

PD-AAU-211

A.I.D. EVALUATION SUMMARY PART I

(BEFORE FILLING OUT THIS FORM, READ THE ATTACHED INSTRUCTIONS)

IDENTIFICATION DATA

A. REPORTING A.I.D. UNIT:
USAID/Somalia
 (Mission or AID/W Office)
 (ES# 87-01)

B. WAS EVALUATION SCHEDULED IN CURRENT FY ANNUAL EVALUATION PLAN?
 yes slipped ad hoc
 Eval. Plan Submission Date: FY 87 Q 3

C. EVALUATION TIMING
 Interim final ex post other

D. ACTIVITY OR ACTIVITIES EVALUATED (List the following information for project(s) or program(s) evaluated; if not applicable, list title and date of the evaluation report)

Project #	Project/Program Title (or title & date of evaluation report)	First PROAG or equivalent (FY)	Most recent PACD (mo/yr)	Planned LOP Cost ('000)	Amount Obligated to Date ('000)
649-0131	Family Health Services (February-March, 1987)	1984	12/89	10,100	10,100

ACTIONS

E. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR	Name of officer responsible for Action	Date Action to be Completed
1. A strategy will be developed to help the project achieve a greater focus of overall objectives. Current project is diffuse with myriad activities and ultimate child spacing goals need to be emphasized.	USAID/URC/GSDR	1/88
2. A plan will be implemented so that the current emphasis on ORT is decreased and substituted with breastfeeding messages.	USAID/URC/GSDR	1/88
3. 1988 and future workplans should put greater emphasis on service delivery.	USAID/URC/GSDR	10/87
4. Social marketing funds in URC contract need to be reprogrammed to mutually agreeable areas.	USAID/URC	10/87
5. Operations research findings should be streamlined into project decision making and should be used to achieve Objective # 1.	USAID/URC	1/88

(Attach extra sheet if necessary)

APPROVALS

F. DATE OF MISSION OR AID/W OFFICE REVIEW OF EVALUATION: mo 7 day 5 yr 87

G. APPROVALS OF EVALUATION SUMMARY AND ACTION DECISIONS:

Signature	Project/Program Officer	Representative of Borrower/Grantee	Evaluation Officer	Mission or AID/W Office Director
<i>[Signature]</i>	E. <i>[Signature]</i>	Hussein Elabe	R. Rhoda <i>[Signature]</i>	Lois Richards
Typed Name	PROJ	Fahie, Permanent Sec. MONP	PROG	Director
Date: <u>12 Aug 87</u>		Date: <u>25/8/87</u>	Date: <u>8/17/87</u>	Date: <u>8/18/87</u>

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K. ATTACHMENTS (List attachments submitted with this Evaluation Summary; ~~attach~~ attach copy of full evaluation report, even if one was submitted earlier)

"Report of the Midterm Evaluation, Somali Family Health Services Project, USAID Project Number 649-0131", Evaluators: Robert Worrall and Diana Altman, February 28-March 19, 1987.

ATTACHMENTS

L. COMMENTS BY MISSION, A/D/W OFFICE AND BORROWER/GRANTEE

Mission generally concurs with evaluation findings and considers them objective and useful. Mission is somewhat disappointed that attention is given to detail rather than a hoped-for overall direction.

The Mission recognizes the potential for loss of momentum and coordination among participating organizations beyond the PACD; however, this issue is not within the control of USAID and the project.

COMMENTS ON FULL REPORT

b

M. EVALUATION ABSTRACT (do not exceed the space provided)

This mid-term evaluation, conducted two and half years after the Family Health Services Project was first approved, is the first formal AID review of the project. In general, the two-person PSC evaluation team finds the project to be making relatively smooth and effective progress toward purpose achievement, though a great many detailed recommendations are provided to help fine tune and refocus the project. The evaluation report itself is lengthy (80 pages) and contains a level of detail that may not be of particular interest or concern to those not directly involved in the project's implementation; nonetheless, there are useful and thoughtful points of broader AID-wide concern that can be culled from this evaluation.

The purpose of the Family Health Services Project is "to strengthen the capabilities of Somali institutions to promote, support, coordinate and sustain family health programs." The evaluation report notes that "there has been substantial progress to date toward strengthening the capabilities of participating organizations to promote, support and coordinate [family health] programs." The team, however, is less optimistic about the prospects of attaining the project's stated goal, "to improve the quality of life for the Somali people". The evaluation report states that "...progress toward such a lofty goal at this early stage has to be largely limited to process (or formative) factors. 'Setting the stage to achieve' perhaps best describes the implementation efforts to date." The project purpose is to be achieved through the implementation of four components: (1) the collection and analysis of demographic data; (2) information and educational activities; (3) the delivery of clinical services; and (4) the conduct of operations research. Regarding implementation, the team finds that the inclusion of five diverse organizations in project decision-making and management serves to both strengthen and weaken the project. On the one hand, the collaboration among organizations that has characterized the project has been a plus, as has been the responsibility for project coordination through a private sector association created by Parliament specifically for this project. The unifying theme of IEC among three of the four project components has also been seen as a benefit. On the other hand, the report notes that these strengths can also be weaknesses: "By nature, ongoing collaboration of organizations with differing overall goals and functions has a built-in fragility." Further, the coordination of government organizations by a private sector association may not prove viable over time. Finally, the team expresses the concern that too much emphasis on IEC could lead to a focus on processes (i.e., the mechanisms of IEC) to the neglect of results (i.e., behavioral change goals).

L. EVALUATION COSTS

1. Evaluator Team		Contract Number DB TDY Person Days	Contract Cost DB TDY Cost (US\$)	Source of Funds
Name	Affiliation			
Diana Altman	Independent	30 days	\$10,900	649-0131.
Robert Worrall	Consultants	each	\$13,120	

2. Mission/Office Professional
Staff Person-Days (estimate) 9

3. Borrower/Grantee Professional
Staff Person-Days (estimate) 20

ABSTRACT

COSTS

A.I.D. EVALUATION SUMMARY PART II

J. SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS (To exceed the 3 pages provided)

- Purpose of activities
- Purpose of evaluation and methodology used
- Findings and conclusions (relate to questions)

- Principal recommendations
- Lessons learned

Mission or Office USAID/Somalia

Date this summary prepared July, 1987

Title and Date of Full Evaluation Report "Report of Mid-Term Evaluation, Somali Family Health Services Project", February 28-March 29, 1987.

Purpose of Activity Evaluated: The purpose of the Family Health Services Project is "to strengthen the capabilities of Somali institutions to promote, support, coordinate and sustain family health programs." This purpose is to be achieved through implementation of four interrelated project components: (1) the collection and analysis of demographic data; (2) information and educational activities; (3) the delivery of clinical services; and (4) the conduct of operational research.

Purpose of Evaluation and Methodology Used:

This was a scheduled mid-term evaluation to assess project progress to date. The two-person team spent one month (February 28 - March 29, 1987) in Somalia, reading extensive project documentation, interviewing a wide variety of project participants within AID, with the contractor, with the GSDR and with the private sector and visiting project sites in an effort to gain as full and accurate a view of the project as possible.

Findings and Conclusions: The team found that, in general, "there has been substantial progress to date toward strengthening the capabilities of participating organizations to promote, support and coordinate [family health] programs... The project consists of four separate but interrelated components and is implemented by a collection of five different Somali organizations. Given this complex project design, coordination and collaboration is essential." While the evaluation notes that collaboration has been good to date, it also points out the inherent fragility of systems that are dependent on extensive interorganizational coordination such as this project (particularly in the case of this project where the main coordinating body is a newly established private sector organization which coordinated the work of a number of governmental agencies). The report also points out the potential danger of becoming too focused on implementation and not focused enough of achieving objectives (i.e., of emphasizing processes over results).

Target beneficiaries of the project include: (1) personnel of Somali family health institutions; (2) national policy-makers and local leader; (3) the general population engaged in discussions and campaigns to increase awareness of family planning services; and (4) married couples involved in the development and distribution of family health services. The project itself estimates that, by the end of project, 50% of Somali couples will have been introduced to ("made aware of") family health services, a feasible achievement with attention to a few recommendations, the evaluation team says. The evaluation report also anticipates the following achievements by the end of the project in December 1989:

(1) the level of awareness of modern contraceptive methods will have been increased by 15%; (2) the level of awareness of the dangers of female circumcision will have been raised by 10% within the five project areas; (3) knowledge of how to accurately mix and administer ORS (oral rehydration salts) among mothers will have been raised by 10% in the five project areas; (4) the contraceptive prevalence rate will have increased to 8%. "The combined impact will be healthier women and children in Somalia and in turn, as a result of the Project, there will be observable improvement in the quality of life. Improvements in areas such as financial management, program administration, project monitoring and evaluation will also have been realized". These projects achievements are all the more noteworthy in light of the fact that Somalia's Muslim traditions are typically opposed to family health/family planning activities.

Principal Recommendations:

Lessons Learned:

(1) Short-term (life-of-project) interorganizational coordination and collaboration may not necessarily lead to long-term institutional development and self-sustainability. Although it is too early to judge yet by the experience of this project, common sense might indicate that the simpler the organizational structure, the better the chances of institutionalization.

(2) Project implementation needs to maintain an objective orientation. Too often, the "forest" can be obscured by the "trees."

J.

XD-AAW-211-A

ISN 1180

**Report of the Midterm Evaluation
Somali Family Health Services Project
USAID Project Number 649-0131**

Period of Evaluation February 28 - March 29, 1987

Evaluators:

**Robert P. Worrall
Dianna L. Altman**

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Glossary of Acronyms

AMREF	African Medical Research Foundation
AED	Academy for Educational Development
AID	Agency for International Development (U.S.)
AV	Audio-visual
B.A.	Bachelor of Arts
BOCD	British Organization for Community Development
BUCEN	Bureau of the Census (U.S.)
CAA	Community Aid Abroad
CBD	Community Based Distribution
CBD/C	Community Based Distribution/Communication
CSD	Central Statistical Division
CDC	Curriculum Development Center
CHWs	Community Health Workers
CIPL	Commodity Import and PL 480 Funds
DDC	Diarrheal Disease Control
DDD	Domestic Development Department
DDD/Westinghouse	Demographic Data for Development
EA	Enumeration Area
EPI	Expanded Program for Immunization
EOPS	End of Project Status
FDA	Food and Drug Administration
FH	Family Health
FH/FP	Family Health/Family Planning
FHS	Family Health Services
GSDR	Government of Somalia Democratic Republic
HPTI	Health Professions Training Institute
HE	Health Education
IEC	Information, Education, and Communication
IPPF	International Planned Parenthood Federation
INPLAN	Integrated Population/Development Planning II
INTRAH	International Training for Health Program
IMPACT	Innovative Materials for Population Action
IUDs	Intrauterine Devices
IMT	Italian Medical Team
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
JHU	Johns Hopkins University
KAP	Knowledge, Attitudes, Practices
MCH	Maternal and Child Health
MING	Ministry of Information and National Guidance
MOI	Ministry of Information
MONP	Ministry of National Planning
MOH	Ministry of Health
MOE	Ministry of Education
NFP	Natural family planning
NM	Nurse midwife
OPTIONS	Options for Population Policy
OR	Operations Research
ODC	Other Direct Costs
ORS	Oral Rehydration Solution (or salts)
ORT	Oral Rehydration Therapy
ORWG	Operations Research Working Group
PEC	Past Enumeration Census
PCC	Project Coordinating Committee

PCS	Population Communication Services
PHC	Primary health care
PHD	Doctorate of Philosophy
RAPID	Resources for Awareness of Population Impacts
REDSO	Regional Economic Development Support Office
SCR	Swedish Church Relief
SDA	Settlement Development Area
SFHCA	Somali Family Health Care Association
SOSH	Somali Shilling
ST	Short term
SWDO	Somali Womens Democratic Organization
STDs	Sexually transmitted diseases
TA	Technical Assistance
TBA _s	Traditional Birth Attendants
TOT	Training of Trainers
TOT/C	Training of Trainers in Communicatlon
TL	Tubal Ligation
TD	Temporary Duty
TV	Television
UNC	University of North Carolina
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
URC	University Research Corporation
USA	United States of America
VSC	Voluntary Surgical Contraception
USAID	United States Agency for International Development
WC	World Concern
WED	Womens Education Department
WHO	World Health Organization

Introduction

The Midterm Evaluation team visited Somalia for four weeks, February 28 - March 29, 1987. The Team reviewed available project documentation from the USAID mission, relevant GSDR ministries, the Somali Family Health Care Association, and participating organizations in order to compare design objectives and expectations with actual implementation and progress of the Family Health Service Project. The team interviewed appropriate USAID and GSDR personnel, SFHCA and URC Contractor Staff, consultants, and project beneficiaries. Site visits were made to assess organizational capabilities and achievements to date.

The Team expresses its appreciation to USAID Mission officials, in particular to Gladys Gilbert, Special Projects Manager, GSDR officials, and representatives of the contracting organization. All were uniformly helpful and supportive in providing information relative to the Project.

Any misstatement of fact or misinterpretations of purpose or intent are the responsibility of the evaluators.

EXECUTIVE SUMMARY

The Somalia Family Health Services Project Paper signed on July 7, 1984 calls for evaluations in 1986, 1988, and 1989. Since the contract between USAID and the University Research Corporation (the contractor) was not signed until October, 1985 the first (mid-term) evaluation was delayed until February 28-March 29, 1987.

The evaluators were charged with assessing progress toward Project goals and objectives and identifying strengths and weaknesses in design and implementation. The evaluation also called for comments on USAID performance, the contribution of technical assistance, effects of Somali policies and procedures on Project implementation, probable Project outcome based on performance to date and recommendations for improvement, adjustment, and reorganization.

The team reviewed extensive documentation both prior to and during the mission, interviewed numerous USAID and GSDR officials, consultants, contractor representatives and project beneficiaries and made site visits within Somalia. Before leaving the country, the team made separate oral reports to the USAID Mission, contract representatives, and to the SFHCA staff and representatives of Project participating organizations. A full report was left with the mission before departure.

The long-term goal of the Family Health Service Project is to improve the quality of life for the Somali people measured in terms of improved maternal and child health and improved population data.

The purpose of the 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, information, and educational activities, delivery of clinical services, and the conduct of operational research. Each of these constitute a component of the Project.

The Grantee is the Government of Somalia, represented by the Ministry of National Planning, whose Permanent Secretary is chair of the Project Coordinating Committee. The primary executing agencies are the Central Statistical Department of the MONP, the Family Health/Family Planning Division of the Ministry of Health, and the Somali Family Health Care Association. Other participating organizations are the Somali Womens' Democratic Organization, the Curriculum Development Center, MOE, and the Womens' Education Department, MOE.

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

The Project design is unique in three distinct ways: (1) it places heavy reliance on the ability of four diverse organizations and agencies to cooperate and collaborate in activities designed to achieve the Project goals and objectives, (2) it vests responsibility for coordination of these organizational and agency efforts in a non-government group (SFHCA) expressly created for the purpose by the Parliament, and (3) it assigns a major role among the Project components to information, education, and communication.

USAID has supported four other major family health projects in Somalia including the JHPIEGO Reproductive Health Training Project, the INTRAH Family Health Training Project, the Westinghouse Family Health Survey, and the Family Health Initiatives Project. The current Family Health Services Project is substantially more ambitious than its predecessors and, given the intricate nature of organizational relationships, also much more complicated.

The environment for implementing a population program in Somalia is constrained by many political, religious, and tradition-bound restrictions. Somali traditions developed over thousands of years have helped to define the culture and have contributed to survival of the people. These traditions serve as the standards against which new ideas and changes are evaluated.

The President is said to be generally in favor of the child spacing on health grounds, but he and members of the Revolutionary Council are understandably unwilling to push family planning services if the people are not interested in birth spacing. Current government strategy is to pursue a quiet policy of active support of MCH/FP and population education so as to allow the desire of the people for improved family planning services to be demonstrated. Unfortunately, while studies show that Somalis support planning for education and the necessities of life, anything perceived as intended to limit the number of children is considered a sin.

The Family Health Service Project consists of four components: (1) Population Data and Policy, (2) Information, Education, and Communication, (3) Clinical Family Health Services, and (4) Operations Research.

Component I, Population, Data, and Policy

Component I includes seven different activities totaling about 40 percent of the \$20.3 million Project budget with \$1,795,000 committed directly by USAID. Activities include a national census, establishment of a mainline computer for processing the census data, post enumeration and related work, analysis and reporting of the 1980 Population Survey, Analysis of the 1982 Settlement Survey, Demographic Studies, Workshops on Data Analysis, and Planning Techniques and National Population Conferences.

Although there was an original delay, the census was eventually carried out within two weeks of the projected schedule. The formidable task of enumerating nomads was facilitated by placing enumerators at livestock waterholes. A post enumeration survey consisting of a 1 percent sample

was carried out within two weeks of the general census. Computer hardware and software with which to process the data is in place. Calwang, the manufacturer, has successfully tested it. USAID has authorized all but the last quarter payment.

However, several problems remain. Calwang, the contractor for training all CSD programmers, supervisors, and keypunch operators insists that training cannot begin until the computer is online, and this has been delayed by site preparation, equipment installation, and testing. USAID has urged Calwang to proceed with basic training which may not require working computers. A second problem was created when BUCEN cancelled a contract to field a team of data processing advisors in late 1986. UNFPA has agreed to provide a three person team beginning in June 1987 plus three demographers in 1988 to assist in data analysis.

Related activities in Component I will be discussed in the body of the report; however, in regard to the two national conferences called for in the Project paper in 1986 and 1988 the team suggests rescheduling the first one for 1987 in order to capitalize on the early results of the census and the second in 1989 to take advantage of the more substantial analysis expected by that time. The team strongly recommends increased policy activities based on results of the census by possibly using the services of such centrally funded Projects as INPLAN, IMPACT, OPTIONS and RAPID II.

Component II. Information, Education, and Communication

The USAID contribution to Component II, IEC, is \$2,695,000 for technical assistance, training, commodities, and contingencies. The GSDR contribution of \$3,025,000 includes staff salaries, materials, equipment, per diem, travel for training, and other educational activities.

The need to place strong emphasis on IEC was written into the Project Paper as follows, "the GSDR understands and the design team concurs that unless more detailed population and health information is available and well understood by both decisionmakers and the general public, Somalia will not be able to move forward with the necessary population and family health policies." The team noted that even though the President has publicly stated his support both birth spacing (for health reasons) and authorized the formation of the SFHCA as the key facilitating organization in the FHS Project, there is no broadscale support for the Project elsewhere in the Government. Thus the role of IEC in creating an environment for family and population planning is uppermost at this time.

As the Project has moved from the planning to the implementation stage, however, the distinctions between policy and program have often been obscured both as a result of an involved system of participating organizations and agencies, boards and committees, and interlocking of membership in those groups. The Project Coordinating Committee, headed by the Permanent Secretary of the Ministry of National Planning, the lead agency for the FHS Project, is the primary policy making group. However, the SFHCA, which has the responsibility for coordinating the activities of the FHS Project is governed by a Board, several of whose members are also on the PCC. The IEC Directors Group represents the heads of each of the participating agencies and organizations which meet regularly at the SFHCA to guide the FHS Project. Again the membership of this group is

prominently represented on the other two bodies. The IEC Directors group, which is enthusiastic and well motivated, tends on one hand to preempt some policy decisions which should be the responsibility of the PCC and on the other hand involves itself in operational matters rightfully the domain of the IEC staff of SFHCA. At the same time, the FHS staff frequently feels the Board is not as sensitive to and helpful with the Project as it should be. Several of the evaluation team's recommendations are directed to clarifying some of these relationships.

The system for developing and delivering information, education, and communication on family health in Somalia is still evolving at this stage of the Project. As is always true, the problem is infinitely simpler at the urban level than in the hinterlands. The Project designers envisioned a system in which the mobilization skills of SWDO, the local educational facilities and staff of WED, the materials production and curriculum design skills of CDC and the health service network of the MOH would be orchestrated by SFHCA to accomplish the Project objectives. In Benadir, the district for the capital, Mogadishu, this system is working well because the IEC Directors are nearby and communication is dependable. However, in the four Project regions further removed, the unifying influence of the IEC Directors is more difficult to implement. Before the URC became involved, an initiative was taken to establish nurse educators in each district. This failed because those selected were not from the areas they were serving; and a new approach had to be taken. The IEC Directors, with inputs from the IEC Advisor, established a Core Trainers group, followed by the selection of Regional and District Communicators representing each of the participating organizations. In the first 18 months, 13 Core Trainers were given overseas training following which they trained the Regional and District Communicators in a five phase program which is described in the body of the report. A significant outcome of the Phase 2 and 3 workshops was a set of Action Plans for each district, focusing on interpersonal communication with priority target groups. This system worked well until fall of 1986 when the IEC Directors decided, following a trip to Zimbabwe, to replace Action Plans with Community Based Distribution/Communication as it is conceived in Zimbabwe. As a result, the strategy for reaching local people with health service message was at least temporarily interrupted.

A major IEC campaign, however, is underway in Hodan District which is one of the nine districts constituting Benadir. The first deals with oral rehydration, to be followed by six week campaigns on female circumcision and birth spacing. Results will be assessed, adjustments made, and similar campaigns made during 1987 in five other districts, including one each in the five Project regions. While the evaluators raised caution over deemphasizing Action Plans, they also endorsed the concept of field testing IEC campaigns in order to develop models for the remaining three years of the Project. The idea of relating IEC delivery with service delivery as it is done in Zimbabwe supports a major recommendation of the Team, that is that greater emphasis be given to the private sector in service delivery.

Other issues on which the team made recommendations for improvement, adjustment, or emphasis included materials development, establishment of a Resource Center, greater use of mass media and provision of technical advisory services.

Component III Health Services Delivery

The FHS Project faces several handicaps in the area of service delivery including the low status of the Ministry of Health, the effect of having nine different donors in the establishment of Primary Health Care facilities, dependence by the FH/FP Division on existing MCH facilities where infant and child care is emphasized, competition within the Community Health Department with a variety of preventative and environmental programs, ambiguity among organizations and agencies involved in the FHS Project concerning the place of family planning and lack of understanding of its responsibility for IEC activities within the FH/FP Division.

On the positive side, a new Minister and two new Vice Ministers, each with appropriate credentials, have been appointed, improved financial procedures under a new chief accountant have been established, and the FH/FP Director, Dr. Rukiya Seif, a long-time supporter of family planning, serves as the major link between the MOH, the service delivery arm, and the FHS Project.

Service delivery receives the second largest funding of the four components. Total USAID and GSDR commitment is \$5,945,000, half of the \$4,000,000 USAID contribution is for commodities. The commitment for contraceptives commodities (\$1,309,000), which represents 13 percent of all dollar inputs, signals USAID's intent that the FHS Project strongly emphasize family planning. Technical assistance absorbs the second largest dollar input, \$1,040,000, and the remainder, \$436,000, is for contingencies. The GSDR contribution (\$1,930,000) is to pay for training and supervision related travel, per diems, personnel salary supplements, materials, office and training center costs and all service delivery activities.

Training is given prime emphasis in this component, the first input being an improved and expanded cadre of trainers and in-service and pre-service training. The second is the establishment of an MCH training site. Services for voluntary surgical sterilization, infertility, and sexually transmitted diseases constitute input three, improved management systems and facilities input four, and expanded health services input five.

Since 1980, 270 nurses and nurse midwives have been trained and 80 have attended refresher courses. INTRAH has trained 42 trainers in over 16 weeks of sessions, and 21 persons have had overseas training in family planning, about 16 since the FHS Project began. However, local training has dropped since 1985 when 20 people received new training and 90 received refresher training. The Evaluators noted that recent consultants consistently mention the lack of knowledge and/or application of FHS skills to service delivery. There is clearly an imbalance between the extensive training needed by field personnel and out-of-country training, the relative cost of which is hardly comparable. This is especially disturbing in view of the great need to train nurses and midwives in the 93 MCH clinics throughout Somalia.

There has not been nor appears to be any plan to develop adequate training materials for in-service training of nurses. The manual used has been cited as outdated and inadequate by several consultants. The Team concurs with this view and urges the provision of TA to

develop materials and improved training methods. Although the nursing school recently added FH to its curriculum and the Post-Basic school now includes FH, nurse midwives reportedly still do not receive such training. Up until now, only those doctors who will be associated with special services have received training (at JHPEIGO). The Project Paper calls for training modules for PHCs, CHWs and TBSs. Since these people likely will be used as CBD/C workers, this is another area where training materials are urgently needed.

The FH/FP training facility has not been established, although plans now call for this in 1987. The search for a site is complicated by the fact that it must accommodate office space, a warehouse for contraceptives and other commodities, as well as training space. The Team feels that it may be wise for the FH/FP Division to establish the training facility as soon as possible in quarters separate from the other functions.

A unit devoted to voluntary sterilization and sexually transmitted diseases has been established at Benadir Hospital in Mogadishu, and others are scheduled at Kismayo and Hargeisa during 1987. However, sterilization is against Islamic tradition and Somali law and is seen as potentially counterproductive to acceptance of the FHS Project.

Improved management and facilities is the second priority MOH activity in the Project Paper. A local U.S. consultant helped the FH/FP Division evaluate its management structure in 1985 and made recommendations which became the basis for a planning workshop. The current MCH Advisor also has developed some other possible alternatives for reorganization of the FP/FH Division. More emphasis on management is requisite although the Director and Advisor have taken important steps to improve supervision of MCH clinics. For example, supervisors are assigned to monitor clinic activities in all 8 regions where contraceptives and new record forms have been placed.

A consultant provided by CDC each year from 1982 to 1985 and again by URC in 1987 evaluated the FH/FP logistical supply and record keeping system. Her recommendations, plus the initiatives described above, should assure proper warehousing, inventory control, and logging in and out by expiration date of contraceptives, rationalize the logistical supply line and provide a simple, routine, easily maintained record system on new and continuing users by method. A quick observation by the Team confirms the report of the January 1987 consultant that, while there may be progress in the last few months, much more must be done to institutionalize a MIS as part of daily management.

The Project Paper provides for TA at six month intervals to assist the FH/FP Division to improve financial accounting and management. Little has happened until February of this year when URC, at USAID's request, provided a consultant to advise SWDO and CDC as well as the MOH on accounting procedures. The results of this TA and the efforts of the MCH Advisor along the same lines depend on the willingness of the Division to use the suggestions.

The final input in Component III is the expansion of health services. Here it is evident that the FH/FP Director and her staff are committed to such a course. Adequate supplies and equipment are on order as of February, 1987, and steps such as equipment inventory and maintenance

schedule guidelines are being taken to improve MCH clinics. The projected need for contraceptives, however, appears to have been overstated. A rough calculation of total fertile couples in Somalia shows the expected orals alone would supply over 15 percent of these couples. The end of Project target is 8 percent acceptance. Even assuring the 1987 order was to supply the pipeline in 1990, the contraceptive needs in the Project Paper are excessive.

The FHS Project focuses on expanding delivery services through MCH clinics. Contraceptives have been placed in 40 clinics and 7 hospitals in eight regions. The goal is services in 60 clinics and 20 hospitals. Unfortunately, the PHC system expected to supplement MCH expansion is advancing sporadically and slowly. While it seems a rational decision to cooperate with other donors to avoid duplication and reduce recurrent costs, it is impractical given current realities. The Project thus is rightly looking into other means of service delivery. Expansion through the private sector is a positive move which identifies physicians, nurses, CiWs and TBAs as part of the network. Another active private sector outlet are represented by the drugshops operated in small towns and villages. A 1985 PRICOR study showed that over 90 percent of Somalis purchased drugs from private sources, the most common of which were the drugshops.

The FH/FP Division has become quite involved in strategy and design of IEC activities. While there is good reason for FH/FP to make inputs into strategy decisions, involvement in the more technical aspects of IEC could divert attention from the main purpose - service delivery. The issue of proper balance between demand creation through IEC and provision of supplies and services is discussed in several of the Team's recommendations.

Component IV Operations Research

USAID's contribution to Component IV is \$1,610,000, including \$1,040,000 for technical assistance, \$15,000 for training, \$380,000 for commodities, and \$175,000 for contingencies. The GSDR contribution is \$810,000, including salaries, travel and per diem, packaging of contraceptives, and related costs.

The Component IV outputs are as follows:

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 of contraceptives.

The OR Unit was established in late February, 1986 at the time of the arrival of the Advisor. The Technical Committee charged with advising on activities and reviewing proposals was formed in May. The OR Director, Abdiraham M. Nero, a long time SFHCA employee, was in place prior to the arrival of the Advisor, Robert W. Morgan. The OR Unit is part of the SFHCA and, thus, under the direction of the executive staff and Board.

Several major problems have faced the OR Unit from the beginning. First, there is no discreet budget as there is for other units. All OR shilling costs must come through the SFHCA and be approved by the Board of Directors. No budget was submitted to MOF by the Association for 1986. The DDD literally interpreted the Project Paper schedule, which calls for establishment of the OR Unit a year after the contractor is selected, so budget approval was delayed until December 1986.

The second problem relates to the perception that OR is less important than other activities. For example, the OR Working Group is made up of individuals representing each of the cooperating organizations. Since the participants receive no extra compensation and, given the lack of commitment by their employers to OR, they are often unavailable for OR activities.

Output 2. The two week seminar described in the Project Paper for all contract advisors, their counterparts, and research and management staff of cooperating organizations, was held as a two day workshop in November, 1986. A second workshop is planned for late 1987. The Director participated in a Project study tour to Korea, Thailand, and Bangladesh and participated in a special short course at the East-West Population Institute enroute. The ORWG received valuable on-the-job training in connection with a two village KAP baseline and radio listening study as well as the Hodan survey and analysis accompanying the first IEC campaign.

The third output calls for three large and other small scale studies: however, there is little suggestion of what is large or small.

The most ambitious OR study during 1986 was carried out in two villages in Jowhar District, Middle Shabelle Region, from September 1-4, 1986. In-depth interviews of 396 people revealed baseline information on social, demographic and health behavior, plus KAP levels on nutrition, breastfeeding, use of ORT, child spacing, and female circumcision. Characteristics of radio/TV listening and viewing were also surveyed.

In preparation for the first IEC campaign in Hodan District, the OR Unit conducted a needs assessment followed by a pre-test. Immediately after the two week campaign, a post-test was scheduled. Data collection was similar to that of the Jowhar District Survey, but focussed on the Tabela and community leaders who were to participate in the campaign.

The major survey activity for 1987-99 is the Family Health Survey II. According to the Project design, the OR Unit is to take the lead role assisted by a USAID add-on of TA from the Demographic Data for Development central contract. The evaluation team feels this activity is better placed with the MONP.

The fifth output, Program Monitoring Systems, is intended to help other components and participating organizations identify successful approaches or suggest adjustments. Little has been done thus far, but the pre- and post-tests in Hodan represent monitoring functions.

The final output is Contraceptive Social Marketing; TA is the responsibility of AED under a subcontract. The first activity was an analysis carried out by an AED consultant in followup of a feasibility study initiated by USAID and conducted by SOMARC in 1984. The AED

consultant suggested that careful analysis of the institutional framework is the logical starting place for developing CSM in Somalia. She also suggested several market research studies which the OR unit might usefully undertake in preparation for developing a marketing strategy. The evaluators feel that CSM is a premature activity in the early development of the FHS Project in Somalia for several reasons, perhaps the most troublesome being the high visibility of CSM and the cost of implementation in Somalia. In the context of a country still unsure of its stance on family planning, the implementation of a CSM program by an organization (SFHCA) just getting off the ground could have negative results. On the other hand, the private sector appears to be thriving as the GSDR experiments with relaxing restrictions, and this could bode well for a CSM Project in the future. One of the Team's recommendations deals extensively with the possibilities of greater use of the private sector for community based distribution. This has significant implications for the future of CSM in Somalia.

Observations and Recommendations

Overall Project

1. The estimate of project expenditure varies according to which exchange rate is used. DDD appears to be using the SOSH 17.9 exchange rate which appears in the Project Paper, to calculate expenditures. The Project Agreement, however, which is the legally binding document, stipulates that the exchange rate prevailing at the time of disbursement is to be used.

The Team, therefore, recommends that USAID take the necessary steps on behalf of the Project to make clear that the Project Agreement is binding. Furthermore, the budget for the remainder of the Project based on the Project Agreement definition should be assured and not left to annual negotiations.

2. The Project Directors in the participating organizations have expressed the need for training in the procedures related to the DDD budget review process. A workshop designed to explain the guidelines for budgeting and an overview of the DDD budget review process is needed. The accountant at SFHCA would benefit from specialized instruction in these procedures in order to assume additional responsibility for the FHS budget.

The Team makes the following recommendations:

- a. That USAID make arrangements for appropriate training of Project Directors and the accountant at SFHCA in DDD budget review process and procedures.
- b. That careful consideration be given to the adoption of a consolidated budget representing all participating agencies. This would serve to demonstrate a unified commitment to the Project by the participating organizations and provide an opportunity for the MONP, the lead organization, to lend its prestige to the unified budget request.
3. The SFHCA Board has the opportunity to provide more consistent and effective support of the Project, but the following factors are handicapping its efforts: (1) Board procedures and responsibilities are not clearly spelled out; (2) the separate roles of the Board and the Project Coordinating Committee are not being observed; (3) the multiple membership of individuals on boards and committees diffuses responsibilities and authority.

The Team recommends that the role and procedures of the Board be clarified vis-a-vis the Project Coordinating Committee and the IEC Directors. If technical assistance is needed in the process, USAID should provide it.

4. SFHCA representation at the field level is not equivalent to that of the other participating agencies. The mechanism used to effectively coordinate the activities of the five participating organizations in Mogadishu is mitigated in the regions by distance, time, travel expense and difficulty of communication. In addition, although there are some SFHCA volunteers serving at various locations in the regions, they are either unpaid or staff members of one or more of the participating organizations and subject to conflicting interests.

The Team recommends that SFHCA explore alternative mechanisms for allowing its volunteers to have a role equal to that of other institutions in the field, perhaps utilizing OR in the process.

5. The present central role of IEC in the Project is justified given the low levels of KAP about FH/FP, the strong desire for many children, the lack of commitment to education and the absence of family and population policy. The IEC component should, however, be developed in unison with service delivery and exploration of various delivery systems to supplement MOH clinical services should begin immediately. The tradition of private sector sales of drugs is well established in Somalia through pharmacies in urban centers and drug shops in rural areas. Doctors are permitted to maintain private practice and, in areas where they are available, are providing the bulk of FH/FP services on a fee basis. Nurses operating out of their homes routinely provide FH/FP services for a fee. Even TBAs and CHWs often act as private sector fee providers.

The Team, therefore, makes the following recommendations:

- a. That the Project stress the provision of FH/FP services through the private sector.
- b. In view of the high visibility of social marketing projects, the Project should move first into community based and other distribution modes as a means of assessing the feasibility and acceptance of social marketing during any extension of the project. OR should be used extensively, particularly in connection with the test IEC campaigns, to develop the parameters for social marketing, advertising and promotion.
- c. The Project Paper calls for TA to the OR Unit of the SFHCA to explore the feasibility of using alternative delivery systems.

TA should be provided to assist the FHS Project as a whole in assessing the various available options for service delivery to supplement the MCH clinics. The TA consultant's scope of work should include an analysis of organizational structure and management of the delivery of supplies through all potential providers and delivery modes. Such TA and analysis would be most valuable if provided to the FHS project as soon as possible.

6. The Project designers clearly perceived the need for a strong family planning emphasis in the Project. This is documented by the substantial budget provision for contraceptive supplies. At the same time, the designers recognized the importance of process development in the Somalia situation in which most of the usual facilitating factors for introducing family planning are missing. Thus IEC was given a central role as a means of initiating a formative process, hopefully resulting in a set of guiding principles for future Family Health/Family Planning program development.

Given this context, Oral Rehydration Therapy is a logical initial thematic emphasis in combination with female circumcision and child spacing. However, ORT bears little relationship to child spacing except the tenuous one that if children survive, mothers may be willing to listen to messages on FH/FP.

The Team recommends that the Project carefully monitor the results of the first set of IEC campaigns, being sensitive to changes in KAP. If there is sufficient evidence of increased support for child spacing, emphasis in the future campaigns should be shifted away from ORT and toward child spacing. The Team suggests that breastfeeding, which is within the spectrum of child spacing methods, is a particularly suitable substitute for ORT and an appropriate FHS emphasis. The team feels that the decision on major campaign themes or sub-themes be made on the basis of careful research on prevailing attitudes and behavior changes rather than on administrative grounds or even the current policies of other international assistance agencies.

7. The Train-the Trainer process initiated in the regions early in 1986 is a particular strength of the project. A core trainers group was established; Regional Communicators were identified, placed, and trained; action plans were developed, implemented and tested; and an ongoing process of team building was begun on the part of those representing each region.

The team recommends:

- a. That the IEC Directors adopt the training design developed during 1986 and reaffirm with the Regional Teams the importance of continuing to carry out their action plans.

b. The IEC Directors should, to the extent of their ability, provide support to the Regional Teams through visits to the regions, letters both to the teams and to the regional officials and hopefully sometime soon, statements in the mass media. Providing copies of prototype IEC materials to the Regional Communicators before they are otherwise finalized and distributed would serve to build team feeling and morale.

c. The substantial body of knowledge represented in the Training of Trainer workshops, field presentations and action plan implementation should be used as the bases for a training manual. If technical assistance is required, the Project should provide it.

8. The SFHCA's rented facility is inadequate to meet present needs and will become more so as audio-visual equipment arrives and the Resource Center is developed. Although the availability of office space for key staff is better than in the previous building, the meeting space has drawbacks and the space available to the Resource Center is entirely inadequate.

The team recommends that the possibility of securing more space in the existing building be explored or, if that is not feasible, new and larger space which will serve all present and expected future needs should be sought as soon as possible.

9. In the normal life of any USAID project, roles and responsibilities of organizations as well as personnel will change. These changes, along with new procedures and perhaps even new policies, may shift emphasis or create a new set of rules. This can, in turn, cause tension, which can only be ameliorated if there is a common understanding of the changing situation.

The Team recommends that USAID convene a meeting of the PCC, FHS Project Directors and senior staff of Somali participating organizations, URC TA counterparts, and relevant USAID personnel to discuss the developmental stages of a project. The natural progression from design to implementation to maturity and, finally, to transfer (or termination) should be clarified in light of differing priorities, needs, policies, and procedures. It would be helpful if the USAID Deputy Director (or similar high level official) would issue invitations and chair the meeting. This would strengthen the image of the project in general and lend credibility to the relative importance of FHC as part of the overall program.

Component I

1. The mainline computer is an expensive major piece of equipment intended to assist the GSDR for many years to come. There should be two or three Somalis trained by Calwang to maintain the equipment on a daily basis. This should be for normal, onsite, routine maintenance and in addition to service out of Nairobi or other non-Somali cities as provided for in the Calwang contract.

2. The investment (equipment and training) in the computer facility justifies continued use by the MONP to generate data for improving development efforts. Planning for additional, relevant major studies should begin a.s.a.p. in concert with all donors to the GSDR. Priority always should be given, however, to studies which relate to population issues since UNFPA and AID population assistance provided the facility and training to upgrade processing and analytical capability.

3. The FH Survey II, now under the SFHCA OR activities in Component IV, should become the responsibility of the MONP with assistance from the OR unit. This will, among other things, capitalize on the MONP's upgraded capability, more readily insure priority on computer time, and take advantage of skills learned and aptly applied in the recent, outstanding implementation of the census enumeration. Results of the survey, also, would have more credibility and impact on policymakers if generated under the MONP.

4. If funds for support of remaining activities are short (due to cost overrun on the census), priorities should be established. The two demographic studies called for could be sacrificed. The scheduled population conferences and workshops on planning and analysis remain important outputs. If one choice must be made among remaining activities, top priority should be for at least one well planned, top level population conference. In the event that no Project money is available for additional Component I activities, other donor assistance should be sought for the population conference. This conference should be sponsored by the MONP rather than the MOE, as were past population conferences.

Component II

1. The team observes that as the Project has developed, the IEC Directors are becoming increasingly overloaded and, unless greater delineation of responsibilities is made, the Project will suffer. The overload is caused by the following kinds of factors:

- a. The dual responsibility of the IEC Directors for the Project and for their own organization's program;
- b. The increasing decisionmaking role being played by the IEC Directors group in the Project; and
- c. The multiple membership of key individuals in the bodies related to the Project, e.g., PCC, Board of SFHCA, Technical Committees.

Recognizing that Somali custom may not allow for sharp distinctions between the operational and the policy areas and recognizing that in order to move toward that objective the SFHCA IEC Unit must be qualified and readily available to assume operational responsibilities in close coordination with the Directors, the Team recommends:

That the IEC Directors attempt to limit their role in project development to IEC policy leaving the interpretation of that policy and its implementation to the IEC staff.

2. The Team concludes that materials development and production is probably the greatest area of need at this stage of the Project. The process of developing prototype materials for use in the test campaigns has been carefully conceived and carried out, and operations research has revealed valuable information on the kinds of materials most needed. The IEC advisor, because of his heavy responsibilities, however, cannot be expected to give the necessary time to this important input to the project.

The Team therefore makes the following recommendations:

- a. That technical assistance in materials development and production be provided for a minimum of one year, the individual selected to possess to the greatest degree possible both the creative qualifications and skills in the mechanics of production.
 - b. Equipment placed in the CDC should be accompanied by a specialist in maintenance and repair who can train others effectively in those skills (or as an alternative, a service contract with a proven organization should be negotiated).
 - c. The URC should be provided the budget flexibility to have materials produced outside Somalia where circumstances require it.
 - d. If necessary, an amendment to the Project Paper accommodating the realignment of IEC materials made at the November 1986 Project Review should be made using regular USAID procedures.
3. The Resource Center was seen by the Project designers as a key component in Project development. Unfortunately it has been delayed for a number of reasons and, at best, will only be available in its full form for about half of the Project's life. The IEC Directors have agreed on a set of guidelines for the operation of the Center as well as the scope of services to be provided.

The Team recommends that suitable space be identified for the Center within the next 3 months. If this requires additional construction, then the Board should help arrange it. The library area of the Center, with its resource materials collection, should be centrally located, and the audio-visual materials production section should be readily available both to the SFHCA IEC staff and to their counterparts in the participating organizations. Space planning should include the requirements of the librarian and the audio-visual technician.

4. The Ministry of Information and National Guidance (MING) has affirmed its interest in collaborating with SFHCA in developing FH/FP programming both on Somali radio and television. Both the Baseline Survey and the several surveys conducted by the OR unit confirm that mass media is effective in transmitting FH/FP messages. The IEC Directors in the debriefing meeting of the Evaluation Team expressed their desire that the MING be included as a participating organization in the Project. The Team, therefore, recommends:
 - a. That a steering committee representing SFHCA and MING (Radio Somalia and Somali Television) be established to develop guidelines for radio and television broadcasting of Project related FH/FP programming.
 - b. That a local budget be made available to the MING based on the adoption of steering committee plans for radio and television programming.
 - c. That a goal of commencing radio and television broadcasting be set for no later than the end of 1987.
5. The IEC Directors designated the SFHCA as the participating organization responsible for developing activities to influence political and religious leaders. This is an appropriate role for a non-government organization and one that is carried out by IPPF affiliates all over the world. The Board has signified its intention to make this a special concern.

The Team recommends:

- a. That the SFHCA acting through its Board move aggressively to inform and educate religious and political leaders. In terms of political leaders, the Board should seek the opportunity to collaborate with the Ministry of National Planning in its efforts to use the results of the recent census and post surveys to develop IEC activities designed for policymakers.
 - b. The Board should also consider availing itself, along with the MONP of the USAID centrally funded services of OPTIONS and IMPACT which, along with RAPID II, are prepared to assist in developing IEC programs for policymakers. In reaching both religious and political leaders, the Board should include these located in the regions as well as in Mogadishu.
6. The Project Design gave substantial importance to the Technical Advisory Committee which would operate in close coordination with the IEC Directors. The TAC was to include representatives of each of the participating organizations and was to ensure that each group's interest in technical accuracy and interpretations of technical input were protected. The functions of the Committee, however, were subsumed by the IEC Directors, and the committee was abandoned.

The Team recommends that when questions of technical interpretation or technical accuracy arise, the SFHCA employ the base possible specialists available and pay what the market requires.

Component III

1. The long term advisor should be available to the end of the Project period. The URC contract should be amended to include an additional six months.
2. Training for clinical service delivery remains a weak point for the FH/FP Division. Top priority should be given to training. Emphasis should be on more in-country and less overseas training at this juncture.
3. TA should be provided to assist the FH/FP Training Unit to develop more effective training systems. This is especially important as less sophisticated providers (e.g., CHWs and TBAs), are brought into the FHS project service delivery system.
4. The OR Unit should assist the FH/FP Evaluation Unit to assess why training appears to persist in having a missing link between learning and practice.
5. The OR Unit, also, should provide assistance to monitor quality control of service delivery on an ongoing basis.
6. There is a continued, unmet need for up-to-date, suitable training materials for all levels of service provider. This includes materials for pre-service and in-service training. TA should be sought immediately to help the FHFP Division develop materials, since training materials and teaching aids are the foundation for training systems. Adaptation of existing materials is preferable to the time consuming development of new materials, and resulting materials should be in Somali, as well as English, to facilitate learning according to individual language skills. All materials produced should be properly tested prior to final printing.
7. The FH/FP training facility should be established immediately. This facility should be established independent of the office and warehouse move if suitable space to accommodate all three functions is not located by June 1, 1987.
8. Additional TA may be needed in the future to assist with simplifying and training in the MIS. This is a second priority need.
9. Provision of Voluntary Surgical Contraception as part of services to be provided by special FH services clinics is not appropriate. VSC is illegal, proscribed by the Islamic religion, and politically sensitive. It might be preferable to refer to such model clinics as fertility and infertility service facilities. They should provide quality fertility care, infertility services, and preventive and curative services for STD. VSC should be eliminated from such clinics.
10. Expansion of service should not be narrowly interpreted as confined to MOH facilities. It is the intent of the project design and a rationale action to include private sector medical providers as part of the service delivery system. This will allow greater client access to FH care and elicit support for the Project from the medical community.
11. Delivery of quality FH care is the keystone of the FHS Project. This is primarily the responsibility of FH/FP. The Project design focuses all activities of this components on upgrading provider skills to deliver services. IEC activities are the responsibility of the IEC unit of the SFHCA and meant to be a support and service to other components. While it is important for FH/FP to communicate its needs for IEC materials to the SFHCA IEC Unit, FHFP should remain aloof from involvement in detailed design, testing and production of materials, and in strategy planning for the media. It is important, however, that the FH/FP make substantive input to policy and overall planning so that IEC activities will effectively create demand and support for FH services, which, indeed are the essence of the entire FHS Project.

Component IV

1. The OR Unit of the SFHCA needs additional staff if it is to effectively perform its important support functions to the other three components. A coordinator, who can assist with management and administration and with institution and field liaison, is needed to strengthen the capability of the OR Unit. This will free the Director for more skilled, professional tasks. The Coordinator's position should be funded and filled as soon as possible. Money should be included in the OR budget for contracting services from cooperating organizations for individuals to perform OR related tasks on an as needed basis. This will provide on-the-job training for a future cadre of skilled personnel for the project and the organizations.
2. The TA Advisor's position is scheduled for two years. Since the Unit was established almost a year ahead of schedule and approval given for simultaneous arrival of the advisor, there is need to extend this position for at least a year and preferably to the end of 1989.
3. Small studies responsive to the needs of other components and the Project as a whole are more important than large, time and manpower consuming studies. Such studies are more in the nature of OR and in keeping with the special needs of the FHS Project. The FII Survey II, e.g., is more an evaluation of project impact and, therefore, less appropriate for the OR Unit and the Project development than are relevant, small-scale studies which will guide the Project in policy and implementation. Numerous small-scale studies, also, are a superior training tool for cooperating institutions, and training personnel outside the OR Unit is one of its prime tasks. The annual workplans for OR, therefore, should concentrate on smaller, frequent studies which will produce information to maximize project effectiveness in achieving the Project goal.
4. OR can greatly assist Components II and III by undertaking monitoring services which will help personnel evaluate performance and identify activities needing adjustment. The objective of such OR services is to achieve maximum benefit from component activities. Key personnel from cooperating institutions should be made aware of the valuable monitoring functions the OR Unit is prepared to undertake or assist in designing. Individual organizational needs should be prioritized and scheduled in the OR annual workplan according to relative importance and benefit to the Project as a whole.
5. The Social Marketing Project is also addressed in recommendations relevant to the entire FHS Project and in Section V E. of Component IV. CSM is a major program and a highly visible activity. It is preferable to postpone such a program until the concept of FH is more widely accepted in Somalia.

I. Project Goal

The long-term goal of the Family Health Services (FHS) Project as stated in the Project Paper is to improve the quality of life for the Somali people, the measure of achievement being improved maternal and child health and improved population data. The current life of the Project is 32 months dating from the signing of the Project Paper and only 18 months dating from the signing of the Contract with the University Research Corporation. Although there were activities underway before the Contract Team arrived, they were not focused on a unified set of implementation strategies. The foregoing is to say that progress toward such a lofty goal at this early stage has to be largely limited to process (or formative) factors. "Setting the stage to achieve" perhaps best describes the implementation efforts to date.

AID has supported four other major family health activities in Somalia since 1979. They include JHPIEGO Reproductive Health Training Project; the INTRAH Family Health Training Project; the Westinghouse Family Health Survey; and the Family Health Initiatives Project. Each as provided experience and helped to establish the foundation upon which the present Project is based.

The development of this Project took place over a two year period, including a review of Somalia's population activities by USAID technicians in 1983. The Project Design team, lead by Margaret Neuse, then USAID Population Advisor in Somalia, included a highly competent group of demographers, computer specialists, project design specialists, census experts, IEC specialists and other social scientists. They represented the Bureau of Census, REDSO and USAID Contractors, in addition to USAID. Their Somali counterparts were distinguished representatives of the organizations that now constitute collaborating Project organizations.

The Project design recognizes that 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 socioeconomic development. Sensitivities regarding population and family planning 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 are being incorporated into maternal and child health and primary health care programs to help reduce infant and child mortal. At the same time, the development of family health services offers a potential counterbalance to adjust the growth in population that results from lower mortality rates. The Project also provides for improved population data and the means to relate those data to policy regarding future prospects arising from the growing population.

Improvement in the health of mothers and the saving of infant and children's lives represents unquestionably worthy contributions to the quality of life in Somalia. Whether a growing awareness of increased survival of their children will cause Somali couples to accept modern contraceptive methods cannot be predicted; indeed, research evidence on the question is inconclusive. However, the effort is justified, and the FHIS Project design appropriately supports the effort.

II. Project Purpose

The purpose of the Family Health Service 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 Grantee is the Government of Somalia represented by the Ministry of National Planning (MONP). The Permanent Secretary is chair of the project coordinating committee (PCC). The primary executing agencies are the Central Statistical Department (CSD) of the Ministry of National Planning (MONP), the Family Health/Family Planning (FH/FP) Division of the Ministry of Health (MOH) and the Somali Family Health Care Association (SFHCA). Other contributing agencies include: the Somali Women's Democratic Organization (SWDO) and the Ministry of Education's Curriculum Development Center (CDC), Health Education Unit (HE), and Women's Education Department (WED).

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

Three distinctive characteristics of the Projects serve to identify design and implementation strengths and weaknesses:

1. The collaboration of five relatively diverse organizations, each providing a unique set of resources to the Project, each representing a unique constituency.
2. The coordinating responsibility vested in the private sector Somali Family Health Care Association created by the Parliament to perform this role vis-a-vis the involved government agencies.
3. The common unifying focus on IEC among three of the four Project Components.

At this early state of project implementation, these three characteristics are strengthening factors toward accomplishing the Project purpose. There has been a remarkable degree of cooperation and coordination among all participating organizations. (The exception is the MONP, which has relatively independent sub-goals, purpose, and tasks.) These same characteristics, however, are potential weaknesses for the following reasons:

1. By nature, ongoing collaboration of organizations with differing overall goals and functions has a built-in fragility.
2. Coordination of the activities of government ministries and personnel by a private sector agency (in this case, in a socialist state) is tenuous, experimental, and sanctioned as an unofficial convenience to government.
3. A strong IEC program is necessary in Somalia, both to influence policymakers and opinion leaders and to create demand for FH services among potential accepters. However, unless progress toward these objectives is carefully monitored and adjustments made there is always the possibility of focusing too much on the mechanisms of IEC while neglecting the behavioral change goals.

The following observations about the participating organizations should be viewed within the context of the above strengths and weaknesses: each of the strengths contains the potential for a future, counterproductive weakness.

The MONP's CSD is responsible for developing data to support a population policy and has almost no involvement, thus far, in coordinated Project efforts. The CSD recently conducted a national census and will report the statistics and results of other demographic surveys at major population

conferences. Dr. Hussein Elabe Fahiyeh, Permanent Secretary of the MONP, and Awil Mohamed Farah, head of CSD, however, are on the PCC.

The Ministry of Health is the key organization in terms of FH service delivery. The Family Health/Family Planning Division created in 1981 is part of the Division of Maternal and Child Health (MCH) under Department of Community Health. In this department are all other health services directed to the rural and urban populations in Nutrition, Diarrheal Control, Primary Health Care (PHC) Expanded Program in Immunology (EPI) and School Health. Dr. Rukiya Mohamed Seif is the Director of FH/FP and is represented on the Project Coordinating Committee (PCC), SFHCA Board of Directors, and IEC Committee. MOH workers located in MCH Clinics and Primary Health Centers provide FH as well as other health services and also contribute to the FHS Regional Project Communicator Teams, which are expected to carry out coordinated IEC campaigns in the field.

The Curriculum Development Center is the basic unit in the Ministry of Education (MOE) charged with developing curricula and producing the supporting materials. The Health Education Unit within the CDC relates most directly to the FHS Project through its development of classroom materials in family health education. The CDC is also related to the Project through the development of printing and related production capability. Hassan Obsiye Dahir is the Director and participates in the Project as a member of the PCC and an IEC Director.

The Women's Education Department within the Ministry of Education has the responsibility of operating Family Life Centers in the districts in close cooperation with local governments. WED also conducts a variety of non-formal educational programs for women. District educators operating from the Family Life Centers are members of the Regional Communicator's Teams. Hawa Aden, Director of WED, is one of the PCC members, a Project IEC Director, and Board member of SFHCA.

The Somali Women's Democratic Organization is the women's arm of the National Party and maintains a grassroots mobilization capability. The target audience is women and the communication strategy features regular weekly home visits. SWDO is represented on the Regional Communication Teams. The IEC Coordinator is Abdullahi Issa Gaad who is a Project IEC Director as well as PCC member.

The Project design exploits the mutually complimentary strengths of each of these organizations. WED contributes orientation and training facilities, SWDO the mobilization experience, CDC the curriculum and materials development expertise, the MOH the link to health and family health services. While the interrelated system has developed to a significant degree in the short life of the Project, it is yet to be proved viable in the regions where monitoring, supervision, and physical facilities are often lacking.

The SFHCA has the lead role in coordinating the activities of the other organizations in the Project. The complexity of relationships can be gathered from the fact that SFHCA is a private group operating among government agencies, it is an IPPF affiliate with separate funding from the parent organization, and its board is composed of representatives of Somali institutions with most direct concern with family health. Furthermore, the Association has to deal directly with USAID and with the Contractor, the University Research Corporation, each of which has very specific regulations and requirements. Although SFHCA has a competent staff, it is at this stage of the project a relatively untested organization. The establishment of such an organization in Somalia is highly unusual, and there is little experience to guide it.

A Project Coordinating Committee was formed by the lead agency for the Project, the Ministry of National Planning. The PCC includes each of the participating agencies plus the Ministry of Information and National Guidance. The staff of SFHCA serves as the Secretariat for the Committee and prepares documents, arranges meetings, prepares agendas, keeps minutes, and submits reports.

Experience thus far shows that there is a substantial lack of delineation between the functions of the Coordinating Committee, the IEC Directors group and Board of SFHCA. In part, this is caused by the multiple membership on the different bodies by key individuals. As the FHS Project developed, the IEC Director's group has assumed the responsibility of the PCC. The Project Paper includes the requirement for technical assistance in each year of the Project to assist the staff of SFHCA to develop and refine the roles, responsibilities, and procedures of the Coordinating Committee.

The emphasis given to IEC in the Project is unique among current country family and population programs. The Project design provides for building a comprehensive IEC resource base in the SFHCA. This resource base will be available to the participating organizations for developing their own activities as well as for developing unified activities. The services available to the participating organizations include IEC training, operational research, materials development and evaluation, audio-visual equipment and production, and IEC planning and strategy development. In sum, the centralized resources at the SFHCA have the potential to substantially strengthen the capabilities of Somali institutions in IEC.

The development of systems to adequately deliver services on a timely, wide-spread basis are not keeping pace with IEC efforts. First, the Project design may rely too heavily on clinical delivery through the MOH's MCH and PHC clinics. Second, there is recognition in the project paper of the need to experiment with other, non-MOH delivery systems; but suggestions for implementation, organization responsibility and structure and budgetary support are much less clear. While every effort should be made to strengthen the capability of the MOH to delivery FH services, this team feels additional delivery systems to supplement MOH clinical delivery will be necessary if the Project is to adequately deliver services to meet the demand which will be created by the major IEC efforts.

Potential FHS providers include: doctors and nurses, TBAs, CHWs, Tabela leaders, school teachers, WED's Family Life Teachers and drug shop owners. All are worth exploring and testing as means to expand delivery and provide easier access for consumers. One or more can be the foundation for effective CBD program. Although any one of these groups is a potential provider of free supplies, all, however, should be viewed as possible entrepreneurs.

Use of the entrepreneurial private sector, which by definition, functions on remuneration for services, will require decision-making about logistics and cost factors. Logistics include considerations regarding: who will supply, what methods will be provided, where goods will be obtained by providers, when goods will be available, or how goods will be routinely supplied. Cost factors relate to decisions such as supplying providers with free or priced goods, at what prices "middlemen" fees, and control over consumer price. If goods are sold by the FHS Project, this can bring nominal funds back to the Project. With the complexity of the Project and multiple organizations involved, however, sale of goods by the Project will create obvious and normal competitive problems. It appears preferable to continue to allow flow of free AID supplied contraceptives through currently existing mechanisms. USAID will have to clarify the possibilities for supply of free contraceptives, especially on an official basis, to doctors and other medically trained persons operating in the private sector.

We are especially optimistic about distribution through drug shops since (1) the system already is regularly and well supplied; (2) consumers overwhelmingly use and prefer these outlets for drug needs; and (3) many drug shop owners are entrepreneurial TBAs, CHWs, or other local folk. In addition, one of the recommendations of this evaluation report is to postpone social marketing during this five year project period.

There has been substantial progress to date toward strengthening the capabilities of participating organizations to promote, support, and coordinate FH programs. The capability to sustain FH programs which meet their full potential can only be reached, however, if IEC and service delivery develop on a parallel course and are mutually reinforcing. The support of the MONP, the lead organization, and its commitment to developing a positive policy atmosphere also will greatly enhance achievement of the Project purpose. If present cooperative efforts are maintained and the SFHCA can continue to function well in its coordinating role vis-a-vis the participating organizations, the Project has an excellent chance of fully achieving its purpose.

COMPONENT I

Population Data and Policy

Sub Goal: to provide accurate, timely data and analysis to guide policies and programs leading to the project goal of improved quality of life.

Purpose: to strengthen capabilities of Somali institutions to collect, process, analyze and apply population data through: 1) transfer of computational technologies, and 2) training and TA to improve technical and management skills.

Intended Outputs:

1. Computer hardware and software upgraded
2. New population census completed
3. Report on analysis of 1987 Population Survey
4. Report on analysis of 1982 Settlement Survey
5. Two demographic studies
6. Two workshops on data analysis and planning techniques
7. Two National Population Conferences

EOPS:

1. Central Statistical Department (CSD) of the MONP will have improved computational technology
2. MONP have improved technical and management skills.

I. Relevant Background Information and Interrelationships with Other Components

For several reasons, Component I is an effort relatively independent of the other three. It, nevertheless, has potential for major impact on the entire project because of its role in policy formation by the GSDR and its tie-in, through the MONP, to several important government ministries.

- A. This component has inputs from multiple donors. In addition to USAID, support comes from UNFPA and the Italian government. AID, through centrally funded contracts, provides additional assistance.
- B. Activities are performed under the MONP, the ministry directly responsible for the entire FHS project and a high priority ministry for the GSDR. The MONP is the recipient of a larger share of funding than any of the other components.
- C. Although there are several activities scheduled in Component I, the major activity is the 1986 census. The enumeration, analysis and reports are under the direction of the CSD, which will have primary access to and oversight of the new mainframe computer and software (the most advanced computer technology in the SDR).
- D. A key link to and support for other components comes from the Permanent Secretary of the MONP. Hussein Elabe Fahiyeh serves as chair to the Project Coordinating Committee (PCC), the policy body for the FHS project. Elabe also has an interest in success of the SFHCA and one of the senior staff of MONP and head of CSD, Awil Mohamed Farah, serves on the Association's Board of Directors and on the PCC. The Permanent Secretary has a keen grasp of the impact of high fertility and rapid population growth on education, health and other government services, general development efforts, and the role of women.

- E. The prime relationship to Components II - IV is to provide data to support their activities and to provide the basis for high level policy decision which will lend credibility to overall project goals and activities. Policy support should be strengthened through the involvement in several Component I activities of several ministries, opinion leaders, politicians, regional and local officials, and the intellectual and scientific communities. The following ministries, e.g., cooperated in the census enumeration: Ministry of Interior, Ministry of Education, Ministry of Transport, Ministry of Finance, and Ministry of Defense.

II. Inputs

- A. This Component is absorbing the lion's share of the 20.3 million dollar USAID and GSDR financial commitment to the FHS project. The census overwhelmingly has been the most expensive of the seven activities in Component I. Total commitment to this component is close to \$ 1,795,000 by USAID, about \$ 1,000,000 each by UNFPA and the Italian Government, and the Somali Shilling equivalent of close to \$ 7,000 by GSDR. Computer related USAID costs account for \$1,150,000 alone.
- B. Substantial technical assistance, primarily for the census, comes from the donor community as part of this funding, and AID centrally funded contracts have added/will add inputs to other Component I activities. UNFPA, e.g., provides experts in cartography, census planning and implementation, data analysis and demography; and USAID supports training of Somali nationals in computer programming, key punching, etc. (part of computer costs). AID, through central contracts, assists activities related to output 3, 4, 5 (planning, analysis of studies, and reports on demographic studies), 6 (workshops), and 7 (national conferences). Total USAID dollar commitment to TA is \$450,000 spread across all seven activities. Contingency is at \$ 195,000.

III. Progress Toward Accomplishing Component Outputs 1 - 7

I. Upgraded Computer Capability

Facility and Equipment: Hardware and software for a mainframe computer are in place; and the facility, located in the MONP building, appears to be exceptional, with more than adequate, efficient capability. It is located in a well planned, well lighted work space. There are several separate workrooms housing micro computer centers, several of which are PC's which can operate independent of the mainframe. There were delays in installing equipment due to site preparation. Major difficulties and deficiencies by Italian engineers appear to be corrected, and only minor problems await correction (soundbarriers for AC Units and touch-up painting).

Power Supply: A separate generator for operating the computer and several large air conditioning units can alternate with city power supply, and there is a UPS, or failsafe device, to hold data if power is interrupted from either source.

Equipment Testing: Calwang, the manufacturer, has sent technicians from Nairobi to install and test the system. The equipment has passed tests regarding major hook up, and a few minor tests will be conducted soon through generator power (fuel allocation to the MONP has been short and city voltage is irregular). Calwang does not foresee problems which could not be rectified easily and quickly. USAID recently authorized all but the last quarter payment to Calwang. The company provides a maintenance service contract.

Data Processing: Calwang is the contractor for training all CSD selected programmers (8), supervisors (2) and key punch operators (4). The company has maintained the position that training cannot begin until the computer is on line. Delays in site preparation, equipment installation, and testing have precluded meeting the time schedule for training, and Calwang has remained firm about the need to first have the system fully operational. USAID has communicated to Calwang/Nairobi to begin immediately any basic training which may not require working computers. Lack of trained personnel, among other things, will cause several months delay in data processing. A second delaying factor is BUCEN's cancellation of a contract with AID to provide a team of data processing advisors in the fall of 1986. UNFPA has agreed to provide the 3 person team, scheduled to arrive in June, 1987. UNFPA also will provide 3 demographers in 1988 to assist Somali demographers in data analysis. The rescheduling of data processing and subsequent analysis likely will delay information from the census by as much as six months or more. The project design team in 1984 anticipated data processing as a problem area because there was no UNFPA representative in Somalia; UNFPA, however, has been responsive in providing qualified TA in a timely fashion beyond that originally agreed to. The delay in data processing because of training and BUCEN's withdrawal from the Project is most unfortunate since none of the other anticipated problems with the census itself materialized.

2. Census

Problem areas identified by project team: There were numerous concerns related to mapping, nomadic population, overall management, requisite cooperation from other ministries and from regional and local officials, and logistics in implementation. Any problems which arose were not sufficient to impede the census. The entire effort seems to have gone well both in planning and execution.

Planning: The beginning of planning process was delayed for six or so months. The schedule laid out called for 15 months from initial work through the Post Enumeration Census (PES). This is far more realistic than the 9 months envisioned in the project paper. The entire effort fell behind schedule by only two weeks, a remarkable feat. Mapping of census enumeration areas (EAs), recruitment and training of over 15,000 enumerators and supervisors, development of questionnaires, preparation of maps, pretesting the plan, printing materials, physically demarking areas, and transport logistics—all in preparation for the actual census—requires good management and commitment from many people. The census enumeration in urban, rural and nomadic areas was conducted on schedule. Clearly, personnel of the CSD and the UNFPA TA advisor, John Rumford, worked well together.

Enumeration: The day of the census was declared a legal holiday by Presidential Decree. Enumerators (mostly students) went into assigned urban areas and villages and took position at nomad watering holes. (The census was purposefully conducted during the driest season when nomads congregate at traditional watering places.) Somalis cooperated willingly in the enumeration and few problems arose regarding reticence to respond to questions. Even nomads, about whom there was much concern, seemed very willing to participate. The nomad enumeration was observed by USAID representatives who were positive and enthusiastic in their reports.

Post Enumeration Census: A 1% sample survey was conducted within two weeks of the enumeration to check accuracy of the questionnaires. The PES, too, came off with few problems. While a few persons objected to being queried again so soon, most understood and complied with requests to answer questions. All in all, the census was considered a great success and very gratifying to the planners and all who cooperated in this large effort.

3. Analysis 1980 Population Survey:

The report on this analysis was published in May, 1986. A survey of a national sample (8000 households) to elicit basic demographic data was done by CSD with UN assistance in 1980-81.

The material was not thoroughly analyzed at the time the project paper was written in mid-1984. Although the final report was affected within 6 months (in Jan. 1985) of approval of the project, publication was not completed by CSD until months 17 with assistance from Data for Demographic Analysis Division of the Institute for Resource Development at Westinghouse, the expected central contractor. This evaluation team was not able to learn details about the delay. We consider it unfortunate that the published report was not available for the National Seminar sponsored by the MONP in November 1985. Also, this survey produced valuable demographic data which may have been underutilized as the GSDR geared up for the new census. It appears that publication (although probably not initial analysis) came after planning for the census began. The Survey did show that good basic demographic data can be generated in a country with such diversity of population (urban, urban-rural, rural, nomadic, refugee). The following selected data are taken from the National Survey of Population 1980-81, Report on findings, May 1986.

CBR : 48

CDR : 17

TF : 7.4

Fertility variables: H Nomad 8.1; other urban 8.0;

M Mogadishu 7; L Rural 6.3

IMR 147/1000

45% under 15 years

GR: 3.1%

Average age of marriage for women: 20 years

Polygamous marriage: 1 in 5 women

Literacy% : men 49; women 22 (drop off after age 24);

all 36% (highest urban)

Employment in agriculture: men 64%; women 86%

Self employed: men 75%; women 90%

4. Analysis 1982 Settlement Survey:

This survey of 2000 nomadic households in settlement areas was conducted by the Settlement Development Agency (SDA) with assistance from the University of North Carolina (UNC). The data is to provide information on socio economic consequences of settlement schemes for nomads. The analysis and publication was expected to be available for the November 1985 National Seminar and scheduled for completion in February 1985. UNC has reassumed responsibility for analysis and reporting, and the report is expected by CSD by the end of 1987.

5. Two Demographic Surveys:

The evaluation team found a somewhat circuitous and time-consuming trail regarding responsibility for satisfying this output. Two Studies, one on "Male Attitudes Toward Family Planning, Female Circumcision, and Related Health Topics" and the other "Review of Population Law," are said by the CSD to satisfy this expected output. These studies, initiated and funded by Rapid II several years ago and submitted to RAPID by SFHCA to fulfill a "contractual obligation," appear to be authored by Somalis not associated either with the MNP or the SFHCA, which finalized the papers. This should be clarified and the studies reviewed before these papers are considered as the two FHS project demographic studies. This is especially true since the CSD speaks of negotiating with Rapid II (which has an agreement with SFHCA) for two other studies, one on fertility differentials and another on the collection of vital statistics. It would seem that the MONP has good internal capability to conduct well planned demographic surveys. This ministry has a trained demographer on staff, another due back from US training this year, and will have 3 demographers provided by UNFPA in 1988.

6. Workshops on Data Analysis and Planning:

Two workshops are to be conducted during the life of the project, according to the project paper schedule, in months 34 and 36 or mid 1987. These small workshops are intended to insure that data produced under this project component are utilized by Somalis and

incorporated into the development planning. There is a letter of understanding at USAID and the CSD dated April 22, 1986 from Margaret Neuse to Awil Farah regarding agreed to dates for these workshops. The timing may need to be revised to accommodate delays in processing, analyzing and reporting on the recent census.

7. National Population Conferences:

The project paper calls for national conferences in months 28 (Fall 1986) and 44 (Spring 1988). Although information from the 1980-81 National Survey on Population (published May of 1986) could have formed the basis for convening such a 1986 conference for policymakers, it seems reasonable to opt for postponement awaiting early analysis of the new census. This analysis, however, likely will fall behind schedule for reasons discussed under output. It may be wise to consider scheduling a conference in 1987 to focus on the May 1986 publication, capture the momentum of the recent well publicized census, and publicize the project as a whole. Certainly the project could benefit from policy and opinion leaders who might lend support to the project in this early stage of launch. The conference targeted for early 1988 probably should coincide with fresh analysis of the census and be postponed until 1989. This also would spread the time between the 2 conferences more sensibly.

IV. Adequacy of Inputs to meet Component Sub-goal

- A. Financial commitments to satisfy outputs 1 and 2 were not adequate. Approximately \$ 2,500,000 in Shillings in additional monies were allocated by the GSDR to complete the census, install the computer system and train personnel. The cost overrun on these two items will impact on monies remaining for the other five activities if the exchange rate issue is not resolved as the rate prevailing at the time of disbursement of shillings.

The new computer facility is an expensive and exceptionally fine addition to the GSDR's capabilities to generate sophisticated information for development planning. It is hoped that the computer will be fully utilized (and properly maintained) to produce a continuing data base beyond the census. Priority for use, however, should fall in areas related to FHS and population growth. USAID population funds and UNFPA gave substantially to the development of the computer and analytical capability of the MONP. It seems reasonable to suggest that the capability be used to continue to support development of population policies for Somalia.

- B. Two more demographic surveys are anticipated by the CSD and SFIICA (the lead organization through its OR Unit according to the project paper) in cooperation with Rapid II through USAID mission add-ons to the centrally funded contract. While such yet undefined studies could provide valuable data and be of long range benefit for monitoring population and fertility changes, this organizational plan may not be the most feasible mechanism, especially if funds are short. The well trained Somali and 3 UNFPA supported demographers at the MONP should be able to attract funding from outside the project for relevant studies. The National Research Council of the Somali Academy for Science and Art, whose secretary is currently employed by USAID for this FHS project, might be a natural complement for demographic research. Whichever donor sources fund more research and whatever organizations are involved, the evaluation team feels the OR unit of the SFIICA should not be intimately involved. This unit should have more than enough demand on time, skills, and personnel for project specific operations research needs.
- C. The two workshops (output 6) are expected to be funded primarily by centrally funded AID contracts, such as DDD of Westinghouse or the Inplan contract. These workshops, if well executed, could be valuable inputs to increasing the skills of Somalis for planning and analyzing data related to population and FHS issues. If funds and TA are not available through central contract mechanisms and if project funds are exhausted, the project's cooperating organizations and USAID probably can assist the MONP to identify and attract other means of support.

- D. Project personnel and managers may decide it is not reasonable or financially feasible, (i.e., the exchange rate issue) to schedule two national population conferences during the life of the project. The CSD seems to feel analyzed census data is prerequisite to the first of these two. Since analysis and reporting is likely to fall considerably behind schedule, opting for one conference may be a sensible decision. A well publicized, top level national conference is, however, very important for guiding Somalia toward a national policy. The rapid growth of 3.1%, limited carrying capacity of land plagued by harsh climatic conditions, and stresses on publicly supported services can be more easily communicated to policy makers in such a venue. The conference should take place no later than mid 1989 or, hopefully, before. If preliminary reports analyzing the census can be made available for such a conference, it could still take place as scheduled in the fall of 1988. This earlier date would provide greater benefit to the FHS project, and the second conference at the end of 1989 might still be held. All efforts should be made to find ways to convene such conferences on schedule. If USAID or AID support is not available, UNFPA or other non-US government support must be sought
- V. Activities Designed Are Sufficient To Achieve the Project Goal and Component Subgoal
- A. If the full complement of shillings is released to the project and AID centrally funded contracts provide the anticipated inputs, continued good planning (as with the census) will enable implementation of all seven activities. Outputs 1, 3 and 4 are or should be completed by the end of 1987. This team feels strongly that activities leading to outputs 2 (census) and 7 (population conferences) should receive priority for implementation. They will have the greatest impact of all 7 activities on the development of policies to support the entire FHS project. They also will have the greatest influence on Somali initiatives to continue efforts in FHS beyond the five year project period.
- B. A major follow-up survey to the Baseline study done in 1984 is planned for 1988. This probably is premature and should be scheduled for 1989. The lead organization named in the project paper is the SFHICA with assistance from an AID central contractor. Again, the MONP will have demography capability internally to conduct such a survey and a sophisticated computer capability as well. This would make it more of a Somali effort under the aegis of a strong ministry. TA from an AID contractor still would be a valuable input. The SFHICA OR Unit still could provide assistance. The same reasoning for shifting responsibilities given for two demographic studies (output 5) applies. The OR unit can provide more needed support to the entire FHS project with smaller, project specific studies. In addition, data analysis can be presented at the second national conference as part of the MONP package of population studies.
- C. This component of the FHS project seems sure to achieve the EOPS of provision of improved population data, identified in the project paper as an indicator of the long-term goal. This opinion is based on the assumption that demographic data will be focused toward the impact of increased population growth on Somalia's total development effort. Baseline data about infant and maternal mortality, fertility changes, literacy and other socioeconomic variables should be used to support the implications of changes in growth rates and how these influence quality of life. The beneficiaries of the FHC project all should be impacted by activities implemented by this component. The prime beneficiaries in the short run are the personnel (and capabilities) of the MONP and Somali policymakers. Longer term benefits will accrue to the general public and to Somali couples and their children, especially those of female gender, who will be brought more into the development process as contributors to GSDR efforts at modernization.

COMPONENT II, IEC

Information, Education, and Communication

Sub-goal: 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.

Purpose: To increase the operational capability and effectiveness of the institutions involved in the delivery of family health information, education, communications and other related services. Since 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 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.

Intended Outputs:

1. IEC Baseline Data Report
2. Annual Work Plans 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

EOPS:

1. Participating institutions will have improved technical and management skills in production, analysis and application of data
2. There will be an increase in IEC programs supporting family health services
3. There will be greater effectiveness of service personnel in motivating couples to adopt and continue FH practices

I. Relevant Background Information and Interrelationships with Other Components

A. Interrelationships of the Components

The component is minimally related to component no. 1, Population Data and Policy at this stage of the Project since that component has until very recently been preoccupied with data collection and compilation. As the data is processed and related it will become valuable input for IEC messages, strategies and campaigns, particularly as they relate to policymakers and opinion leaders. The planned policy studies and the National Population Conferences are especially relevant to the activities of the FHS staff as it expands its effort to influence policymakers. Leadership of the FIIS project by the Ministry of Planning should facilitate appropriate joint policy related activities with the SFHCA. The role of IEC in helping to create a favorable climate for FH/FP in Somalia through the support of policy initiatives cannot be overemphasized.

Relationships with Component II, Clinical Family Health Services, although vital to the project's goals of achieving increased child spacing as a means of reducing infant and maternal mortality, are not well developed at this stage. This relates to a number of weaknesses within the Ministry of Health which is the chief provider of family health services. These will be described in the assessment of progress in component III.

Since the IEC objectives of the FHS Project assume maximum interaction between the participating organizations and the IEC Unit of SFHCA including coordination of activities, it should be expected that relationships with MOH will expand in the future. It is essential to the success of the project that demand for and supply of FII/FP services be in balance.

Interaction and mutual support between the component and component IV, Operational Research is at a high level and has been a major facilitating factor in the establishment and development of IEC activities to date. While the details of this relationship will be elaborated in the assessment of progress for the component, in brief it involves the identification of priority audiences for the FHS Project, their socio-economic characteristics and the level of their knowledge, attitudes and practices concerning family health services. It likewise involves exercise of systems analysis of the functions of the cooperating organizations at various operating levels and within selected areas.

B. The environment for implementing IEC activities in Somalia

Any attempt to assess progress toward the goal of the IEC component 'to increase knowledge, create positive attitudes and encourage the use of safe and reliable methods of child spacing' must recognize the uniqueness of the environment for affecting such changes in Somalia.

Somali traditions developed over 1000 years have helped to define the culture and have contributed to the survival of the Somali people. These traditions serve as the standards against which new ideas and changes are evaluated. One of the poorest countries in the world, the Gross national product per capita in 1983 was only \$US 250. Calorie intake related to requirement compares unfavorably with other parts of Africa and other areas of the world.

The population growth rate is over 3 percent, total fertility rate about 6.5 percent and the infant mortality rate about 147. Forty four percent of the population is under 15 years of age, and the average marriage age of women is 20. Thirty seven percent of women are economically active.

Awareness of modern methods of contraception among women of childbearing age is estimated to be only about two percent. The desire for many children is widespread, indeed the idea of limiting the number is generally considered sinful.

The overall literacy rate is only 36 percent. Written communication dates only from 1972 when a Somali script was adopted and Somali made the national language. Three national newspapers, one in Somali, one in English and one in Italian are published by the Government in Mogadishu and a regional station at Hargeisa. The national broadcast day is 6:00 to 8:00 a.m. and 12:00 noon to midnight. Television is broadcast only from 6:00 p.m. to 11:00 p.m.

The president is said to be generally in favor of child spacing on health grounds, but he and members of the Revolutionary Council would be understandably unwilling to push family planning services if the people are not interested in birth spacing. Current Government strategy is to pursue a quiet policy of active support of MCH/FP and population education so as to allow the desire of the people for improved family planning services to be demonstrated. In the meantime, the ministries of Health, Education and Information seem ready to move ahead quite vigorously.

A particularly unusual feature of the FHS is its close relationship to one of the few private organizations in the country, the Somali Family Health Care Association. SFHCA, established 1983 by Parliamentary decree is an IPPF affiliate which perceives its role as multi-faceted, but health and family planning education is central to its program.

C. Relationships of the component design to the special needs and requirements of Somalia

The central role of IEC within the FHS Project is unusual among current national health and population related programs. As the Project Paper explains 'the GDSR 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'. There seems to be ample justification for stressing IEC activities at this point in Somalia's health and population experience, for although the President gave his endorsement to the establishment of the SFHCA there is apparently no broadscale support for it elsewhere in the Government. In fact, as will be discussed elsewhere in this report, budgets for FHS activities of participating organizations often lack advocacy in the operations of the Domestic Development Department (DDD).

The decision to entrust the coordinating responsibility among the participating organizations to the only private group among them has important implications. It removes the Government from potential criticism for directly promoting a sensitive issue and leaves open the opportunity to disavow support for the institution in the event of unfavorable public reaction. This role is very commonly played by affiliates of the International Planned Parenthood Federation. Typically, social activists and intellectuals serving in volunteer status have provided the leadership, and often substantial funding to establish a private association which often operates with the tacit approval of government. These associations generally begin developing and dispensing information about family planning, followed by establishing clinics and other means of service. In the absence of official government policies or weak commitment by government the private association often develops information, education and persuasive campaigns to enlist policy makers and other opinion leaders in support of family and population planning.

As the FHS Project has developed the role played by the IEC Directors increasingly demonstrates the soundness of the project design and its relevance to the Somali context. It has become proforma for the senior officer in the relevant department of each organization to attend the monthly IEC Director's meetings at SFHCA. Whereas in the early stages some representatives tended to designate an alternative, as the group has taken on more and more importance, participation by the senior officials is mandated by the group. The IEC Directors have become the principal decision making body and as a consequence find it necessary to meet more often. Field visits to facilitate coordination of efforts in the five Project regions are required. One of the effects of this increased time commitment by the IEC Directors is that they are giving less attention to the technical aspects of the IEC program. The Technical Advisory Committee, described in the Project Paper, has for all intents and purposes been phased out. Since the need for technical advice is so varied, the formal structure of a standing committee was considered impractical and since all members expected to be paid, the costs were substantial.

Concern about diminished attention to technical advice is particularly focused in the Health Ministry which perceives its role as insuring the medical/health accuracy of messages and materials produced in the FHS Project. The Director of the MOH Health Education Unit is especially sensitive to the issue, however, this may be a result of the MOH itself not defining a role for its Health Education staff in the project. It should also be noted that the HE Unit is not located in the Community Health Division which is most directly related to the FHS project.

The SFHCA has proved to be an appropriate and congenial location for the centralized planning of FHS activities and in particular the IEC component. The parallel attention being given to operational research and related attention to systems analysis aimed at identifying the individual and combined strengths and weaknesses of the participating institutions should assure the program initiatives are kept in synchronization with changes within and among the target audiences. Care will need to be exercised that the IEC Directors in their enthusiasm avoid dealing with issues which can be more readily handled by the IEC staff of the Association.

The process by which the three current subject matter areas, child spacing, female circumcision and oral rehydration/therapy were selected is another demonstration of the soundness of the component design. Although ORT was not prominently mentioned in the Project Paper it was selected, along with female circumcision, as an important supportive theme for child spacing. Even though demographers have been reluctant to claim a cause and effect relationship between lower infant mortality and acceptance of longer birth intervals it is an appropriate basis for IEC message development. In terms of component design, the significance of the selection of the three subject areas lies in the consensus of the participating organizations on a combination of messages consistent both with the individual groups' objectives and their corporate objectives.

Specific responsibility for addressing the political and religious leaders is assigned to the SFHCA in the component design. This is consistent with similar situations in other countries where the concepts of family and population planning are not well understood or accepted by such leaders. The association will need to consider how its efforts to reach political and religious leaders can be increased during the remainder of the project. Thought should be given to coordination of such efforts with those of component I in which the resources of such centrally funded projects as RAPID II, OPTIONS and IMPACT are being used or are under consideration.

II. Inputs

A. USAID contribution \$2,695,000

- Technical Assistance \$1,770,000 including 48 person-months of a long term advisor; 7 person-months (adjusted during the project) of short term consultant assistance for IEC; 24 person-months for a curriculum development advisor.
- Training, \$190,000. Including: 34 person-months of short term training (adjusted during the Project) and 12 person-months of study tours.
- Commodities \$440,000 (adjusted during the Project) including: audio-visual equipment, vehicles, office equipment and supplies.
- Contingencies \$295,000.

B. GSDR contribution \$3,025,000, including salaries for staff especially hired for the project, salary supplements, materials, equipment, per diems and travel for training, and other associated costs for the educational activities.

III. Progress Toward Accomplishing Component Outputs 1-5 and Adequacy of Inputs to Meet Component Subgoal.

A. IEC Baseline Data Report

A particular strength of the project design is the coordinate role of operations research among the project components. Operations research is essential to the measurement of "positive changes in the family health behavior of Somali couples" identified in the component sub-goal. One of the early activities of the Project was the Baseline study conducted in April 1985. The study established an objective set of base measurements of knowledge, attitudes and practices among seven target groups measured. Subsequent surveys and studies by the OR Unit are amplifying this body of knowledge and pinpointing it to more specific target groups. (There is a summary of recent OR in three locations included in Component IV under III., Output 3, Focused Studies of Program Operations) While the Baseline Survey provides a broad background of KAP levels, more focused surveys are needed as the basis for planning discreet campaigns.

It is impractical to attempt a comprehensive summary of the findings of the Baseline Survey in this report, however, some representative results are particularly revealing and seen to point up the issue of assessing progress in the component.

MCH Personnel: "all seem to have favorable attitudes towards contraception and are opposed to Pharaonic circumcision".

Regional and District Medical Officers: "some are fully supportive of family health programs, others reluctant and even discourage aspects of the program."

Pharmacists: "They are providing contraceptives and information about them."

Community Health Workers: "They are trained to offer primary health care in their own villages and are the only potential communicators in direct contact with rural villages."

Secondary School Teachers: "Most have learned about pills and condoms from radio and nearly all agree with the concept of child spacing but many have negative attitudes toward modern contraception because of side effects and the possibility of adultery and prostitution."

Religious Leaders: "Many believe their religion requires child spacing and encourages breastfeeding for two years. Several had detailed knowledge of modern contraceptives."

Political Leaders: "Some who have attended seminars know about national population growth, others nothing at all. Most know about debate over female circumcision. Nearly all know about modern contraceptives, having learned from MCH personnel and radio."

Adult Men and Women: "Three fourths of all adults were agreed on the following:

- Planning (for family finances, education, etc.) is good but planning the number of children is a sin.
- Having 10 children is ideal.
- Schools should teach about planning for families.
- Very few adults have ever used contraceptive methods, other than breastfeeding."

Secondary School Students: "Of those interviewed in four cities, only a minority knew about family planning and contraceptives. They learned from radio. Nearly all approved birth spacing but were hesitant about modern contraceptives because of side effects and religious concerns."

Surveys taken by the OR Unit in 1986 and early 1987 generally support the above results. These are discussed under Component 4. In terms of IEC planning the KAP of the principal target groups appear to be appropriate for birth spacing promotion if sensitively done. Radio clearly offers a major opportunity in Somalia for reaching dispersed groups with FH messages.

In preparation for the first Project campaign in Hodan District, the OR Unit conducted a needs assessment followed by a pretest. Following the two week campaign (in progress at the time of the evaluation) a post test will be done.

Data was collected on 1) social, demographic and medical behavior, 2) KAP on mother and child nutrition, breast-feeding and use of ORS, child spacing and on the health hazards of female circumcision and 3) radio/TV listenership patterns and other communications data.

The survey focused on Tabela and community leaders who were to participate in the campaigns. Although the data is not analyzed, the preliminary results were extremely valuable in planning the campaign. Similar surveys are planned for the other campaigns to be conducted in other regions in 1987.

B. Annual Work Plans Which Integrate FH IEC Activities

Annual work plans were initiated by the five participating organizations at the beginning of the FHS Project and have been produced each year in December. In December 1986 a Life of Project Workplan for the contractor, the University Research Corporation was produced under the direction of the Chief of Party and Project Manager.

Progress toward the annual work plans and the Life of Project Work Plan is reported quarterly by each of the participating organizations and is analyzed and assessed in an Annual Program Review in November.

The Annual Work Plans vary considerably in their detail, the most elaborate being produced by the Ministry of Health, the least detailed by the CDC. The question must be raised as to whether there may be a tendency to substitute effort put into work plans for effort put into implementation. That caveat notwithstanding, one of the impressive features of the FHS Project is the attention given to systematic planning and reporting.

As described in the Project Paper, the annual plans identify all IEC activities related to family health requirements for materials and resources and report joint IEC ventures between and among the participating institutions.

In order to assess the component's accomplishments in relation to the Implementation Schedule in the Project Paper the month in which project activities were scheduled to be done must be identified. Following is the schedule of major events in the IEC Component:

<u>Project Month</u>	<u>Month</u>	<u>Activity/Event</u>
1	October 1985	Establishment of IEC Unit and IEC Technical Group
2	November 1985	Assignment of initial tasks to IEC Unit: 1) IEC Preliminary Survey; 2) Manpower Resources Survey; Material Resources Survey; Organization of Resource Center
3	December 1985	Work on three surveys and development of the Resource Center; Preliminary IEC Survey; Existing data gathered and analyzed; field interviewers trained. Completion of manpower and materials survey
4-5	January - February 1986	IEC field survey underway data coming in, analyses started/completed. Guidelines given on formulation of long term IEC strategy from preliminary survey findings. Work starts on IEC Strategy/Plans; Preliminary Work Plans developed.
8	May 1986	Long-term IEC strategy drafted.
9	June 1986	Short-term Advisor in Family Health Curriculum Development (for CDC) arrives.
10-14	July - October 1986	Design of basic IEC/FHJ materials, (leaflets, posters/flip charts, displays, radio programs)
10-12	July - Sept. 1986	Preparation of programs for WED, SWDO, MOH, including training program for implementing staff.

<u>Project Month</u>	<u>Month</u>	<u>Activity/Event</u>
10-14	Sept. - Nov. 1986	Pre-testing of basic IEC/FH materials of new design.
14-15	Nov. - Dec. 1986	Staff training in Area A for Implementation, One Program started.
16	February 1987	First commodities (film and slide projectors, tape recorders, cameras and supplies) arrive and are distributed; orientation given on their use and maintenance arrangements made.

A number of important activities took place before the contract team arrived in Somalia, for example, the Project Coordinating Committee was established, the IEC Baseline Study was conducted, the MOH Contraceptives Logistics System was analyzed and project component work plans were developed. The staff of the participating organizations began to work together, sharing resources for field trips to collect information on knowledge and attitudes about family health.

One of the initiatives taken by the Project prior to the arrival of the contract team which occupied the attention of the Chief of Party and IEC Advisor during his first few months was a defective field IEC system which had to be revised. The recommendations of a consultant to the MOH in 1984 led to the placing of nurse educators in the districts of the Project regions. Since they were not from the districts and the local leadership had no role in their selection, they were ineffective and had to be replaced.

Development of the IEC component was delayed by the departure of the original Director who was negotiating for another job and exercised little leadership. Delay in the release of DDD funds caused IEC activities to be postponed into the second quarter of 1986.

Following is a description of the accomplishments during the first 18 months of the Project, taking note where major digressions from the Implementation Schedule have occurred: The Chief of Party and long-term IEC advisor arrived in October 1985. By the end of July 1986, the MOH and OR advisors arrived. The arrival of the MOH Advisor was delayed by six months because of the original candidate's illness. By the end of December 1985, a contract work plan was developed including administrative and IEC tasks. The OR and MOH work plans were developed in April and August 1986 respectively. Obviously these plans and their implementation were delayed relative to the Implementation Schedule.

During 1986, 45 staff and 25 volunteers were trained from participating institutions in Mogadishu and the five regions. Outcomes of the training included the creation of a Core Trainers Group, Regional Communicators and pilot testing of village communication activities.

Procedures were developed and arrangements made to send 12 staff for overseas training in management and IEC at the University of Connecticut, University of California at Santa Cruz, and the Social Development Center, Chicago by the end of 1986. Two study tours to three Asian countries and Zimbabwe were arranged for eleven participants.

Fifteen person months of technical assistance was used in 1986 to carry out a visual literacy assessment, to train artists at CDC in materials development, to assist WED in development of family health curriculum and to assist CDC to develop health education curriculum for grades 3 and 4.

Two issues of a newsletter, Daryeel, were produced and distributed to 1,000 literate recipients.

A model village was selected to pilot test IEC materials and campaign design. Regional communicators, as part of training, visited several villages and conducted communication activities during the first year.

Although materials were collected, the Resource Center was not activated during the first 18 months of the Project because of space problems and lack of equipment and furnishings.

4. Flip chart on healthy baby
5. Teaching poster on nutritious food

In addition, a storyline was developed to point out the hazards of circumcision to be used as the basis for a photonovela and a possible radio-drama.

Although the consultant was unable to go to the field, the SFHCA Training Director, Amina Hersi, and the Resource Center Manager, Hinda Hassan, tested the visuals in Baidoa and Bay regions. Artists also participated in the field trip, making new versions responding to suggestions of viewers. The consultant concluded that enough materials has been collected to provide the basis for testing the materials in campaigns and that was being done during the evaluations team's visit.

Valuable as the foregoing process was, it reveals serious deficiencies in the utilization of technical assistance. The least that should be expected is full agreement by SFHCA on the need for and terms of reference for technical assistance. Had the purposes of the first visual literacy consultancy been fully realized, there would have been a stronger basis for the two later consultancies. By the same token, if the second visit by Haaland had focused on the field, the whole process of prototype production and pretesting would have been advanced and planning for the first campaign enhanced.

2. Development of Curriculum and Classroom Materials

The Project Paper stressed the importance of introducing basic family health concepts into formal classroom studies and made provision for a short-term technical advisor for the Curriculum Development Center in the Ministry of Education. The CDC assisted by the Advisor is charged with drafting a family health curriculum and study materials for each year (class) of intermediate and secondary school. The draft curriculum is to be pretested, revised, produced, and used in selected areas of the country. Over the life of the Project, 50 sets of materials will be produced for each class.

Health education was introduced into the revised curriculum and a new department established in the Curriculum Development Center in 1984. The CDC's association with the FHS Project began during the same year. The Project provides honoraria for writers and designers, implementation workshops, consultancy services, training, transport, and equipment.

The Health Education staff consists of 8 writers and designers all of whom have BA degrees. Biology is the major discipline represented. Some have had external training and the unit head participated in the University of California at Santa Cruz training in 1986.

The short-term Advisor was recruited and made available to the Health Education Unit at CDC for six months during 1986 and will spend a similar period in 1987.

The Curriculum Advisor has also provided technical assistance to WED in the development of family health curriculum for secondary school girls and Family Life Center teachers, the latter involving a community needs survey in Baidoa district.

By the end of 1986, student books and teacher guides were developed for grades 1 to 4 and grades 5 to 7 are expected to be finished in 1987.

The former Danida advisor, Michael Kiernan, in his terminal report described the following problems related to the health education activities at CDC:

"Some 'teething' problems have been experienced because the goals of the new curriculum do not fit in so easily with SFHCA activities. Health Education personnel are expected to produce 18 weeks of materials every three months like other CDC departments, but also have to take part in IEC activities of a wider variety. The latter are useful and give our staff new experiences but the strain can become a little too much at times."

Staff balance is also a problem, some staff, having more training than others, tend to go ahead on their own, leaving lesser tasks for those with less experience. Attention should be given to developing group work skills in order to realize the benefits of cooperative learning and working.

Providing channels of communication are kept open, there is no reason not to expect the CDC/IEC Cooperative effort to be very beneficial for both parties; the overall goals are the same."

The process of curriculum and materials development is operating efficiently and is generally on schedule. The principal problem lies in materials production, since the CDC has to rely on the State Printing Office which is very slow in filling orders. The first text book produced under the Project was printed in Kenya under special arrangements made by URC. Hopefully, when printing equipment is made available to CDC, presumably in 1987, the production picture will improve.

Another problem relates to distribution after the books and supporting materials become available. No plan was described to the team for distributing the materials to schools other than the usual procedure which is to deliver them to regional centers. It will be important that a careful plan is developed for the introduction of the materials into schools which includes training teachers in their use and a dependable means of delivery.

D. IEC Unit and Resource Center Established

The Project Paper envisions the IEC Unit in SIHICA as a key factor in the day-to-day inter-institutional linkages so central to the Association's purpose. The Director is expected to manage the unit and maintain liaison with the participating institutions. The Resource Center manager is responsible for developing and producing IEC materials, assembling materials from other sources and serving as a repository for IEC equipment and supplies on behalf of the participating groups. The Training Officer is expected to plan, coordinate, and implement in-country training of IEC personnel.

The IEC unit is charged with producing and distributing guidelines for field testing IEC materials and methods and assisting other organizations in actual field testing. The unit also collaborates with the Operations Research Unit to establish a monitoring system for IEC activities. This ongoing monitoring system is expected to provide information on community attitudes and public responses to family health messages and interpret the information in terms of their implications for design changes. Information flowing from the monitoring system is fed into the newsletter which serves as a "house organ" for IEC staff to keep them in touch with field needs and interests. The IEC Unit organizes meetings and seminars to address issues and problems related to family health IEC activities.

The long-term IEC advisor was handicapped during the first few months by not having a vigorous, committed counterpart. The first IEC Director, Abdulla Hirad, although well qualified, was preoccupied with negotiation for a UN position and left after a few months. The current Director, Shukri Abdi Jama, appointed in June, 1986, has assumed full charge of the unit and has earned the respect of the staff, the advisors, and the IEC Directors. The IEC staff is complete except for the librarian and the audio-visual technician whose hiring depends on the availability of suitable quarters for the Resource Center.

The Resource Center development has been one of the weakest links in the FHS Project initiation. Since it depends so directly on the activities of the IEC staff, it has suffered because of the decisions of the Board concerning facilities. The first location lacked space to accommodate the Center and disappointingly the present building, unless extensively remodeled, is also inadequate.

To its credit, the IEC Directors have focused their attention on the purposes and procedures of the Center and at their March, 1987 meeting circulated the following statement of policy:

Resource Center Policy

I. Function

- A. Disseminate results of IEC baseline survey to all IEC technical group members and Directors.
- B. Initiate and organize continuous update of the surveys.
- C. Promote use of baseline data in the planning process of the IEC strategy, IEC work program, IEC procurement, and IEC training plans.
- D. 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. Audio-visual aids (films, slides, posters, pamphlets, cassettes).
 - 3. Equipment (on loan), such as slide projectors, film projectors, tape recorders, electrical generators, etc.
- E. Design guidelines for field testing of IEC materials.
 - F. Distribute and promote distribution of all IEC materials produced by the SFHCA IEC Unit and the participating institutions.
 - G. Organize and monitor a library on all FH/IEC related research findings, case studies, and training materials to be used by planners, policymakers, trainers, and technicians.

II. The Resource Center is:

- A. An educational resource center for:
 - 1. the storage, operation, and maintenance of hardware and software audio-visual materials.
 - 2. the storage utilization and maintenance of essential printing and production materials and supplies.
- B. An information bank for collecting, documenting, and retrieving of:
 - 1. a list of potential and operating centers of similar nature in the country.
 - 2. an up-to-date list of field information, study reports, research findings, survey materials, as well as FH, IEC and related literature in other fields of knowledge.

- C. One of a network of centers in:
- I. a constellation of governmental and non-governmental IEC institutions, with a view to facilitating the exchange of services, expertise, and experience in the production of printed and audio-visual materials.
 - III. Materials and literature in the Center should not be limited to Family Health only.
 - IV. Materials available in the center should be adopted to the Somali context.
 - V. Literature and materials from sources other than the USA institutions should be collected.
 - VI. Management and use policy and procedures of the resource center is left to the Resource Center Manager and long-term Advisor to forward a draft proposal to IEC Directors.
- E. Trained IEC Staff and Family Health Personnel

1. Development of an IEC Training Plan and Strategy

The Project Paper identifies IEC training outputs as emanating from the Baseline Survey and focusing on short-term overseas training and study tours plus in-country short-term courses aimed at improving the effectiveness of IEC staff as well as other personnel providing IEC support to family health services. The training is to be provided by senior IEC staff of the participating organizations, the Project IEC staff, by both long- and short-term advisors and by visiting consultants.

The strategy for implementing IEC training has been to develop a group of Core Trainers representing each of the participating organizations and coordinated by the SFHCA Training Director. Preparation of the Core Trainers began in July 1985 with a workshop for 20 participants on FH/FP conducted by INTRAH. Another 20 core trainers attended a second INTRAH Workshop during September and October 1985 focusing on MCH/FP. The third workshop held in November, 1985 was jointly conducted by INTRAH and JIU Population Communication Services and provided instruction in communication skills.

Closely following the INTRAH/PCS training, Joyce Stanley, a specialist in training design provided by PCS, spent three weeks in Somalia to design a Train the Trainers program. The plan developed by Stanley provided for overseas training for a group of Core Trainers who would assume train the trainers responsibilities on their return. The second phase was a TOT workshop in Somalia utilizing the returned trainers and since the Regional Communicators were by that time appointed, they were included as participants.

The full training design, developed in early 1986, is as follows:

- Phase I: Santa Cruz Training of Trainers
Five IEC Core Trainers will participate in a TOT program that will prepare them for a design and implementation of the first TOT in Somalia. Content will focus on training design and communications.
- Phase II: Training of Trainers - Mogadishu
Part A - Design of the Training

For one week, prior to the actual TOT implementation, the five core trainers from Santa Cruz and two other core trainers who have received additional training will design the TOT for the Regional communicators and remaining Core Trainers.

Part B - The Training of Trainers

The co-trainers will present an IEC training workshop for IEC Core Trainers and Regional Communicators (one from WED, MOH, CDC, SFHCA, and SWDO from each region). The purpose of the workshop will be the development of IEC training and communication skills useful for the family health program. Team building, a community based practicum and development of an action plan will be essential elements of the training program.

Phase III: Field Communication and Training Events

The participants will now take the communication/training events to the field for implementation and evaluation. They will take the programs produced during Phase II, present these to selected participants, and evaluate the effectiveness. Regional staff will be assisted by Core Trainers. This implementation will go on for approximately 6 weeks.

Phase IV: Training of Trainers II

In order to encourage cross regional learning and closure on the initial phase of the field program, the participants will reconvene to share their field experiences vis-a-vis family health communication events. This one to two week workshop will be structured to allow for each region's presentation of the results of their field practicum as well as the development of future plans. This training will be conducted in one of the regions.

Phase V: Quarterly Meetings

Quarterly meetings to update project progress will be conducted in each region. Regional location will allow participants to fully understand the training environment and participating community.

Arrangements were completed and the overseas trainees were able to complete their courses and return for the Phase II TOT. Those who traveled overseas, their organization and the program attended are as follows:

<u>Trainee</u>	<u>Trainee's Institution</u>	<u>Location of Training</u>
Shukri Abdi Jama	SFHCA	Social Development Center, Chicago
Hinda Hassan	SFHCA	. . .
Fadumo Ahmed	SFHCA	. . .
*Maryan Aden	WED	. . .
*Ashia Abdullai	SWDO	. . .
Ahmed Ali	CDC	University of California, Santa Cruz
Halimo Abdi Sh	MOH	. . .
Maryan Ga'al	SWDO	. . .
**Maryan Mustah	MOI	. . .
Maya Haji	WED	. . .
Amina Hersi	SFHCA	University of Connecticut
Faduma Haji	MOH	University of Connecticut

* Did not return from training

** Broadcasts on Somali Radio for SWDO and MOH

Phase II TOT/C took place between April 19 and May 11, 1986. Following a week of pre-training activities in which the returned trainers revised a draft design, reconstructed some modules, designed new modules and practiced presentation, the TOT/C was held at the CDC./ The first week involved formation of regional teams and development of regional communication strategies drawing on the baseline study. Week two focused on study and practice of various IEC training and communication methods. Visual aids, role plays, dramas, songs, poems, and slogans were developed. During week three, participants developed presentations using one media together with discussion. The week closed with development of action plans for the period up until the Phase III TOT in July. Action plans were to encourage the introduction of IEC activities into the regions. The IEC Directors attended during this activity and made suggestions.

The Phase III TOT took place during the period July 23 to 31 in Merca. Purposes of the workshop included follow up of action plans from the first workshop, identifying constraints to regionally based implementation of IEC activities, development of action plans for Phase III, increasing the training skills of core trainers and implementing and evaluating a field training event. All objectives were met and participation was excellent. A highlight of the week was the practice of an IEC event in a rural community followed by peer feedback. Three of the five regional teams reported implementing their action plan with only minor problems, the other two groups implemented alternative activities.

Stanley reported that all participants and some of the trainers had difficulty transferring experiential methods/processes from a workshop setting into a village learning situation. Though varied media were used, the approach varied little. As the participants worked in the field, their need for more problem solving activities became more evident.

The problems faced by the Regional Communicators in their work were identified as follows:

- a. Lack of support by the IEC Directors
- b. Lack of incentives
- c. Lack of training materials
- d. Lack of transport
- e. Lack of audio-visual aids
- f. Lack of communication between Regional Communicators and IEC Directors
- g. Lack of reference materials
- h. Lack of office space
- i. Interference with other programs

2. Out of Country Tours for Study and Observation

The administration of a program of out-of-country travel and study is complicated by the number of participating organizations in the FHS Project. The IEC Directors recognized the potential problems and developed a procedure for selection of participants which they considered fair and equitable.

Two study tours, one to Bangladesh, Thailand, and Indonesia and one to Zimbabwe were organized during 1986. During 1987 the OR Director, OR Advisor, and a representative of USAID visited Zimbabwe. These countries were chosen because, in the case of the Asian countries, they represent Muslim cultures where substantial family and population planning programs are underway. Zimbabwe provides an African example whose program reflects many of the same objectives as those of the FHS Project. Thirteen staff in addition to the OR Advisor participated in these tours.

The Evaluation team interviewed a number of the participants along with those who went to the U.S. for study and received the impression that they highly valued the experience, especially the opportunity to exchange ideas and compare what has happened there with what is possible here. Participants uniformly expressed surprise that family planning programs were so well advanced in Muslim countries. Since the participants were unaccompanied, there were some problems of personal discipline, but that appeared to be limited to Thailand.

The Zimbabwe program which features the concept of community based distribution of communication inputs had considerable impact on the IEC Directors who participated and has substantially affected IEC strategy.

3. Observations on the Development of Training Activities in the FHS Project

USAID, the Government of Somalia, and since 1985, the University Research Corporation's attention to training in its various forms is a notable strength in the Project. The Training Plan developed early in 1986 and endorsed by the IEC Directors was effectively implemented up until the visit to Zimbabwe by the Directors. Following the visit, the impression was created among the Core Trainers and Regional Communicators that the CBD/C approach was being substituted for the action plans developed in the first and second TOT workshops. Literally interpreted, this would mean that the Regional teams so systematically nurtured during the TOT workshop process would suspend implementation of their action plans until the test campaigns in ORT, child spacing, and female circumcision were carried out in the regions and evaluated. It would ostensibly short-circuit Phase V, the quarterly meetings of the Regional Teams, which were designed to strengthen team development and enhance the implementation of action plans. Since the campaigns focus on only two villages in each region, it appears the actions plans which are regionwide not only could proceed in the interim until the campaigns take place, but could conceivably operate during the campaigns as well. The central consideration, however, is the relationship of the IEC Directors with the Regional Teams. There is already dissatisfaction by the teams over the IEC Directors' lack of support for regional activities. It is important for the Directors to clarify the regional strategy and communicate this as soon as possible to the Regional Teams.

F. Implementation of IEC Programs Increased

The Project Paper stresses the following three important measures of the effectiveness of IEC programs:

1. The production and presentation of IEC materials;
2. The implementation of IEC programs; and
3. The number of people who are introduced to and educated about family health.

In anticipation of more research based information resulting from the Baseline Study, the Project Directors established some initial targets which could be adjusted when the report was released. In terms of IEC materials, the targets were:

- a. production of 100,000 leaflets
- b. 3 slide sets
- c. 15,000 pamphlets
- d. 30,000 posters
- e. two weekly radio programs
- f. 1,000 group sessions
- g. 25 community events (implemented by local groups)
- h. Over the life of the Project, 75 percent of the couples in the urban and rural settled areas (approximately 50 percent of all Somali couples) will be introduced to family health and family health sources.

The proposed IEC materials development schedule both for SFHICA and the participating organizations, WED and CDC for the life of the Project are as follows:

<u>IEC Materials</u>	<u>1987</u>	<u>1988</u>	<u>1989</u>
30,000 different posters/flipcharts (1,000 copies)	10	15	5
Nutrition courses			
9 Photonovellas (1,000 copies) (3 to be developed by end of 1986)	3	3	
4 sets of slides (1 for WED)	2	2	
Family health film (approx. 20 min)	1		
Video series - (9 episodes; 20-30 minutes each)	3	3	3
Drama/play (approx. 1 hr, 30 min)	1		
30 radio series/programs (15 min)	6	12	12
20 items of printed material (2 by the end of 1986)	9	9	
IEC Newsletter (3 in 1986)	4	4	4
<u>CDC</u>			
Textbooks	2	2	2
Teacher guides	2	2	2
AV materials	20	20	10
<u>WED</u>			
Pre-service training materials Family health			2
In service materials Family health source book			1

A more comprehensive projection of IEC implementation and evidence of progress to date can be gathered from the following life of project status and goals developed in late 1986.

**Key Activities/
Responsibilities**

**Status and Projected Dates
of Accomplishments**

1. IEC strategy for integrating FH/IEC activities
An overall strategy was developed prior to contractors arrival; it was revised and updated in December 1986 and reflects new directions and priorities
 2. Development of annual IEC work plans
1987 Work plan developed Dec 1986
1988 Work plan to be developed December 1987
1989 Work plan to be developed December 1988
IEC Work plans have been developed by each participating institution; planning meetings held to ensure integration of plans
 3. Establishment of IEC Unit
IEC Unit established in 1985. A new IEC Director hired in 1986. Yet to be hired: librarian and AV technician
 4. Establishment of IEC Center
Materials gathered for Resource Center not yet established as office furnishings have not been received. To be established by June 1987.
 5. Train 785 staff and 2,850 volunteers in IEC (1)
45 staff and 25 volunteers trained by end of 1986. 200 staff and 1,235 volunteers to be trained by end of 1987. 360 staff and 900 volunteers to be trained by end of 1988. 180 staff and 690 volunteers to be trained by end of 1989.
 6. Family Health Curriculum developed for grades 1-12
Student books and teachers guides for grades 1-4 were developed by end of 1986, grades 5-7 to be developed by end of 1987, grades 8-10 by end of 1988, grades 10-12 by end of 1989. Only books for grade 1 printed to date.
Printing waiting for
- (1) Increased from 585 in the Project

- | | |
|---|---|
| 7. Develop 20 sets of AV materials for schools (1) | None developed |
| 8. Sets of materials to support IEC implementation | |
| a. 30 different posters/flipcharts | 3 were produced at end of 1986. 10 to be produced by end of 1987. 15 produced by end of 1988. 5 produced by end of 1989. |
| b. 9 photonovellas | 1 was produced by end of 1986. 3 to be produced by end of 1987. 3 to be produced by 1988. |
| c. 4 sets of slides | 1 set was produced by end of 1986. 2 sets to be produced by end of 1987. 1 set to be produced by end of 1988. |
| d. Film on Family Health | Development to start in 1987, completion 1988. |
| e. Video series | (9 episodes) 3 to be produced in 1987, 3 in 1988. |
| f. Play on Family Health | To be developed and produced in 1988 |
| g. Brochure on SFHCA | Produced in 1986 |
| 9. IEC Newsletter | 3 issues were produced in 1986. 4 issues to be produced in 1987. 4 issues to be produced in 1988. 4 issues to be produced in 1989 |
| 10. Plan and conduct campaigns in Mogadishu and 4 regions | Pretesting of messages and materials conducted in 1986; campaigns to be conducted in 2 districts in Mogadishu and in villages in 4 regions by end of 1987. 1988 and 1989 to be planned. |
| (1) Increased from 585 in the Project Paper, volunteers added | |
| (2) increased from 3 | |
| (3) Reduced from 100 | |

The Evaluation Team was fortunate to be in Somalia during the implementation of the first IEC campaign, in Hodan District. The Team visited the training sessions of the Tabela leaders as well as some of the following sessions in which Tabela leaders instructed their clients

in ORT. The Core Trainers were well prepared, the training materials were on hand, attendance was good and morale was high. The results of the post tests by the OR Unit concerning KAP impact should be revealing.

IV. Activities are/are not sufficient to achieve Project
Goal and purpose and component sub-goal

The Component subgoal is to support FH programs and services with IEC activities which are conducive to positive changes in the family health behavior of Somali couples. The contribution of the IEC component to the Project goal is directly related to this achievement of improved maternal and child health since the role of IEC is to inform and educate potential acceptors of better practices in FH/FP. In contrast to most country family and population planning programs, the Family Health Services Project places IEC at the Center and relates service delivery, population data and policy and operations research to it. The question can rightly be asked, is this a proper relationship; particularly between IEC and service delivery? The Project designers reasoned that in a highly centralized country like Somalia even though the President has given his endorsement to birth spacing for health purposes the overwhelming weight of tradition, religion and culture is in opposition to anything more liberal and progressive than breast-feeding, abstinence and withdrawal. Under such constraining circumstances, a convincing case can be made for beginning with an informational and educational approach and through careful monitoring of attitudes and knowledge maintain an appropriate balance between demand and the availability of services.

The IEC Directors selected a message mix calculated to build confidence in the Project among both potential users of services, i.e., married couples, and those who can influence the environment for acceptance of services, i.e., policymakers and opinion leaders. Thus female circumcision and oral rehydration were chosen as themes complimentary to birth spacing. The suggested end of project objectives are as follows:

- To raise the level of awareness of modern family methods by 15 percent among couples in the 5 Project Regions.
- To raise the level of awareness of the dangers of female circumcision by 10 percent among men, women and teenagers within the 5 Project Regions.
- To increase the knowledge of how to accurately mix and administer ORS to 10 percent of mothers within the 5 regions.

If these objectives are realized even in part, experience in other situations and the weight of research findings show that maternal and child health will benefit and if that happens the quality of life improves.

The potential of the IEC Component to facilitate the Project purpose is easier to predict than its potential for achieving the Project goal. The IEC Component directly supports the family health by building understanding of the sources available. In the FHS Project, the IEC Component has a key role in the coordination of inputs by the participating organizations because of the IEC resources of the SFHCA. The developing relationships among the participants in the Project provide the potential for sustaining family health programs in Somalia.

COMPONENT III

Clinical Family Health Services

Sub Goal: To upgrade clinical family health services and thereby improve the quality of life for the Somali People.

Purpose: To strengthen the capabilities of selected Somali Institutions to plan, implement, and evaluate clinical family health services through upgrading technical skills, management, commodity supply, and facilities.

Intended Outputs:

1. Improved and expanded cadre of trainers and in-services and pre-services training.
2. Established MCH training site
3. Established services for voluntary surgical contraception, infertility, and sexually transmitted diseases
4. Improved management systems and facilities
5. Expanded family health services

EOPS:

1. Greater effectiveness of services personnel in motivating couples to family health practices
2. Upgraded and expanded family health services of the MCH

i. Relevant Background Information and Interrelationships with Other Components.

- A. The MOH is viewed as a relatively low priority ministry by the GSDR.
- B. A new minister of the MOH has just been appointed to replace the previous unsuccessful leadership. New vice ministers (2) have also been appointed. The Minister is now a respected physician and the vice ministers have similar appropriate credentials.
- C. The MOH financial section, which had been managed with questionable competency, has a new chief accountant heading up financial management.
- D. Several donors, especially UNICEF and WHO (funded by UNFPA), support similar and sometimes seemingly overlapping programs. Although these efforts are intended to complement each other and fill gaps, this often creates tensions among divisions and division managers.
- E. The MOH has a commitment to establishing a PHIC system throughout Somalia, which is to be the keystone of health care, especially in more rural areas. No one donor is responsible for this national effort; nine different donors are involved in helping to establish PHIC service systems (regional centers to village units) in 14 of 18 regional

administrative units (see overleaf table). These efforts operate mostly independent of the others. USAID, which had a major commitment to PHC in Somalia until recently, withdrew because the effort failed. This has repercussions on the fledgling FHS project. The MOH also gives priority to PHC over FH/FP and MCH.

F. The FH/FP Division uses the facilities (MCH Centers) of the MCH division. MCH is a separate program with emphasis on infant and child care (there is a WHO counterpart pediatrician advisor). The same MCH staff personnel serve for both the MCH program and the FHS project. MCH projects have higher priority in the MOH than FHS.

G. The FH/FP Division was established within the Community Health Department under the direction of the Director General for Preventive Medicine. Community Health has several projects (Childhood Immunization, Nutrition, Diarrheal Control, School Health, MCH, FH/FP, PHC) funded by different donors. Public Health is a department parallel to community health and has 7 separate donor supported environmental and disease control programs (e.g. malaria, leprosy, infectious disease).

H. Family health is relatively new to Somalia. The Division was established in 1981 with USAID support as the Family Health/Family Planning Division. Family planning is viewed with ambiguity as a concept and as a term at this time since it is considered too controversial for policymakers and the general public. The delivery of family planning services under the rubric FHS seems acceptable to the MOH, which appears to have the clearest understanding of all organizations involved in the FHS project that contraceptive services are the focus of this project.

I. The authors of the FHS project paper intended that the FH/FP division continue but not increase its IEC activities since it was seen as a prime service delivery mechanism. It was considered more as a beneficiary rather than generator of IEC materials and strategies. There is no mention of IEC activities in the project description as part of Component III.

J. The director of FH/FP, Dr. Rukiya Seif, serves as a key member of the SFHCA, sits on the PCC, and is a member of the IEC Directors committee. She is a major link to all aspects of the project and the bridge between the MOH, the service delivery arm, and the entire FHS project. Dr. Rukiya is a long time supporter of family planning.

K. Interrelationships: the prime relationship to the project is with Component II. successful IEC efforts, which are designed to create demand, depend on a responsive service delivery systems. Without the latter, IEC can even be counterproductive. The IEC component, by the same token, has the strongest relationship to Component II as its major support system. Component III activities, service statistics, and identification of problem areas can help define IEC directions and activities. Component IV, operations research, can be a second important support if properly utilized to assist with data generation and monitoring to help determine the relative success of FHS delivery mechanisms. There also is an important interrelationship with Component I since MOH service statistics can assist the MONP and MONP policy efforts will lend credibility and visibility to FHS services. In addition, Component III activities, performance, and leadership will influence the opinions of policy makers and the general public and, therefore, impact progress toward a national population policy and legislation.

II. Inputs.

A. Service delivery receives the second largest funding of the four components. The total USAID and GSDR commitment to Component III is \$5,945,000; USAID's inputs to the

PHC IMPLEMENTATION

DONOR	REGION
WHO	L/Shabelle
UNICEF	M/Shabelle
UNICEF	Lower Jubba
UNICEF	N/West
UNICEF	Awdal
UNICEF Italian Medical Team	Mogadishu (Wadajir)
I.M. Team	Hiiran
I. M. Team	G/Guduud
British Orgn. Comm. Develop. (B.O.C.D.)	Sool
Community Aid Abroad (Australian) (C.A.A.)	Sanaag
U.S.AID	T/Dheer & Bay
Swedish Church Relief (S.C.R.) + World Concern +	Middle Jubba
AMREF	
African Medical Research Foundation	Geddo (Luuq)

MOH are \$4,000,000, and \$1,930,000 equivalent in Somali Shillings will come from the GSDR. Over half the USAID commitment is for commodities purchases. It is worth noting that \$1,309,000 in commodities is allocated for contraceptives, which accounts for 22% of all dollar inputs to the MOH and 13% of the USAID commitment to the entire FHS project, including Component I. It seems clear that the intent of the Mission and the project paper team is that the FHS project centers on family planning. Technical assistance absorbs the second largest dollar input, \$1,040,000, for both long and short-term professional assistance. Expected TA efforts from centrally funded contracts with JIPEIGO, AVS and INTRAH would add approximately \$ 250,000 more. Training under this component is allocated at \$ 195,000 (USAID) which, as a separate item, points up the prime emphasis on training. The contingency is \$ 436,000. The GSDR contribution is to pay for training and supervision related travel and per diems, personnel salary supplements, materials, office and training center costs, and all service delivery activities.

B. TA is divided between a long-term contractor advisor (36 person months), who serves as counterpart to the FII/FP Director, and short-term TA (20 person months) related to 1.) logistics, management and financial systems, 2.) assessing potential delivery systems, 3.) establishment of a model clinic, 4.) physician training, and 5.) training TBAs and CHWs.

III. Progress Toward Accomplishing Component Outputs 1-5.

Although some activities predated signature of a contract with URC in Oct. 1985, many activities geared up with the arrival of the long-term advisor, Duc Tien Nguyen, Ph.D., counterpart to Dr. Rukiya Seif. Nguyen and his family arrived in July 1986, six months after URC expected to have the advisor in the field. Their original candidate became terminally ill just prior to departure from the U.S., and URC fortunately, was able to recruit two candidates for long-term advisor to the FII/FP Division. Nguyen, who has a strong management background but less experience in training, was selected by Dr. Rukiya as her counterpart. Progress in this component must be viewed with this background in mind since Duc Nguyen has been resident for less than nine months when the evaluation team arrived.

I. Training

Training is clearly the prime emphasis of this component. The project paper states, "The emphasis of all technical assistance will be on the training of counterpart staff." (p. 143)

Two of the outputs (1 and 2) are related to training. Output 1 is the only one of the five which receives such special attention in the project description: it is detailed far more extensively in the implementation section, is mentioned in the technical analysis as "the primary mechanism for expanding and upgrading family health services" (p. 37), and is keynoted in the project description, which states, "the principle focus...extend and upgrade family health services" and "the principle needs for upgrading are in the training of the staff."

History and Progress: Since 1980, 270 nurses and nurse - midwives (NMs) have received training, and 80 attended refresher courses (see overleaf for Table Summary from J. Rooks Feb. 1987 Report). INTRAH has been the most actively involved in training. In addition to in-service and refresher training, INTRAH has trained 42 trainers in over 16 weeks of sessions (3 visits for 4-6 week periods). In addition, 21 persons have been out of the country for family planning related training, about 16 since the FHS project began. The intensity of local training has dropped off since 1985 (20 new persons trained and 90 received refresher courses). It is disconcerting that recent and past consultant reports consistently mention the lack of knowledge and/or application of FII skills to service delivery.

SUMMARY OF USAID - FUNDED IN-COUNTRY FHS TRAINING
FOR SOMALI NURSES AND MIDWIVES 1980 - 1986 ALL COURSES

<u>DATE</u>	<u>LENGTH</u>	<u>CO-SPONSORING AGENCY (US)</u>	<u>SITE</u>	<u>CONTENT</u>	<u>NUMBER TRAINERS</u>	<u>NUMBER SOMALI</u>	<u>TRAINERS AMERICAN</u>
1980	?	JHPIEGO	Benadir	?	10	?	?
1981	4 weeks	INTRAH	Mog.	Non-clinical FHS	20		?
1982	4 weeks	INTRAH	Har.	"	20	2	2
1982	4 week	INTRAH	Bay	"	19	2	2
1982	3 weeks	INTRAH	Mog.	integration	20		2
1982	2 weeks	INTRAH	Mog.	Visual AIDS	13		2
1983	3 weeks	INTRAH	Mog.	Non clinical FHS	20	2	
1983	2 weeks	INTRAH	Mog.	Visual AIDS	17		2
1983	4 weeks	INTRAH	Mog.	TOT **	15	2	2
1983	4 weeks	INTRAH	Mog.	FH skills	20	2	2
1983	4 weeks	INTRAH	Kismayo	FH skills***	11	2	
1984	4 weeks	INTRAH	Hargeis	FH skills**	17	2	
1984	4 weeks	INTRAH	Bay	FH skills**	18	2	
1984	4 weeks	INTRAH	Burco	FH skills**	20	2	
1984	6 weeks	INTRAH	Mog.	TOT	12	2	2
1984	4 weeks	INTRAH		FH skills	20	3	
1984	4 weeks	URC	Hargeis	"	20	2	
1984	4 weeks	URC	Kismayo	"	20	2	
1984	4 weeks	URC	Burco	"	16	2	
1984	1 week	URC	Mog.	Discussion of FHS program, problem solving	48	SFH staff	
1985	2 weeks	INTRAH & URC	Mog.	Curric. Dev. for refr. training	10	Some	1

The project paper calls for an intensive training effort with 10 sessions each year over the life of the project. It targets 680 persons to be trained. All levels of nurses and NM are to undergo training in initial skills in FHS (200), clinical skills and management (140), refresher training (250), supervision and management (30) and TOT (60). Training in FHS is also called for in the curriculums of the nursing, midwifery and Post-Basic School of Nursing. CHWs and TBAs in the non-AID funded PHC program are also targeted for training in FHS.

The head of the training unit of the FHS reports that all Nurses and NMS in Benadir Region have been trained. From arrival of URC at year end 1985, through the third quarter of 1986, personnel training in the FHS project took place both out-of-country (11 persons, including the MCH Director, traveled to the US or other African countries) and in-country [number of persons unknown] through 2 refresher courses (Kismayo and Burao) and 2 logistics courses (Mogadishu). There clearly is an imbalance between the extensive training needs for field personnel and out-of-country training. The relative cost-effectiveness of the two can be hardly compared. This is especially disturbing in view of the extensive needs for training of nurses and NMs located in 93 MCH clinics throughout Somalia. The 1987 FH/FP workplan appears to call for less than adequate in-service training, includes arranging more out-of-country training, and has establishment of a training center as a number 2 priority. TA is scheduled in clinical and tutor (presumably for the Post-Basic School) training, and there will be a request for visual aids (VA) training. This is no plan, however, for developing any curriculum or non-VA materials to assist the training effort.

Materials and Training Aids: There has not been nor appears to be any plan to develop adequate training materials for in-service training of nurses. The project has ordered AV equipment and models as training aids. This is an excellent step but should not be considered a substitute for needed curriculum materials. The manual used for training, which has been evaluated by several consultants as outdated and inadequate, was produced several years ago. This team concurs that it is grossly inadequate, especially since there are no other materials. The project paper calls for short term TA...to develop curricula and training materials... (p. 25). There was a two week course for 10 participants in 1985 (with INTRAH TA arranged by JIU/PCP) for the purpose of teaching curriculum materials development skills. It appears nothing was produced in or following the workshop.

A recent consultancy (Feb. 1987) by Judith Rooks cites lack of up-to-date training materials as the greatest weakness in the training system. This team has strong concern that this area no longer be neglected. Training materials are basic for in-service training (through both group and individual learning) and as clinic reference materials. Training of field personnel is imperative. It was viewed in 1984 as a prime need. It still is three years later.

Pre-Service Training: The same need for an improved curriculum persists in pre-service training. We are told that the nursing school recently added FH to its curriculum, but NMs still do not have such training. Reportedly, the Post-Basic School now also includes FH. It would be advantageous for a content training specialist to evaluate the information and counseling methods taught to new students.

Physicians: The project plans to incorporate training for physicians in FHS skills, especially more advanced techniques, in 1987. Up until now, only those doctors who will be associated with special services (see output 2) have received recent training; this was at JIPEIGO. The TA and FH/FP director are preparing a work scope for short-term TA to train physicians in Mogadishu. There also is a plan for a workshop at mid-year. The physician training and workshop will begin to bring more of private sector medical personnel into the project. They can be valuable supporters as well as service providers. Under the guidance of FH/FP Division at the MOH, training will be offered to a wider range of private sector medical personnel, as time goes on, so as to expand the service delivery system.

CHW and TBA Training: The project paper calls for developing curriculum modules for training PHC, CHWs and TBAs. Since the FHS project expects to test these village people as CBD/C workers, this is another area where training materials development should proceed with alacrity. This is especially true since the majority of CHWs and TBAs will be illiterate.

Training and Operations Research: The OR unit can provide a valuable service to this component by monitoring training. For example, a sample of MCH clinic workers could provide quantitative feedback on training received vs. KAP in clinic operation and client service. Pre and post tests might be conducted for trainees. Whatever the project determines as appropriate studies, the imperative is to glean information on how to make training more effective.

Donor Coordination: While it would seem efficient to coordinate training efforts with other donors, especially in their PHC projects, in practice this has not worked well. The example comes from guidelines for medical review, which was an attempt to develop a common document to be used in MCH and PHC units. Different donors and their representatives have their own guidelines (and agendas), and some do not participate (or offer to work); thus the result of the effort may be inappropriate to the project's needs and/or seriously delayed. The team feels it is better if the FHS project develops its own training plans and necessary curriculum materials while "borrowing" appropriately from what is available already.

2. Training Site

A FHI MCH training site has not been established yet. This may reflect the priority status of training in this component. The project paper calls for establishment of a training site at the Post-Basic School by mid-1985. Plans now call for such a site sometime in 1987; it is targeted as a low priority task in the workplan.

Although office space renovation is considered as part of output 4, it is related to the training site and will be addressed as part of output 2. Although the Director and TA counterpart will retain an office at the MOH, the FH/FP Division is seeking office space near, but outside, the MOH. Since space is at a premium in the MOH compound and renovation would be required to bring present space to an adequate facility, renting appears to be a good decision. It was decided that renovation at the Post-Basic School would not be adequate or reasonable. In any case, poor experience with renovation in Mogadishu indicates renting would be a faster and more assured way to get better workspace. If the rental situation proved unsatisfactory, the unit could seek other quarters; this would not be possible after costly renovation. The search for a facility is complicated by the fact that one site is to house office space, a warehouse for contraceptives plus other commodities and supplies, and a training site. The search is further complicated by the fact that cost for space must come from the shilling budget and, therefore, approved by the MOF. With all these complications, it might be wise for the project as a whole if FH/FP established the training site, as soon as possible, in separate quarters. This would relieve the pressure on the office/warehouse move.

3. VSC, Infertility and STD Services:

Establishment of Facilities: A unit has been formed in Mogadishu at Benadir Hospital, the premier women's hospital in Somalia. Two others are scheduled, one at Kismayo and another at Hargeisa Hospitals; there is a plan for establishment of units in 1987. Implementation at the Benadir Hospital of the Special FHS program was not part of the 1986 budget, but it is included in 1987.

Training: Two physicians have received training at JHPEIGO in fertility services, and the Chief of OBGYN, Benadir, attended the 1986 International Congress on Fertility and Infertility. Thus far, the unit is small and not well known, but one of the JHPEIGO trained physicians takes a keen interest in widely publicizing infibulation related infertility, which could be of great support for the female circumcision aspect of the FHS project. There does not appear to be much emphasis on training for nurses or support personnel by the project.

Services: Sterilization is against Islamic tradition, the Sharia, and Somali law. This service is seen by many associated with the FHS project as a potentially dangerous part of the project as an official policy. Some physicians apparently perform laparoscopy in their private practices. There is understandable reticence about moving ahead with this part of the special services, especially as part of a package of FH services.

4. Improved Management Systems and Facilities

This is the second priority activity for this component identified in the project paper. In the short time he has been resident in Somalia, the Advisor and FH/FP Director have made improvements in management. This is a tribute to good rapport and hard work.

Facilities: The renovation of space and warehouse for the FH/FP Division of the MOH is discussed under output 2. Office equipment and supplies will be obtained when the space is selected; typewriters are supplied by the URC contract.

Personnel Management: TA from a locally resident US citizen was secured in 1984 or 1985 to help the FH/FP Division evaluate its management structure for effective operation at central and field levels. The consultant was to make recommendations about roles and responsibilities and help develop a work program for staff and units. The recommendations were to be followed-up by the long-term Advisor. At the end of her consultancy, the FH/FP staff met in a workshop to discuss the recommendations. We understand there was discussion regarding how the 4 units and personnel at the central office might work together more effectively and provide better support to the field, but that no substantive changes in organization or responsibilities were made. There still appears to be a gap in the decision making chain in the Division under the old structure, which is essentially a Director, Deputy Director, and 4 unit heads (Training, IEC, Medical Services, and Evaluation). The Deputy Director's position appears difficult to fill; there have been several short tenured employees. At the evaluation team's initiative, Dr. Nguyen has shared suggestions for possible alternative organizational structures. Since the team has not had an opportunity to explore this with FH/FP staff or carefully study daily needs and functioning of the Division within the MOH, it is beyond our capability to advise on an alternate structure. There seems a clear need, however, to have one or more persons serve the Director to help share the work load and act in her behalf during absences from Mogadishu or Somalia.

Supervisory activities in the field are assuming more direction as the Director and Advisor work together to organize personnel and assign responsibilities for specific districts and MCH clinics with a more regular pattern of visits. Supervisors (6) are assigned to monitor clinic activities in all 8 regions where contraceptives and new record forms have been placed. A checklist for supplies and performance has been developed. The FH/FP division is making important steps toward better management and improved patient care.

Supply Logistics and Client Records: The CDC provided consultants in 1982, 1983, 1984 and 1985 to evaluate and assist the FH/FP Division with developing logistical supply and record keeping systems. In 1985, as part of her assignment, one consultant destroyed outdated goods. This consultant, Anita Bennetts, returned under a URC TA in January 1987. Normally such systems would a) assure proper warehousing, inventory control, and logging in and out by expiration date of contraceptives, b) rationalize the logistical supply line for regular supply to MCH clinics, and c) provide a simple, routine, easy to maintain record system on new and continuing users by method. A quick observation by the team confirms the report of the January 1987 consultant that, while there may be progress in the past few months, much more must be done to entrench MIS as part of daily management. The warehouse situation is temporary; and, hopefully, storage and records will be improved with the move to new space. Although more MCH clinics and hospitals now are stocked with fresh contraceptives supplies, distribution still is on an ad hoc basis, i.e., when personnel come to Mogadishu or central staff travel to a district. Client records appeared to be too complex, difficult to interpret quickly, and cumbersome to combine for eliciting summary information. FH/FP, in its 1987 workplan has as a second priority (one scale of 1 to 3), a MIS for all FH/FP activities. In view of other work pressures and needs, i.e., curriculum development and training, the present established systems are sufficient for now; good implementation, however, should be a first priority. This team believes Bennetts' recommendation to perfect the systems in Benadir first and move to regions later is sound. Clinic management is part of in-service training; since training is a top priority, regional implementation of the MIS should be part of this training for field staff.

Financial Accounting: Progress in output 4 appears to be moving slowly. The project paper calls for short-term TA at six months intervals, starting in the fall of 1984, to assist the division with improving fiscal accounting and management. In addition to training relevant personnel, the TA advisor was to monitor financial accounting of this MOH division, and the Advisor was to maintain oversight of financial systems. This seems a presumptuous expectation. Indeed, little was done until February of this year when URC sent a consultant, at USAID request, to advise SWADO and CDC on accounting procedures. This same consultant assisted the FH/FP Division during his stay. While it would be beneficial from a training perspective to have visits by an outside consultant, such a plan is dependent on the willingness of the MOH. As for monitoring by the Advisor, it probably is not wise to jeopardize good working relations with the Ministry by pressing this point.

Medical Review System: This is addressed under training as part of the initial attempt to coordinate efforts with other donors. Medical guidelines were written by the Advisor after a joint donor meeting to discuss content and policy. These may be too stringent and certainly appear too lengthy to be of use to MCH field workers. Guidelines will be important, however, as services are expanded beyond the medically well trained, but they should be more simple and in the Somali language.

5. Expansion of Services:

There appears to be better planning by the FH/FP Director and her staff, in concert with the Advisor, to prepare for expansion of services. Expansion of the delivery system is scheduled in the project paper as an on-going activity from the project's beginning. Key persons involved with this component (and project staff in general) have a keen understanding of the needs for a broader and deeper penetration of the delivery system. There is concern about reaching more remote areas with supplies as well as IEC messages. Earlier discussion in Part II of the overall project progress stresses the need to balance delivery of services with IEC efforts. Indeed, implementation of service delivery must always be a step in advance in order to adequately respond to demand created by IEC efforts.

Clinical Supplies and Equipment: Adequate supplies and equipment are on order as of Feb, 1987. These will be placed in MHC clinics as soon as possible after arrival. The list of equipment/supplies ordered was developed with inputs from project personnel of both the URC and the MOH; it appears to be a reasonable list which will upgrade MCH clinics substantially. Project personnel and consultants have repeatedly pointed up the inadequacy of the MCH clinic facilities to provide basic, let alone quality, FH/FP services. According to the Advisor, an equipment inventory and maintenance schedule guideline has been prepared.

Contraceptive Commodities: The project paper list of 5 year's supply of contraceptives includes large quantities of condoms (104,598 gross) and orals (2,706,319 cycles), and lesser quantities of jelly (63,471 tubes) and applicators (4,690) plus a limited number of IUDs (16,780) and IUD insertion kits (100). A rough calculation of total fertile couples in all of Somalia indicates the expected orals order alone would supply over 15% of these couples. The EOP project target is 8% acceptors. Even if it were assumed that the 1989 order was meant to supply the pipeline in 1990, the contraceptive needs addressed in the project paper are excessive. As mentioned earlier, a large quantity of outdated contraceptives were destroyed in 1986. It seems prudent not to risk a repeat exercise, especially since a large percent (22%) of Component III. dollar allocation (\$1,308,927) is to contraceptives. In addition, other methods have been or are ordered (foaming tablets, cream and applicators) and injectables have been requested by the MOH from UNFPA. It might be wise to officially change the project paper's cited contraceptive need/costs. Revised estimates were made as far back as the fall of 1984, but the original estimates remain the official projections. This, of course, affects money allocated for other component needs. The FH/FP Division has rationalized the contraceptive order for 1988-89 as part of the recent commodities order (originally to be ordered November 1986) for what appears, based on present stocks, to be a realistic projected need (Noriday 225,000, condoms 200,000 units, Koromex 4.5 oz. cream and applicators 7,764). This will free up dollars which can be used for other needs with inadequate inputs. Stocks should be closely monitored, however, as the IEC campaign begins because of the substantial lead time in the AID ordering cycles.

Vehicles: There were five vehicles scheduled in the project paper for this component. Five Jeeps are in country and assigned to the MOH FH/FP Division. There was some question, upon their arrival, regarding use by other MOH projects; this appears to be resolved after substantial negotiation. The FH/FP vehicles will be transferred from temporary storage to the new office/warehouse site once the FH/FP Division move is made. A vehicle maintenance schedule has been developed and servicing arranged for. Fuel, which is to be provided by the MOH, could be a continuing problem as service delivery logistics become more demanding with expansion and proper implementation of regular MCH clinic resupply. There are chronic fuel shortages in Somalia, which impact all development projects, ongoing ministerial programs, and private sector activities. As the project expands, the need and reasonable expectation for actual use (and maintenance) by the FH/FP Division of additional vehicles should be monitored carefully; it takes approximately 1 1/2 years for vehicle orders to be filled.

Provision of Services: The project paper focuses on upgrading clinical services, primarily through MCH Clinics. Contraceptives have been placed in 40 clinics and 7 hospitals in eight regions. The EOP goal established in the project paper is services in 60 MCH clinics and 20 hospitals (the FH/FP Division suggests 15 hospitals as more realistic because of present difficulties with servicing Northern regions of the country). As discussed earlier, equipment and supplies are now on order. The section covering progress in training deals at length with needs to bring skills of nurses and NMs up to par. There have been some efforts to train physicians in FHS. Progress in the area of FH clinical services provision is moving slowly but steadily forward. Even the project paper goal (60 MCH clinics and 20 hospitals), however, does not expect coverage to all 93 MCH clinics, thus limiting expectation of expansion to a select population with access to these target MCH service points.

Unfortunately, the PHC system, which the project paper suggests as a vehicle to supplement MCH clinic expansion, is advancing sporadically, unevenly, and generally at a slow pace. Regular, up-to-date information on the status of this nine donor effort, region by region, is not only hard to come by, but it is virtually impossible to attempt to incorporate regular service delivery efforts into. While it seems a rational decision to attempt cooperation with other donors for efficiency, to avoid duplication of efforts, and to reduce recurrent costs of service delivery, it is impractical in light of realities. This is disappointing, especially since the CSDR national plan for PHC includes CHWs and TBAs as primary distribution points for drugs. The project, thus, rightly is looking into other potential means of service delivery beyond the targeted MCH clinics and hospitals.

Expansion to the private sector is a very positive move and consistent with the spirit of the project paper, which identifies physicians as well as CHW and TBAs, albeit working with PHC, as part of the delivery network. The 1987 work plan calls for IEC and training of non-government providers. First steps already were made in publicizing the FHS project to the medical community at the 1986 National Fair: there was an exhibit, including contraceptives, as part of the MOH display. The project participated in the MOH health education campaign. As part of this MOH effort, 192 sessions on FHS were conducted at 48 sites, including government ministries and institutions. There is an active and, apparently, thriving private sector medical system in Somalia. Even though almost all the 450 +/- doctors are assigned to government facilities (which they may not attend), physicians' private practice accounts for the majority of FH delivery. As in most countries, however, most doctors reside in urban areas, the capital being the favored city (an estimated 75%). The pattern for nurses, NMs, and nurse tutors is the same, although more reside outside Mogadishu: most provide private services. The project clearly will benefit from tapping this sector as providers and gain allies as well.

Another active private sector is the drugshops, operated at the small town and village level by entrepreneurs, often TBAs and CHWs, who sell a variety of drugs at the local level. A 1985 PRICOR study of a 1% sample of Somalia indicates 90.4% of the population purchases its drugs from the private sector, with the village drug shop cited as the most frequent source. Most people said they preferred to see improvements in the private sector drug supply over the public sector. This, in spite of the fact that 93% of private sector outlet had drug supplies, while almost none were found in public sector units. It seems eminently reasonable to have the FHS project use this system as well as the private sector medical system. We feel this might be done under this component, initially along with overall Project IEC efforts, to reach into villages via the Regional Communicators.

6. New Direction:

The FH/FP Division has become quite involved in strategy and design for IEC. The Division is represented on the IEC Directors Group, and its IEC unit has become

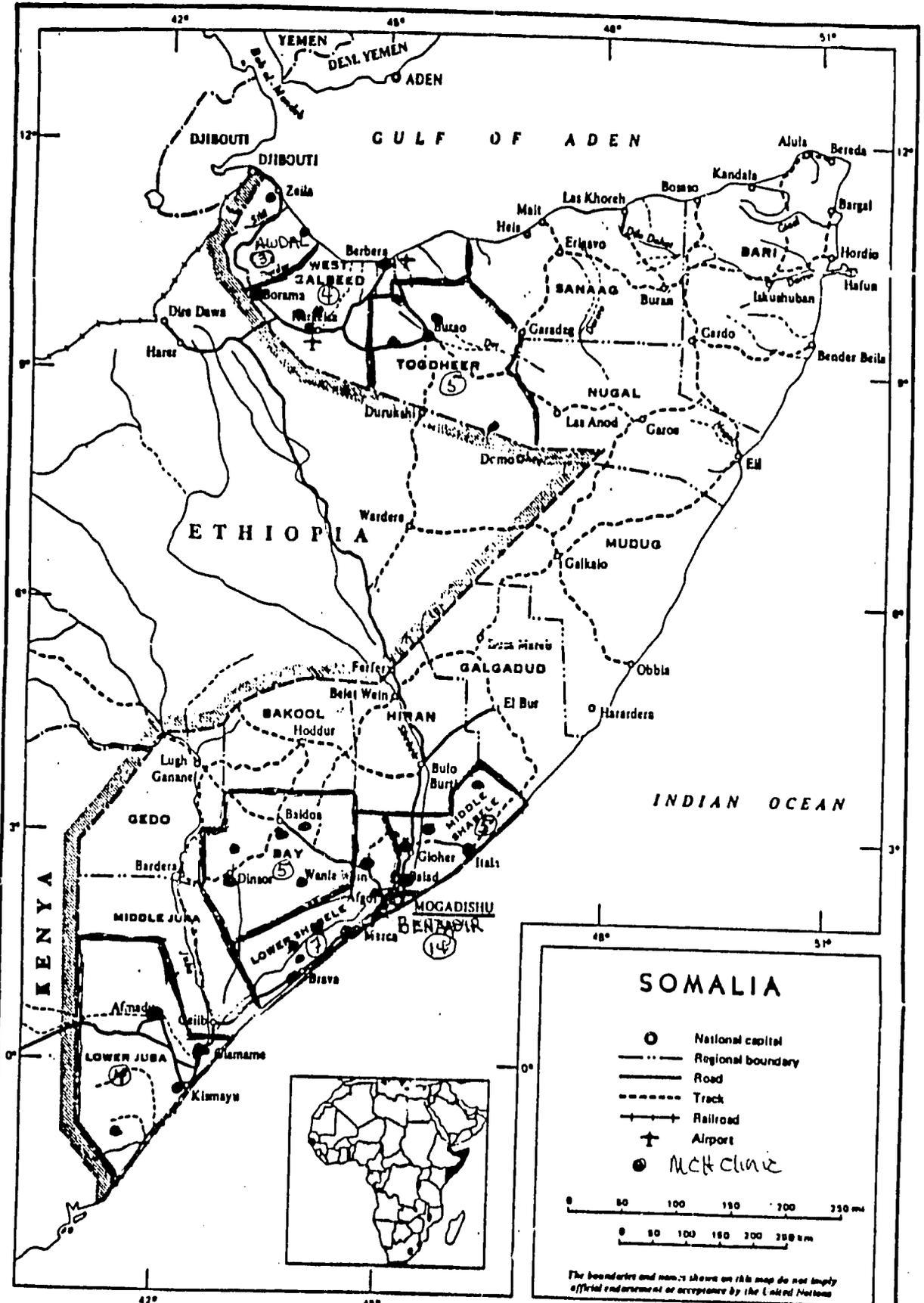
substantially committed to IEC activities. While there is good reason for FH/FP to have inputs into strategy decisions, involvement in more technical aspects of IEC activities could divert attention from the main function of the FH/FP Division, namely service delivery. As discussed earlier, there is much to do in curriculum development and training, in management and supervision, and in establishing a training site - all to prepare staff of MCH clinics and other health providers to deliver quality, consistent FH care. Most of these activities must proceed rapidly if the FH/FP Division is to gear up to meet demand which the IEC campaign is expected to generate. FH/FP certainly will be one of the beneficiaries of IEC materials, and its central management staff should make inputs regarding FH/FP IEC needs. The concern raised here is that the temptation to become substantially involved in design, production and implementation, which has its own fascination, may consume staff time and energies disproportionate to needs of the primary role and function necessary to make the FHS project succeed. It seems clear the original project design, which omits any substantive role for FH/FP in the IEC effort, viewed the Division as the service arm of the project.

The need to balance IEC with service for a successful FHS project seemed to be foremost in the minds of the design team. Both are important; but IEC (and OR) is meant to be a support to the key component, service delivery. The FH/FP Division, hopefully, will continue to concentrate on its central, prime role in the FHS project, delivery of quality services. The 1987 FH/FP workplan addresses, in several places, expansion to the private medical sector as well as inputs to non-medical providers, (the CBD approach). A recent consultant report (Rooks, Feb. 1987) takes cognizance of contraceptive delivery systems, by method, via potential providers, such as TBAs, CHWs, Teachers, Tabella leaders, WED's Family Life teachers, and even drug shops. This reflects what FH/FP calls its three level approach (See chart overleaf from Rooks). This team, along with Rooks, strongly supports this overall plan for service delivery expansion in the FHS project. It is quite appropriate for FH/FP to include the medical community in its plan for expansion of service delivery. The project paper, however, rightly gives responsibility for CBD of commodities to the SFHCA. The OR unit has scheduled, as part of its output 3, studies related to strategies for extending services through alternate delivery systems as well as studies of fees for service and selling of contraceptives. What is unclear is how and by whom implementation of CBD will be effected, since the project design team gives responsibility for training TBAs and CHWs to the FH/FP Division of the MOH. This team strongly suggests responsibility for coordinating all aspects of CBD fall with SFHCA. In the long run, this is not only more in keeping with medical orientation and skills of the FH/FP Division, but will avoid any potential charges that the MOH is cooperating with the private, non medical sector too closely.

IV. Adequacy of Inputs to Meet Component Sub-Goal.

A. The long term advisor is scheduled for three years, yet the project has been extended to the end of 1989. This position should, we feel, correspond with the remaining life of the project. Dr. Nguyen was hired in June, 1986. The URC contract and project paper would need amending to allow this position to extend an additional six months, or until December, 1989.

B. Short term technical assistance to assist with training, clinical service management, and financial accounting may not be adequate. In spite of past consultancies, the FH/FP Division can benefit from additional assistance related to developing training systems, the large job of curriculum development and teaching aids for pre-and in-service training, and financial accounting. There should be adequate monies available from an overall allocation in the project paper to contraceptives for USAID to provide such TA. URC likely still has funds remaining for additional TA to FH/FP.



MCH TARGET POPULATION FIGURES, DISTRIBUTION OF MCH CENTRES
AND MCH STAFF IN THE COUNTRY & MCH RELATED ACTIVITIES (EPI,PHC)

Region	1985* of Tot. Pop.	Z	Target Population		MCH centres	MCH Staff					Superv. ^a	EPI Opera-	PHC Operational
			Under 5 (17.82)	women 5-49yrs.(22.42)		MHN/midw.	Gen. Nrs	Aux.Nur	Tr.TBAs	Untr.TBAs			
- Banadir	600 020	10.3	106 804	134 405	14 ✓	27	47	-	160	-	6	x	-
-N/West	529 090	9.0	94 178	118 516	6 7	2	15	-	-	-	-	x	x
-Owdal	226 550	3.9	40 326	50 747	3 ✓	1	2	-	-	-	-	-	-
-Togdheer	442 850	7.6	78 827	99 198	6 ✓	1	16	-	-	-	-	x	x
Sool	57 300	1.0	10 199	12 835	2 ✓	-	2	-	-	-	-	-	-
Sanag	249 810	4.3	44 466	55 957	3 ✓	-	5	-	-	-	-	x	x
Nugal	72 100	1.2	12 834	10 150	3	2	3	2	-	-	-	-	-
Hiran	253 020	4.3	45 039	56 679	3 -	1	2	2	-	24	-	x	x
Galgadud	295 170	5.0	52 540	66 118	5 -	-	4	2	-	15	-	x	-
Bari	256 440	4.4	45 646	57 443	6	4	3	2	-	-	-	-	-
-Bay	520 280	8.9	92 610	116 543	5 -	4	5	1	-	160	-	x	x
Bakool	171 580	2.9	30 541	38 434	4 -	-	4	2	-	12	-	Dis.	-
Mudug	359 050	6.1	63 911	80 427	4 -	-	5	2	-	-	-	-	-
-L/Shabelli	658 330	11.3	117 183	147 466	8 ✓	11	10	-	58	122	-	x	x
-N/Shabelli	406 130	6.9	72 291	90 973	8 7	4	7	2	-	80	-	x	x
Gedo	271 180	4.6	48 270	60 744	6 -	1	3	4	-	16	-	Dis.	-
-L/Juba	314 220	5.4	55 931	70 385	5 4	1	2	2	-	20	-	x	-
H/Juba	170 520	2.9	26 310	38 197	3	-	4	2	-	8	-	-	x
TOTAL	5 853 650	100	1 041 950	1 211 217	92 93	59	139	23	218	452	6		

^a Each national supervisor is responsible for 2 MCH centres in Banadir and three regions in the country

Figures based on Population estimate, Ministry of Planning and an annual growth rate of 2.92

10/11

C. There should be more than adequate funds for training Somali health personnel, especially since more training should take place in-country in the future. The FH/FP Division, e.g., has reduced the number of persons to be trained overseas from 54 to 42.

D. Dollar inputs for commodities are more than adequate. The excessive allocation for contraceptives has been addressed several times. Vehicles appear to be adequate for the present needs, but this should be monitored as the MCH clinical and private medical sector services expand. More money may be needed for training materials and aids purchased with dollars.

E. Total dollar inputs appear quite adequate, especially since dollars can be reallocated from contraceptives and out-of country training. The inputs in Somali shillings may be short, even at disbursement exchange rates per the Pro Ag. Travel and per diem, salary supplements and materials may become more costly than anticipated if the FH/FP is to adequately serve eight regions, much less consider expanding to more of the remaining uncovered 10 regions.

V. Activities as Designed, By And Large, Are Adequate To Achieve The Project Goal, Purpose And Component Sub-Goal.

A. Training: The project design calls for minimal outside assistance for in-country training. Since there will be fewer persons going abroad for training and since past training efforts in-country have not produced adequately trained clinic personnel, more TA for training seems imperative. This is especially true for development of curriculum materials for both pre- and in-service training (an area which has received the expected TA assistance already) and for improving training systems and on the job training.

B. Training Site: It is not possible to give an opinion on this since the expected TA has not been arranged for and the site is non-existent. If a well equipped, well managed clinic is established, it should be adequate to meet anticipated training needs.

C. Special services (VSC, Infertility and STD clinics) The concept of establishing such clinics in the 3 major cities was sound. It was preferable, however, to call these Fertility and Infertility Clinics and to eliminate the requirement to include VSC. There is also a potential danger in identifying STD as a FHS Project service. The international highlighting of AIDS (a non fertility related disease) and increased funds available to focus on this problem (which is of serious epidemic proportions) could divert attention from the FH aspects intended for special services in the project design.

D. MIS and Facilities for FH/FP Division: The activities planned for a MIS are adequate even though forms which were developed are too complicated; implementation, however, is not working well. New facilities for office space and warehouse, while necessary, have not been secured. The project paper calls for renovation at the Post Basic School of Nursing; the FH/FP Division has opted to rent instead. This should provide better, more efficient space, if properly chosen. Selection and move to new quarters will complete this needed activity.

E. Expansion of Services: Activities as designed may not be adequate. The project paper focuses on the MOH system and calls for service delivery in up to 60 MCH clinics and 20 hospitals in eight of the more populous regions. FH/FP expects to reach more than 8 regions and have more than 60 clinics, equipped and supplied with contraceptives, but suggests 15 rather than 20 hospitals. Not all nurses and NMs will be skilled in inserting IUDs (140 targeted in the project design). Related activities are supervision to assure

maintenance, adequate stocking of contraceptives, and quality control of care. The subgoal is to upgrade clinical FH services; no numerical goal, vis-a-vis acceptors or continuing acceptors, is stipulated as part of the sub goal. In fact, not even contraceptive acceptors is stipulated, although the full description of the sub-goal implies acceptors, as does mention of the large quantities of contraceptives as the only 'drug' supplies under commodities. Activities related to the expansion of services output, therefore, must be viewed only in relation to the objective of reaching stipulated numbers of clinics and hospitals. Seen this way, the activities, if effected, are bound to achieve the component subgoal. What is lacking in the project design is sufficient attention to service delivery outside the MOH system. Alternate FHS delivery through the private medical sector and via other potential non-medical providers is addressed in other parts of this report.

COMPONENT IV

OPERATIONS RESEARCH

Sub Goal: to monitor, evaluate and guide operations of FH programs.

Purpose: to strengthen capabilities of Somali institutions to: 1) evaluate program implementation, 2) investigate and identify most effective service delivery approaches and 3) assist in planning program implementation.

Intended Outputs:

1. Establish an Operations Research Unit
2. Train in OR Methods through a Seminar
3. OR Reports on Focused Studies
4. Report on FH Survey II
5. Program Monitoring Systems
6. Contraceptive Social Marketing Program

EOPS: a. Participating institutions will have improved technical and management skills in data production, analysis, application. b. Implementing personnel will have improved OR skills c. Programs will be guided by an effective OR system d. An upgraded MOH FH services will be established. e. Greater efficacy of service personnel in motivating couples to adopt and continue FH practices will be effected.

I. Relevant Background Information and Interrelationships with other Components.

- A. OR is a new concept in Somalia. Its efficacy as a tool to guide implementation and/or to improve programs is not yet well understood.
- B. OR will be dealing with controversial subjects. FH (family planning) is untried and, seemingly, questionable in Somalia. This is complicated by a policy decision to include topics such as female circumcision along with child spacing, under the rubric family health.
- C. OR skills (indeed research skills in general) are at a premium in Somalia. Local availability of expert technical advice and experienced research persons make this a difficult environment in which to conduct OR.
- D. There is a paucity of data which can be used to guide the early efforts of the FHS project. The need for and potential heavy demand on OR by the FHS project dictates balancing needs, careful planning and prioritizing.
- E. OR is a unit within the SFHCA. As such, it is under the direct control of the Executive staff and the Board of Directors.
- F. There is no discrete budget for the OR Unit as there is for every other component. All OR shilling costs must come through the SFHCA and be approved by the Board of Directors. USAID dollar inputs for commodities appear to relate only to contraceptive activities; the OR Unit is hampered by lack of vehicles and basic office equipment specifically consigned to the Unit.

- G. The OR unit operated without a shilling budget in 1986. The project paper calls for establishment of the OR Unit a year after the contractor is selected. URC's response to the RFP and subsequent contract with USAID, however, calls for placement of the long term (2 years) OR Advisor in the field shortly after contract signature (November 1985). The SFHCA established its OR Unit to coincide with the URC contract plan. Unfortunately, no budget for 1986 was submitted to the MOF. The DDD literally interpreted the project paper schedule, expecting establishment of the OR Unit at the end of 1986, and delayed approval of any budget until December, 1986.
- H. The OR Unit was hampered in its operation and image by lack of adequate access to transport.
- I. The OR Research Associate, counterpart to the Advisor, was to be selected after arrival of the Advisor according to the project design. Abdirahman M. Nero, a long time employee of the SFHCA, was selected for this position as OR Director prior to arrival of the Advisor, Robert W. Morgan. The Advisor and Director appear to make an excellent team.
- J. The prime interrelationship is with Component II for which OR can serve as a generator of original data as well as a monitor and evaluator of IEC strategy, messages and media. Component III has need for independent monitoring and assessment of its training, management and service delivery systems. Experienced assistance to the FII/FP MCH program will free staff for concentrating on delivery and benefiting from ideas for upgrading operations. Components I and IV have complementary skills and objectives for formulating a better data base on population issues.

II. Inputs.

- A. Total financial commitment is the equivalent of \$ 2,467,000. Total USAID dollar contribution is \$1,610,000, the GSDR is expected to contribute at least \$ 810,00 in Shilling equivalent, and another \$ 47,000 input for the FII Survey II is expected from the centrally funded AID contract for Demographic Data for Development. This Component has the least funding support of all 4 Components.
- B. TA (\$ 1,040,000) will absorb the major share of USAID's commitment. Expected TA is as follows:
 - 1 person for 24 person months (pm) OR Advisor
 - 1 person for 13 pm CSM short term (S.T.) over Life of Project;
 - 3 persons for 14 pm for special studies S.T. over the Life of Project;
 - 4 persons for 5.5 pm FII Survey II S.T.;
 - 1 person for 3 pm service delivery evaluation S.T.;
 - 1 person for 2 pm training OR S.T.

Thirty two of the person months are for major activities related to CSM, FH Survey II and three Large Scale Studies.

- C. The training commitment (\$ 15,000) is for study tours for the OR Director (8 weeks). TA (2pm) to assist in an in-country training workshop is included as part of TA costs.
- D. Commodities (\$380,000) include vehicles and materials for use in CSM packaging and promotion CSM contraceptives are included in Component III, and account for the majority of the anticipated contraceptive order (condoms, primarily, plus orals).
- E. Contingency is at \$ 175,000
- F. The GSDR contribution (\$ 810,000 equivalent in Shillings) is to pay salaries for personnel, travel and per diem expenses, and related cost for the OR Unit and CSM. It is also to cover the cost of labor for packing contraceptive units in the CSM project.

III. Progress Toward Accomplishing Component Outputs 1-6

The two problems anticipated by the design team have proved to be valid concerns: 1) this component is perceived within the project as relatively less important than others, and 2) maintaining regular communication with participating institutions has been difficult. This has made the job even harder for a component operating without adequate resources since its formation.

1. OR Unit Establishment

The OR Unit was operationally formed with the arrival of the Advisor in late February 1986. First tasks included developing a statement of purpose, a workplan, and a 1986 budget. The Technical Committee called for in the project paper was formed by May: this group is to meet quarterly to advise on activities and review/approve OR proposals. It is to be composed of persons representing cooperating institutions who have skills in evaluation and management as well as local individuals recognized as having research and/or management skills. The Technical Committee is still in the formative stage of functioning in its intended role. Top management of cooperating institutions see a lesser role for the OR than the IEC Unit and devote energies to the latter. Skills relevant to OR are in scarce supply in Somalia, so the professional advisory function of the Technical Committee is weak. This makes the staff of the OR unit feel more isolated from the dynamics of the project than the IEC Unit and FH/FP Division. This, in combination with the lack of budget and minimal staff, has kept the OR Unit from fully capturing the imagination of cooperating institutions. With more support and requests for assistance, the OR Unit could be laying plans to make substantial inputs into institutional needs for monitoring and evaluation and for on-the-job training of personnel in OR. The greatest interest has come from WED and SWDO. An excellent example of the lag in understanding the value of OR is evidenced in appointment of the OR Working Group (ORWG). These are persons from cooperating institutions seconded to the OR Unit to assist with research needs. More than once, individuals have been called back by their employers when need for their service arose. One obvious flaw in the ORWG is that individuals remain on the payroll of their institutions, which receive no compensation for their loss. Nor do the members of the ORWG receive any extra monetary incentive for their work with the OR Unit. Training in OR, clearly, is not seen by either institution or individual as adequate incentive.

2. Training

The Project paper calls for both in-country and out-of-country training.

a. The two week seminar scheduled in the project paper for all contract advisors and their counterparts, as well as research and management personnel of the cooperating institutions was revised to a 2 day seminar held in November, 1986. The workshop agenda addressed OR methodology, OR as an aid to implementing FII programs, and special relevance to each institution and to the project as a whole. A second workshop is planned for the Fall of 1987.

b. Out-of-country training took the form of participation in a project study tour to Korea, Thailand and Bangladesh. The Director, who was the OR representative on the tour, also benefited from a short term course at the University of Hawaii enroute and an OR workshop in Dhaka.

c. The ORWG, in spite of limited exposure to OR methodology, received on the job training as it prepared for and conducted interviews in the major research project of 1986, the 2 village KAP baseline and radio listening patterns study and the Hodan Survey in Mogadishu. They also participated in an examination of working relationships of Regional Communicator teams and observed/analyzed Regional Communicator workshops in Merka and Mogadishu.

3. Focused Studies of Program Operations

This output calls for three large and 'other' small scale studies. A substantial amount of TA is called for in the project paper budget. There is little direction on what these studies should be, nor is there any definition of how to determine large and small. Suggested areas for investigation are: a) cost recovery from user fees or sales; b) strategies to extend CBD; and c) gaining community support for IIC and FH services. Given the limitations of the OR Unit in 1986, and the Project decision to test model campaigns utilizing Regional Communicators, the OR Unit opted for a KAP and radio listenership survey in 2 selected villages in Middle Shabelle, and needs assessment in the urban sub-community of Hodan. Also, systems analysis of four organizations cooperating in the project -- WED, SWDO, MOH, CDC -- was conducted at the regional level (Middle Shabelle). The OR Unit anticipates that extension of one or both of such studies to other regions will develop into one large scale project.

Operations Research Unit Survey in Jowhar Districts, Middle Shabelle Region

From September 1-4, 1986 the OR Unit conducted a survey in two villages designed to reveal baseline information on social, demographic and medical behavior, KAP levels on mother and child nutrition, breastfeeding, use of oral rehydration solution, childspacing, and health hazards of female circumcision as well as patterns of radio/TV listening/viewing and other communications characteristics. In-depth interviews were conducted with 396 persons.

Results showed that 47 percent of men and 57 percent of women favored sunni circumcision. The 28 percent who opposed circumcision included 32 percent of women and 22 percent of men. Younger women were more opposed, 50 percent of those 16-24 opposing. Since these figures varied substantially from estimates given by local leaders, the OR researchers concluded that it will be necessary to rely on generating their own social, medical and demographic data as the basis for future analyses. These data on attitudes toward female circumcision vary dramatically from the Baseline study in which a low of 34 percent of urban women in Mogadishu to a high of 75 percent in Kismayo favored Pharaonic circumcision for their daughters. The Jowhar survey revealed that 27 percent of homes had radios, which reflected the relative wealth of those owning and tending cattle. The implication of the finding for the development of the FHS Project is in seeking social and economic characteristics conducive to project success, access to radio being an example.

Community Leaders Needs Assessment, Hodan District, Banaadir Region

In preparation for the first Project campaign in Hodan District of Mogadishu, the OR Unit conducted a needs assessment followed by a pretest. Immediately after the two week campaign (in progress at time of the evaluation), a post test will be done.

Data was collected on (1) social, demographic and medical behavior, (2) KAP on mother and child nutrition, breast-feeding, use ORS, child spacing, and the health hazards of female circumcision, and (3) radio/TV listenership patterns and other communications data.

In addition to original research described above, the Unit assisted the SFHCA in completing analysis and reports for two studies which Rapid II had contracted with the SFHCA. These are the same studies described in Component I, Part III, 5, as meeting the CSD commitment to Rapid II and Output 5 of Population Data and Policy, Component I.

4. FH Survey II

This major survey is called for in 1987-1988; total time from planning to completion of the report is one year. OR is expected to be the lead organization to advise and coordinate the effort. TA is to be provided through a mission add-on to the Demographic Data for Development central contract, which is to provide 5.5pm of intermittent TA. The MOH and CSD of the MONP are to co-survey the work. The entire effort appears to be a major, hard to administer, complex affair. USAID has agreed that the effort should be postponed from 1987-88 to 1988-89, since a) it is now prematurely scheduled because the URC contract was not signed until late 1985, and b) no organization or planning has been started yet. The USAID FHS Project Director also agrees the FII Survey would be better placed under the responsibility and aegis of the MONP.

5. Program Monitoring Systems

This output is intended to help other components and cooperating institutions identify successful operations or suggest reallocation and adjustment of resources. It is also intended to help identify problem areas. Another function could be to help develop simple service monitoring systems for more effective operations. Little has been done, thus far, to assist organizations, but the pre and post tests in Hodan serve this monitoring function. This will expand with OR in other campaign areas.

The team views this as one of the major areas in which OR can service and support the program. We find it disappointing that there has not been more progress in this activity area, apparently because institutions have not taken advantage of OR.

6. Contraceptive Social Marketing

The first consultancy was scheduled in the project paper for 15 months before the OR advisor arrived and the OR Unit was to be established. This would have been virtually simultaneous with arrival of the IEC Director/Chief of Party. URC prudently delayed this input until May-June of 1986.

This activity is under subcontract to AED, which provided the consultant for a three week analysis. The consultant followed up work initiated by USAID in 1984, when a SOMARC (Futures Group) consultant did a feasibility study in preparation for the project paper. The AED consultant 1) built on this report, 2) developed a series of questions which need to be explored, and 3) suggested a second consultation visit to, among other things, lead a workshop on social marketing and help the SFHCA develop a policy task force to guide a CSM program. She wisely identified careful analysis of the institutional framework as the starting place for development of a CSM in Somalia. She also suggested several marketing research studies which the OR Unit might undertake in preparation for developing a marketing strategy.

IV. Adequacy of Inputs to Meet Component Sub-Goal

A. Total dollar inputs by USAID to this component appear more than adequate. The expected allocation of these funds to TA, training and commodities, however, will need reconsideration (this is elaborated in section IV of this component). Early consideration for necessary adjustment is critical. The Somali Shilling inputs are inadequate to support the OR Unit in its intended activities and to implement the needed OR studies. The GSDR is to pay for staff, travel costs for all field work, all costs related to equipping/supplying the unit, and all costs related to the CSM project (except for product raw materials for packaging and promotion). Furthermore, it appears that no separate budget for the OR Unit was ever developed, i.e., OR costs are assumed under the SFHC budget. This means Shilling support for OR must be approved by the Board and Executive staff out of its total allotment from the DDD.

B. Other than the long-term Advisor, technical assistance inputs by outside consultants appears excessive. The project paper calls for short term (S.T.) assistance by 10 different specialists for 37.5 p.m. of TDY. An analysis of the intended and seemingly more reasonable use of TA is in Section V. The long-term Advisor position either should be extended to a three year period with a S.T. TDY of 6-8 weeks during 1989 or to coincide with the end of the project (December 1989).

C. Inputs for training (\$15,000 plus Shillings for local workshops) are inadequate. Dollars allocated for out-of-country training for three persons, however, may be excessive since the CSM project should be delayed (see discussion under V) or will need to be readjusted for different kinds of overseas training. Shillings allocated are too few for the in-country training required to inculcate OR concepts and develop skills. Budgets and allocation, again, are provided at the discretion of the SFHCA.

D. Dollar inputs for commodities appear to all relate to the CSM project, an activity for which the team recommends postponement to a period beyond the 5 year project. Four vehicles and spare parts are scheduled for social marketing; packaging materials also are included in dollar inputs for this activity. No vehicles, typewriter, computer, or other needs of the OR Unit appear to be included in USAID commodity inputs. Selected miscellaneous training materials for OR workshops are the responsibility of URC. Clearly, the needs of the OR Unit for commodities are inadequate to carry out the intended activities. This should be adjusted a.s.a.p. after discussion with the OR Director and Advisor regarding their needs over the next three years. Since CSM vehicles are scheduled (but not yet ordered), adjustments can be made with relative ease.

V. Activities As Designed are Not Adequate to Achieve the Project Goals, Purpose, and Component Sub-goal.

A. The establishment of the OR Unit within the SFHCA was practical since the Association is the coordinating body for the FHS project, is nongovernmental, and relatively non-bureaucratic. One of the disadvantages, however, is control by the Executive Staff and Board of Directors, especially over funds for daily operation and staff. An additional disadvantage is that research and surveys are dependent on the goodwill and interest of cooperating institutions, who also are expected to provide personnel for fieldwork. The strong emphasis on IEC as a major focus of the FHS project and the SFHCA's central role in IEC tends to overshadow the functioning and work of the OR Unit. In addition, Component I, under the MONP, which has natural ties to and a support system for Component IV, relates only tenuously with the SFHCA and with all other Components of the project. Weighing advantages and disadvantages, placement in the SFHCA appears to have been the most reasonable of alternatives.

More forethought should have gone into staffing and operation, however, in view of the large responsibilities given to the OR Unit. The FH Survey and CSM projects alone would have pressed the capabilities of the OR Unit as presently staffed and funded. The limitations built into the functioning of the OR Unit are especially vexing because the project design team perceived low priority status as one of the two problems facing Component IV.

The OR unit should have more staff, and there should be a longer term commitment to the Advisors position. A Coordinator and secretary, hired part or full time as needed, should be built in as full time local staff positions. The Unit's budget should include monies which can be used to "sub-contract" with cooperating institutions for temporary staff for the ORWG. Such sub-contracts should include some monies for the institutions as well as incentives for each person assigned to the OR Unit. This will enable the Unit to have some control over the persons selected as well as avoid "losing" those people back to their organization at critical times of need by the OR staff. OR management also should have the freedom to hire temporary help from outside the cooperating organizations, if necessary, and temporary should be viewed with flexibility. USAID should arrange for vehicles for the Unit as soon as possible and for any equipment the Unit now lacks or must share sporadically with others at the SFHCA. The SFHCA should lobby for the OR budget as rigorously as for that of all its projects. It would be helpful if staff of the SFHCA also assisted in giving the Unit more visibility and credibility with cooperating organizations and the Board. This would help overcome the other problem identified by the project design team, namely, maintaining good communications with participating organizations.

- B. The training called for in the project paper puts heavy emphasis on study tours. It would seem preferable to train more Somalis in OR skills through on-the-job experience than one or two persons with more study tours. By spreading the training costs in a more cost effective way, there will be a larger reservoir of persons who have concepts and skills in some aspects of OR. The 2 week seminar in the project paper plan might be more effectively broken into several smaller workshops, which is what the OR Unit apparently plans to do. The six months 'apprenticeship' on-the-job training in the 1987 OR work plan appears to be an excellent means to widen OR skills for Somalia. Training should be seen as a far more valuable activity for the OR unit than major research projects such as those called for in outputs 4 and 6 of the project design.
- C. The activities related to focused studies described in the project paper as 'three large-scale studies and, other small-scale studies' are, we believe, intentionally nebulous and unspecified. The three suggested areas which need information and analysis, however, are sound. They need not be, however, expensive, large, overly ambitious undertakings. The team believes the OR Unit should proceed with investigation of all three, preferably in the following order.
- a. Approaches to encourage community involvement and support of the FHS Project IEC campaigns and delivery services (this is already under way as evidenced by the M. Shabelle and Hodan surveys described in section III.3. of this component).
 - b. Strategies for extending services to rural areas such as CBD by TBAs CIWs, WED, SWDO and drugshops. A formal plan should be developed for implementation asap with assistance from project paper identified TA of 3 months duration.
 - c. Approaches to recovering delivery costs by charging fees for services or payment for contraceptives (much information can be gathered during any research related to b. above).

Other focused studies should be developed based on needs and priority. While it is both important and desirable to be responsive to research needs identified by cooperating institutions, the OR Unit will have to exercise prudence not to become overextended to the point of becoming involved in efforts which will dilute more important information gathering or result in questionable results. This is especially relevant in light of monitoring activities expected as part of output 5. The possibilities for small studies responsive to prioritized, expressed needs could be an area in which more local research expertise might be used. Some of the dollar commitments to TA from outside consultants and organizations might be utilized more effectively for such local skills. Local currency commitment to the CSM project also could be considered for this as well as to pay for related research costs for which the OR Unit is limited and hampered.

- D. The FI Survey scheduled as an OR unit activity has been addressed in II.4. This appears to have been 'misplaced' under OR; it is a large survey for which responsibility could have been placed elsewhere. The team and USAID feel reconsideration to make this a MONP project is appropriate.
- E. The program monitoring of day-to-day IEC and service delivery systems is a well conceived and important activity for OR. Monitoring with a view to improving systems and revising strategies for more effective operation is one of the better ways to achieve project goals and purpose. This is an excellent and well placed function for the OR Unit. Acceptance of the monitoring role as a management (rather than evaluation) tool will depend on the understanding by personnel of cooperating institutions of its value to their programs. This would be an affirmation of their vision as directors and managers. The communication skills of the OR Unit as well as the SFHCA Board and management about OR monitoring functions may be key to the success of this activity in helping the project meet its long term goals.

- F. The team feels CSM is a premature activity at this stage in the early development of a FHS Project in Somalia. The most successful CSM projects have been initiated in countries with established family planning programs where family planning is a well accepted concept. Most family planning programs in Africa are relatively new. There are no old successful CSM programs in Africa south of the Sahara. Even those which have been tried in African countries where family planning programs had had several years to develop ultimately floundered. This is not to imply that CSM cannot work in Africa; it is a matter of timing and political backing.

The recent consultant's report on a CSM project for Somalia identified strong political support as one of the key elements for success. Two other essential elements which she identified are: a) operation free of bureaucratic ties and constraint, which can hamper the need for rapid program changes in response to the dynamics of the market place; and b) a strong, regularly functioning product distribution system from original supplier to retail outlet. It appears that these elements, among others, are lacking in Somalia at present. Many of the key persons this team spoke with are nervous about high level political acceptance, even of overt promotion of family health, as family planning is euphemistically called in Somalia. They cite support from policy leaders as uncertain. It is important to remember that a major role of the FHS Project is to help develop appropriate policy in support of family planning. The second element -- bureaucratic constraint -- is only somewhat solved by placing the CSM project under the responsibility of the neophyte SFHCA. The Association is feeling its way as a non-governmental body in a historically socialistic country. It must tread carefully in the formative years. Not only would policy for a CSM project be in the hands of the Board, but budgetary needs would be under the control of the MOF. This includes salaries for staff (experienced entrepreneurs generally are not enthusiastic about accepting government dictated salaries) and for advertising, promoting, and, most likely in the Somali context, distribution costs. Product distribution would be difficult and expensive. Development of strategies both for distribution and advertising/promotion are complicated by almost non-existent infrastructures for these services in an officially government controlled commercial system.

There are other constraints as well. The most effective means to advertise products is the use of radio, which is controlled by the MOI, and advertising of drugs on the radio is illegal. Pricing strategies would suffer from constraints such as unstructured pricing policies. No distributor margins or consumer prices are fixed, and taxes and fees on businesses are high. There is, also, no official policy about providing AID donated goods to the private sector either by USAID or the government. The private sector and small businesses, however, appear to be thriving as the GSDR experiments with relaxation of strictures on the private sector; this could bode well for a CSM project in the future.

Perhaps the most troublesome consideration at this juncture are the high visibility of CSM programs and the cost to implement CSM in Somalia. In the context of a country still unsure of its stance on family planning, the implementation of CSM by an organization (SFHCA) just getting off the ground could raise red flags for the future of all family health services. The negative constraints discussed above would make the development of CSM in Somalia strategically difficult and costly. One of the rationals for CSM is that it can be a more cost-effective programming strategy, and a measure of success is cost per couple year of protection (CYP) based on a now established formula. Within the parameters in which CSM would be operating in Somalia, cost per CYP likely would be exceedingly high. This would not be beneficial for a long term evaluation of CSM either in Somalia or as an international program strategy.

In sum, all of the above factors lead this evaluation team to conclude that mounting a CSM project during this initial 5 year FHS project could be counterproductive to the entire effort.

M

UNIVERSITY RESEARCH CORPORATION
BUDGET EXPENDITURES & PROJECTIONS
SOMALIA FAMILY HEALTH SERVICES

649-0131-C-00-6001-00

June 30, 1986

Budget Category	1/87 Revised Total Budget	10/85-10/86 Year I Budget (1)	Exped. to date 6/30	Est. Oblig. (thru Sept. '86 (2)	Total 1&2	Balance Yr I Budget	Est. Percent of Yr I Budget Spent Sept. 86
Salaries	786,124	222,081	93,178	46,660	139,838	82,243	62%
Fringe	221,254	59,962	25,157	12,598	37,755	22,207	62%
Consultant	64,652	15,000	-	-	-	15,000	0
Transp. Travel	212,394	82,245	98,500	16,718	107,218	(22,973)	127%
Allowances	181,630	54,500	22,606	11,172	33,778	20,722	38%
Other Direct Costs	202,065	52,051	52,717	12,134	64,851	(12,800)	124%
Participant Training	447,514	90,464	80,108	68,750	148,858	(58,394)	164%
Subcontracts	512,913	94,392	32,006	46,230	78,236	16,156	82%
Commodities	535,000	400,000	3,161	48,361	51,522	348,478	12%
G&A	765,940	220,610	138,421	63,852	202,273	18,337	91%
Sub Total	3,954,486	1,293,305	537,854	326,475	864,329	428,976	--
Pee	237,269	77,733	32,271	19,596	51,867	25,866	66%
Total	4,191,755	1,371,038	570,125	346,071	916,196	454,842	

**Somalia Family Health Services Project
Budget Analysis by Category**

Salaries and Fringes

Expenditures for Year I include OR advisor in country for 6 months & MOH advisor for only 4 months. This budget line also includes OR technical assistance from URC staff which was not provided during this first year.

Experience to date suggests that we underestimated the level of administrative and financial home office support required by Project. This kind of support which was not included in budget has been charged against the secretarial line. A more realistic figure for home office support (secretarial and financial would be 60 person months at salary level \$24,000 per year to cover both secretarial and financial/administrative activities).

Consultants

Consultants not used this year because these were to be consultants used in the MOH/Clinical area & the MOH Advisor arrived in Somalia in July. Mike Savage who worked was hired as an interim employee and this his consultancy was covered in the salary line.

Travel and Transportation

Budget was based on lower weight/shipping allowances, and did not, for example, include consumable allowances. AID regulations have since changed and shipping allowances are higher. Also we did not budget for moving a family since the original MOH Advisor was single.

Allowances

Expenditures to date reflect the fact that we have not had field staff in country for the entire year. Based on salaries on field staff - a surplus of approx. \$4-6,000 (depending on salary increases) can be expected in this line item next year.

Other Direct Costs

Spending in ODC is exceeding budget. The following factors are involved: 1) rent is based on URC person days - that is higher than anticipated; 2) telex/telephone running at about 1.5 - 2x budget; 3) problems with CIPI. budget allocations (Somali counterpart budget) have made it necessary for us to use field budget to pay for items (e.g., materials and transportation) which should be covered through local Somali budget. Contract budget should also include costs for producing materials, films, etc. ODC line item should take into account the need to use contract funds to expedite the field work. Will need to develop a more realistic budget for ODC taking all these factors into account.

Short-term overseas training has been a major activity this year and the reason for emphasizing training has been sound. By the end of the first year we will have spent approximately 1/2 of the 4 year budget for participant training. However, most of the training to date has been for IEC staff. MOH and OR staff will need to receive their share of training. In addition, as the program develops, IEC staff will need training in other areas (e.g., production of visual materials, radio, etc). At this point it looks like this area is underbudgeted given Somali staff needs, emphasis on training among each of the 5 participating institutions, and staff turnover.

Subcontracts

We have two subcontracts: one with the Academy for Educational Development for assistance with the Curriculum Development Center and the

conduct of a social marketing program (total #362,964) and the second with JHU/PCS for short-term assistance in IEC. By the end of the first year we will have obligated almost the entire amount of the PCS subcontract budget (72,000 out of budget of 74,964) and we have only just started the IEC program. The project called for 7 person months of short-term TA in IEC over the 4 years of the contract and approximately 9 person months will have been provided by the end of the year. The Chief of Party estimates the need for approximately 20 additional person months for short-term IEC TA.

URC has been very pleased with its working arrangements with JHU/PCS. They have provided excellent assistance in the IEC area and given their expertise we would like to continue to use them on this project. We are prepared to request a modification in their contract so additional monies can be added to it.

Commodities

Commodity procurement is just beginning and the total amount obligated for this year represents the first shipment. Our assessment at this point is that the commodity budget could be decreased by \$200,000 without adversely affecting the project. The project does not require a lot of equipment. Training and technical assistance are much more important to developing institutional and staff capability. In addition, we have real concerns about the use and maintenance of much of the equipment that might be ordered. We have observed that the AV equipment maintenance is non-existent. We would thus like to proceed seriously and cautiously in ordering equipment.

C. Somali Institutional Environment and Counterpart Relationships

Problems involved in implementing a project of the intricacy of FHS have been discussed earlier in the report. Recognizing that problems exist, it must be noted that cooperation between and among the involved Somali organizations and agencies is at a high level, and the potential for creating an efficient and effective system for FH and IEC services is correspondingly high. The SFHCA, although at an early stage in its development, has demonstrated its ability to work competently with all levels of the government bureaucracy.

The SFHCA Director, Ahmed Mire Shire, is a well qualified and committed administrator. His effectiveness is enhanced by the work of the Administrative Officer, Mohamed Abdullahi Rage, and the Secretary, Anab Dahir Obsiye.

The counterparts Shukri Abdi Jama, IEC Director, and Abdirahman M. Nero, OR director, are providing solid leadership in their areas. The IEC staff, Amina Hersi, Training Officer, Hinda Hassan, Ahmed Sheikh, Assistant Program Officer, are effectively performing their varied functions. The team had little contact with the accountant, Ahmednuur Sahal, and clinic doctor Muhuba Ahmed Guri, but evidence of their work which came to the team's attention was excellent.

D. Policies and Procedures and their implications for the Project to Date

Based upon a brief review (a thorough analysis requires more time to fully absorb than available), this team feels that policies and procedures of the Government of Somalia have not proved to be a major barrier to implementation of the Project. Perhaps the most troublesome has been the delays in the release of local funds which have caused substantial delays in implementing annual plans. Supplemental budget request have not been acted upon. Likewise, the policy of the Government of using the exchange rate contained in the Project Paper has contributed to a feeling of uncertainty and indecisive planning. DDD policy on whether the Project Paper financial statements (budgets) are illustrative rather than binding has not been clearly defined in regard to the FHS budget.

The timetable for budget submission is unclear. During 1986 the Project budgets were developed and submitted to MONP in August. In November, USAID

requested project budgets, and the earlier submissions later were revised to reflect work plans.

Budgeting practices vary among institutions: some, for example, budget for a proportion of staff time devoted to project activities, while others budget for full time even though staff may not be working full time on the project.

Policies and procedures of the GSDR concerning delivery of family health services is a crucial concern to the implementation of this project. This issue is addressed in several places throughout this evaluation report.

V. End of Project Status

The Project staff has estimated that 50 percent of Somali couples will have been introduced to family health and family health service by December 1989. This seems a feasible project achievement if (1) introduction means only creating awareness and (2) if the SFHCA moves promptly in use of mass media.

The following objectives will also have been achieved by the end of the Project:

- a. The level of awareness of modern contraceptive methods will have been increased by 15 percent.
- b. The level of awareness of the dangers of female circumcision will have raised by 10 percent among women, men, and teenagers within the five project areas.
- c. Knowledge of how to accurately mix and administer ORS among mothers will have been raised by 10 percent among women, men, and teenagers within the five project areas.
- d. The contraceptive prevalence rate will have increased to 8 percent.

Increased awareness of family health, child spacing, and modern contraceptives will result in improved health among mothers and children. Greater awareness of the dangers of female circumcision will have resulted in reduced incidence of the practice, and knowledge of ORS will result in greater use of the method. Other topics and messages will be tested during the Project period which will enhance acceptance and continuation of family health practices. The combined impact will be healthier women and children in Somalia and, in turn, as a result of the Project, there will be observable improvement in the quality of life. Improvement in areas such as financial management, program administration, project monitoring, and evaluation will also have been realized.

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