

PN-AAJ-987



**AMERICAN PUBLIC HEALTH ASSOCIATION**  
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**Washington, D.C. 20005**

THE DEVELOPMENT OF  
POPULATION AND FAMILY PLANNING PROGRAMS  
IN SOMALIA:  
AN ASSESSMENT OF INITIATIVES AND ASSISTANCE

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During The Period:  
FEBRUARY 13, 1981 - MARCH 7, 1981

Supported By The:  
U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT  
(ADSS) AID/DSPE-C-0053

AUTHORIZATION:  
Ltr. AID/DS/POP: 11/13/81  
Assgn. No. 582045

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## ACKNOWLEDGMENTS

The team wishes to thank all the people who made this report possible. The Agency for International Development in Washington (AID/W) and the American Public Health Association (APHA) provided essential documents and orientation. Mr. Arjuna Abayomi Cole and Dr. Rukiya Mohammed Seif, who accompanied the team to many meetings and on field trips, were especially helpful. Officials of the Government of Somalia were both gracious and helpful. The Ministry of Planning organized the team's schedule and provided guides, translators, and transportation.

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## EXECUTIVE SUMMARY

The evaluation team, composed of Willard Boynton, a public health physician, Richard Montieth, a family planning program analyst with the Centers for Disease Control (CDC), Muhammed Nizamuddin, a demographer with POPLAB,\* and Fran Simmons, a demographer and sociologist, spent three weeks in Somalia. There, the team reviewed and collected information on current population and family planning activities, the climate for acceptance of a national program, and planning for future development.

### Background

Somalia is an archetypical developing country. It is burdened by the Sahelian drought, a border war that has created a population of refugees (as many as one million), and a faltering planned economy. (The country is socialistic.) A large country, Somalia covers 637,000 square kilometers; the average density is six persons per square kilometer.

Somalia is hot and dry. Only a small proportion of the land is suitable for agriculture. The majority, perhaps 75 percent, is rural poor. These persons engage primarily in animal-raising (goats, cattle, and camels) and are nomads or semi-nomads. The people are racially homogeneous, muslim, and traditionalists. The one-party socialist government is highly organized at all levels.

### Statistics

All statistics should be considered estimates that vary with the source. The population is approximately four million, and, in addition, there are one million refugees. The per capita income is \$120 per year. The birth rate is 48/1,000 and the death rate is 20/1,000; these give a natural increase of 2.8 percent. Maternal mortality is more than 10/1,000 births, and infant mortality is approximately 150/1,000 births. These figures are very high. Probably one-third of all Somali children die before reaching the age of five. The population is young, with 45 percent under 15 years of age.

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\* International Program of Laboratories for Population Statistics, Department of Biostatistics, University of North Carolina at Chapel Hill.

## Health Services

Health problems abound, health status is poor, and health services are primitive outside Mogadishu, even by the standards for less developed countries (LDCs). Malnutrition is extensive; almost 40 percent of all Somali children have second- or third-degree malnutrition. With little safe water or sanitation, and given the lack of knowledge of hygiene, diarrheal diseases particularly take a high toll of children. Tuberculosis affects one-third of all children between the ages of five and nine, and 1 percent of the population have positive sputums. Schistosomiasis, malaria, and childhood infections are common.

Health services in hospitals and MCH clinics in Mogadishu are fair. In the fifteen regions and eighty districts outside Mogadishu, services are poor. There is a lack of trained staff, insufficient medicaments, non-functioning equipment, intermittent transport, little information feedback for management, and a dearth of resources in general. The Government of Somalia (GDRS) and the AID, the World Health Organization (WHO), UNICEF, the United Nations Fund for Population Activities (UNFPA), and the United Nations Development Program (UNDP) recognize that health services need to be improved. Less than 2 percent of the budget is allocated to health at this time.

The GDRS plans to provide primary health care for all by the year 2000. Its concept of delivering primary health care to the bulk of the population, consistent with its socialist philosophy, is correct. However, execution is not advanced. The WHO has had a primary health care demonstration in one region for ten years, but the program has not been replicated. UNICEF is providing medicaments and equipment in all regions. The UNFPA is assisting MCH centers in twelve regions. Medical students are being trained in community medicine and receive some field practice at the village level. The AID, through a contract with Medical Services Consultants, Inc. (MSCI), will assist the Ministry of Health (MOH) in establishing primary health care (PHC) programs in four of the sixteen regions. The AID proposes to contract with International Training in Health (INTRAH) to assist the MOH in training auxiliary health workers.

## Population and Family Planning

A national population and family planning program is being developed for Somalia, but it is immature. The prospects for its success are mixed. There is no national policy on family planning. Tradition, a low population density, and an expressed desire for children because of high infant mortality and the needs of the military favor a pronatalist policy.

The Parliament has approved childspacing. All the Government officials who were interviewed agreed that childspacing as a health measure to protect mothers and children is permissible and desirable. No one supports efforts to control excessive births to enhance social and economic development, although the director general of the Ministry of Planning (MOP) has requested assistance to develop demographic data. He feels that a population policy will not be considered until the need for population control is demonstrated convincingly with improved demographic and economic data.

To date, childspacing has been accomplished by nursing children for two years and abstaining from sexual intercourse while the men are away from the villages and herding cattle. Discreet inquiry revealed that breastfeeding does not always produce infertility for two years. The high rate of hospitalization for complications of "miscarriage" may be attributed, in part, to induced abortions.

Few contraceptives are available. The ten doctors trained by Johns Hopkins University have trained twenty others; it is expected that sixty more doctors will be trained this year. None of those who have been trained has a regular supply of contraceptives. The doctors depend on Schering to supply samples. Most clients must buy oral contraceptives (OCs) at pharmacies; the cost is two dollars a cycle.

The doctors have one laparoscope which is used frequently for diagnosis and has been used for six sterilizations, of which two involved ethnic Somalis. In the past two years, the two doctors working in the UNFPA project have inserted ten IUDs and have given OCs to thirteen clients. The director of Maternal and Child Health in the MOH has an undetermined number of IUDs and OCs, but he has not distributed them to the thirteen MCH centers and the ten obstetrical and gynecological clinics in Mogadishu or to any of the MCH centers in the regions, even where there is a doctor trained in the Johns Hopkins program or a public health nurse trained in the two-week program of the International Planned Parenthood Federation (IPPF). The director plans to distribute IUDs and OCs when training has been completed. Initially, the OCs will be given only after examination by a doctor who will visit the MCH clinics two days each week.

The ten doctors who were trained by Johns Hopkins are eager to do family planning; they need only a good supply line. Their leader is organizing a family welfare association which will be associated with the IPPF. He estimates that there are 10,000 contraceptors in Somalia, despite the severe restrictions on supplies. Most of these persons use OCs purchased at pharmacies; thus, use cannot be verified by clinical records.

The IPPF trained twelve nurse-supervisors last year, and it is training an additional twelve at this time. It has been promised that the MOH will supply contraceptives to the MCH centers where the clinical training will take place. During the team's visit, the MOH provided some OCs to the IPPF for its training course for nurses.

Most of the people who were interviewed agree that there is a demand for childspacing in Somalia. The team was told repeatedly that as many as half of all postpartum patients request help to space children because they wish to "rest." The IPPF representatives surveyed sixty-six women at home and found that sixty-four of them desired contraception to space their children. The medical need for spacing is confirmed by the high rates of severe anemia in pregnant women and malnutrition in children.

Certain political and social forces are reinforcing the need for family planning. The Somali Women's Democratic Organization (SWDO) is a powerful political and social organization that reaches to the village level and has an extensive chain of communication. It is favorable toward childspacing. The Family Life Program of the Ministry of Education (MOE) also has a network that could be used. Both the Government of Somalia and the MOH want to build a network of MCH services through which to channel contraceptive services. With the assistance of the AID, MSC1, INTRAH, the WHO, UNICEF, and the UNFPA, they should be able to reach this goal in the next several years.

### Summary

Somalia has a great need for family planning. There is potential for developing a program, but the program will have to be broad-based, conservative, and provide MCH services. It is apt to be expensive. An aggressive program sharply focused on population control would not be acceptable. It may be possible to create a climate for and acquire the experience needed to implement a real national population and family planning program. The AID should pursue work in this area. It would be counterproductive for the team to try to assist the Somali government in writing a national population and family planning program at this time. There are no family planning services for refugees; nor are the prospects for developing such services good. The AID can take specific steps to make childspacing effective and to lay the groundwork for a national program. These steps are described in Chapter VI.

## ABBREVIATIONS

APHA	American Public Health Association
CBD	Community-Based Distribution
CDC	Centers For Disease Contro
CRS	Contraceptive Retail Sales
CSD	Central Statistics Department
DOS	Department of State
FAO	Food and Agricultural Organization (of the United Nations)
FHI	Family Health Initiative
FIFO	First-In-First-Out
FLE	Family Life Education
FLP	Family Life Program
FPA	Family Planning Association
FPIA	Family Planning International Assistance
GDRS	Government of the Democratic Republic of Somalia
GOS	Government of Somalia
IEC	Information, Education, and Communication
INTRAH	International Training in Health
IPDP	Integrated Population and Development Policy
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics

KAP	Knowledge, Attitude, and Practice
LDC	Less Developed Country
MCH	Maternal and Child Health
MCH/FP	Maternal and Child Health and Family Planning
MNP	Ministry of National Planning
MOE	Ministry of Education
MOH	Ministry of Health
MOI	Ministry of Information
MOP	Ministry of Planning
MSCI	Medical Services Consultants, Inc.
OB/GYN	Obstetrics and Gynecology
OC	Oral Contraceptive
PDP	Population and Development Policy
PHC	Primary Health Care
PHCU	Primary Health Care Unit
POP/FP	Population and Family Planning
POPLAB	International Program of Laboratories for Population Statistics
PVO	Private Voluntary Organization
RTI	Research Triangle Institute
SWDO	Somali Women's Democratic Organization
TBA	Traditional Birth Attendant
U.N.	United Nations
UNDF	United Nations Development Fund
UNDP	United Nations Development Program

UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WEC	Women's Education Center
WHO	World Health Organization
WHS	Westinghouse Health Systems
WIFA	Women in Fertile Age

## I. INTRODUCTION

### Purpose of the Assignment

Four persons were selected to review current population and family planning activities in Somalia, to determine whether the country might accept a national health program, and to plan for the subsequent development and implementation of health-related projects.

The United States Agency for International Development (USAID), through the Johns Hopkins Program for International Education in Gynecology and Obstetrics (JHPIEGO), provided funds to Benadir Hospital for one year of the three-year Somali Reproductive Health Program. The Ministry of Health (MOH) received funds to develop Family Health Initiatives (FHI), a comprehensive program to be coordinated with the Primary Health Delivery Project. Additional grants were made to collect data on births and deaths in Somalia.

For this assignment, the consultants were asked to review these programs and to complete the following tasks:

- Assess population and family planning-related health factors, including high levels of infant and maternal mortality and morbidity, special concerns of women and children, and logistics, including supplies, outreach to rural areas, and the effects of immigration and emigration.
- Assess the managerial and administrative capacity of the Ministry of Health, the Ministry of Planning (MOP), and the Ministry of Education (MOE), and of private sector institutions (the private voluntary organizations, or PVOs), to use effectively U.S. population assistance in commercial distribution projects, community-based distribution (CBD) programs, and social welfare outreach programs.
- Assess demographic factors, including immigration, emigration, and refugees.
- Assess related social, religious, and environmental factors and constraints.
- Develop a strategy of population assistance that would cover: participant training and in-country training; the development and analysis of demographic and statistical data for development planning; the development of policy, or the creation of conditions

conducive to population and family planning assistance; the development of childspacing and family planning services; relevant research; relationships among other sectors (e.g., agriculture, nutrition, sanitation, water); manpower needs; management (administration, institutionalization of population factors); and the achievement of the government's goals.

### Composition of the Team

The following persons were selected for this assignment:

- Willard Boynton, a public health physician, and team leader;
- Richard Montieth, M.P.H., a family planning program analyst;
- Muhammed Nizamuddin, Ph.D., a demographer;
- Fran Simmons, Ph.D., a demographer and sociologist.

### Methodology

The team spent three weeks in Somalia. They interviewed staff of the MOH and the MOE and visited the MOH warehouse, pharmacies, and several maternal and child health (MCH) clinics, where they examined equipment, supplies, and records, and studied operations. The consultants met with officials of the United Nations Development Fund (UNDF), the United Nations International Children's Emergency Fund (UNICEF), and the World Health Organization (WHO). These organizations gave the team a variety of documents on their programs. At the time of the evaluators' visit, a representative of the International Planned Parenthood Federation (IPPF) was in Mogadishu for a third time to train nurse-supervisors in family planning and to organize a family planning association. This person was a valuable contact for the team.

Constraints

Travel within Somalia was difficult because there was a shortage of gasoline and advance travel funds. More than \$800 of personal funds had to be expended for gasoline and air tickets to visit three regions. It was impractical to visit refugee camps, but a trip was made to the Hargeisa Hospital, where refugees are hospitalized.

## II. REVIEW OF SOCIAL AND CULTURAL FACTORS

Many social, cultural, and environmental factors are affecting the development of a national family health and childspacing program in Somalia.

### Health of Mothers and Children

The needs assessment for Somalia of the United Nations Fund for Population Activities (UNFPA) indicates that maternal and child mortality is high. An estimated 25 percent to 33 percent of all children die before age five. Malnutrition is widespread among children, as is gastroenteritis. Among the major causes of maternal morbidity are malnutrition, anemias, and toxemias. Government officials often attribute the high total fertility rate (estimated at 6.1 for 1970-1975) to the high incidence of death of children. Without a reduction in child mortality, it is doubtful that women at low parity, especially women in rural areas, can become active participants in a family planning program. Thus, a program of health care that has been demonstrated to be effective in reducing child mortality would be a forerunner to a countrywide program of family planning.

### Education

The number of students who attend primary and secondary schools has more than doubled since the 1975 revolution; however, only 25 percent to 35 percent of children between the ages of six and fourteen are in primary school, and only 5 percent of children between the ages of fifteen and eighteen are in secondary school. The data suggest that the level of education of the Somali people is low, although the government's massive literacy campaign was successful. There are vast differences in the levels of education among urban, rural-settled, and rural-nomadic populations. The farther one goes from an urban center, the more children one finds who are not attending school. Similarly, the number of females who are in school has increased, but the pressures of the family (need to care for siblings and perform chores) and early marriage result in higher dropout rates for girls than boys.

The government system of self-help applies to education as well as other sectors; villages and towns are expected to build their own schools. In this system, formal education for the majority of the Somali people must be considered a long-term goal. Programs to introduce family planning through the school system (e.g., UNICEF's proposed project) would reach few women. Programs that reach women outside the traditional classroom would be more effective.

## Religion

The religion of the indigenous population is Islam. Although there are no statements in the Koran that either support or oppose family planning, opposition to family planning for religious reasons is cited frequently as a ground to exercise caution in introducing family planning in Somalia. Political and religious leaders in Somalia are not likely to become favorably disposed to family planning until the existence of family planning programs in other Islamic countries has been demonstrated.

## Urban and Rural Differences

Approximately 40 percent of the Somali population live in settled areas. The remaining population is either nomadic or semi-nomadic. In the settled areas, there are major differences in education and health. For example, in the capital city, Mogadishu, there are thirteen maternal and child health centers, but in the northern city of Hargeisa there is one. In addition, the attitudes of the Somali people are more traditional outside Mogadishu. Any program of family health and childspacing would have to reflect a consideration of these differences. Furthermore, the practices and attitudes of the nomads need to be considered carefully.

## Media Influence

The Ministry of Information (MOI), in conjunction with the Ministry of Health, broadcasts a weekly health program. Each program covers a wide variety of topics, and physicians often are asked to discuss specific health problems. Radio Mogadishu, on which the programs air, has a broadcast range that covers the entire Somali Republic and neighboring countries with Somali populations.

The MOI's health programs are an excellent opportunity to educate the population in the benefits of childspacing to ensure the health and safety of mothers and children.

## Attitudes Toward Family Planning

The Government of the Democratic Republic of Somalia (GSDR) has endorsed in principle the concept of childspacing for the health and safety of mothers. The Somali Women's Democratic Organization (SWDO) wants to communicate to women the importance of having a small number of healthy children, as opposed to many children who are sick. However, it recognizes that in a country with high infant mortality, it will be difficult to convince women that it is better to have fewer, healthier children.

There are indications that childspacing is accepted, at least in Mogadishu. In one of its field studies, the International Planned Parenthood Federation found that sixty-four of sixty-six women interviewed about their desires for more children said they "were tired and wanted to rest for at least two years before becoming pregnant again." (See Appendix I, Part III.) The field interviews were by no means a representative sample of Somali multiparous women, and the sample was too small to be of statistical significance; nonetheless, attitudes toward the idea of spacing children were positive. This finding, it is said, was a surprise to the staff who conducted the interviews.

A Knowledge, Attitude and Practice (KAP) survey of a representative sample of Somali women in both urban and rural areas needs to be conducted so that all sectors of the government are apprised of the attitudes of women toward family planning.

### III. DEMOGRAPHIC DATA COLLECTION AND POPULATION RESEARCH

The Central Statistics Department (CSD) in the Ministry of National Planning (MNP) is the main governmental agency charged with the collection and dissemination of statistics. In June 1980, a law was passed authorizing the CSD to collect, analyze, and publish statistics; to conduct censuses and surveys; to implement standards; to supervise and coordinate all governmental statistical work; to review statistical forms and questionnaires; and to promote non-governmental statistical activities. The CSD, as the core of Somalia's statistical system, has a vital role in the effective and efficient operation of the system.<sup>1</sup>

#### Population Censuses

Though various estimates of population size are used by different agencies, no reliable population statistics on national, regional, and district levels are readily available. Before 1975, no nationwide population census had been conducted. After several years of preparatory work, a comprehensive census of population and livestock was taken in February 1975. Because of some technical problems, the official results of the census have not been released; however, the preliminary results indicate that the population is 3,494,000.

At this time, there are no reliable estimates of fertility, mortality, and migration because data on recent births have not been tabulated for the 1975 census; however, estimates based on pilot studies indicate high rates of fertility and mortality. It is generally believed that significant regional demographic differentials exist, particularly between the north and south, and between nomadic and settled populations. A comprehensive analysis of the 1975 census, the U.N. 1980 Survey of Population, and the 1980 and 1981 demographic surveys of the International Program of Laboratories for Population Statistics (POPLAB) would shed some light on the reported differentials in fertility, mortality, and other demographic variables.

The proposed 1985 Population and Housing Census may strengthen further the base of demographic data in Somalia. To strengthen the staff of key sections, the Department of State (DOS) has initiated negotiations with the U.N. and other donors to provide long-term training fellowships and equipment and to help build the necessary field structures for the 1985 census.

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<sup>1</sup> Somalia Needs Assessment for Population Assistance, Report No. 22, UNFPA, New York, 1979.

### Demographic Surveys

Of the few demographic and socioeconomic surveys that have been conducted in Somalia, most were intended to be pilot studies and covered a district or regional population only. Before 1980, no nationwide demographic survey had been conducted in the country. The CSD conducted a nationwide survey of population in 1980; the results are not available because the data have not been cleaned and edited. POPLAB conducted a demographic survey in 1980 for the settled population, and in early 1981 it did the same for the nomadic population. The survey covers three densely populated regions in the south, including Mogadishu. The data have been processed; the preliminary report is expected to be available sometime in the summer of 1981. In addition to fertility and mortality, the questionnaire included questions on internal migration, major occupation, major industry, employment status, and economic assets, including the age and sex of livestock owned by the households.

The CSD has prepared a national multipurpose household survey program for the period 1980-1985 in accordance with the U.N. National Household Survey Capability Program. It is expected that this survey program will yield many needed data on population, health, nutrition, and other socioeconomic variables. It also will generate the data required for population projections and the construction of life tables, and provide information for socioeconomic planning and policy information.

### Vital Statistics and Civil Registration

The Government of Somalia (GOS) is fully cognizant that the civil registration system is one of the three important sources of population statistics, the other two being the population census and the sample surveys. Sporadic attempts have been made to launch a nationwide civil registration system. The efforts have not been successful because a large proportion of Somalia's population is nomadic and lacks an adequate infrastructure for health and social welfare programs. Somalia does not have at this time a regular vital statistics system which can generate data continuously.

Somalia passed a law in 1953 requiring that each birth, death, marriage, divorce, etc., be registered systematically; however, the law could not be enforced for the same reasons that efforts to create a national civil registration system failed. The current thinking at the MNP and the CSD is that (1) regional CSD offices should be established to coordinate the national household survey program; (2) survey funds should be administered to study and determine population trends, levels, and differentials to fill the data gap, and (3) the ways and means should be found to institute the civil registration system in the settled population, and subsequently in the nomadic sectors.

### Health Statistics and Special-Purpose Surveys

Reliable statistics on health conditions, the prevalence of major diseases, the incidence of infant, childhood, and maternal mortality, and the causes of infant deaths are not available in Somalia. The Ministry of Health recently developed a five-year health plan (1981-1986) which includes provisions to collect such statistics through demonstration projects, clinic records, and a surveillance system. The routine statistical records of services provided, the kind and number of trained medical and paramedical staff, the number of hospital beds, and number of mobile clinics, etc., are available in each district and clinic, but at this time no system exists to collect, coordinate, and compile such data. Nor does Somalia have a program of surveys on health conditions, morbidity, and the prevalence of contraception, although both the CSD and the Ministry of National Planning are conscious of the need for these health statistics and other special-purpose surveys. In fact, the Ministry of Health intends to undertake a health-and-nutrition-status survey in the next five-year (1981-1986) health plan period.

The inadequacies and limitations of available population and socio-economic data, the presence of a large nomadic population which makes it difficult to provide services and to collect data, and the shortage of trained manpower to launch successfully a data-gathering and analysis program contribute to Somalia's problems in addressing the urgent issues of human and economic development.

## II. PROGRAM MANAGEMENT

### Introduction

The Ministry of Health of Somalia does not have an active family planning program. In introducing family planning in the country, progress has been made in training staff in reproductive health care, both in Somalia and the United States. The goal of the training, which has been primarily for physicians, is to develop support among the Somali medical community for family planning in the context of maternal and child health care. The results have been discouraging. For all practical purposes, the MOH does not provide family planning services through its network of health facilities, and it is not likely that many of these services will become available in the near future. The programs that purport to expand maternal and child health and family planning services throughout the country are in different stages of development. Only one major project, the Johns Hopkins Program for International Education in Gynecology and Obstetrics, a training course for physicians and nurses, is under way. Others are waiting to be fielded.

In these circumstances, there was little to assess. The team could not examine the structure and operations of the MOH contraceptive supply system, the completeness and accuracy of the data systems, and the management of the family planning program because there is neither a service program nor a contraceptives supply in the country.

The team did review the MOH's logistics system and health statistics at central, regional, and field levels to determine how commodities and data might flow if a family planning program were implemented. Discussions on the availability of contraceptive supplies were held with staff at Benadir Hospital. In addition, an attempt was made to determine how many UNFPA-donated contraceptives are available in Somalia.

### The Logistics System of the MOH

The MOH logistics system can be characterized as an allocation ("push") system of fixed-interval and fixed-order size. Every three months, MOH hospitals and clinics receive a fixed quantity of drugs and medicines. As a result, there are imbalances in the system; items either are over- or under-stocked. Emergency orders are common; they are filled, or partially filled, only if the requested supplies are available. Usually, supplies are not available because the MOH procures its supplies once a year and often runs out of the commodities that are in greatest demand. UNICEF also supplies the MOH with medicines, drugs, and equipment.

The MOH maintains a central warehouse in Mogadishu and regional warehouses in sixteen regions. The regional warehouses are located in the regional and district hospitals. To obtain their supplies each quarter,

the regions send a vehicle to the central warehouse in Mogadishu. In some cases, public transportation is used. This is done for two reasons: the MOH central warehouse does not have the vehicles or staff it needs to resupply the regions, and the only way the regions can be sure that all the supplies arrive intact is to send someone to "ride shotgun" on the supplies while they are en route. The regional warehouses resupply the MCH centers in the regions through supervisors or MCH nurses who obtain the supplies when they visit the regional offices.

Inventory control cards are used in the central warehouse, but there is no evidence that these cards are used in the regional warehouses or the MCH centers which the team visited. Although the supply system is a fixed-interval and fixed-order size, the regions use a form to request supplies from the central warehouse. The form also doubles as a shipping invoice.

An inspection of the central warehouse in Mogadishu and of a regional warehouse revealed that proper warehouse procedures are not always followed. For example, the team found boxes stacked against walls (some water damage was noted); they also observed that boxes were not stacked on pallets and that some drugs were stored beyond their expiration dates, indicating that the first-in-first-out (FIFO) principle of warehouse management is not always followed.

In summary, the MOH logistics system is typical of the systems found in many developing countries. The team does not think that the current supply system could support adequately a large-scale family planning program. The team would recommend that the technical assistance of an expert in supply management be sought.

Funds have been allocated in the budget of the Primary Health Care Project for a "management and warehouse specialist." In addition, the team from Medical Services Consultants, Inc. (MSCI) includes a logistics officer who will design and implement the logistics system which will support the AID-funded Primary Health Care Project.

### Health Statistics

The data available for health planning and evaluation are not adequate. Some data, such as data on the number of doctors, hospitals, and hospital beds, are easily accessible. Some information on the number of patients treated and vaccinated is also available, but it is too meager and too scattered to be a reliable indicator of health conditions in Somalia. Records of births and deaths are poor. The health statistics are poor in urban areas, and those on rural and nomadic populations are almost nonexistent. The statistical gap is wide. The results of a few sample surveys are available, but they are old (except the POPLAB survey) and they do not cover the entire country.

Data collected in MCH centers and in regional and district hospitals are used primarily for control of patients; they are neither aggregated nor reported to the next administrative level. There is no evidence that data are analyzed by anyone at any level in the Somali health care system. This is because the Office of Planning and Statistics in the Ministry of Health is understaffed and lacks logistic support (i.e., office equipment, vehicles, etc.). In addition, the regional and district health offices are not staffed with personnel responsible for data collection and analysis.

A limited amount of data is collected on patient contacts made in MCH centers and regional and district hospitals. These data could be processed if the MOH had the capability to process information.

In the MCH centers, data on women and children seeking care are recorded. The centers maintain a control card on each patient which shows the kind of service the patient receives and the date of the next visit. A duplicate of this card is given to the patient. The control card for women has a section to record family planning information (i.e., kind of method). Of course, this section is not completed because family planning services are not offered. Ledgers also are used to record, for example, children receiving food supplements. It is the team's impression that data collection is not uniform from one center to another.

In July and August 1980, Dr. Fred Munson, Ph.D., professor of hospital administration at the University of Michigan, assessed the management information system of the MOH. In his report he identified the data that the MOH needs for planning, evaluation, and routine management decisions, the sources of the data, and what the role and organization of the Department of Planning and Statistics should be. The team concurs with Dr. Munson's findings and recommendations. The report does not contain a detailed design of the methods of data collection and analysis, nor a strategy to implement them; therefore, a follow-up visit by Dr. Munson or another consultant with similar qualifications is essential. As part of the follow-up, a uniform reporting system should be designed and implemented in all health facilities that provide family planning services. The team recommends that USAID/Somalia act promptly on this matter. (For a copy of Dr. Munson's report, see Appendix G.)

The Ministry of Planning is the chief statistical information-gathering organ of the country. It is responsible for collecting the statistics needed for development planning and policy decisions. The Department of Planning and Statistics should coordinate with the Ministry of Planning to define data requirements, identify methods and develop a schedule for data collection, and define the responsibilities of each ministry in carrying out these functions.

## Contraceptives

In 1980, the UNFPA provided through the WHO 44,111 monthly cycles, 5,600 IUDs, and 41,920 condoms. (It should be noted that this information was obtained via cable from Washington. The MOH, the United Nations Development Program (UNDP), and USAID could not provide these data.)

The consultants twice tried to make a physical inventory of these contraceptives, but they were unable to count the supplies because the storeroom in the administration office, where the products are stored, was always locked.

The IPPF training consultant, Mrs. Kamal, did gain access to the storeroom. She reported that approximately 3,600 cycles of Neogyron are on hand. She did not count the condoms or IUDs in the storeroom, but she did say she saw only a couple of boxes of each. The team cannot explain the discrepancy in the figures provided by the UNFPA and Mrs. Kamal. The team believes the contraceptives were not distributed to family planning patients. An investigation should be made to determine how the commodities were disposed and to assign accountability.

Mr. Arjuna Cole, the USAID health and population officer, is receiving limited quantities of oral contraceptives and IUDs (Copper T) from Mr. Hal Pederson, DS/POP/W. The products are sent by diplomatic pouch. Mr. Cole has only one box (600 cycles) of oral contraceptives on hand.

The quantity of contraceptives in Somalia is limited and the MOH is reluctant to distribute UNFPA products to JHPIEGO-trained physicians who want to provide contraceptive services. The availability of contraceptive services has been affected as a result. The contraceptive supplies that Mr. Cole receives from Washington are insufficient to meet demand. Patients who request contraceptives are instructed to obtain them from a pharmacy.

If Mrs. Kamal is successful in implementing family planning services in the ten MCH centers in Mogadishu, the supply problem will become even more acute. If the MOH continues to supply the centers, the UNFPA supplies will be depleted rapidly if demand is high.

Clearly, more contraceptives are needed. USAID/Somalia should decide how they will be procured, either bilaterally or through an intermediary (e.g., Pathfinder, Family Planning International Assistance (FPIA), IPPF). But procurement should be coordinated between USAID/Somalia, the MOH, and Benadir Hospital. The contraceptives should be obtained as soon as possible.

It is not known what the demand for family planning services will be if contraceptives are made readily available. Nor is it known whether the MOH will continue to provide family planning services in the ten MCH centers in Mogadishu after Mrs. Kamal leaves. The JHPIEGO graduates have not kept records on the number of family planning patients they have served or referred to pharmacies for contraceptive supplies. These data are needed

to determine how many contraceptives should be procured. In the absence of such information, the team recommends that a one-year supply for 5 percent of the women in fertile age (WIFA; 15-44) be obtained. The method mix should be 55 percent orals, 40 percent IUDs, and 5 percent condoms. Quantities are based on the following calculations:

- Number of women 15-44 living in Mogadishu: 200,000 WIFA
- Number of women who will contracept if 5 percent of women 15-44 are using a method:

$$5 \text{ Percent} \times 200,000 = 10,000 \text{ Users}$$

- Oral Contraceptive Requirements:

$$10,000 \text{ Users} \times 55 \text{ Percent Using Orals} \times 13 \text{ Cycles} = 71,500 \text{ Cycles}$$

Oral contraceptives are shipped in cartons of 600 cycles each; thus, 72,000 cycles, or 120 cartons of 600 cycles each, should be procured.

- IUD Requirements:

$$10,000 \text{ Users} - 40 \text{ Percent Using IUDs} = 4,000 \text{ IUDs}$$

According to the physicians whom the team interviewed, Copper T IUDs should constitute the bulk of the IUD order.

- Condom Requirements:

$$10,000 \text{ Users} \times 5 \text{ Percent Using Condoms} \times 100 \text{ Condoms} = 50,000 \text{ Condoms}$$

Condoms are shipped in cartons of 40 gross each (5,760 condoms); thus, 51,840 condoms, or 9 cartons of 40 gross each, should be procured.

A data system should be designed to record, by method, the number of contraceptives distributed to users. These data should be reported each month to USAID/Somalia. The information will be useful in determining and forecasting usage rates.

## V. PROGRAMS FOR WOMEN

The Government of Somalia has at least two programs geared toward the special needs of women which have the administrative infrastructure needed to use effectively U.S. assistance in family health and childspacing. The two programs are the Somali Women's Democratic Organization and the Women Education Service of the Ministry of Education.

### The SWDO

The SWDO is the official voice of representation for women in the Somali Republic; its president serves in the Parliament. The SWDO has branches in every region of the country and boasts a membership of 70 percent of all Somali adult women.

Structurally, the central office of the SWDO has thirteen members who work on specific areas, such as health, education, and the development of skills. Locally, each village (in urban areas, each district) has five representatives who organize activities that are of particular interest and relevance to the village. The representatives are responsible for carrying out activities that are of national importance (these are determined by the central committee). The facilities of the orientation centers, which were established in almost every village and town after the 1975 revolution, are used for program activities. In areas where there are nomads, representatives of the nearest village or town visit water points and inform nomadic women of the activities of the SWDO.

### Education Centers

The Women Education Service is a department of the Ministry of Education. It serves adult women, the majority of whom are illiterate and range in age from fifteen to forty-five. The women are mostly housewives; their backgrounds are both urban and rural.

There are eighty-one district centers located in all regions and in an additional twenty refugee camps. In 1979-1980, 3,714 students were enrolled in courses in these centers. The program covers three areas: basic literacy, development of skills, and family life education (FLE). The program is designed to be completed in four years; the women attend classes in half-day sessions. An entire year is devoted to the family life component, which covers nutrition of mothers and children, personal health and hygiene, disease prevention, and care of children.

The faculty of the centers are trained at training centers established by the MOE with the assistance of UNICEF. Most of the women are pre-service trainees of the MOE, but they may come from other agencies (e.g., the agency for resettlement). The entry-level requirement for teachers is a primary school education. The training for family life education teachers lasts one year and is followed by three years of inservice training. (For a description of the program for teachers and students, see Appendix H.) In addition to teaching regular classes at the centers, family life teachers give periodic lectures and demonstrations on various subjects, including home economics, nutrition, and child care, to the women in every district. Sessions are held on Wednesdays and Fridays at the orientation centers.

### IEC

The structure of the two women's groups would lend itself to a program of information, education, and communication (IEC) in family planning. For any effort in IEC, the teachers would have to be trained, and the prospective students would have to be considered. For example, staff and village representatives of the SWDO would have to be trained at the same time that FLE teachers are being trained in family planning. This approach would ensure that both the women who are in an education program and the women who are not students would receive instruction in family planning.

## VI. RECOMMENDATIONS

### General Recommendations

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

In Somalia, family planning services will have to be provided as a part of MCH services. Thus, the AID must ensure that the MSCCI and International Training in Health (INTRAH) include childspacing as a health measure. The MSCCI, the team feels, is reluctant to include family planning because it might alienate counterparts. To educate contractors and health training institutions in the importance of childspacing, the AID should disseminate such literature as Dr. Jacques May's "Contribution of Family Planning to Health Nutrition."

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

Only a small quantity of the UNFPA-supplied contraceptives is on hand in the country. USAID/Somalia's contribution to the family planning effort in Somalia is limited. The combined stock is not sufficient to meet current demand. In this circumstance, the continued availability of contraceptives cannot be ensured.

3. *The JHPIEGO Reproductive Health Training Program should be evaluated to determine how it has affected the availability of family planning services in the country.*

The JHPIEGO program has pioneered in the establishment of services in the country, but, although physicians have been trained, the availability of contraceptive services has not increased appreciably. The reasons should be investigated, and, if necessary, the program should be modified.

4. *USAID/Somalia should make a thorough investigation to determine why implementation of the Primary Health Care Project was delayed. It should provide the assistance needed to expedite implementation.*

The Primary Health Care Project is the main vehicle to extend maternal and child health and family planning services to rural areas. The conservative estimates are that the project will be fifteen months behind schedule when field activities begin.

5. *USAID/Somalia should define clearly the roles of each participant in the Primary Health Care Project and specify when each will intervene.*

The proposed role of the INTRAH is not clear at this time\* and its intervention does not appear to be timed with that of the other participants. In addition, the INTRAH may duplicate training that the IPPF is providing now.

6. *To strengthen the proposed KAP studies (to be done by the Department of Social Sciences, University of Somalia, as a part of the Family Health Initiative Project), a U.S. institution, such as Westinghouse, POPLAB, or the CDC, should be contracted to provide technical assistance.*

The Department of Social Sciences does not have the expertise to conduct a scientific sample survey. Therefore, the team recommends that outside assistance be obtained.

7. *The AID should explore, through an experienced intermediary, such as PSI or Westinghouse, the possibility of a Contraceptive retail sales (CRS) program involving the appropriate governmental agencies and the Pharmaceutical Association.*

Oral contraceptives and condoms are sold openly in pharmacies; this seems to indicate that Somalia has no laws restricting the importation of contraceptives or sale across the counter. Pharmacies are the primary source of contraceptives in the country at this time. Therefore, it is worthwhile to study the possibility of implementing a CRS program that would reduce the retail cost of contraceptives.

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\* Editor's Note: Following submission of this report, the AID mission in Somalia submitted a description of the INTRAH's role. The INTRAH is to assist the MOH in training 118 nurses and midwives in family health, family planning, MCH, and related fields. The purpose of the training will be to develop the MOH's capabilities to provide family health and family planning services, training in clinical and non-clinical skills, supervision, and integration of family health and family planning services.

8. *The Department of Planning and Health Statistics of the MOH needs an adequate information system. A management information system will ensure that Somalia's health care system is more responsive to the health needs of the people.*

At this time, few data are collected and analyzed by the MOH. A reporting system is essential for effective management.

9. *Both AID/W and USAID/Mogadishu should coordinate activities with the IPPF.*

The IPPF is pioneering in the training of nurse-supervisors in family planning, and it is getting some contraceptives to clinics that can use them. The AID needs to coordinate with the IPPF the distribution of contraceptives. It might try to induce the IPPF to supply injectable progesterone while it supplies oral contraceptives and condoms. Injectable progesterone is acceptable in Somalia, and it is desired to enhance lactation in a people among whom malnutrition is widespread.

10. *The health component of the Somali Women's Democratic Organization should be used to communicate family health and childspacing information. Women in the districts who are responsible for health information should be trained to disseminate information on and promote childspacing.*

Because all women are encouraged to attend the orientation centers, where the SWDO conducts its activities, a health component which informs women of childspacing practices could reach many women who need services. Women could be trained effectively in-country in workshops and elsewhere. For example, they could tour other (preferably Islamic) regions where family planning programs are active. The expertise of such organizations as Pathfinder, the University of Chicago, and the FPIA should be used.

The goal of the training in communication will be to reach women in the community; therefore, adequate attention should be given to the preparation in the Somali language of posters and audiovisual materials that reflect an understanding of the culture of the country. The training should originate first in the orientation centers in the health districts of Mogadishu, where MCH clinics have trained staff ready to give advice on and administer contraceptives, and then be expanded to MCH clinics in other districts as staff become available.

11. *Those who are training teachers in family life education should be given in-service training that covers childspacing and reproductive health.*

Topics on childspacing and reproductive health are not included in the curriculum for those who teach family health education. Because the Women Education Center (WEC) delivers in-service training to teachers, the trainers should be given a course in childspacing and reproductive health that would prepare them to go into the field and provide in-service training to teachers there. The curriculum for family life teachers should be modified to include reproductive health and childspacing. Organizations such as Pathfinder and the University of Chicago should be contracted to provide the technical assistance needed to develop short- and long-term curricula.

12. *A series of family health and childspacing programs should be developed for radio and broadcast by the Ministry of Information.*

The MOH broadcasts programs on health on national radio. Given the existing infrastructure and the importance of radio as a tool to disseminate information in Somalia, radio programs on childspacing would reach many people. Organizations with the expertise to develop media materials (e.g., the University of Chicago) should be contracted to provide technical assistance to the MOH.

### Specific Recommendations

#### A. Integration of Demographic Factors in Economic Planning

The lack of reliable data on demographic and other socioeconomic factors obstructs the work of development planners and policymakers in Somalia. The director-general of the MOP emphasizes in particular the need to strengthen the capability of the CSD to collect, compile, analyze, and interpret data on population and health. His objective is to enhance the understanding of key government officials of the interrelationship between demographic variables and development planning. The director-general also emphasizes the need for the timely collection of data on key demographic factors, as well as the competent analysis and interpretation of the effect of these factors on socioeconomic planning. He believes that a sound, scientific population policy for Somalia can be formulated if the collection and analysis of data are improved.

The MOP should receive technical assistance to conduct a Population Impact Analysis of the government's forthcoming five-year development plan. Although the Government of Somalia does not claim to follow any explicit population policy, it has formulated policies, programs, and projects that have had second-order consequences for population growth. The proposed (1982-1986) development plan can be expected to have such consequences. This plan includes provisions to extend health care coverage to the grass-roots level by providing primary health care services; extend water and sanitation services to rural areas; expand basic education, technical education, and education in home improvements; increase the number of women engaged in work in the private and public sectors; introduce various measures to improve the status of women; improve transportation, communication, and the administrative infrastructure; and formulate specific policies on internal and international migration. All these activities will affect socioeconomic variables, which, in turn, will affect fertility and mortality. There are few in Somalia who understand how government programs affect such demographic factors as nuptiality, fertility, mortality, and rural-urban migration.

Recently, McGreevy (1975) and others developed a methodology to assess the impact of government policies on population growth and programs with specific objectives other than influencing the rate of population growth. The team recommends that this methodology, known as Population Impact Analysis, be used to determine the effects on population growth of the proposed five-year (1982-1986) development plan. Such a study could be conducted profitably by the Population and Development Policy (PDP) Division of Battelle Memorial Institute or the Integrated Population and Development Policy Program (IPDP) of the Research Triangle Institute (RTI).

A seminar and workshop involving all the key ministries of the Somali government should be organized in Somalia to present the analysis and findings of the Population Impact Analysis. The effort could be organized with the help of the IPDP and RTI.

#### B. Collection of Health Statistics and Special-Purpose Surveys

According to the director of the CSD, there are no organized efforts in the MOP to collect, compile, and report health statistics. However, it has been proposed that a Health Statistics Section be established in the CSD to collect and compile health statistics in coordination with the MOH and other health-related institutions. Data are needed on the incidence and prevalence of different diseases, the number of patients who attend different MCH centers, the number and categories of health staff in the various districts and regions, and the ratio of clinic staff to population served. Different hospitals, MCH clinics, and social security outpatient clinics do provide contraceptive services, but they can provide no data on the number of acceptors, the kind of contraceptive

accepted, age and parity, and other characteristics of acceptors. The health service outlets have no standardized procedures for collecting data, and they do not maintain records on patients. The MOP recognizes that there is an urgent need to collect data and compile statistics on health and family planning to monitor services properly. The MOP intends to make the Health Statistics Section of the CSD responsible for coordinating these activities.

No data are available on Somalis' knowledge of and attitudes toward contraceptives. The attitude of the population toward desired family size, values related to children, and the practice of contraception are not known. Key officials, including medical and civil service personnel, differ widely about the felt need of the Somali people for contraception. Generally, they take a cautious approach to the delivery of family planning services. In the absence of reliable data, their cautious and conservative attitude may not be unwarranted.

The MOP proposes to obtain relevant data by conducting special-purpose surveys on the Somalis' knowledge of and attitudes toward contraceptives, including various indigenous methods.

The team recommends that technical assistance be provided to set up the Health Statistics and Surveys Section. It also recommends that the Centers for Disease Control and the Westinghouse Health Systems (WHS) be invited to assist the MOP in planning and conducting the surveys. Information is needed on prevailing norms about children, desired size of family, religious beliefs about family planning, actual practice of contraceptive methods (particularly indigenous or "nomadic" methods), and the availability and acceptability of modern contraceptives.

The lack of trained manpower to plan and implement the surveys and research studies is the MOP's most serious handicap. The team, therefore, strongly recommends that health and population experts be contracted to organize special training workshops for middle-level Somali professionals. This would be done in-country to strengthen the training institutions. The National Institute of Statistics and Applied Economics could best be used for this purpose. The University of Chicago's Community and Family Study Center, or the Department of Population Planning at the University of Michigan, should be invited to assist the National Institute of Statistics and Applied Economics.

In addition to in-country training, the team recommends that fellowships be provided for training abroad. The following personnel should receive fellowships:

- Head, Health and Population Statistics Section, CSD, MOP. This person should enroll in a one-year training program in public health at the University of Michigan or Johns Hopkins University. He should major in health surveys and population programs.

- Head, Demography and Social Statistics Division, CSD, MOP. This person should be enrolled in a one-year course at either the University of Chicago or the University of Michigan. He should major in demographic surveys, sampling, and research methods.
- Senior officials of the MOP. These persons should participate in study tours of selected countries in Asia and Africa. The purpose of the tours would be to observe population and family planning programs. The tours would last four to six weeks.

### C. Data Processing and Analysis

During the next five years, the MOP will initiate large-scale data-gathering activities. It will administer the Survey of Population--II, the Labor Force and Migration Survey, various health and population surveys, and many other special-purpose surveys. Data must be processed from the 1975 Population and Livestock Census, the 1980 Survey of Population, and the 1980 and 1981 POPLAB Demographic Surveys. The MOP feels that it is particularly important to process and analyze the data that have been collected and to provide relevant information to the ministries and departments to ensure that development plans are formulated and implemented effectively. The GOS is planning to integrate all the censuses and surveys, including those being conducted by the various ministries, and to process all the data at the MOP's data processing center. The government hopes that the UNFPA will assist in upgrading the computer center so that it can service the country's ever-increasing needs for processed data.

The GOS feels that the training of computer center staff is essential to the development of local expertise. The UNFPA has allocated some funds to train four programmers for six months in the United States, but these persons will not be able to meet the ever-increasing demands for data processing services. To ensure that the computer center operates smoothly, at least the following staff must be trained in the United States:

- two systems analysts for twelve months each;
- four programmers for eight months each; and
- two data management specialists for two to three months each.

To date, no software has been installed at the computer center because the NCR computer has too small a memory (32K). The GOS is hopeful that the computer facilities will be upgraded by 1982. After the

improvements have been made, the MOP expects to install efficient packaged programs to analyze social sciences data. The team recommends that technical assistance be provided to the MOP to procure and install the following packages:

--SPSS:

--COCENT; and

--CONCUR (or any other editing package).

#### D. Establishment of Regional Statistical Offices

The director-general of the MOP feels that the Central Statistics Department does not have sufficient staff to collect, compile, process, and analyze all the statistical data which the various ministries need. Considerable delays occur in producing the statistical information the government needs. Because of the long distances between the capital city of Mogadishu and other regions of the country, the supervision of field surveys and other data-collection efforts is becoming more expensive, more difficult, and more time-consuming. The few staff available at the CSD must be sent to far-flung regions to supervise even routine data-collection efforts.

The director-general strongly feels that any assistance the MOP receives to establish regional statistical offices in the four regions where primary health care programs are being conducted will facilitate and enhance the efficiency and productivity of the Central Statistics Department. The proposed special-purpose surveys, including the KAP surveys and health statistic surveys, will be conducted more efficiently if regional infrastructures are established.

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**Appendix A**

**PROPOSED ITINERARY FOR EVALUATION TEAM**

## Appendix A

### PROPOSED ITINERARY FOR EVALUATION TEAM

Expected Time of Arrival: February 15, 6:30 a.m.

Accommodations: Al Uruba Hotel

February 16: 9:30 a.m. - 2:00 p.m., Ministry of National Planning

February 17: 9:30 a.m. - 2:00 p.m., Ministry of Health

February 18: 9:30 a.m. - 2:00 p.m., Benadir Hospital and Faculty of Medicine

February 19: 9:30 a.m., Chairman, SDWO, Ministry of Education

February 20: The team will work separately with the following different departments:

(1) Ministry of National Planning

(a) Director-General

(b) Director of Central Statistics Department

(2) Ministry of Health

(a) Acting Director-General

(b) Director of Primary Health Care

(c) Director of Planning and Statistics

(d) Director of Nutrition and MCH

(3) Benadir Hospital

(a) Dr. Mohamed Warsame, Director

(b) Dean of Medical School

(4) Ministry of Education

(a) Huas Aden

(b) SDWO

(5) Others

(a) Chairman, SDWO

(b) Hussein Aden, Chairman, Somali Study Association

**Appendix B**  
**LIST OF CONTACTS**

Appendix B  
LIST OF CONTACTS

Arjuna-Abayomi Cole, Population Officer, AID  
Nicholas Marieni, Acting Director, USAID/Mogadishu  
Michael Adler, Director, USAID/Mogadishu  
Warren Putnam, Agricultural Officer, AID  
Hussein Celeste Fabiye, Director-General, MOP  
Awil Mohammed Farah, Director of Statistics, MOP  
Dr. Rukiya Mohammed Seif, FHIP Coordinator  
Dr. Ahmed Mohammed Hassan, Director-General, MOH  
Dr. M.A. Gulaid, Director, Primary Health Care, MOH  
Dr. A.S. Abbas, Director, MCH and Nutrition, MOH  
Dr. Khalif Bile, Dean of the Medical School  
Dr. Warsame Ali, Director, Benadir Hospital  
Osmon Ali Janna, Director-General, MOE  
Mr. Asare M. Yahie, Chief, Data Processing Center, MOP  
John J. Cipalla, Team Leader, MSC I  
Mr. M.P. Rao, U.N. Senior Adviser, Data Processing, MOP  
Mussaged Galood Ahmed, Chairman, SDWO  
Mr. M. Afzal, U.N. Demographic Adviser, MOP  
C. Bonanni, UNICEF Representative  
Olaf Svennevik, UNDP Representative  
Dr. Sharif Habib Iman, Department of MCH/FP, MOP  
Dr. Kamal, Director, Baiybaba Regional Hospital

Dr. Hasson, Graduate, Johns Hopkins Program, Baiybaba

Dr. Ali Isse Abdu Karim, Director, Merka Regional Hospital

PHN Hawa Ali, Kurtenwary District MCH Clinic

Mrs. Imtiaz Kamal, Regional Program Director, IPPF

Dr. Abobor Hasson Guled, Statistical Unit, MOH

Dr. Mohammed Hassan Dirkir, Regional Director, MOH, Hargeisa

Mrs. Hawa Aden Mohamed, Director, Women Education Center, MOE

Mohamoud Dalmer, Director, Radio Mogadishu, MOI

Appendix C  
SAMPLE MEDICAL CHART

SABABAHA XANAANADA GAARKA AH  
DA'DA

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SABABAHA XANAANADA GAARKA AH  
DA'DA

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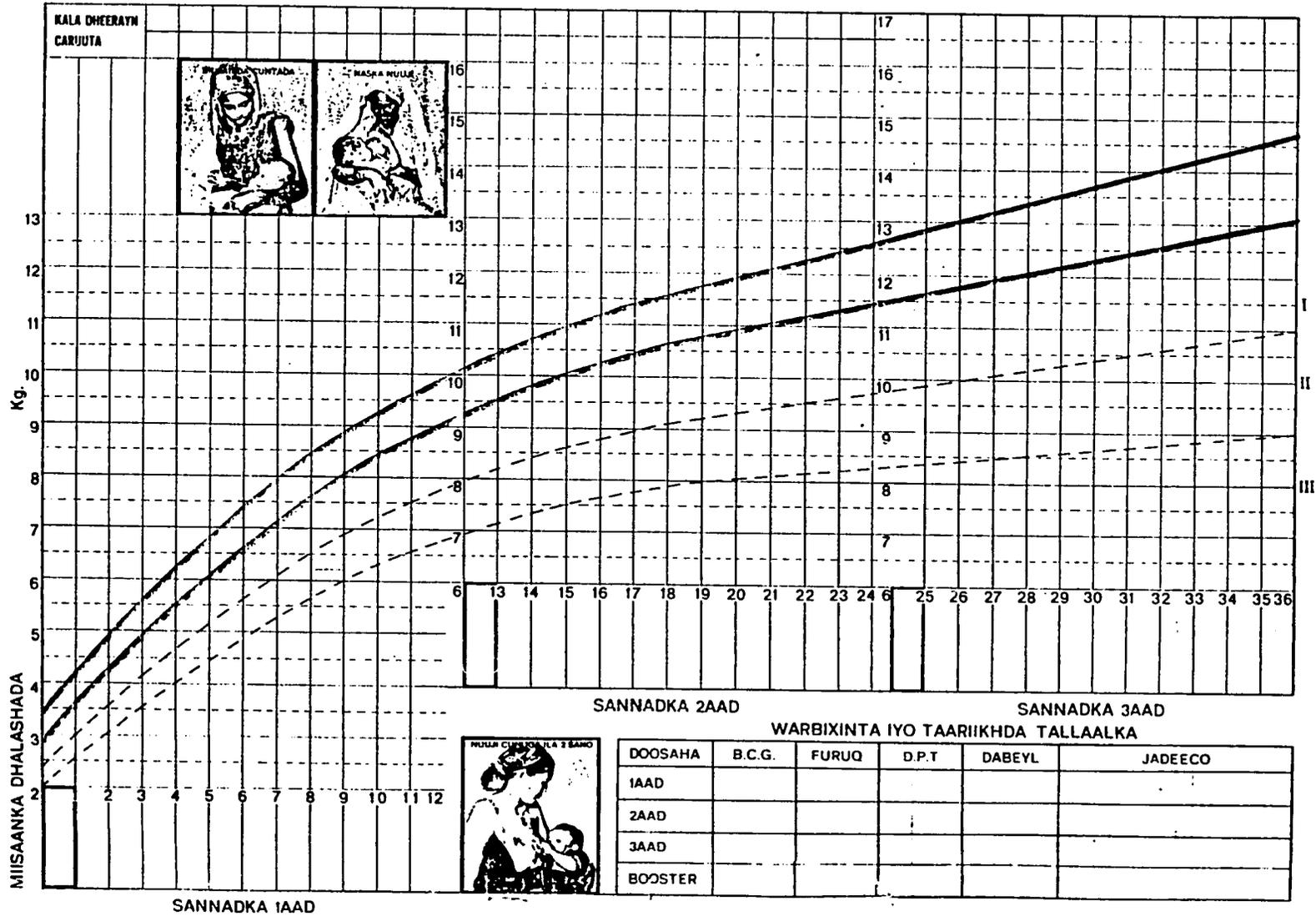
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**Appendix D**

**GUIDELINES FOR CARE OF MOTHERS  
IN ANTENATAL AND FAMILY PLANNING CLINICS**

## Appendix D

### GUIDELINES FOR CARE OF MOTHERS IN ANTENATAL AND FAMILY PLANNING CLINICS

#### First Visit

- A. Activities in common for the AN and FP mother:
1. Registration: Giving a registration number.
  2. Interviewing: Taking and recording:
    - Social history
    - Medical history and current health status
    - Obstetrical history
    - Menstrual history and date of last menstrual period
    - Weight and blood pressure.
  3. Conducting "Top-to-Toe" examination\* and recording findings.
  4. Providing the mother with a "Mother's Card."
  5. Giving appointment for return visit.
  6. Giving instructions as needed.
  7. Screening mothers for whom pregnancy now and in the future would present high risk.
- B. IN ADDITION, for the AN mother:
1. Inquiring about minor discomforts and giving advice.
  2. Inquiring about complaints that might require medical attention.
  3. Estimating date of delivery.
  4. Testing urine for albumen and sugar.
  5. Conducting other routine tests.

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\* See guide for Top-to-Toe examination.

6. Checking on food habits and giving advice on nutrition.
7. Giving iron and vitamins.

C. IN ADDITION TO "A" for the FP client:

1. Past use of contraceptives.
2. After a suitable method has been selected, provide and arrange for the contraceptive and give clear instructions in its use.

# First Visit

## GUIDE FOR "TOP-TO-TOE" PHYSICAL CHECKUP

<u>Examine</u>	<u>Look For</u>	<u>Purpose and Importance of Each Step</u>	
		<u>For the Antenatal Mother</u>	<u>For the Family Planning Client</u>
Head	Skin Disease	Need for diagnosis and treatment*	Same, plus ACOM**
	Lice, Nits, Dirt	Would need treatment or cleaning; tells about health habits; points out the need for health education and checks children's heads	Same Health-related Does not ACOM
Eyes	Infection	Need for treatment	Same
	Anemia	Need for treatment	Same, plus ACOM
	Jaundice	Need for diagnosis and treatment	Same, plus ACOM
Face	Pigmentation	One of the presumptive signs of pregnancy	When present without pregnancy, ACOM
	Oedema	Points to pre-eclampsia, kidney disease, severe allergy; need for diagnosis and treatment	Need for diagnosis and treatment; ACOM
Mouth	Dental Decay	Treatment	Does not ACOM, but help can be provided by referral to a dentist
Neck	Enlarged Glands	Diagnosis and treatment	Same, plus ACOM
Breasts	Areaola	Darkening may be sign of early pregnancy in the primigravida	Unrelated
	Nipples (shape)	If depressed, need to be corrected to prepare for breastfeeding; advice needed	Unrelated

D-3

\* Medical orders are needed whenever there is need for "diagnosis and treatment."  
Refer the mother to the doctor.

\*\* ACOM = Affect Choice of Method.

<u>Examine</u>	<u>Look For</u>	<u>Purpose and Importance of Each Step</u>	
		<u>For the Antenatal Mother</u>	<u>For the Family Planning Client</u>
Breasts (cont.)	Mass	Diagnosis and treatment	Same, plus ACOM
Nails	Color	Indication for anemia; points to the need for advice and treatment	Same, plus ACOM
Pulse	Rate and Quality	Might indicate heart disease. Weak and/or irregular pulse needs further investigation	Same, plus ACOM
P.V. Digital	Kind and Odor of Vaginal Discharge	Unusual amount, color, and smell indicates need for further investigation	Same, plus ACOM (ruling out menstrual bleeding)
	Size and Position of Uterus	Important in early pregnancy	If size suggests early pregnancy, need for further investigation before a contraceptive is provided; mother could be mistaken or may be lying about her LMP
	Tenderness of Fallopian Tubes	Needs medical attention	Needs medical attention, plus ACOM
	Any Masses	Need medical attention	Need medical attention, plus ACOM
	Vaginal Discharge	Same as above in digital P.V.	Same as above in digital P.V.
P.V., with Speculum	Cervical Erosions	Need treatment	Same, plus ACOM
	Cervical Polyps	Need treatment	Same; might or might not ACOM
	Skin Infection or Disease	Might suggest infection, allergy, or worm infestation; needs diagnosis and treatment	Same, plus ACOM

Appendix E

INDICATORS FOR THE CONTROL O  
MATERNAL AND CHILD HEALTH PROGRAMS

## Appendix E

### INDICATORS FOR THE CONTROL OF MATERNAL AND CHILD HEALTH PROGRAMS

#### 1. Prenatal Care

- Identify Pregnant Women in Area

$$\frac{\text{Number of Pregnant Women}}{\text{Total Number of Live Births}} \times 100$$

- Detect Edema and Headache

$$\frac{\text{Number with Edema and Headache}}{\text{Number of Pregnant Women Attended}} \times 100$$

$$\frac{\text{Number of Pregnant Women with Invested Edema and Headache}}{\text{Number of Pregnant Women Attended}} \times 100$$

- Provide Pregnancy Hygiene

$$\frac{\text{Number of Pregnant Women Who Received Instruction}}{\text{Number of Pregnancies Attended by Services}} \times 100$$

#### 1.2 Control of Normal Pregnancy

- Maintain Active Register of Pregnant Women Under Control

$$\frac{\text{Number of Pregnant Women Under Control}}{\text{Number of Births Attended by Health Services}} \times 100$$

- Conduct Urinalysis

$$\frac{\text{Number of Urinalyses Conducted}}{\text{Number of Pregnant Women Under Control}} \times 100$$

- Examine Pregnant Women

$$\frac{\text{Number of Examinations Performed}}{\text{Number of Births Attended by Services}} \times 100$$

- Classify Pregnant Women According to Risk

$$\frac{\text{Number of At-Risk Pregnant Women Classified}}{\text{Total Number of Difficult Pregnancies}} \times 100$$

- Examine Pregnant Women with Complications, According to Established Medical Orders

$$\frac{\text{Number of At-Risk Pregnant Women Examined by Nurse and Physician}}{\text{Total Number of Pregnancies with Problems}} \times 100$$

- Distribute Food Supplements: Powdered Milk, Vegetable Mixtures, Iron, Vitamin A, etc.

$$\frac{\text{Number of Pregnant Women Who Received Supplements}}{\text{Total Number of Births Attended by Services}} \times 100$$

### 1.3 Prevention of Infections

- In Miscarriages

$$\frac{\text{Number of Septic Miscarriages}}{\text{Total Number of Miscarriages}} \times 100$$

- In Premature Rupture of Membranes

$$\frac{\text{Number of Pregnant Women with Infections Caused by Premature Rupture of Membranes}}{\text{Total Number of Pregnant Women with Rupture of Membranes}} \times 100$$

### 1.4 Treatment According to Established Medical Orders in Infections Caused by Miscarriage or Premature Rupture of Membranes

$$\frac{\text{Number of Treatments for Infections Caused by Premature Rupture of Membranes}}{\text{Total Number of Pregnant Women with Rupture of Membranes}} \times 100$$

### 2.2 Attendance at Normal Birth in Clean and Safe Manner

$$\frac{\text{Number of Births Attended by Services}}{\text{Total Number of Births Attended}} \times 100$$

## 2.3 Care of Newborn

$$\frac{\text{Total Number of Live Newborn}}{\text{Total Number of Births Attended}} \times 100$$

## ● Prevent Infections

## Apply Antiseptic Solution to Eyes

$$\frac{\text{Number of Newborn with Eye Infections}}{\text{Total Number of Live Newborn}} \times 100$$

$$\frac{\text{Number of Newborn with Eye Infections Who Received Treatment}}{\text{Number of Newborn with Eye Infections}} \times 100$$

## Clean, Bind, and Treat Cord

$$\frac{\text{Number of Newborn with Infected Cord}}{\text{Total Number of Newborn Attended by Services}} \times 100$$

## Prevent Heat Imbalance

$$\frac{\text{Number of Newborn with Heat Imbalance}}{\text{Total Number of Newborn Attended by Service}} \times 100$$

3. Postnatal Care

## 3.1 Education on Mediate Postnatal Care

$$\frac{\text{Number of Mothers Giving Birth Who Received Instruction}}{\text{Total Number of Mothers Giving Birth}} \times 100$$

## 3.2 Treatment in Case of Infection According to Established Medical Orders

$$\frac{\text{Number of Postnatal Infections}}{\text{Total Number of Births}} \times 100$$

$$\frac{\text{Number of Postnatal Infections Treated According to Established Medical Orders}}{\text{Number of Infections at Birth}} \times 100$$

## 3.3 Initiation of Breastfeeding

$$\frac{\text{Number of Newborn Who Received Supplementary Feeding}}{\text{Number of Newborn}} \times 100$$

4. Mediate Care of Newborn

## 4.1 Examination of Newborn

$$\frac{\text{Number of Newborn Examined}}{\text{Number of Newborn}} \times 100$$

## 4.2 Education of Mother

$$\frac{\text{Number of Pregnant Women Who Received Instruction on Care of Newborn}}{\text{Total Number of Pregnant Women Attended by Service}} \times 100$$

5. Family Planning6. Health Care of Children Under Five

## 6.1 Control of Children's Health

- Record and Solicit Information According to Established Procedures

$$\frac{\text{Number of Children 0-5 Years Registered}}{\text{Total Number of Children 0-5 Years}} \times 100$$

- Take Weight Curve

$$\frac{\text{Number of Children 0-5 with Weight Curve Taken}}{\text{Total Number of Children 0-5}} \times 100$$

- Immunize

$$\frac{\text{Number of Children 0-5 Who Received First DPT Dose}}{\text{Total Number of Children 0-5}} \times 100$$

$$\frac{\text{Number of Children 0-5 Who Received First and Second DPT Doses}}{\text{Total Number of Children 0-5}} \times 100$$

E-5

<u>Number of Children 0-5 Who Received First, Second, and Third DPT Doses</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First Dose of Tetanus Toxoid</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First and Second Doses of Tetanus Toxoid</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First, Second, and Third Doses of Tetanus Toxoid</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First Dose of Polio Vaccine</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First and Second Doses of Polio Vaccine</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received First, Second, and Third Doses of Polio Vaccine</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received Anti-Measles Vaccine</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received Anti-Smallpox Vaccine</u>	X	100
Total Number of Children 0-5		
<u>Number of Children 0-5 Who Received Anti-Malaria Vaccine</u>	X	100
Total Number of Children 0-5		

● Education

<u>Number of Pregnant Women Who Received Instruction in Feeding and Hygiene</u>	X	100
Total Number of Pregnant Women Attended		
(Feeding of Healthy and Sick Child)		
(Hygiene of Child and Environment)		

## 6.2 Care of Malnourished Child

- Periodic and Regular Weight Check

$$\frac{\text{Number of Children 0-5 Whose Weight Checked Periodically and Regularly}}{\text{Total Number of Children 0-5}} \times 100$$

- Distribution of Food Supplements: Powdered Milk, Vegetable Mixtures, Iron, Vitamin A, etc.

$$\frac{\text{Number of Children 0-5 Who Received Food Supplements According to Established Procedures}}{\text{Total Number of Children 0-5}} \times 100$$

## 6.3 Care of Sick Children According to Established Medical Orders

- Diarrhea

Treatment:

$$\frac{\text{Number of Dehydrated Children 0-5 Who Received Treatment}}{\text{Number of Dehydrated Children 0-5}} \times 100$$

Oral Hydration:

$$\frac{\text{Number of Dehydrated Children 0-5}}{\text{Number of Children 0-5}} \times 100$$

Parenteral Hydration:

$$\frac{\text{Number of Children 0-5 With Diarrhea Who Received Treatment}}{\text{Number of Children 0-5 With Diarrhea}} \times 100$$

Prescribe and Issue Antidiarrheal Drugs

$$\frac{\text{Number of Children 0-5 With Diarrhea}}{\text{Number of Children 0-5}} \times 100$$

Prescribe and Issue Antispasmodics

$$\frac{\text{Number of Children 0-5 With Spasms Who Received Treatment}}{\text{Number of Children 0-5 With Spasms}} \times 100$$

$$\frac{\text{Number of Children 0-5 With Spasms}}{\text{Number of Children 0-5}} \times 100$$

### Education

Specific Feeding

Oral Hydration

Administration of Drugs

Hygiene

$$\frac{\text{Number of Mothers Who Received Instruction in Specific Feeding, Oral Hydration, Administration of Drugs, and Hygiene}}{\text{Total Number of Mothers}} \times 100$$

Respiratory Diseases:  
Antipyretic Treatment

$$\frac{\text{Number of Children With Respiratory Diseases Who Received Antipyretics}}{\text{Number of Children 0-5 With Respiratory Diseases}} \times 100$$

$$\frac{\text{Number of Children 0-5 With Respiratory Diseases}}{\text{Total Number of Children 0-5}} \times 100$$

### Education

Maintenance of Proper Temperature

Administration of Liquids

$$\frac{\text{Number of Mothers Who Received Instruction in Maintenance of Temperature and Administration of Liquids}}{\text{Total Number of Mothers}} \times 100$$

**Appendix F**  
**OUTLINE OF PRIMARY HEALTH CARE TASKS**

**MEDICAL SERVICE CONSULTANTS, INCORPORATED**

**OUTLINE OF PRIMARY HEALTH CARE TASKS**

**Prepared For**

**Government of Somalia Democratic Republic**

**Rural Health Program**

**January 1981**

## PRIMARY HEALTH CARE TRAINING

### Basic Tasks to be Learned by Trainers

#### A. MATERNAL AND CHILD HEALTH

##### 1. Prenatal Care

###### 1.1 Guidance and Follow-Up

- Survey Pregnant Women in Area
- Detect Edema and Headache
- Educate in Prenatal Hygiene

###### 1.2 Control of the Normal Prenatal

- Maintain Active Register of Pregnant Women Under Control
- Record and Solicit Information According to Established Procedures
- Take Blood Pressure
- Take Weight
- Conduct Urinalysis
- Examine Pregnant Women
- Classify Pregnancies By Risk
- Examine Pregnancies with Abnormalities According to Established Medical Orders
- Educate On

Prevention and Detection of Hemorrhages  
Prevention of Infections  
Feeding

Encourage Production and Conservation of Foods  
with High Nutritive Value and Give Guidance on  
Their Proper Consumption

Preparations for Delivery  
Preparations for Care of Newborn  
Guidance on Postnatal Care

- Administer Tetanus Toxoid
- Distribute Food Supplements (Powdered Milk, Vegetable Mixtures, Iron, Vitamin A, etc.)

###### 1.3 Prevention of Infections In Cases Of

- Miscarriage
- Premature Rupture of Membranes

1.4 Treatment According to Established Medical Orders in Cases of Infections Resulting from Miscarriage or Premature Rupture of Membranes

2. Care During Delivery

2.1 Supply of Minimum Equipment and Supervision of Use

2.2 Clean and Safe Care of Normal Delivery

- Prevent Hemorrhage
- Check Spontaneous Separation of Placenta
- Examine Placenta
- Observe State of Uterus
- Place Child at Breast to Stimulate Uterine Contractions

2.3 Care of Newborn

- Prevent Asphyxia
- Eliminate Secretions
- Apply Simple Resuscitation Techniques
- Prevent Infections
- Apply Antiseptic Solution to Eyes
- Cleanly Tie and Treat Umbilical Cord
- Prevent Heat Loss

3. Postnatal Care

3.1 Education on Medicate Postnatal Care

- Hygiene of Mother and Newborn
- Feeding of Newborn, with Emphasis on Breastfeeding

3.2 Treatment in Case of Infection According to Established Medical Orders

3.3 Initiation of Breastfeeding

4. Mediate Care of Newborn

4.1 Examination of Newborn

4.2 Educate Mother On

- Importance of Breastfeeding
- Registration of Birth
- Hygiene
- Importance of Surveillance of Child's Health

5. Family Planning

5.1 Guidance and Motivation of Community in Use of Traditional Methods

5.2 Guidance in Use and Application of Other Methods, Such As

- Pills
- IUDs

5.3 Follow-Up of Users

5.4 Taking and Forwarding of Samples for Cytology

5.5 Surveillance of Positive Cases

5.6 Follow-Up of Positive Cases

6. Health Care of Children Under 5

6.1 Health Care of Child

- Record and Solicit Information According to Established Procedures
- Chart Weight on Weight Curve
- Immunize
- Educate Mother On

Feeding of Healthy and Sick Child  
Hygiene of Child and Environment

6.2 Care of Undernourished Child

- Periodic and Regular Weighings
- Distribute Food Supplements (Powdered Milk, Vegetable Mixtures, Iron, Vitamin A, etc.)

6.3 Emergency Care of Sick Children According to Established Medical Orders

- Diarrhea

Treatment

Oral Hydration  
Parenteral Hydration  
Prescription and Issue of Antidiarrheal Drugs  
Prescription and Issue of Antispasmodics

Educate On

Specific Feeding  
Oral Hydration  
Administration of Drugs  
Hygiene

- Respiratory Diseases

Antipyretic Treatment

Educate On

Maintenance of Proper Temperature  
Administration of Liquids  
Maintenance of Suitable Ventilation

B. PUBLIC HEALTH

Activities

1. Educational Activities With Community

1.1 Guidance and Motivation of Unlicensed Practitioner on Health Care

1.2 Guidance and Motivation in Prevention and Care of Gastrointestinal Disease

- Hygiene
- Hydration
- Feeding
- Antidiarrheal Drugs

1.3 Guidance and Motivation in Prevention and Care of Respiratory Diseases

- Environment (Ventilation)
- Hydration
- Antipyretics

1.4 Guidance and Motivation on Immunization

2. Emergency Care of the Sick

2.1 Care of Respiratory Diseases

- Register Patient at Health Station
- Take Temperature
- Question Patient On

Respiratory Difficulty  
Cough and Catarrh  
General Discomfort  
Difficulty in Swallowing  
Sore Throat  
Chest Pain

- Recognize Symptoms
- Treatment According to Established Medical Orders

Antipyretics

Antibiotics  
Sulfa Drugs

- Educate On

Environment  
Administration of Drugs  
Administration of Liquids  
Rest

2.2 Gastrointestinal Diseases

- Register and Solicit Information According to Established Procedures
- Take Temperature
- Question Patient On

Number and Characteristics of Stools  
Number and Characteristics of Vomiting Attacks

- Recognize Symptoms
- Treatment According to Established Medical Orders

Oral Hydration  
Parenteral Hydration  
Antidiarrheal Drugs  
Antibiotics  
Sulfa Drugs  
Antispasmodics

- Educate On

Hydration at Home  
Administration of Drugs  
Feeding  
Hygienic Measures

2.3 Parasitosis

- Treatment According to Established Priorities
- Education on Parasitosis Prevention

2.4 Skin Diseases

- Register and Solicit Information According to Established Procedures
- Observe Characteristics of Lesions
- Recognize Affliction

- Treatment According to Established Medical Orders

- Cleanliness
  - Topical Medication

- Educate On

- Personal Hygiene
  - Clothing Hygiene
  - Environmental Hygiene

## 2.5 Eye Diseases

- Register and Solicit Information According to Established Procedures
- Observe Characteristics of Affliction

- Irritation
  - Edema
  - Pus

- Treatment According to Established Medical Orders

- Cleanliness
  - Ophthalmic Ointment or Drops
  - Antibiotics
  - Sulfa Drugs

- Educate On

- Personal Hygiene

## 2.6 Tetanus

- Register Patient
- Question Patient On

- Background of Wound
  - Difficulty in Swallowing
  - Difficulty in Moving Jaw
  - Painful Convulsions

- Observe Muscular Rigidity
- Treatment According to Established Medical Orders

- Antitetanus Serum
  - Antibiotics
  - Cleaning Wound

## 2.7 Abdominal Pain

- Register Patient
- Question Patient On

Pain  
Nausea and Vomiting

- Observe

Feeling of Anxiety  
Profuse Sweating  
Pallor  
Hypersensitive Abdomen  
Fever (Take Temperature)

- Treatment According to Established Medical Orders

Antispasmodics

- Educate On

No Liquid or Solid Food  
No Purgatives or Enemas

## 3. Control of Most Common Communicable Diseases

### 3.1 Tuberculosis

- Take and Transmit Samples of Sputum From All Respiratory Patients
- Control Positive Cases
- Register Cases Under Treatment
- Follow Up Positive Cases
- Educate on Administration of Drugs

### 3.2 Malaria

- Identify Suspicious Cases
- Take and Transmit Blood Samples
- Treatment of Positive Cases According to Established Medical Orders
- Follow Up Cases

### 3.3 Rabies

- Register Suspicious Cases

- Question On

Biting Animal  
Date of Bite

- Observe Site and Characteristics of Lesion
- Treatment According to Established Medical Orders
- Educate On

Elimination of Stray Dogs  
Vaccination of Dogs  
Notification of Bites  
Observation of Suspicious Animals

3.4 Venereal Diseases

- Identify Suspicious Cases
- Register Suspicious Cases
- Treatment According to Written Medical Orders
- Follow Up Positive Cases
- Hygiene Education

3.5 Immunizations (Tetanus Toxoid, DPT, BCG, Polio, Measles, Yellow Fever, Smallpox)

- Conduct Immunizations in Short-Term Programs
- Conduct Immunizations in Long-Term Programs
- Register Number of Immunizations Performed, By Age Group and Dose
- Transmit Information on Number of Dose Given, By Age Group

4. First Aid in Most Common Accidents

4.1 Maintain Respiration

4.2 Prevent Asphyxiation

4.3 Protect Patient

4.4 Prevent Shock

4.5 Arrest Bleeding

4.6 Prevent Infections and Other Complications

- Clean Wound
- Apply Specific Serum

4.7 Immobilize Patient

4.8 Transport Patient

Basic Environmental Sanitation

A. WATER

1. Activities With Community

- Identify Problem
- Motivate
- Organize
- Promote Signing of Contracts to Obtain Contributions and Secure Operation and Maintenance of Project

2. Construction or Installation

- Promote Contributions

3. Operation

- Supervise Operation and Maintenance
- Recover Investment
- Financial Control

B. EXCRETA DISPOSAL

1. Activities with Community

- Identify Problem
- Motivate
- Organize
- Promote Signing of Contracts to Obtain Contributions

2. Construction and Installation of Latrines

- Promote Contributions

3. Follow Up

- Supervise Operation
- Recover Investment

Health Information

A. HEALTH SERVICES STATISTICS

1. Information on Number of Inhabitants in Locality
2. Recording of Data on Births, Illness, and Mortality in Locality
3. Transmission of Information to Higher Level
4. Notification of Pronounced Mortality (Persons and Animals) in Locality
5. Notification of Unusual Presence of Any Disease
6. Recording and Transmittal of Information on Services Provided

B. REGISTRATION OF VITAL STATISTICS

1. Promotion of Registration of Births and Infant Mortality, Including Newborn

## Appendix G

REPORT TO THE MINISTRY OF HEALTH  
ON THE DEVELOPMENT AND USE OF  
MANAGEMENT INFORMATION FOR THE  
SOMALI HEALTH CARE SYSTEM

REPORT TO THE MINISTER OF HEALTH  
ON THE DEVELOPMENT AND USE OF  
MANAGEMENT INFORMATION FOR THE  
SOMALI HEALTH CARE SYSTEM

by

Fred Munson  
Yassin F. Ismail

August 7, 1980

This report was prepared during Dr. Munson's visit to Somalia, July 24 - August 9, 1980. It has benefited from discussions with the following people:

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Dr. Abdullahi Mohamed Guled, Director of Primary Health Care

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The Somali health care system can be made more responsive to the health needs of the people with the collection and use of data that allow wise decisions to be made with little delay. For this to occur, three things must be in place:

1. The appropriate data must be collected and analyzed.
2. The management structure of the ministry must continue to decentralize.
3. The Directorate of Planning and Statistics must be equipped to identify, supervise the collection of, collect, and analyze data, and use portions of data directly in planning activities.

This report will cover each of the three requirements.

### Data Requirements

The central function of management information is to provide data for planning, for evaluating, and for making routine management decisions. It has no other important function. All data that are collected should meet this test of usefulness, or not be collected. Several kinds of data may be identified.

#### A. Financial Data

These include monthly or annual operating costs, by category, of individual units and programs, and appropriate recognition of capital or other fixed costs (e.g., overhead).

#### B. Staffing and Personnel Data

Data on the number of personnel, by category (or by full-time equivalents), in each unit and data on turnover, training, and experience fall into this category.

#### C. Service Statistics

These data would include number of surgical procedures, out-patient visits, or patient days in a hospital. In a PHCU, they would

include number of persons treated, prenatal visits made, immunizations given, etc.

#### D. Productivity Data

These data are used to calculate the amount of service (output) per unit of financial or staff input (e.g., cost per patient day, cost per immunization, visits per nurse, etc.). Productivity data are among the most important data used to make comparisons between similar units, to measure improved performance from training or other inputs, or to determine what kind of programs should be expanded.

#### E. Community Health Status Data

These data include vital statistics and surveys, and service statistics which specify diseases or injuries present (or treated). Such data indirectly measure the outcomes of preventive measures. Actions which have improved purity of water supply, for example, should have an outcome of reduced diarrhea in the community. This should show up in reduced demand for treatment of diarrhea. The same relation should hold for prenatal care and newborn health status.

#### F. Quality Data

Quality of health care may be measured by inputs, by process, or by outcomes. The number of staff fully trained or the number of PHCUs fully staffed and equipped are both input measures of quality. More fundamental input measures would record quality of community water supply, waste disposal, mosquito control, economic status, and other structural factors that affect the health status of the community.

Distinct from input measures of quality, process measures focus on behavior of personnel believed to produce good health outcomes. The completeness of a diagnostic procedure and the conformity (or lack of conformity) of prescribed treatment with generally accepted standards are two well-known measures of quality.

Outcome measures are the most desirable in principle; indeed, all community health status indices are "outcome" measures of quality. Typically, they reflect the outcome of many inputs, and thus more narrowly limited measures are sometimes more useful. For example, hospitals may keep track of infection rates and mortality rates--all indices of the hospitals' "output."

The most important data are productivity and health status data. Primary attention should be given to these data, for they are most useful in making the kinds of decisions which will be faced in the coming years. Quantity data are of a lower-order priority, because quality is, to some extent, built into health delivery through training programs. In the case of hospitals, however, it would be appropriate to begin collecting a minimum set of quality data. There is a widespread concern that hospitals in Somalia have more beds than can be adequately staffed. A particular concern is the shortage of qualified nurses. The accumulation of quality data may help contribute to wise choices between building more beds and taking steps to increase the supply of trained nurses.

It is useful to think of data as coming from three different kinds of sources:

- regularly collected data from service-providing units;
- special surveys; and
- data drawn from sources outside the ministry (finance, agriculture, international organizations, etc.).

Most important are the regularly collected data from hospitals, regional health centers, PHCUs, etc. Good systems of data collection from these sources are not currently in place, and two important steps in securing data will be the design of collection methods and the training of personnel to use these methods. An exception to this is the case of refugee camps, where the refugee health unit, with the aid of CDC personnel, has introduced health records and a monthly reporting system that could prove to be among the more useful data sources available to the department. Other data collection systems (e.g., from district-level health units) should be designed to ensure comparability with this system so that data can be additive.

Detailed data are difficult to collect accurately. The emphasis should be on simple and accurate data, and not sophisticated data that may be inaccurate and incomplete. It is also easy to think of data that "would be interesting to know," but this leads to demands for detailed, sophisticated data. Only data that will answer important questions should be collected.

Some important data will be collected from special surveys. The most important survey is the nationwide epidemiological study that is almost ready for administration. It will be very important to pick up the planning for the analysis of the nationwide survey and make sure that all is ready for its prompt tabulation and analysis when the raw data begin to arrive, perhaps in November 1980.

Data drawn from sources outside the ministry should be used whenever it is more efficient to use them than to collect data directly, or when data are otherwise unavailable. The director of planning and statistics should ensure that his department is aware of relevant sources of such information and make full use of those sources when necessary.

### The Planning and Statistical Department

The department should contribute to performance of the ministry in three ways. It should:

- provide a data base and analytic capacity for long-term policy decisions,
- evaluate experimental or other projects to determine their effectiveness, and
- provide data for regular monitoring of performance.

To do this, the department needs to develop one unit for statistics and reports and a second unit for planning and research.

#### A. Statistics and Reports

This unit will perform the core activities of the department. These are:

1. Develop data collection methods (design forms and pretest and develop instruction manuals, etc.) and train personnel who will collect and assist in initial implementation.
2. Design tabulation procedures and perform or advise on the tabulation of raw data.
3. Develop plans for analysis, design layout of data displays, and prepare explanatory text.

The unit's goals will be accuracy, completeness, and rapid tabulation. It will aim to ensure that data for routine administrative control are quickly available and become known for their reliability. The

section will necessarily expand considerably, for hand-tabulation will be required.

The possibility of using computer storage, so that simple analysis of large volumes of data will not be so time-consuming and labor-intensive, must be addressed here. We suggest that early computerization be avoided.

Computers are useless until raw data are organized; that task is still ahead of the Planning and Statistical Department. Moreover, computerization should operate in parallel with hand-tabulation for some time, at least until all the bugs are worked out. The Department of Planning and Statistics should remain constantly in touch with computer applications (e.g., the one in the National Planning Commission). But it should avoid using them until the logic and operational methods of the data system are clearly worked out.

## B. Planning and Research

This unit will perform the major analytic activities of the department. These are:

1. Design management information reports. In collaboration with those who will use the report, determine information needs, define data requirements, cooperate with the statistics and records unit to develop the system.
2. Design evaluation projects. In collaboration with senior ministry personnel, specify projects, programs, or services requiring special evaluation. Select evaluation model, specify data requirements, and analysis to be performed, for data manipulation and analysis by statistics and records unit. Prepare report on conclusions of evaluation project.
3. Continue policy analysis. In addition to the routine reports and special projects, a critical function of the department will be to relate continually epidemiological and vital statistics to national health goals to reach that crucial point where national purposes are translated into action alternatives and the costs and probabilities of success are weighed.

This unit's goals will be rigorous analysis, innovative planning, and cooperative attitudes that will encourage other segments of the Health

Ministry to consult freely with it on evaluation projects and other data needs. Its primary orientation will be to the director-general and minister, acting as the analytic and innovative source of new health policy initiatives. In the early stages especially, it will work to strengthen the capacity of the regional health coordinators (regional medical officers) to become effective, and indeed powerful, coordinators of the health services in their regions.

### C. Staffing the Planning and Statistics Function

At this time, the Planning and Statistics Department has a new person with a degree in math (statistics and reports), plus some tabulators, but no one in planning and research, other than the co-author of this report. The return of Dr. Tarabulsi will, of course, add strength to the department, but more staff will be needed. In addition to clericals (tabulators, file clerks, secretaries), the department should add the following personnel:

- an additional person for statistics and records, with training in the technical development of information systems;
- an economist with interests in micro-economic analysis to concentrate on the development and use of productivity indices; and
- an epidemiologist to continue the development and use of health status indices.

Yassin Ismail's value to the department would be increased measurably if he were able to attend a four- to six-week course on health administration. A summer course for public sector health managers in England, or perhaps Australia, would be a possibility, as would a specially-developed program in the U.S.

Staffing also must be considered for regional offices, for it is there that responsibility must eventually rest for the collection and tabulation of much regularly collected data. We recommend that a statistical clerk be placed in every region, with a senior statistical clerk in those regions where the volume of health activity is greatest. Eventually, there will be a need for a statistical clerk in every district, with a senior statistical clerk at the regional level responsible for seeing that complete and accurate data are accumulated from all parts of the region.

Training of statistical clerks is already in hand, but other training opportunities should be investigated. We should note here that training

is far more expensive than strict cost calculations suggest. The better trained a person is, the more likely (s)he will not continue to work for the ministry. Therefore, one must plan to train several people just to have a job filled for half a dozen years. Unfortunately, there are few alternatives. Among the other training possibilities that should be considered are the following:

- SIDAM

This organization has had its difficulties, but it has a considerable experience behind it, and it is dedicated to providing relevant, practical training in development administration.

- Administrative Staff College of India, Hyderabad

This is a well managed, aggressive management training organization with experience in training primary health center doctors (in India) in management methods. Also, it has experience running a similar program in Iraq.

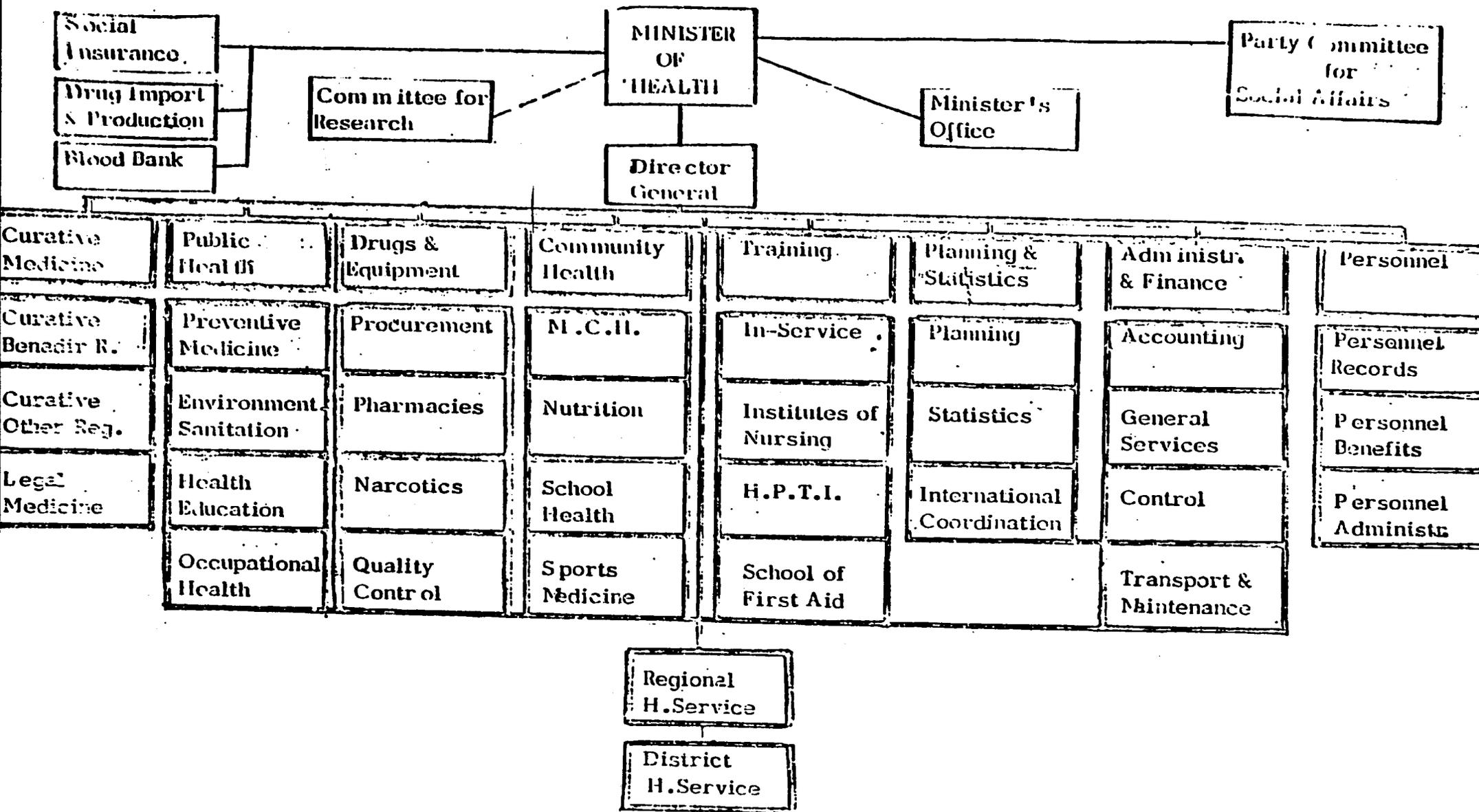
There are, of course, other institutes on the African continent; our feeling is that European or U.S. training should be avoided, except where absolutely necessary, and Somalian programs should be used whenever possible. We should help build our own infrastructure.

### Issues of Organization

The structure of the Ministry of Health is shown in Exhibit 1. As is evident, much attention is given to the central ministry departments, little to the regional or district levels. The regional health coordinator (regional medical officer) is, in fact, a key position; (s)he has considerable authority. Each regional health coordinator also reports to the governor of the region; it is probable that the position will grow in authority and responsibility for quite practical reasons. There are organizational reasons as well. An efficient organization will decentralize those decisions which will be made more wisely, promptly, and economically at lower levels; it would be logical for the region to take responsibility for coordinating and integrating activities which are linked with at least four separate directors (public health, curative medicine, MCH, primary health care) at the ministry level. As a long-term goal, maximum discretion

Exhibit 1

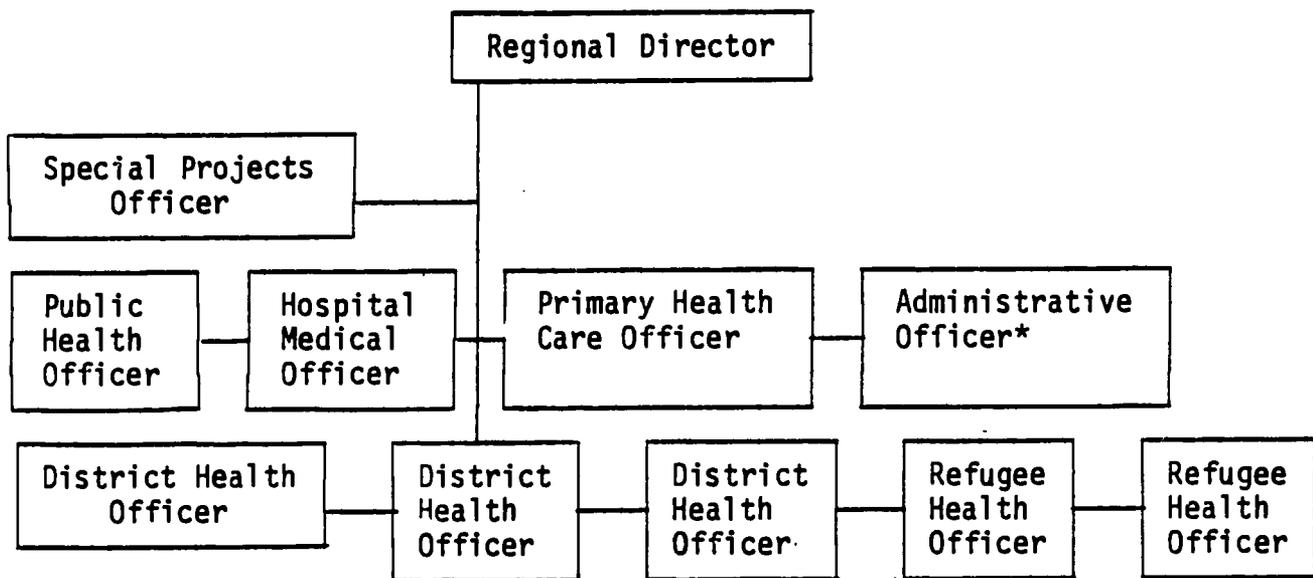
ORGANIZATION OF THE MINISTRY OF HEALTH



should be placed with regional health coordinators, and the design of data systems should reflect their potential use of control data.

The current situation in the regions does not permit this degree of regional autonomy. In some areas, the RHC is the senior doctor in the (regional) hospital, has little staff support, and little time to supervise or train staff in management. Additional authority for the internal reallocation of budgets, or staff, or to select services for special development would require management ability which is not present everywhere, and management support services which are not present at all.

Over the long term, it would be sound to increase the strength of the regional office. This can be done by recognizing (see structure outlined below) the integrating role that the office should play.



\* Statistics, finance, personnel, supplies, transport, construction, and maintenance.

The roles are clear, with the exception of the special projects officer. This position would handle special activities, such as integrating vertical health programs into the region, coordinating inter-regional training, doing special on-site evaluations, etc. It also would be a training position for persons ready to move into responsible regional positions.

Such a structure can only be a goal, but for regions such as the Northwest and Lower Shabeli, it is not unrealistic. Strengthening the regions is a prerequisite to effective decentralization.

## Action Steps

In the foregoing sections three objectives were mentioned. There remains the problem of designing specific methods to achieve those objectives and of putting the methods into action. We cannot, in this report, provide either the detailed design of methods or the appropriate implementation tactics. Nor should we. These steps must be shared with the people who will be responsible for making a success of the management information system. Therefore, the first action must be to strengthen the Department of Planning and Statistics.

The Department of Planning and Statistics is at this time weak in staffing at all levels and logistic support. To promote its service capability, it is essential that these areas be strengthened. This can be done by providing sufficient transport and office equipment for data processing. A minimum of three vehicles would be needed for the department, one of which would be for special travel to the regions where supervision is needed in the duty stations. The office equipment would include such machines as duplicators, calculators, stencils, photocopying machines, etc. Three air conditioners for the senior officials would be needed to improve working conditions in Mogadishu, where the weather is relatively hot most of the year.

It is important that more staff, both senior- and junior-level staff, be recruited and placed in the department. The two senior posts (i.e., an epidemiologist and a graduate, preferably an economist) ought to be appointed immediately to head the sections of statistics and planning, respectively. At a later date, a section for research must be created, in keeping with the five-year Country Health Plan, which will be published soon. The mathematics graduate now in service can be transferred to the planning section or given primary responsibility for the statistical activities in the statistics section, while the epidemiologist, in addition to overall supervision, can take direct responsibility for survey design and implementation activities.

An important technical skill in short supply is foreign-language typing. Two typists, skilled in English and Arabic, must be added to the department.

To attract trained staff to the department and to upgrade the productivity of those now there, it is considered imperative that incentives, in the form of training opportunities and involvements, be provided. An increase in salary or an allowance to augment the current personnel stipend would be a great motivating factor. Since the regular budgetary limitation does not allow for any increase in salary or for an allowance, an alternative source of financing may be sought to satisfy the demand, at least temporarily.

The working space of the department is rather small. There are only three offices, including that of the director. A minimum of three more offices will be needed to accommodate the two sections and their supporting clerical staff. A room in which to store documentation also will be needed.

**Appendix H**

**DESCRIPTION OF THE FAMILY LIFE EDUCATION PROGRAM  
OF THE MINISTRY OF EDUCATION**

## Appendix H

### DESCRIPTION OF THE FAMILY LIFE EDUCATION PROGRAM OF THE MINISTRY OF EDUCATION

#### Introduction

Families are the basic units of society. As women are, for the most part, responsible for the care and rearing of the family, and thus the nation, women's education plays a vital and strategic role in the society.

The beginning of changes in any society starts in individual homes. It is the sum of changes in individual households which adds up to a progressive community, and eventually to a stronger nation, and by educating the women, who carry so many responsibilities in the home, the process of change and development can be accelerated.

The Ministry of Education, in collaboration with the ministry of the local government has established family life centers in every district. The aim of the program is to teach women how to be a good mother, that is, to teach the basic skills of homemaking, nutrition, child care, sewing, and income-generation through skill-training, such as handcraft and sewing. The educational program is divided into two parts: family life education and skill-training.

#### Family Life Education

This level of education is available in every district.

The Family Life Education Program is sixteen months (two years). The aim of the program is to teach women:

- methods and techniques to save time and labor;
- handcraft (preparation of various articles);
- management of income;
- sewing, mending, repairing, and washing of the family clothes;
- food and nutrition (preparing, cooking, preserving, and storing food);

--child care; and

--personal hygiene and environmental sanitation.

In addition, the Somali language, political education, and various general subjects are taught.

When the mothers finish this program they either can go on to the skill-training program, which lasts two years, or leave with a certificate that indicates successful completion of the Family Life Education Program.

### Skill-Training

The program in skill-training is carried out in all regions. Officials hope to extend it to all the districts.

A two-year program, it covers two kinds of training: sewing (dress-making) and handcrafts. The aim of this program is to teach women special skills to enable them to participate in income-generating activities or cottage industries, or to work in other industries and hotels.

COURSES OF STUDY

Family Life Education

The Family Life Education Program is sixteen months. Each year of the program is eight months. The following courses are taught.

A. Home Management and Home Improvement

- The needs of the pregnant mother
- Planning for the baby's arrival
- Feeding of infants (food requirements of different infants)
- Children's clothes
- Importance of taking children to hospitals for treatment or immunization
- Exercise

B. Food and Nutrition

- What food and nutrition are
- How proper food is prepared in the home
- Improvement of food
- Growing food at home (home gardening)
- Preserving and storing fruits and vegetables and using these foods out of season
- Exercise

C. Health Education

- Important principles of health
- Human body and its physiology

- Good habits of health (personal health and hygiene)
- First-aid and treatment of illness in the home
- Importance of safe drinking water
- Cleanliness of bath space and bath facilities
- Communicable diseases and their prevention
- Importance of going to hospitals
- Exercise

D. Handcraft

- Construction of articles (baskets, mats, fans, brooms, bags, etc.) using various kinds of traditional materials, such as banana and palm leaves, sisal, egg shell, etc.
- Making toys for children
- Exercise

E. Textiles and Clothing Construction

- Importance of sewing skills
- Fundamentals of hand-sewing and embroidery
- Hand-sewing of baby garments
- Use and care of sewing machine
- Sewing by machine baby's garment (little girl's dress)
- Mending and repairing the family's clothing
- Exercise

F. Political Education

- Declaration of Somali Revolution
- Reason of 21 October Revolution

- Improvements and changes in Somalia after the Revolution
- Importance of writing in the Somali language
- Exercise

G. Somali Language and Mathematics

- Reading and writing
- Improving writing, writing meaningful words
- The four mathematics operations
- Methods of measuring (by meter, ruler, etc.)
- Methods of weighing
- Exercise

Skill-Training

The Skill-Training Program consists of two courses of study: dress-making and training in handcrafts.

## A. The Program of Clothing

The dressmaking program is two years. The first year is seven months, four periods in each day, twenty-four periods in one week (i.e., 700 periods each year). The first year consists of theory and practice. The theory program is 112 periods, four periods a day each week. In this program to acquire knowledge or an understanding of basic home economics the following subjects are taught:

● Somali Language	24 Periods	Six Periods Per Month
● Mathematics	14 Periods	Two Periods Per Month
● Child Care	14 Periods	Two Periods Per Month
● Food and Nutrition	24 Periods	Four Periods Per Month
● Design and Theory of Clothing	14 Periods	Two Periods Per Month

The practical program offers the following courses of study:

- construction of pattern of garment for child;
- cutting child's garment;
- sewing child's garment;
- finishing and embroidering child's garment; and
- ironing child's garment.

During the seven-month program, different skills are taught each month, as follows:

1. First Month

- Cutting and constructing patterns, sewing and embroidering garments for a new baby
- Making panties for a new baby
- Care and maintenance of the sewing machine

2. Second Month

- Smog dress and pants for 4-to-8-month-old baby
- Smog dress and pants for 1-to-2-year-old baby

3. Third Month

- Construction of various patterns and different models of dress for 3-to-4-year-old girls or boys
- Skirts for 4-to-5-year-old girls

4. Fourth Month

- Shirt for 4-to-5-year-old children (boy and girl)
- Trousers for 4-to-5-year-olds (boy and girl)

5. Fifth Month

- Sunsuit for 6-month-to-one-year-old baby
- Shirt and skirt for 7-to-8-year-old girl

6. Sixth Month

- Exercise (smog) dress for 6-month-to-1-year-old baby
- Garments for new baby, garment and pant for 4-to-6-month-old baby

7. Seventh Month

- Exercise (smog) dress for 1-to-2-year-old girl
- Shorts for 1-to-2-year-old
- Shirt for 1-to-2-year-old

In the second year, theory is taught again. The following subjects are studied:

● Somali Language and Political Education	42 Periods
● Mathematics	42 Periods
● Drawing Clothing (Theoretical)	14 Periods
● Child Care and Nutrition	<u>14</u> Periods
Total	112 Periods for Seven Months

Books on home economics and on language, mathematics, political education, etc., are used. In the second year, the practical program is 558 periods, five days a week, four periods a day. Different skills are taught each month.

1. First Month

- Smog dress for 5-to-6-year-old girl
- Smog dress for 2-to-8-year-old girl
- Shirt for 12-to-13-year-old child

2. Second Month

- Shirt for 14-to-15-year-old child
- Exercise Shirt for 12-year-old child
- Trousers for 7-8-year-olds

3. Third Month

- Trousers for 11-to-13-year-olds
- Trousers for 14-to-15-year-olds
- Exercise Trousers for 7-to-8-year-olds

4. Fourth Month

- Woman's shirt and skirt
- Dress for 8-to-9-year-old girls
- Exercise (smog) dress

5. Fifth Month

- Trousers for 4-to-5-year-old children
- Trousers for 6-to-7-year-old children
- Small jacket for 4-to-5-year-olds
- Small jacket for 6-to-7-year-olds

6. Sixth Month

- Shirt with long sleeves for 3-to-4-year-old children
- Shorts for 3-to-4-year-old children
- Trousers for 8-to-9-year-old children
- Dress for adult woman

7. Seventh Month

- Small jacket for 8-to-9-year-old boy
- Exercise trousers and long-sleeved shirt

## B. Handcrafts Program

The theory part of this program is the same as that of the clothing skill program; the first year is 588 periods, five days a week, four periods each day. The following topics are taught:

- weaving braids of palm leaves (plain braid, rick-rack braid) and sewing mats and basket;
- dying the palm leaves and sisal;
- making articles of sisal (e.g., threads, bags, mats); and
- making articles of banana fiber (e.g., various kinds of bags).

During the first year, the following activities are conducted:

### 1. First Month

- Basket (normal one)
- Basket (modern model)

### 2. Second Month

- Small bag made of palm leaves
- Big bags for women made of palm leaves

### 3. Third Month

- Exercise: small bag made of palm leaves
- Waste basket made of palm leaves

### 4. Fourth Month

- Cloth-storing basket made of palm leaves
- Bag made of sisal

5. Fifth Month

- Mat made of sisal
- Small bag made of banana fibers

6. Sixth Month

- Big bag made of palm leaves
- Big bag made of banana fibers
- Broom

7. Seventh Month

- Exercise: big bag made of banana fibers
- Exercise: big bag made of palm leaves

In the second year, theory is studied and practical exercises are required. The theoretical program is the same as the second year of the clothing skill training program. Students learn about articles made of palm leaves, banana fibers, leather, and sisal. Different activities are scheduled for each month.

1. First Month

- Big palm leaf basket for storing clothes
- Bed for baby and bedsheet and mattress made of palm leaves

2. Second Month

- Bed for baby made of palm leaves
- Complete sitting chairs made of sisal or palm leaves
- Pillow for decoration
- Wall-hangings of sisal (for decoration)

3. Third Month

- Bag made of cloth
- Bag made of leather
- Bag made of plastic fibers

4. Fourth Month

- Exercise: making bed for baby

5. Fifth Month

- Two bags made of leather
- Two bags made of leather and palm leaves

6. Sixth Month

- Two hats made of palm leaves
- Bag made of skin or banana fibers

7. Seventh Month

- Exercise: bag made of leather\*

---

\* Local materials can be substituted for materials that are not available.

## THE FAMILY LIFE CENTERS IN THE REGIONS

<u>Region</u>	<u>District</u>	<u>Number of Classes</u>	<u>Total Number of Students</u>
Babadir (Moqdisho)	Shibis <sup>a</sup>		
	Shibis <sup>b</sup>		300
	H/weyn	8	100
	B/Dere	4	50
	Wardigly	3	45
	Hawl wadag	6	55
	Hodan	4	60
	Waberi	3	50
	Waberi (M/Jama)	3	40
Wadajir	4	40	
Lower Shab.	Marka <sup>c</sup>	4	68
	Qoryolei <sup>c</sup>	4	64
	Afgoi <sup>c</sup>	3	45
	Janale <sup>c</sup>	4	45
	Wanle wein <sup>c</sup>	2	60
	Barava <sup>d</sup>	4	100

---

<sup>a</sup> Training center for family life teachers

<sup>b</sup> Training center for skills teachers

<sup>c</sup> Orientation and demonstration program

<sup>d</sup> Resettlement

<u>Region</u>	<u>District</u>	<u>Number of Classes</u>	<u>Total Number of Students</u>
Lower Shab. (cont.)	Kurtun warei <sup>C</sup>	6	150
	Sablale <sup>C</sup>	6	150
Central Juba	Dijuma <sup>C</sup>	6	200
	Bu'ale <sup>C</sup>	2	65
	Gilib <sup>C</sup>	2	40
	B/Dere <sup>C</sup>	1	20
Lower Juba	Kismayo <sup>C</sup>	4	64
	Gamame <sup>C</sup>	2	34
	Badada <sup>C</sup>	2	20
	Afmado <sup>C</sup>	2	48
Bay	Baidao <sup>C</sup>	4	55
	Bur-hakabo <sup>C</sup>	3	50
	Dinsor <sup>C</sup>	3	45
Bakol	Hudur <sup>C</sup>	3	50
	Wagid <sup>C</sup>	2	27
	El-barde <sup>C</sup>	1	20
	Yed <sup>C</sup>	1	20
	Teyeglow <sup>C</sup>	1	20
Gedo	Garbaharey <sup>C</sup>	2	30
	Luq <sup>C</sup>	1	20
	Dolow <sup>C</sup>	1	20

<u>Region</u>	<u>District</u>	<u>Number of Classes</u>	<u>Total Number of Students</u>
Gedo (cont.)	Elwaq <sup>C</sup>	1	20
	Belet hawo <sup>C</sup>	1	20
Central Shab.	Gohar <sup>C</sup>	4	110
	Balad <sup>C</sup>	5	149
	Adale <sup>d</sup>	6	184
Hiran	Belet wein <sup>C</sup>	4	69
	Bulo-burte <sup>C</sup>	3	30
Galgudud	Duse-mareb <sup>C</sup>	4	80
	El-bur <sup>C</sup>	3	50
	El-dher <sup>C</sup>	2	20
	Adado <sup>C</sup>	1	20
	Abud waq <sup>C</sup>	1	20
Mudug	Galkacyo <sup>C</sup>	4	90
	Hoby <sup>C</sup>	2	40
	Harar-dere <sup>C</sup>	2	40
Bari	Bosaso <sup>C</sup>	4	66
	Isku-subann <sup>C</sup>	2	27
	Bandar-beile <sup>C</sup>	2	19
	Qandale <sup>C</sup>	2	21
	Qardo <sup>C</sup>	2	23
Nugal	Gorowe <sup>C</sup>	3	50

<u>Region</u>	<u>District</u>	<u>Number of Classes</u>	<u>Total Number of Students</u>
Nugal (cont.)	Eil <sup>C</sup>	2	30
	Lasanod <sup>C</sup>	2	73
Togdere	Buro <sup>C</sup>	6	112
	Sheikh <sup>C</sup>	2	37
	Odwein <sup>C</sup>	2	38
	Buhudle <sup>C</sup>	2	40
North West	Hargeisa <sup>C</sup> (5 centers)	12	200
	Bebilei <sup>C</sup>	2	45
	Berbera <sup>C</sup>	3	38
	Borame <sup>C</sup>	3	45
Sanag	Erigavo <sup>C</sup>	2	60
	baran <sup>C</sup>	1	20
	El-afwein <sup>C</sup>	<u>1</u>	<u>20</u>
	TOTAL	<u>210</u>	<u>3,850</u>

Family life teachers gave lectures and demonstrations on various subjects, including child care, nutrition, clothing, home management, and handcrafts, to women in every district. The women gather on Wednesday and Friday afternoons at the orientation centers.

JAMHUURIYADDI DIMOGRAADIGA SOOMAALIYA  
WABAARADDA WAXBARASHADA & BARBAARINTA

BARNAAMIJKA XARUNTA TABABARKA MACALLIMIINTA DHAQAALAGA  
GURIGA IYO XIRFADDA SHIBIS

MOQDISHO

THE PROGRAM OF HOME ECONOMICS AND SKILL TEACHERS  
CENTERS - SHIBIS

MOGADISHO

April 17, 1980

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## THE HOME ECONOMICS TRAINING CENTERS SHIBIS MOGADISHO

Prospectus

Somalia has an ambitious program for economic and social development. The policy on socialism and self-reliance has focused attention on the vital role of education in achieving development objectives. The women of Somalia are achieving political and legal equality. Their participation is essential to the success of the development plans, yet they can only contribute fully if they also share with men the expanding educational opportunities, both the formal and informal opportunities, which the nation is providing as a necessary step in improving rural as well as urban life. The rural and urban women are, to a large extent, responsible not only for the physical welfare, stability, and well-being of their families, but also for contributing to the economic resource of the household through agriculture and the management of all other available resources.

In any society change begins in the individual homes and farms. It is the sum of change in individual households which adds up to a progressive community, and eventually to a stronger nation; by educating the women, who carry so much of the responsibility in the home, the process of change and development can be accelerated.

As the one way of reaching both urban poor and rural women, the Ministry of Education has institutionalized educational services for women. These services are staffed by home economists, family life teachers, and skill teachers. These family life teachers and skill teachers are trained as activators, and their task is to encourage improvement in all aspects of home and family life. To do this successfully, they must have a sound knowledge and understanding of the problems which beset rural women, and they must have practical skills to improve home life. Thus, the Ministry of Education established the family life teacher training center and the skill training center at shibis Mogadisho to provide necessary technical education to enable teachers to do their work satisfactorily both in the villages and the towns.

The centers also provide training for a variety of workers in skills related to home economics.

The training centers were established by the Ministry of Education in January 1976 with the assistance of UNICEF. Teaching began in April 1976. The centers have a residential capacity of 300 students and facilities for teaching food and nutrition, textiles and clothing, arts and crafts, home management and home improvement, political education, child care, child development, health education, and supplementary activities, including cultural activities, singing and games.

By September 1980, the centers will have facilities for teaching institutional management and catering, community development, economics, and cooperatives. There also will be a production unit.

In addition to the director, the home economic supervisors, and the principals, these centers have professional staff proficient in each skill.

### Entry Requirement

Most students are pre-service trainees of the Ministry of Education. Sometimes other ministries and agencies, such as the ministry of local government, and resettlement agencies send women for training in particular courses related to home economics. The centers have a minimum entry qualification: eight years of schooling (Standard 8).

### Area of Training

The following courses are offered:

- Courses for family life teachers. One year, beginning in November; after one year, service is followed by three years inservice.
- Course for daycare assistants. Same as above.
- Courses for leaders from rural areas and resettlements. These courses are arranged for special groups; particular attention is given to the resettlements. The length varies from one month to six months, depending on the particular needs of the group.
- Course in dress-making. One year, followed by inservice.
- Course in handcrafts. One year, followed by inservice.
- Short refresher course for ex-trainers of the center.
- Course in institutional management and catering (to begin in 1980).

Examinations are held at the end of each course. The results are combined with results obtained during teaching practice, fieldwork, course work, and practical work in the centers.

Summary of Programs

A summary of the programs, objectives, and courses offered is given in the following pages.

A. Courses for Family Life Teachers

The objectives of this course are to equip the trainees with:

- an understanding of the problems of poor families;
- the ability to understand the beliefs, attitudes, opinions, and aspirations about home and family life of rural and urban women and their families;
- the determination and skill to study the economic, social, and physical conditions of the people with whom they work;
- techniques in planning and carrying out programs in the field and organizing training for women to enable them to help rural families to improve their family life;
- a realistic approach to extension education in the context of self-help;
- an appreciation of the rural population on whom the future of the country depends, a devotion to their task of helping to improve home life, and a willingness to live and work with people and to help them to help themselves;
- a willingness to call on workers in other services to help solve villages' problems and to assist those other workers in every way they can;
- to prepare the teachers to be more competent in supervising home economics activities in the field; and
- to equip the teachers with the skills and educational techniques which will enable them to teach basic home economics to women.

The course includes basic training in home economics, field study, practice-teaching, and intensive training in specialized courses.

1. Food and Nutrition

a. First Four Months

- Introduction to Nutrition
- Introduction to foods
- Weights and measures
- Body processes
- Nutrition and meal management
- Milk and milk products
- Psychological aspects of food selection
- Menu plan
- Meal preparation
- Meal service
- Study of nutritional problems in Somalia
- Examinations

b. Second Four Months

- Nutrition for pregnant nursing mother
- Nutrition for children and teenagers
- Nutrition for young adults and adults
- Nutrition for adults over 45 years of age
- Foods for the sick and convalescent
- Malnutrition and avoidance
- Primary nutritional diseases
- Undernutrition and starvation

## H-23

- Obesity meal planning
- Meal preparation
- Food preservation
- Final examinations

### 2. Home Management and Home Improvement

#### a. First Four Months

- Introduction history of housing in Somalia
- Caring for various kinds of materials, and cleaning, washing, and ironing of different kinds of clothes
- Home decoration and construction
- Roles and responsibilities of family members in home management
- Care of kitchen equipment and traditional cleaning materials

#### b. Second Four Months

- Things to know before building a house
- Care of different kinds of floors
- Small household equipment repairs
- Construction of various household cleaning equipment

### 3. Textiles and Clothing Construction

#### a. First Two Months

- Use and care of sewing equipment

## H-24

- Advantages of sewing and tailoring
  - Hand-sewing
  - Making baby garments
  - Textiles of natural and man-made fibers
  - Survey
- b. Second Two Months
- Fabric recognition
  - The process of tie-and-dye
  - Field visits
  - Use, care, and maintenance of the sewing machine
  - Importance of mending and repairing family clothing
  - Measuring and pattern construction (shifts, sleeves, collar, skirt, dress)
  - Pattern construction from catalogues, actual observed styles, explanation provided, individual creation
  - Construction of skirt and shift
- c. Third Four Months
- Measurement and pattern construction of mens' shirts
  - Shirt construction (two styles)
  - Visiting local stores, local tailors, textile plants
  - Construction of various articles of clothing for adults and children

4. Health Education

a. First Four Months

- Introduction
- Good health and health education
- Altering pictures of health roles of supportive workers
- First-aid and personal health
- First-aid theory and practice
- Personal health and hygiene
- Review

b. Second Four Months

- Community health and welfare
- Aims and methods of health education
- Disease and the concept of ignorance
- Communicable diseases and their prevention
- Review of priorities in health improvement

5. Child Care

a. First Four Months

- The needs of children
- Pregnancy and childbirth
- Planning for the baby's arrival
- Mother and child care after baby is born

- How children grow and develop physically, mentally, and socially
- Children's diseases
- Habit-training
- Socialization of the child
- Youth and adolescence

b. Second Four Months

- Youth and their training
- The family in Somalia
- Roles and responsibilities of family members
- Protection of mothers and children
- The United Nations declaration of children's rights and needs of handicapped and neglected children

6. Arts and Handcrafts

a. The First Five Months

A. Materials Made From Palm Leaves

- Weaving palm leaves in traditional form
- Weaving palm leaves in modern form
- Weaving baskets with different designs
- Weaving trays (plates) with different designs
- Dying palm leaves
- Decorations for traditional houses using palm leaves

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- Decorations for modern houses using palm leaves
- Drawing various articles made from palm leaves

### b. Last Three Months

#### B. Material From Sisal

- Weaving sisal
- Making macrame from sisal
- Weaving sisal in traditional form
- Weaving sisal in modern form
- Decorations for traditional houses using sisal
- Decorations for modern houses using sisal
- Drawing various articles made from sisal

## B. Courses for Skill Teachers

The program for skill teachers is divided into two parts: clothing and textiles and handcrafts. In the course in clothing, the students must know how to construct various articles of clothing and how to take measurements and how to use, care for, and maintain a sewing machine. They also must practice teaching. In the course in handcrafts, students must know what materials are available and how to use them, recognize traditional patterns and modern styles, identify articles made from palm leaves, sisal, and leather, create articles for decoration, and practice teaching. The course lasts eight months.

The practical program in clothing includes cutting, sewing, finishing, and ironing clothes for children and taking different measurements. The practical program in handcrafts includes weaving four kinds of palm leaves, dying palm leaves, using traditional materials with different patterns made from palm leaves, making various articles using sisal, and making bags from palm leaves and sisal.

Students acquire a knowledge of the Somali language, arithmetic, home management, child care, politics, health, and nutrition.

### 1. Practical Program in Clothing

#### a. First Month

- Tunic for a little baby
- Pants for a baby (two kinds)
- Baby's dress

#### Summary of Course

- |             |  |
|-------------|--|
| Measuring:  | Measuring various clothes<br>(newborn-to-1-year-old) |
| Cutting:    | Cutting patterns and cloth for baby                  |
| Sewing:     | Hand- and machine-sewing of various kinds            |
| Drawing:    | Suitable designs for baby clothes                    |
| Embroidery: | Sewing 10 kinds of hand embroidery                   |

b. Second Month

- Boy's shirt (8-9-years-old)
- Boy's shirt (10-11-years-old)
- Boy's shirt (12-13-years-old)
- Boy's shirt (1-2-years-old)

Summary of Course:

Measuring: Measuring boy's shirt (1-14-years-old)

Cutting: Cutting pattern and cloth for shirts  
(4 kinds)

Sewing: Hand- and machine-sewing, especially  
collar, pocket, and button holes

Ironing: Ironing shirts

c. Third Month

- Dress (1-2-years-old)
- Pants for a baby (1-2-years-old)
- Shirt (2-4-years-old)
- Long Trousers (2-4-years-old)

Summary of Course

Measuring: Measuring shirt (1-4-years-old)

Sewing: Hand-sewing, especially buttons, and  
other finishings; machine-sewing,  
especially shirts and trousers, pockets;  
sewing different kinds of cloth

Drawing: Different hand and stamp designs for  
baby clothes

## H-30

**Embroidery:** Different kinds of embroidery

**Ironing:** Ironing children's clothing, especially shirts and trousers

### d. Fourth Month

- Boy's Trousers (8-9-years-old)
- Boy's Trousers (10-11-years-old)
- Boy's Trousers (12-13-years-old)
- Boy's Trousers (12-14-years-old)

#### Summary of Course

**Measuring:** Measuring trousers (1-14-years-old)

**Cutting:** Cutting pattern of trousers, using various kinds of cloth (1-14-years-old)

**Sewing:** Sewing trousers of various kinds, especially pockets

**Drawing:** Drawing many kinds of trousers

**Ironing:** Ironing trousers

### e. Fifth Month

- Skirt for elementary school uniform (7-8-years-old)
- Shirt for elementary school uniform (7-8-years-old)
- Blue jean skirt (3-5-years-old)
- Trousers for intermediate school uniform (10-15-years-old)

Summary of Course

Cutting: Cutting skirt in various types and taking measurements

Sewing Sewing skirt in old and modern styles

f. Sixth Month

- Jarleston dress (7-8-years-old)
- Dress (10-12-years-old)
- Blue jean trousers (2-4-years-old)

Summary of Course

Cutting: Dress-cutting in various types, measuring and cutting modern long trousers and shorts

Sewing: Sewing modern trousers and dress in many types

g. Seventh Month

- Blue jean coat (4-5-years-old)
- Blue jean coat (6-7-years-old)
- Blue jean trousers (4-5-years-old)
- Blue jean trousers (6-7-years-old)

Summary of Course

Cutting: Cutting modern coat

Sewing: Sewing a coat with collar, pocket, and belt, and sewing automatic buttons

h. Eighth Month

- Opening and assembling the sewing machine
- Cloth-skill training
- Examination

All subjects are included in the final examination. Students who pass receive skill certificates.

2. Practical Program for Handcrafts

a. First Four Months

- Sisal bag (4 kinds)
- Palm leaf bag (4 kinds)
- Bag made from banana leaves (4 kinds)
- Drawing, weaving, and sewing by hand and machine

b. Last Four Months

- Box for storing dresses and baby's bed of palm leaves
- Hats made from palm leaves
- Rug made from sisal
- Traditional plate or tray made from palm leaves
- School satchel (bag)
- Baby's baggy from cone sugar
- Women's bag from leader

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### Summary of Course

**Drawing:** Drawing various kinds of school satchels and women

**Cutting:** Paper and cloth cutting or leather bags of many kinds

**Sewing:** Hand- and machine-sewing of bags in many types

**Finishing:** Finishing and decorating bags in various types

Women Education Center Program

<u>Date</u>	<u>Number of Students and Teachers</u>	<u>Courses</u>	<u>Duration of Courses</u>
1976	26	Trainer and leadership courses in family life and skill programs for Mogadishu	9 Months
1976	100	Courses for family life teachers	9 Months
1976	50	Courses for child care teachers	9 Months
1976	26	Trainer and leadership courses in family life and skill programs for the regions	3 Months
1977	100	Courses for family life teachers	9 Months
1977	50	Courses for child care teachers	9 Months
1977	64	Courses for clothing teachers	7 Months
1977	26	Courses for handcraft teachers	7 Months
1978	26	Upgraded courses for clothing teachers (Level II trade test)	6 Months
1978	13	Upgraded courses for handcraft teachers (Level II trade test)	6 Months
1978	135	Training assistants for clothing teachers for resettlements	6 Months
1978	75	Training assistants for handcrafts teacher for resettlements	6 Months
1978	45	Training assistants for day-care teachers for resettlements	6 Months
1978	61	Training in skills and family life education for regions	6 Months

<u>Date</u>	<u>Number of Students and Teachers</u> *	<u>Courses</u>	<u>Duration of Courses</u>
1978	150	Upgraded courses for teachers in family life programs (1976-1977)	2 Months
1978	25	Courses in leadership in daycare programs	2 Months
1979	72	Courses in skills and family life programs for the regions	6 Months
1979	150	Upgraded courses for family life teachers (1976-1977)	2 Months
1979	28	Courses for tie-and-dye teachers	4 Months

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\* Between 1976 and 1979, 1,212 teachers were trained.

Appendix I  
IPPF SECRETARIAT TRIP REPORT

# IPPF SECRETARIAT TRIP REPORT

MIDDLE EAST & NORTH AFRICA REGIONAL OFFICE

REPORT SUBMITTED BY: (Mrs) Imtiaz Kamal		POSITION: Programme Officer (Training)	
CO-TRAVELLERS:		POSITION:	
ITINERARY AND DATES:			
25 August 1980, to Mogadishu via Rome 14 September 1980 to Tunis via Jeddah			
TRIP OBJECTIVES AS STATED IN TRAVEL REQUISITION:			
TRAINING OF TRAINERS			
<p><b>SUMMARY OF FINDINGS AND RECOMMENDATION:</b> The Government has not yet stated their policy about FP activities. Even though FP services are not available as part of other health services, there has been progress in the FP activities in Somalia in the last one year. Three doctors have been trained in Laparoscopies by Johns Hopkins PIEGO and two have been trained locally. Laparoscopies are being done for diagnosis and contraception in Banadar Teaching Hospital. Contraceptive services are provided on demand by the physicians in their private clinics. The Somali Women's Development Organisation is keen to start I&amp;E activities on a national scale. UNFPA has approved a five year programme costing \$ 6 million for population related activities. PIEGO is supporting a 3 year project for training of doctors. USAID is preparing a \$ 500,000 project proposal for "Family Health Initiation" as a part of the Primary Health Care Project. There seem to be adequate funds coming in for FP activities.</p> <p>A training course for trainers was conducted during the mission. Ten senior nurses and a laboratory technician instructor attended the course. A senior MCH nurse joined in for clinical training.</p> <p>A brief was prepared and presented to the Health Minister with a suggested plan of action for training and starting FP services as a part of MCH services.</p> <p><b>Recommendations :</b></p> <ol style="list-style-type: none"> <li>1. IPPF should restrict its assistance to develop manpower by training so that provision of services becomes possible as funds seem available from various other sources.</li> <li>2. The FP role of the health workers should be defined so that training can be given accordingly.</li> </ol> <p style="text-align: center;">(Please see overleaf)</p>			
ATTACHEMENTS:		DISTRIBUTION :	
- MAIN REPORT / - OTHER: Appendices 1,2,3.		Deputy Secretary General / Regional Director / File / Other : REC Members - Dr. S.A.Abbas, Director MCH/FP Ministry of Health, Mogadishu, Somalia - Dr. Mohammed Wasamè, Bena'ar Teaching Hospital, Mogadishu	
SIGNATURE OF TRAVELLER(S) <i>J. Imtiaz Kamal</i>		APPROVED <i>RAM</i>	
26 Sep 1980.			

/...

FP should be integrated into the existing curricula of all health personnel. Some selected material on FP should be translated into the Somali language. IPPF can provide the material and UNFPA or USAID can be requested to fund the translation and printing.

TRIP REPORT

Mogadishu - Somalia  
26 August - 11 September 1980  
(Mrs. Imtiaz Kamal)

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Background

In October 1979 when the Director of Programmes and Programme Officer (TR) visited Somalia, it was agreed upon that Mrs Hava Aden, Director of the Family Life Education, Mogadishu will come to Tunis in the first quarter of 1980 and get 2 weeks training from the Training Officer MENAR in teaching of FP to non medical community workers. She was to develop a curriculum so that FP could be included in the Family Life Education programmes. When Mrs. Hava Aden's schedule did not permit her to come to Tunis until June 1980 it was suggested that the Training Officer should go to Somalia and train her there.

When a cable arrived from Dr. S.A. Abbas, Director MCH/FP requesting the writer to visit Somalia for 2 weeks in the second half of August, all concerned took it to be a response to the original plans of training Mrs. Hava Aden. Upon arrival in Mogadishu, the writer learned that this request was from the Directorate of MCH/FP to train nurse-trainers.

Purpose of the visit

In principle the purpose of the visit remained the same i.e training of trainers, but there was a change in the category and number of trainees.

Pre-visit preparation

As is obvious from the above information, the pre-visit planning was geared to train an educationalist. A lot of material was prepared about the teaching of family planning to persons without any medical or nursing orientation. But fortunately, the writer decided to carry a lot of material for distribution to the libraries of schools of nursing, Health Personnel Training Institute, various Officials and to senior nurses. This included copies of IPPF publications "FP for Nurses and Midwives", "What is IPPF" the People magazine's issues on "The Muslim World" and "Female Circumcision" and the circular indicators "Have you seen the light". These proved tremendously helpful.

Initial Planning

Discussions were held with the Director of MCH/FP, Director of post-basic school of nursing, Senior Supervisor MCH/FP and WHO's Nurse Educator.

Director MCH/FP was very keen to train as many nurses from the MCH Centres, as possible. He suggested a group of 30. After exhaustive discussions and taking into account the pros & cons of training a larger group of nurses it was eventually decided that a group of senior nurses should be trained as trainers, who in turn will be able to train others with some guidance. The number decided upon was ten.

A laboratory technician instructor requested to attend as an observer for a few days but she got very interested and requested to attend the whole course.

#### Activities during the mission

The first two days were spent in preparation of the schedule, material for training, contacting the trainees and dealing with the logistics. The writer also met with all the nurses and public health nurses working in the MCH Centres of Mogadishu. They were oriented to the training courses for trainers and the future plans for their on the job training. In this session information was collected on their activities on various days of the week. This was done to select the areas and days for home visiting and the MCH Centres for clinical experience.

Two films were reviewed to determine their relevance to the training course. One was on normal child birth and the other on Preventive Medicine in Somalia. It was decided not to use either of the films. The meetings with various officials and agencies/organisations were organised at timings that did not interfere with the scheduled training activities.

The draft schedule was discussed with Dr. S.A. Abbas. He approved it.

#### Training

The training activities were divided into two parts. The first part was devoted to helping the trainees to become knowledgeable about FP as they had no background in FP. In the second part they were to learn about the training process.

After the first three days of intensive classroom activity the time was divided between the classroom and the field.

#### Approach to Training

Lecture -discussion, role play, guided self activity, independent work and group work were methods used for achieving the academic objectives.

Use of audio-visual aids was limited to one film, some drawings and diagrams.

Home visiting, supervised clinical practice, demonstration and return demonstration, the multiplier approach, guided self-activity and individual guidance were used for achieving the skill producing objectives.

The English version of the IPPF Publication "Family Planning for Nurses and Midwives" was used as the text book for part I of the training. This will be supplemented by cyclostyled material a complete set of which has been given to the Senior Supervisor MCH.

#### Home visiting

Since it was not possible to take 10 trainees for home visiting in one group, they were split into three groups.

The trainees who had no experience in home visiting were supervised by the writer and the other two groups were supervised by two of the MCH/FP Supervisors.

#### Clinical experience

Because of a lot of guided self-activity and also the number being too large for supervised clinical experience in one MCH Centre, the trainees were divided into two groups. They took turns to get their clinical experience. The only male member of the group decided not to go for field work.

Since FP services are not yet available, the teaching was done on post-natal mothers. The trainees were taught the technique of interviewing, taking and recording medical and obstetrical history, performing top to toe examination, using all their findings to recognise contraindications for the pill and the IUD and counselling the mother. Some mothers were motivated and referred to the El-Coab MCH Centre for IUD insertion. (Please see Part II of Appendix 3 for further details of the field work).

#### Evaluation of the training course

##### By the trainees

In the pre-evaluation it was revealed that all (except one) trainees understood FP as family limitation and their knowledge of contraceptives was based on what they had "heard from here and there". They did not have access to any written material.

Teaching and lecturing were synonymous to them.

Throughout the duration of the course the first 5-10 minutes were spent on the critical evaluation of the previous day's teaching/learning activities. Hence the post-evaluation was infact a summary of what had already been conveyed by the trainees but it was carried out just the same. (Please see page 6 of annex 1).

##### By the trainer

With the exception of one trainee who was luke warm throughout every one exhibited interest and enthusiasm. They worked very hard, did most of their assignments on time, sought guidance, took part in discussions and demonstrated their keeness for more knowledge and experience.

The discussions were very frank. They expressed their fears and doubt about the pill and the IUD. They asked questions about human sexuality and about when and how to tell the children about where babies come from. They expressed their views about social problems like female circumcision, sexually transmitted diseases abortion, births out of wedlock, reasons why women continue to produce children etc.

Their evaluation of the teaching/learning activities was very objective and the writer fully agreed with it all including the fact that some of the objectives were not fully achieved, hence they need further guidance before they can function independently as clinical FP workers and trainers. The reason for the first being nonavailability of FP services and for the second, extremely limited time coupled with their varying degrees of difficulty with the English language.

All this was conveyed to Dr. S.A. Abbas in the debriefing session.

Final analysis with the Director MCH/FP.

Dr. S.A. Abbas was kept informed about the progress of the training course in brief sessions on alternate days. In the final session he was apprised of the evaluation of the trainees, their needs and the fact that they cannot carry out training unless FP services are available in the MCH Centres. According to Dr. Abbas 1650 packets (i.e 4950 cycles) of oral contraceptives are available in the medical stores of the Directorate of MCH/FP. The mothers cards have already been printed. Since the training will start in 5 out of the 10 MCH Centres of Mogadishu, Dr. Abbas sees no difficulty in starting the services and the training simultaneously. This stock will provide protection to 825 pill users for 6 months plus to another 200 mothers with the IUDs. During this period more supplies can be provided by IPPF if the USAID supplies do not arrive. (The Family Health Initiation Project has provision for supply of contraceptives). Dr. Abbas was also informed that the trainees have been given the assignment of applying their knowledge and experience gained during the course in developing their training plan. The five MCH/Supervisors will work in a group as they are the ones who will start on the job training in the MCH Centres. These nurses need follow-up. Miss khin M. Aye, WHO Nurse Educator has very kindly agreed to keep in contact with them but she could not assume the full responsibility because of her heavy work load and the nature of her professional background.

All concerned agreed that a maximum of 6-8 weeks should be allowed between the training of trainers and their direct involvement in imparting training to other nurses. As soon as they have developed their training plans they should receive guidance in finalising these plans and start implementing them, because the provision of child spacing services depends on training the staff of the MCH Centres. This training should start before the end of 1980.

The possibility of further technical assistance by IPPF was discussed. The writer informed Dr. Abbas about the heavy schedule ahead of her but if the trainers are ready with their plans and the Directorate of MCH/FP wishes to implement them as suggested above then there is a possibility of her being available in the month of November only.

#### Meetings

##### 1. Meeting with His Excellency, Major General Abdallah Fadl, Minister of Health :

Upon the request of the Director MCH/FP, the writer had prepared a brief on the need and indications for providing child spacing services in Somalia (Appendix 3), and a suggested plan of action. It was discussed with His Excellency and it received his full endorsement. His Excellency wished to be conveyed to IPPF his appreciation for the Federation's interest and support and his gratitude for training their nurses. His Excellency was informed that the trainers trained by IPPF will need supervision when they conduct their first training course and hopefully after that they will be able to function independently.

Somalia's participation in the forthcoming seminar on Infertility in Baghdad in December 1980 was also discussed. His Excellency told the writer that Dr. Abdul Gadir Gebgeblè has been nominated to attend. (The nominee was contacted and his nomination form duly filled was brought back to MENARO).

##### 2. Somali Women's Development Organisation (SWDO)

An afternoon was spent with the Secretary and Assistant Secretary of Foreign Affairs and Secretary of the section of Mother and Child Care. The Senior Supervisor and one of the Supervisors from the Directorate of MCH/FP also attended this meeting. The question of training a trainer for the Family Life Education was discussed. Since Mrs. Hawa Aden, who was nominated last year for this training is very busy and MENARO's repeated efforts to bring her to Tunis for training did not succeed, the SWDO Office bearers conveyed the desire to train someone else who will be able to devote her time to training others. They will convey the name to MENARO in due course of time. This activity will be carried out in the first quarter of 1981.

The SWDO is very keen to start I&E activities for child spacing. This question has been discussed in their national meeting and agreed upon. They plan to use the following approaches :

##### 2.1. Somalia has National Orientation Centres all over the country. In each village there is one and in towns and cities there are more than one e.g Mogadishu has 13.

Every Friday afternoon women gather in these Centres and they are addressed by speakers on various topics of national interest. Depending on the situation of the Orientation

Centres, the Friday gathering can have between 500 to 1,000 women.

SWDO wishes to use these centres for I&E activities. This will involve very little cost. Only the speaker will have to be paid a nominal honorarium for his time and effort,

2.2. The SWDO, being an official organisation, can get free radio time. They would like to integrate FP into the existing Health Education programme on the radio. Those giving talks on child spacing will have to be paid the usual fee. Information as to the exact amount was not available.

2.3. The SWDO has its branches all over Somalia. They would like to bring 52 provincial and district women leaders to Mogadishu for 3 days in early 1981 and give them enough background of knowledge so that they can disseminate information about child spacing in their own areas. This activity will involve considerable expense because of travel and per diem. The estimate of the sum involved was not available.

The SWDO representatives were advised to work out the details of their plan i.e objectives, approach and expenditure, and send it to MENARO for the possibility of funding some of these projects in 1981.

The discussions also included the problem of female circumcision in Somalia. The SWDO are trying to propogate a "token cut" instead of excision". "We hope that this will satisfy those who attach religious importance to it", the Secretary for Mother and Child Care told the writer. They feel total ban will not succeed yet, but they intend continuing their efforts to that end.

### 3. Benadar Teaching Hospital, Mogadishu

Two meetings were held in Benadar Teaching Hospital, where the present situation and future plans for FP were discussed with the Medical Director, the Senior Obstetrician and the Gynaecologist of the hospital.

This hospital is used by the Medical College for providing clinical experience to the medical students. The Johns Hopkins PIEGO project is also based here (Please see page 9 for details of the project activities).

#### Teaching of FP in the Medical College

Six hours of theory on FP included in the medical curriculum, students get some practical experience during their clinical rotation. Every one agreed, however, that the students need more practice in providing FP services particularly in view of the fact that they are required to work in the rural health services for 2 years after graduation.

3.1. Contraceptive services

Contraceptive services are provided by the doctors to the clients on demand. These include hormonal contraceptives, IUDs, and tubal ligation.

The senior obstetrician prefers the injectable Norestrat (a Schering product) to Depo-provera. His observation is that with this product the incidence of amenorrhoea is very much lower than with Depo-provera (data not available).

The IUD popular with this group of doctors is Nova T (a Schering product) They have Lippes Loops but do not know how to sterilise it. The writer explained the use of Tincture of Iodine solution. They said they will start using the Lippes Loops.

Laparoscopies are being done for diagnostic and contraceptive purposes. Tubal ligation is obligatory for a women undergoing a fourth caesarean section.

A written consent of the couple is obtained before tubal ligation. Demand for contraceptive services.

The Medical Director (a gynaecologist) and the senior obstetrician are of the view that there is a demand for contraceptive services and that when services for child spacing are integrated into the MCH services, mothers will make good use of them. They are providing these services to their private clients.

3.2. Plans to start of Family Planning Association :

The Medical Director informed the writer that a group of doctors have discussed plans for forming a family planning association. They would like some guidance in this connection. The writer pointed out the need for caution against the FPA becoming a purely medical organisation. They are going to discuss this issue during their forthcoming training course for doctors which is due to start on 1 November 1980 where 20 doctors from all over Somalia will be present.

This group also expressed the need for FP Handbook for doctors, Intramuscular Valium Injection and I.U.D. insertion kits. This request is being processed.

International input

UNFPA

The writer accompanied by the Director MCH/FP, met with the Resident Representative UNDP. The purpose of this meeting was to find out the input of the UN agencies for purposes of interagency collaboration and avoiding duplication.

The major input in the area of population related activities is that of the UNFPA. It is a 5 year programme (1980-1985) with a budget of \$ 6,000,000. The programme has been approved by UNFPA but not implemented yet. The projects included in this scheme are : Basic data collection and analysis; Population dynamics and policy formulation; Maternal and child health/child planning; Information, education and communication (2 projects, one each through the Ministries of health and education); Special programmes including Women's programmes.

The Resident Representative, while discussing the role of IPPF, agreed that technical assistance of IPPF in the area of training can be of invaluable help.

WHO/UNFPA

Discussions were held (2 sessions) with Dr. M.K. Alaghbari, WHO Programme Coordinator in Somalia. These centred around the 5 year health plan, WHO's input and the UNFPA/WHO's MCH/FP Services Project. The Medical Officer of this project has taken up another post in WHO Head Office and left for Geneva a few weeks ago. His replacement is awaited.

The possibility of WHO office's assistance with handling of translation of some FP material into the Somali language was discussed. Dr. Alaghbari could not promise any help. He said that this facility was extremely limited.

USAID

The writer had requested a visit to the USAID office to get upto date information on the Primary Health Care project and its FP activities. (Please see Somalia trip report of A.Habbab and I.Kamal, October 79, Page 4, item 7,b). She was instead invited to take part in a meeting attended by 3 USAID staff members, Director of Primary Health Care, Director of MCH/FP Medical Director of Benadar Teaching Hospital, and the Senior Supervisor MCH/FP.

The Health Authorities and the USAID are in the process of preparing a project proposal (due 30 September 1980) which will complement their Primary Health Care Project. This project entitled " Family Health Initiation " aims at integrating FP IE&C and services into the primary health care activities. Training of health personnel will be a large component of this project. Its budget is \$ 500,000, and it is expected to be implemented before the end of 1980.

The writer was requested by the USAID staff members to postpone her departure and assist with the proposal but unfortunately this could not be done. They were assured however of all possible assistance through mail.

#### Johns Hopkins PIEGO

The JHPIEGO activities are based at the Benadar Teaching Hospital. In a meeting with the Medical Director, the following information was collected.

JHPIEGO has trained 3 Somali gynaecologists in laparoscopy in 1980 and provided the Benadar Teaching Hospital with a laparoscope.

Laparoscopies are now being performed for diagnostic and contraceptive purposes. There were five women on the waiting list for tubal ligation for September.

Two more doctors have been trained locally by one of the doctors trained at Johns Hopkins.

JHPIEGO is also providing a 3 year project in Somalia for training of doctors in Family Health. 4 training courses will be conducted in 3 years and a total of 80 doctors (20 in each course) will be trained from all over Somalia. The course content includes Demography and Population, Fertility and Infertility, high risk pregnancies, Contraceptive methods and sexually transmitted diseases. The theoretical part of 3 weeks will be followed by 6 months of clinical experience.

The first course is scheduled to start on 1 November 1980.

#### Summary and Conclusion

There has been some progress in the last one year in the area of Family Planning in Somalia. Women desirous of spacing their pregnancies are provided with means of postponing their next pregnancy by the doctors. These services are not yet available as a part of health services, but there are plans to start them in the near future simultaneously with on the job training for the MCH services health personnel. Laparoscopies are now being done for diagnosis and contraception in one hospital in Mogadishu.

The Somali Women's Development Organisation are keen to start I&E activities all over Somalia.

UNFPA has approved projects worth \$ 6 million in the next five years. USAID has plans for a project worth \$ 500,000 for 1981. Johns Hopkins PIEGO is funding a three year project for training the doctors.

From the discussion with various national and international officials it can be concluded that the major unmet need of the country is the development of manpower at the field level without which the FP services cannot be integrated into the MCH services. Adequate funds seem to be available from various international sources. Hence IPPF's role, as seen by most of those with whom the question was discussed, should be to concentrate on technical assistance in the area of training, as no amount of assistance can have any impact unless trained personnel is available to carry on the work.

Ten senior nurses were given training by MENARO, IPPF, with some further guidance and supervision these nurses can function as FP health workers and trainers. One laboratory technician instructor also attended the course. One of the senior MCH nurses joined in for clinical training only.

#### Recommendations

1. The Directorate of MCH/FP should define the FP role of the staff of the MCH Centres so that they can be trained accordingly.
2. When the trained trainers finish developing the core curriculum, FP should be integrated into the existing curricula of schools of nursing and post-basic nursing and the Health Personnel Training Institute. IPPF can provide assistance in developing teaching modules.
3. Selected material on FP should be translated in the Somali language. UNFPA or USAID should be requested to provide funds for translation and printing. IPPF can assist in selection and preparation of the material.

#### Acknowledgement

The writer is indebted to each and every person with whom she had the pleasure of working and discussing matters of mutual interest. Her grateful thanks are due to His Excellency, Major General Abdulla Fadl, the Health Minister, for sparing his time for discussions, to Dr. S.A. Abbas, Director MCH/FP for his guidance and support throughout the writer's stay, to Mrs. Halima Abdi Sheikh the senior supervisor MCH/FP and Miss Khin M.Aye the WHO nurse educator for their assistance at all times.

She is obliged to all those national and international individuals with whom she met for discussions and apologises for the fact that the timings had to be arranged to suit her convenience.

Her special thanks are due to the group of trainees whose enthusiasm was infectious and who in spite of their family responsibilities managed to attend the work sessions in the evenings.

Persons met

## A. Ministry of Health and Directorate of MCH/FP

H.E. Major General Abdallah Fadl	Minister of Health
Dr. S.A. Abbas	Director MCH/FP
Dr. Abdullah Guled	Director, Primary Health Care
Mrs. Halima Abdi Sheikh (and 4 supervisors working with her)	Senior Supervisor MCH/FP
Medical Officers and Public Health Nurses working in MCH Centres used for field experience	
Mr. Abdallah Hirad	Director, Post basic School of Nursing
Mr. Mohammed Ahmad	Director, Health Personnel Training Institute

## B. Somali Women's Development Organisation (SWDO)

Mrs. Maryam Yusuf Mohammad	Secretary, Foreign Affairs
Mrs. Hawa Haji Egal	Secretary, Mother and Child Care
Mrs. Dowlay Ahmad Mohammad	Assistant Secretary, Foreign Affairs

## C. Benadar Teaching Hospital

Dr. Mohammad Wasamè	Medical Director
Dr. Abdul Gadir Gabgebla	Senior Obstetrician and Professor of Obstetrics Medical College
Dr. Mohammad Adam	Gynaecologist
Dr. (Mrs) Fadooma Haji	Gynaecologist and MCH Specialist
Mrs. Abaido Musa Ali	Nursing Superintendent

## D. UNDP

Mr. O. Svennevik	Resident Representative
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## E. WHO

Dr. M.K. Alaghbari	Programme Coordinator
Miss Khin M. Aye	Nurse Educator

## F. USAID

Miss Sharon Fee	Members of the team working the Family Health Initiation Project
Mr. Rane Dougherty	
Mr. Charles Habis	

## Appendix 1

## Training of trainers

Mogadishu, Somalia  
30 August to 10 September 1980

Programme of teaching/learning activities

Day, date & timings	Teaching/learning activities Classroom/Field/Group work	Student activity and assignments
Saturday 30 August 9.30 a.m.	1. Inauguration of the course Dr. S.A. Abbas Director MCH/FP	1. Reading "FP for nurses and midwives" Pp 1 - 20
10.00 a.m to 11.00 a.m	2. Introductions : "Getting to know each other" and IPPF	2. Daily evaluation : Each student to write 2 sentences in answer to the following questions :-
11 15 a.m to 1.30 p.m	3. "The next 12 days" Our goals and our strategies to reach those goals.	2.1. What did I learn to-day which was new.
	4. Family Planning Discussion : "My concept of FP" Meaning, history, philosophy and need for FP. Advantages of FP. Factors influencing FP behaviour of individuals/couples	2.2. Which was useful 2.3. How will I use it 2.4. What did I do/hear/see that was of no special benefit.
Sunday 31 Aug. 9. a.m to 11.00 a.m	1. Evaluation of yesterday's session	1. Evaluation
	2. Questions/answer session (10 minutes)	2. The married students will write down what methods of contraception they have used (if any) and their own reactions to the method (s). Were there any problems/ side effects.
	3. Definition of "Contraception" Qualities of a good contraceptive. Factors to be considered when offering FP advice and counselling couples.	
11.15 a.m. to 1.30 p.m	4. Review of male & female reproduction	
	5. Methods of Contraceptions; advantages, suitability, reliability and side effects and management, of each method.	3. Reading Pp 21 - 31.

\* Trainer : Mrs. Intiaz Kamal, Programme Officer (Training) MENARO, IPPF  
Coordinator : Mrs Halima Abdi Sheikh, Senior Supervisor MCH/FP

Day, date & timings	Teaching/learning activities Classroom/Field/Group work	Student activity and assignments
<p>Monday 1 Sep. 9.30 a.m to 11.00 a.m</p> <p>11.30 a.m to 1.30 p.m</p> <p>3 p.m. to 6 p.m</p>	<p>Evaluation of yesterday's session Methods of Contraception (continued)</p> <ol style="list-style-type: none"> <li>1. Review of readings &amp; Ev.</li> <li>2. Interview with 3 persons who have used three methods i.e. Withdrawal, Condom, Pill.</li> <li>3. Discussion</li> <li>4. Lecture-discussion on non-surgical Reversible methods Guided study (I.K. available)</li> </ol>	<ol style="list-style-type: none"> <li>1. Evaluation</li> <li>2. Each student to visit a different pharmacy and find out the brand names and prices of oral contraceptives and others if available.</li> <li>3. Readings: p 31 - 45</li> </ol>
<p>Tuesday 2 Sep. 9.30 a.m to 11.00 a.m</p> <p>11.30 a.m to 12.30 p.m</p> <p>3 p.m. to 6 p.m</p>	<p>Evaluation of yesterday's session Methods of Contraception</p> <ol style="list-style-type: none"> <li>1. Discussion on pooled information about the locally available contraceptives.</li> <li>2. Surgical methods; Temporary and permanent</li> <li>3. The infertile couple</li> <li>4. Film : Menstrual regulation</li> <li>5. Self activity Complete notes by discussion among themselves.</li> </ol> <p>Guided study (I.K. available)</p>	<ol style="list-style-type: none"> <li>1. Evaluation</li> <li>2. Conceptualization of own role and to write a Para on how they visualize themselves using the knowledge they are gaining.</li> <li>3. Readings : p 46 to 62</li> <li>4. Evaluation of the film seen to-day.</li> </ol>
<p>Wednesday 3 Sep 9.30 a.m. to 10.30 a.m</p>	<p>Role of the Nurse/PH Nurse, Midwife and other health-worker in FP programmes</p> <ol style="list-style-type: none"> <li>1. Discussion on self concept</li> <li>2. Overall role (lecture discussion)</li> </ol> <p>Case finding- Motivation and referral, clinical, supervisory, administrative and educational roles.</p>	<ol style="list-style-type: none"> <li>1. Students to take each method of contraception and evaluate it using the "characteristics of an ideal contraceptive" as criteria.</li> </ol> <p>(Format provided)</p>

Day, date and timings	Teaching/learning activities Classroom/Field/Group work	Student activity and assignments
Wednesday 3 Sep  11.30 a.m to 1.30 p.m	3. Home visiting for case finding motivation and referral (Group leaders : I.Kamal, Halima & Fadooma Haj.  using areas served by 3 MCH Centres i.e one urban and 2 peri-urban)	2. Keep record of each home visit (Format provided)
Thursday 4 Sep  9.00 a.m to 10.30 a.m   11. a.m. to 1.30 p.m	"Talking Family Planning"  1. Discussion on yesterday's experience of home visiting  2. Role play using yesterday's experience for difficult situations of the field  3. Role definition for purposes of Training  4. Home visiting (change of group members and areas)	For to-morrow morning's discussion Each student to select a training course for a group of students and define their role obligation "after training".
Saturday 6 Sep  9.00 a.m to 10.30 a.m   11.30 a.m. to 1.30 p.m   3.00 p.m to 6.00 p.m	1. <u>Group 1</u> : self activity - group work to discuss "Role definition"  2. <u>Group 2</u> : Supervised clinical experience in the MCH Centre.  3. Lecture discussion on The Training Process and steps involved in a training activity.  4. Individual guidance by I.K.	Each student to write ten objectives for the training course which they have selected.

Day, date & timings	Teaching/learning activities Classroom/Field/Group work	Student activity and assignments
<p>Sunday 7 Sep</p> <p>9.00 a.m to 10.30 a.m</p> <p>11 a.m to 1.30 p.m</p> <p>3.00 p.m to 6.00 p.m</p>	<p>1. <u>Group 2</u> : Self activity. Group work to discuss "role definition"</p> <p>2. <u>Group 1</u> :Supervised clinical experience in the MCH Centre</p> <p>3. Lecture discussion on Developing a curriculum</p> <p>Defining objectives in terms of Observable behaviour (continued)</p> <p>4. Individual guidance for analysing objectives ( by I.K.)</p>	<p>Rewrite objectives after analysis.</p>
<p>Monday 8 Sep</p> <p>9.00 a.m to 11.00 a.m</p> <p>11.30 a.m. to 1.30 p.m.</p> <p>3 p.m. to 6. p.m</p>	<p><u>Group 1</u> : Self activity. Group work for defining content</p> <p><u>Group 2</u>.: Supervised clinical experience</p> <p>Lecture-discussion on Developing a curriculum (contd)</p> <p>Defining content and teaching methods.</p> <p>Individual guidance by I.K.</p>	<p>Each student will take 5 objectives and develop them further to define content and teaching methods.</p>
<p>Tuesday 9 Sep</p> <p>9.00 a.m to 11.00 a.m</p> <p>11.30 a.m. to 1.30 p.m</p> <p>3 p.m. to 6 p.m</p>	<p><u>GROUP 2</u> : Self activity- Group work for defining content</p> <p><u>GROUP 1</u> : Supervised clinical experience</p> <p>1. Evaluation as a component of the training process; Its principles and methodology.</p> <p>2. Defining levels of competence</p> <p>Individual guidance by I.K.</p>	<p>Each student will develop 2 questions to measure the outcome of learning of one objective according of the level of competence expected to be achieved by the student.</p>

## Appendix 2

Training of Trainers  
30 August to 10 September 1980

Mogadishu, Somalia

- List of Participants -

<u>Name</u>	<u>Designation</u>
<u>A. Directorate of MCH/FP</u>	
1. Mrs. Halima Abdi Sheikh	Senior Supervisor of MCH Centres
2. Mrs. Fadooma Haji Mohammad Abukar	Supervisor MCH/FP
3. Mrs. Maryam Ali Mohammad	"
4. Mrs. Momina Afrah Haribè	"
5. Mrs. Fadooma Mohammad Ossoble	"
<u>B. Health Personnel Training Institute Mogadishu</u>	
6. Mr. Omer Mohammed Ibrahim	Principal Tutor
7. Mrs. Khadija Issa Karish	Instructor, Nurse-statistician
8. Mrs. Mohibbo Mohammed Dirra	Instructor, Laboratory Technician
<u>C. School of Nursing Mogadishu</u>	
9. Miss Ayal Mireh Moosa	Nurse-Tutor
<u>D. Binadar Teaching Hospital, Mogadishu</u>	
10. Mrs. Abaido Musa Ali	Nursing Superintendent
11. Miss Makko Awad Warsami	Nurse incharge of Gyn.Ward
<u>E. Yaqshi MCH Centre, Mogadishu</u>	
12. Mrs. Zahra Mohammad Mustafa *	Senior Public Health Nurse
* (attended 3 days of clinical training only)	

Appendix 3

P A R T I.

**Need for dissemination of Information and Education, and provision of services for spacing pregnancies, to the fertile couples of Somalia. \***

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The National Health Plan for 1980-85 aims at improving quality of life by extension of health facilities and by increasing the numbers of the trained health personnel.

The available health care facilities, which at present are far from adequate, are mainly within the reach of urban and peri-urban population.

This is one of the major contributing factors for high morbidity and mortality rates in general and for maternal and infant morbidity and mortality in particular.

Even though country-wide statistics for maternal mortality are not available, figures from one hospital revealed that maternal mortality (related to obstetrical causes of death) is 11 per thousand births.

More than half of country's total deaths take place before the children reach the age of 5.

The infant mortality rate is estimated at between 150 and 177 per thousand live births.

Half of the paediatric hospital beds are occupied by children of one year or under. Intestinal infectious diseases and respiratory diseases account for half of the infant morbidity and mortality.

FAO's survey in 1969 had provided enough evidence that the average person's diet is either inadequate or unbalanced. Nutrition deficiencies and anemias still remain the common causes of general morbidity and mortality.

A contributing factor for high maternal mortality and morbidity is the fertility rate which is estimated at an average of 6-7 children per fertile woman. The frequent and unspaced pregnancies result in continuous maternal depletion. A next pregnancy during lactation interrupts breast feeding and results in infant depletion.

Maternal depletion makes every subsequent pregnancy more risky thus predisposing the mother to disease. Similarly the infant depletion predisposes the infant to disease.

A pregnancy which takes place within a year of the birth of the last child, affects 3 lives adversely i.e. the mother, the youngest child and the foetus.

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\* this material was prepared by MENARO's PO (TR) upon the request of Director MCH/FP Somalia, for H.E. the Health Minister of Somalia.

- a. It affects the mother because her body has not had the time to return to its normal state. Her uterine and abdominal muscles have not regained their tone. Her physical strength has not been replenished and she is still anaemic from her previous pregnancy. The next pregnancy, because unspaced, predisposes her to many risks during pregnancy. Abortion, ante and post-partum haemorrhage, toxemias of pregnancies leading to infant and maternal morbidity and mortality are directly linked with multiparity and intervals between pregnancies. Age of the mother is another factor which contributes to maternal mortality, i.e. The older the woman, the higher the possibility of maternal morbidity and mortality.
- b. The breast fed baby is affected because breast feeding is interrupted. Sudden weaning often results in Kwashiorkor (The word itself means the second baby). Bottle feeding in the hands of an illiterate or overwork ; or unwell mother is a known cause of gastroenteritis, underfeeding and occasionally over-feeding. The pregnant mother whose own health is less than optimum cannot be expected to care for the youngest child (and the rest of the family) properly.
- c. The foetus suffers because it does not receive proper nutrition from a malnourished, anaemic and often sick mother. Malpresentations, malpositions, placenta praevia, and uterine inertia result in obstetrical problems which coupled with inavailability of professional assistance increase the possibilities of pre-natal/perinatal deaths, as well as premature births.

The following three tables are taken from the statistics of the developed countries. It is not difficult to conclude that these figures are much higher in the developing countries.

Table I. Deaths of mothers according to age (U.S.A.)

<u>Maternal Age</u>	<u>Maternal Deaths per 10,000 births</u>
Under 20	5.1
20-29	6.6
30-39	13.8
40 +	34.3

Table II. Deaths of babies according to number of pregnancies (U.K)

<u>Pregnancy number</u>	<u>Perinatal mortality rate per 1000 births</u>
1	24.2
2	26.7
3	30.0
4	33.8
5	50.5

Table III. Prematurity rate by intervals between pregnancies (U.S.A)

<u>Pregnancy interval</u>	<u>Premature births</u>
No previous pregnancy	11 %
Less than 12 months	18 %
12 -23 months	10.3 %
More than 23 months	7.8 %

For Somalia, the exact figures for pregnancy wastage are not known. But if perinatal deaths and abortions are added to the 15-17 % infant mortality the rate will be between 20-25 %. This means that for every 100 conceptions there are between 75-80 children that survive beyond the age of one year.

Any pregnancy that does not promise a living child is a drain on the mother's body, on the family's, the community's and the country's resources.

If out of 100 pregnancies only 75-80 pregnancies will be fruitful then the alternative is to avoid the wastage as much as possible. This can be done, partly, by helping the couples to space their children.

This is preventive medicine and in No Way contradictory to the pronatalistic policy of the Somali Government. Child spacing will only prevent the 20-25% pregnancies that were wasted and in cases of infant and maternal deaths leaving the families less healthy and less happy. It will prevent the utilisation of health services for fruitless pregnancies and improve the chancer of sruvival of every baby born. THis is also not contradictory to the beliefs of the people of Somalia who are Muslims. In Islam breast feeding is propagated for 2 years. To be able to breast-feed a child the mother has to make sure that she does not become pregnant for these 2 years.

#### Conclusion

In the interest of maternal and child health, family's welfare and happiness and the pronatalistic policy of the Government of Somalia, it is important that every child born should have the maximum possible chances of reaching adulthood where he can be a productive and useful citizen. It is therefore important that all known factors that predispose the mother and the child to various diseases and danger of death should be dealt with and removed as far as is possible within the available resources of the country.

Preventive medicine should include spacing of pregnancies as an integral part. The parents should be warned of the risks of unspaced and frequent child bearing and provided with information and means of spacing their children.

All categories of health personnel should be equipped with knowledge and skills to disseminate information as a part of their routine duties of health education.

The MCH Centres are the best institutions to provide services to the desirous mothers/couples for the regulation of their fertility. This service should be given as a part of the MCH services and can be provided when the mother brings her children for immunization as well as during the health workers' contact with the people while providing door to door health services.

The health personnel will have to be trained for this added responsibility.

It is suggested that all categories of health personnel should be prepared for this role before they leave their training schools/institutes i.e. preservice training. Those already trained and employed can be given short courses i.e. inservice training.

Those working in the MCH centres need not be given special courses. They should be given on the job training when the child spacing services are added to the MCH services.

To make this training possible, the curricula have to be developed for various categories of health personnel and the trainers have to be trained to impart training.

A very realistic and simple plan is being enclosed herewith as appendix "A". It has been tried out in many developing countries with situations similar to that of Somalia and has proved practicable and effective.

Evaluation of training by the trainees

All trainees said that :

- .. They know enough about FP to be able to talk about it to clients, to teach it as a subject and to answer questions about the various methods of child spacing.
- .. They would need some supervised practice before they can run a family planning clinic independently.
- .. They will need help for finalising the curriculum and while conducting their first training course.
- .. The time was too short. In spite of working upto 6 p.m (at times longer) they did not get enough practice in developing various parts of a training plan.
- .. The approach used for teaching was new for them. It was "interesting and stimulating but very tiring."
- .. A lot of time could have been saved if every one had been punctual. (This problem was caused by transport difficulties).
- .. They did not have the copies of the material developed and used by the writer (They were promised copies. The senior MCH Supervisor has a complete set which will be stenciled and cyclostyled).

Day, date & timings	Teaching/learning activities Classroom/Field/Group work	Student activity and assignments
Wednesday 10 Sep.  9.00 a.m. to 11.00 a.m.	Analysis of individual student's work by the Group	Assignment for the next 6 weeks :  "Pool your work done individually and develop a complete unit for teaching FP to student nurses".
11.30 a.m. to 1.30 p.m.	Evaluation of the training course	

P A R T II.

Indications of acceptance  
of Child Spacing in Mogadishu

The facts presented below were collected by the eleven trainees during home visits and work sessions in the MCH Centres.

Areas used for home visits were Hodon, El Goab and Dheze. This choice represented urban and sub-urban population which is being served by the MCH centres located in these areas.

Areas used for supervised clinical practice were Wadi Gir and Yaqshi which are located on the out skirts of Mogadishu.

All women, interviewed or examined are below the age of 35 and married.

25 women were visited in their homes and 47 were examined in the two MCH Centres out of these 72 women, two were childless, 2 were pregnant and had come for ante-natal care, two were pregnant without knowing as they were depending on lactation for child spacing and had become pregnant without menstruating.

In the remaining 66 there were only 2 who said they did not want Family Planning. 64 of them said they were "tired" and wanted to "rest" for at least 2 years before becoming pregnant again. 7 women agreed to have IUD. They were referred to El-Goab clinic, which is the only clinic providing this service. One husband had bought a packet of Neogynon from the market but the wife had not started using it because she did not know how to.

2 women said, "God has sent you for me. I have been praying that some one would tell me what to do."

A mother of 7 (youngest two are twins) said her husband spends all the time with the other wife because she has only one child. He says, "There is too much noise in this house. I get no peace."

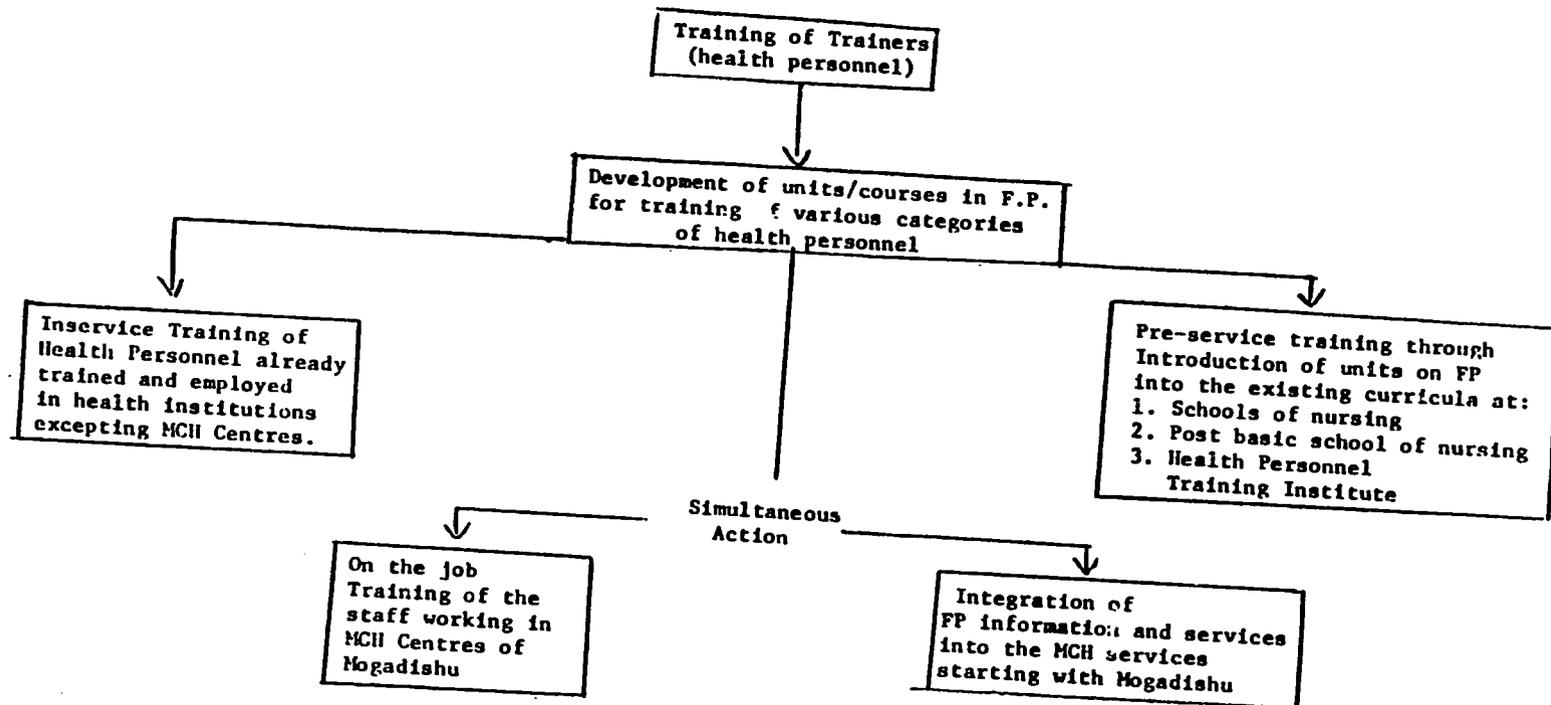
Those wanting to "rest" were all multiparous women having been pregnant 2 to 13 times. With the exception of 5, all others had lost one or more pregnancies through abortion, stillbirth or infant death.

All women were anaemic with the exception of two. This of course was judged only by the physical signs and not by laboratory examination.

The number of mothers contacted is too small to be of definite significance but it had surprised even the trainees who had expected a lot of negative response.

The Suggested Plan

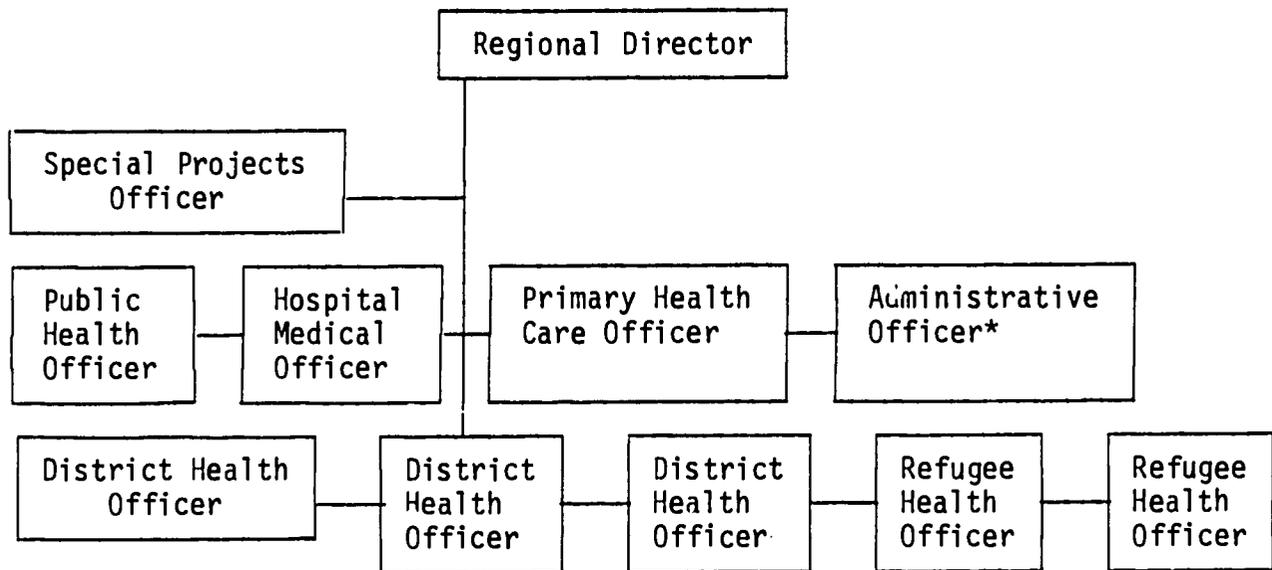
Objective : To initiate action in Mogadishu for eventually providing the fertile couples of Somalia, information and services to help them to space their children.



should be placed with regional health coordinators, and the design of data systems should reflect their potential use of control data.

The current situation in the regions does not permit this degree of regional autonomy. In some areas, the RHC is the senior doctor in the (regional) hospital, has little staff support, and little time to supervise or train staff in management. Additional authority for the internal reallocation of budgets, or staff, or to select services for special development would require management ability which is not present everywhere, and management support services which are not present at all.

Over the long term, it would be sound to increase the strength of the regional office. This can be done by recognizing (see structure outlined below) the integrating role that the office should play.




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\* Statistics, finance, personnel, supplies, transport, construction, and maintenance.

The roles are clear, with the exception of the special projects officer. This position would handle special activities, such as integrating vertical health programs into the region, coordinating inter-regional training, doing special on-site evaluations, etc. It also would be a training position for persons ready to move into responsible regional positions.

Such a structure can only be a goal, but for regions such as the Northwest and Lower Shabali, it is not unrealistic. Strengthening the regions is a prerequisite to effective decentralization.

- child care; and
- personal hygiene and environmental sanitation.

In addition, the Somali language, political education, and various general subjects are taught.

When the mothers finish this program they either can go on to the skill-training program, which lasts two years, or leave with a certificate that indicates successful completion of the Family Life Education Program.

### Skill-Training

The program in skill-training is carried out in all regions. Officials hope to extend it to all the districts.

A two-year program, it covers two kinds of training: sewing (dress-making) and handcrafts. The aim of this program is to teach women special skills to enable them to participate in income-generating activities or cottage industries, or to work in other industries and hotels.

COURSES OF STUDY

Family Life Education

The Family Life Education Program is sixteen months. Each year of the program is eight months. The following courses are taught.

A. Home Management and Home Improvement

- The needs of the pregnant mother
- Planning for the baby's arrival
- Feeding of infants (food requirements of different infants)
- Children's clothes
- Importance of taking children to hospitals for treatment or immunization
- Exercise

B. Food and Nutrition

- What food and nutrition are
- How proper food is prepared in the home
- Improvement of food
- Growing food at home (home gardening)
- Preserving and storing fruits and vegetables and using these foods out of season
- Exercise

C. Health Education

- Important principles of health
- Human body and its physiology

- Good habits of health (personal health and hygiene)
- First-aid and treatment of illness in the home
- Importance of safe drinking water
- Cleanliness of bath space and bath facilities
- Communicable diseases and their prevention
- Importance of going to hospitals
- Exercise

D. Handcraft.

- Construction of articles (baskets, mats, fans, brooms, bags, etc.) using various kinds of traditional materials, such as banana and palm leaves, sisal, egg shell, etc.
- Making toys for children
- Exercise

E. Textiles and Clothing Construction

- Importance of sewing skills
- Fundamentals of hand-sewing and embroidery
- Hand-sewing of baby garments
- Use and care of sewing machine
- Sewing by machine baby's garment (little girl's dress)
- Mending and repairing the family's clothing
- Exercise

F. Political Education

- Declaration of Somali Revolution
- Reason of 21 October Revolution

## H-5

- Improvements and changes in Somalia after the Revolution
- Importance of writing in the Somali language
- Exercise

### G. Somali Language and Mathematics

- Reading and writing
- Improving writing, writing meaningful words
- The four mathematics operations
- Methods of measuring (by meter, ruler, etc.)
- Methods of weighing
- Exercise

Exhibit 1

ORGANIZATION OF THE MINISTRY OF HEALTH

