98,571)	($59,235)	($67,319)	($56,261)	($533,868)

Category/Agency	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Totals
VEHICLE MAINTENANCE							
SWDO		54,747	57,354	59,961	62,568	48,881	283,511
MOH		297,585	286,770	299,805	312,840	244,405	1,441,405
WED		109,494	114,708	119,922	125,136	130,350	599,610
CDC		54,747	57,354	59,961	62,568	48,881	283,511
Social Marketing		391,050	469,260				860,310
SFHCA	13,035	54,797	57,354	59,961	62,568	48,881	296,546
	13,035	962,370	1,042,800	599,610	625,680	521,398	3,764,893
	($750)	($55,372)	($60,000)	($34,500)	($36,000)	($30,000)	($216,622)
BUILDING RENOVATION							
MOH	328,000						328,000
	($18,872)						($18,872)
SPECIAL TRAVEL ALLOWANCES							
MONP (Census)	150,000	450,000	1,150,000				1,750,000
	($8,631)	($25,892)	($66,168)				($100,690)
FSU COSTS							
SFHCA		417,120					417,120
WED		229,416					229,416
SWDO	923,520						923,520
CDC		104,280					104,280
MOH		1,267,002					1,267,002
Social Marketing			844,668				844,668
	923,520	2,017,818	844,668				3,786,006
	($53,137)	($116,100)	($48,600)				($217,837)

Category/Agency	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Totals
EQUIPMENT							
SWDO	570,875						570,875
MOH	886,700						886,700
WED	259,250						259,250
Social Marketing	380,000						380,000
SFHCA	596,277						596,277
	2,693,102						2,693,102
	($154,954)						($154,954)
FUEL							
SWDO		54,890	58,134	60,736	63,948	49,379	287,087
MOH		429,413	454,666	481,592	516,681	404,282	2,286,634
WED		74,970	110,708	133,336	159,066	250,642	728,722
CDC		166,150	169,300	172,450	175,600	159,063	842,563
Social Marketing		700,350	736,899				1,437,249
SFHCA	15,698	65,930	69,069	72,209	75,348	58,866	357,120
MONP (Census)	323,310	1,074,476	3,325,716				4,723,502
MONP (DEM Res)		36,750	38,500				75,250
		+27,514	+28,648	+30,018	+31,401	+24,604	
	339,008	2,602,929	4,962,992	920,323	990,643	922,232	10,738,127
	($19,506)	($149,766)	($285,558)	($52,953)	($56,999)	($53,062)	($617,844)

Category/Agency	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Totals
PRINTING							
Social Marketing		695,200	764,720				1,459,920
MONP (POP Conf)				11,500	12,000		23,500
MONP (Fin Anal)	60,000						60,000
MONP (DEM Res)		63,000	66,000				129,000
	60,000	758,200	830,720	11,500	12,000		1,672,420
	($3,452)	($43,625)	($47,797)	($662)	($690)		($96,227)
COMMUNICATIONS							
SWDO	2,100	2,200	2,300	2,400	2,500	1,950	13,450
MOH		113,400	118,800	124,200	129,600	101,250	587,250
MONP (POP Conf)				1,150	1,200		2,350
	2,100	115,600	121,100	127,750	133,300	103,200	603,050
	($121)	($6,651)	($6,968)	($7,350)	($7,670)	($5,938)	($34,698)
FAMILY HEALTH SVY II					1,939,400		1,939,400
					($111,588)		($111,588)
TRAVEL AND TRANSPORTATION							
SWDO		336,030	105,600	95,220	99,360	77,625	713,835
MOH		236,418	296,736	361,974	431,712	337,274	1,664,114
WED		334,625	772,750	1,181,625	1,623,000	1,572,656	5,484,656
CDC		1,174,710	1,226,720	1,282,480	1,223,040	957,563	5,864,513
Social Marketing		1,038,455	1,127,962				2,166,417
MONP (Census)	555,870	25,660,453	25,617,207				51,833,530
(POP Conf)				4,600	4,800		9,400
(Data Use)				33,104			33,104
(DEM Res)		274,370	289,102				563,472
	555,870	29,055,061	29,436,077	2,959,003	3,381,912	2,945,118	68,333,041
	($31,983)	($1,671,723)	($1,693,675)	($170,253)	($194,586)	($169,454)	($3,931,750)

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Category/Agency	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Totals
TRAINING AND CONFERENCES							
SWDO		573,300	844,960	879,060	1,038,240	905,625	4,241,185
MOH		1,326,040	1,729,640	2,153,800	2,597,400	2,031,600	9,838,480
WED		620,715	1,074,862	1,387,722	1,735,140	1,793,683	6,612,115
MONP (POP Conf)				75,900	81,000		156,900
		2,520,055	3,649,462	4,496,475	5,451,780	4,730,908	20,733,680
			115,000				115,000
			3,649,462				20,848,680
		($144,997)	($209,981)	($258,715)	($313,681)	($272,204)	($1,199,579)
	6,061,169	50,702,736	52,435,255	14,888,237	18,293,947	13,924,296	156,305,640
	($348,743)	($2,917,304)	($3,016,988)	($856,630)	($1,052,586)	($801,168)	($8,993,420)

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Component 1

Ministry of National Planning

Personnel	8,978,630
Materials	262,000
Travel	52,439,506
Special Travel	1,750,000
Fuel	4,798,752
Training and Conferences	156,900
Printing	212,500
Communications	2,350
Subtotal	68,600,638
15% Contingency	10,290,071
Total Somali Shillings	78,890,547

Component 2

Somali Family Health Care Association

Personnel	2,925,475
Materials and Supplies	541,946
Equipment	596,277
Fuel	357,120
Vehicle Maintenance	296,546
F.S.U. Costs (Trust Fund)	
Long term Advisor	
Utilities @ $6,000 PA X 4 years X So. Sh.	417,120
Subtotal	5,134,484
15% Contingency	770,173
Total	5,904,657

Component 2

W. E. D. Budget

Personnel	4,854,513
Materials and Supplies	3,152,188
Equipment	259,250
Travel and Transportation	5,484,656
Fuel	6,728,722
Training and Conferences	612,115
Vehicle Maintenance	599,610
Subtotal	21,691,054
L/T Adv. FSU costs (Trust Fund) Guard Svcs @ $3300 p/a X 4 X 17.38	229,416
	21,920,470
15% Contingency	3,288,071
TOTAL	25,208,541

COMPONENT 2

SWDO Budget

Personnel	849,954
Equipment	570,875
Travel and Transportation	713,835
Training and Conferences	4,241,185
Fuel	287,087
Materials	1,695,313
Vehicle Maintenance	283,511
Communications	13,450
	8,655,210
FSU Costs (Trust Fund L/C)	
House Rental $13,500 p/a x 4 x SoSh	923,520
Contingency 15 %	1,436,810
TOTAL	11,015,540

Component 2

	CDC
Personnel	2,174,500
Travel and Transportation	5,864,513
Fuel	842,563
Vehicle Maintenance	283,511
	9,165,087
L/T Advisor (LI FSU CIPL)	
House Maintenance & Repair 1500 x 4 x SoSh	104,280
SUBTOTAL	9,269,367
Contingency 15%	1,390,405
TOTAL	10,659,772

Component 3

Ministry of Health Budget

Personnel	9,026,463
Materials	2,106,275
Training and Conferences	9,838,480
Travel and Transportation	1,664,114
Fuel	2,286,634
Communications	587,250
Equipment	886,700
Vehicle Maintenance	1,441,405
Building Rennovations	328,000
	28,165,321
FSU Costs (Trust Fund)	
House Rental $13,500 x 3 yrs.	703,890
Utilities	312,840
Security	172,062
Maintenance	78,210
	1,267,002
SUBTOTAL	29,432,323
Contingency 15%	4,414,848
TOTAL	33,847,171

US $ equivalency $1,947,478

Component IV

Social Marketing/OR

Personnel	1,760,760
Office Rent	742,500
Materials	778,404
Travel and Transportation	2,166,417
Equipment	380,000
Printing	1,459,920
Fuel	1,437,249
Vehicle Maintenance	860,310
	9,585,560
B Family Health Survey (II)	1,939,400
	11,524,960
FSU Costs	
House Rent $13,500 x 2 x SoSh	469,260
Utility 6000 x 2 x SoSh	208,560
Security 3300 x 2 x SOSh	114,708
Naintenance 1500	52,140
	844,668
SUBTOTAL	12,369,628
Contingency 15%	1,855,444
TOTAL	14,225,072

SECTION 20.0

CERTIFICATION OF EXEMPTION FROM OMB CIRCULAR A-76

The agreement for the technical services of the staff of the Bureau of the Census, Department of Commerce under a PASA, is exempt from the provisions of OMB Circular A-76 because it is for technical assistance and the facilities and resources of the Bureau of the Census are particularly or uniquely suited to the work to be performed and are not competitive with private enterprise.