

MEMORANDUM

Date: January 15, 1986

To: Dir, Mr. Louis A. Cohen

Thru: RD/RA, E. Tolle *ET*

From: RD/RA, Marion Warren *MW*

Subject: End of Project Report, Rural Health Delivery
Project (649-0102)

Attached for your review is the required end-of-project report on the Rural Health Delivery (RHD) Project (649-0102), following guidelines in Handbook 3.

I have not been able to systematically address all issues recommended for inclusion in such a report. Since no end-of-project evaluation was conducted, it is not possible to fully establish the status of project activities as of PACD, September 30, 1985. Nor was it possible to fully assess impact on beneficiaries, the extent to which stated objectives have been achieved, or the extent to which activities are being sustained by the Ministry of Health. Wherever possible, I used quantified data to indicate Project status or outputs. In other instances, I have had to depend on descriptive documents, hearsay, and information gleaned from discussions with MOH personnel. In a few instances, I could not come up with a definitive answer. The targets used in this report are those that contained under the 1984 revised Project.

cc: DDir: G.Nelson
Proj: E.Birgells
Prog: A.Martinez

BEST AVAILABLE

Background

The Rural Health Delivery (RHD) Project (649-0102) was a 6-year project authorized at a level of \$15.2 million (grant) to assist the Somali Government develop the institutional capability to provide basic health care services to 800,000 rural and nomadic peoples. The Government's contribution was to be \$5.2 million.

These health care services were to be provided in 4 regions (Bay, Togdheer, Mudug, Lower Juba) by a cadre of local community workers trained in primary health care (PHC) skills. Besides developing a trained cadre of PHC workers, the Project was to establish facilities and a program that would be used on a continuing basis, to train new workers and upgrade the skills of others. The training program, the cadre of health care workers, and an infrastructure of health posts and PHC units, were all components of a PHC service delivery model that could be replicated throughout Somalia.

AID's inputs were technical assistance, training, commodities, and construction. In 1980, Medical Services Consultants, Inc. (MSCI) was awarded a contract to implement the Project's technical assistance component. In 1984, after it became clear that the Project design had been much too ambitious, and planned targets could not be achieved within six years, the scope of activities was reduced. The number of regions to be covered was cut back from four to two (Bay and Togheer). 32 PHC units would be constructed instead of 64. Two district health centers would be renovated instead of 16.

By PACD September 30, 1985, actual expenditures amounted to \$8.4 million. A request for an extension of LOP was denied by AID/W , and the Project came to an official close on that date.

Planned and Actual Project Outputs

	<u>Planned Outputs</u>	<u>Actual Outputs</u>
<u>Training</u>	975 Community Health Workers (CHW) and Traditional Birth Attendants (TBA)	82
	315 primary health care unit and district health center staff	250
	27 vital statistics personnel	13

	10 personnel directors for health management	Not known
	10 medical doctors	0
	25 U.S. participants (from above categories)	6
	8 accountants	0
	4 store keepers	0
	8 mechanics	14
<u>Construction</u>	2 regional training centers built	2
	32 primary health care units built	7
	1 garage/warehouse and supply depot built and equipped	1
	8 district health centers renovated	0
<u>Other</u>	supervisory and management system established and functioning	no
	Maternal Child Health (MCH), Expanded Immunization Program (EPI), Refugee Health Unit (RHU), TB, Malaria functions integrated into Primary Health Care System	no
	Health education program established	no
	Logistical support system for storing and distributing supplies in place and functioning	no

Planned and Actual Inputs

AID/MSCI

<u>Planned Inputs</u>	<u>Actual Inputs</u>
493 long-term person-months of technical assistance	476
76 short-term person-months of technical assistance	57
34 vehicles	36
drugs, equipment, supplies, building materials	quantities not known

MOH

Maintain Project vehicles in good working order, and provide adequate fuel	no
Make available an adequate number of qualified personnel for training	yes
Provide a schedule for providing inputs and recurrent cost support	no
Ensure that health care facilities are maintained and supplied with necessary equipment and supplies on a continuing and timely basis	no

The most apparent conclusion that emerges from these figures is that actual inputs and outputs were generally less than had been planned. In some instance, the actual falls far short of the planned. There is general agreement among all the relevant documents that the Project failed to reach planned targets because it was overambitious, badly managed, and rested too heavily on an institution (MOH) that was incapable of carrying its share of the implementation burden.

While MSCI is occasionally faulted for its failure to maintain open communication with the Ministry and to provide qualified staff, it is USAID that is most criticized. The Mission in 1980 did not have the capability to handle (as it was supposed to do) commodity procurement, construction, and contractor support functions (housing, vehicle and equipment maintenance, etc.) The results were long delays in procurement and construction; the procurement of inappropriate commodities; no systematic tracking of commodities; and inadequate support for contract staff.

As has been already suggested, the MOH is a weak institution, without the resources to maintain a sustained flow of health services, supplies, and equipment to rural areas. Like USAID, the MOH could not fulfill its responsibilities to the Project. It could not maintain Project vehicles in good working order, nor could it ensure an adequate supply of petrol. MOH employees at Project sites frequently went unpaid, or did not receive their entire salary. Since the MOH had no system for procuring, storing, distributing, and maintaining an inventory on, medical supplies and equipment, it could not keep Project facilities regularly provisioned with needed pharmaceutical items or training materials.

END OF PROJECT STATUS (EOPS)

Under the PP revision of 1984, the following were to be achieved by PACD September 30, 1985.

1. National training centers established and functioning, turning out a continuous supply of PHC workers for all Somalia.
2. Sufficient number of CHWs and TBAs trained to provide local health services for every village in Bay and Togdheer of 500-2000 population.
3. A functioning medical supply depot, maintenance repair center, and warehouse, with trained mechanics, to provide adequate supplies and support for PHC services.

4. A PHC infrastructure (consisting of health posts, PHC units, and district and regional health centers) that functions effectively as a conduit between villages and MOH headquarters on fiscal, administrative, managerial, and logistical matters.
5. An established system of planning, based on systematic collection and analysis of data.
6. An integrated national PHC program that encompasses MCH, Immunization, Refugee Health Unit, Tuberculosis control, and Malaria control, functions of the MOH.

Based on admittedly second-hand information, it appears that none of these EOPS indicators has been achieved. Two national training centers were established at Baidoa & Burao, but neither one is currently in operation.

The MOH does have a vehicle maintenance and warehousing depot; but has too few trained staff and supplies to adequately serve the needs of either the MOH or the regions.

The numbers of trained CHWS and TBAs in Bay and Togdheer are still small (80+) and short of the 975 deemed necessary to service every village of 500-2000 population.

A PHC infrastructure does exist, but it barely functions. Again, for lack of trained staff and all other resources, the MOH is unable to establish a truly national integrated PHC system. For these same reasons, there are no effective planning, data collection and analysis procedures in place. While there is some recognition that PHC should be the "centerpiece" as it were, of MOH activities, and should therefore be incorporated with related Ministry functions (MCH, EPI, RHU, TB, Malaria), this has not happened.

Accomplishments

Under the revised PP, the goal of the Project was to improve the health of Somalia's rural and nomadic populations. The purposes were:

- (1) to deliver PHC service to two population groups -- rural settled and nomadic peoples.
- (2) to establish training programs capable of providing PHC workers and supervisory staff for the entire country.
- (3) to develop a primary health care delivery model replicable for the entire country.

It is fair to say that the RHD Project while in operation, contributed to efforts to achieve these objectives, especially in the case of Purposes (2) and (3). The Project built, equipped, and staffed two national training centers for short course training of PHC workers. Furthermore, as Somalia's first attempt to establish a country-wide health delivery system, the Project did have some "demonstration effect" that has raised appreciation for the potential which the PHC model offers for improving health conditions in rural areas.

What is particularly unfortunate is that virtually none of its accomplishments is being sustained.