

FAMILY HEALTH SERVICES PROJECT

FINAL EVALUATION

APRIL 2, 1989

001240

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## TEAM MEMBERS

Victor K. Barbiero, Ph.D. (Team Leader)  
RHPNO  
REDSO.ESA  
Box 30261  
Nairobi, Kenya

Anita Bennetts, CNM, DrPH  
Bennetts and Associates  
Health Services Consultant  
2141 Northwest Davis  
Portland, OR 97210

Jenny Huddart, Vice President  
Initiatives Incorporated  
239 Commonwealth Avenue  
Boston, MA 02116

Carol Valentine, MPH  
Consultant in Public Health  
370 First Avenue  
New York, N.Y. 10010

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## LIST OF ACRONYMS

AID/W	Agency for International Development/Washington
CBD	Commodity Based Distribution
CDC	Curriculum Development Center
CDSS	Country Development Strategy Statement
CS	Child Survival
CSD	Central Statistics Department
CSM	Contraceptive Social Marketing
CTO	Cognizant Technical Officer
DfA	Development Fund for Africa
DH	Direct Hire
DHS	Demographic Health Survey
EOP	End of Project
ESF	Economic Support Fund
FH	Family Health
FH/FP	Family Health/Family Planning
FHS	Family Health Services
FSN	Foreign Service National
GDO	General Development Officer
GOI	Government of Italy
GSDR	Government of Somali Democratic Republic
H/CS	Health/Child Survival
IA	Implementing Agency
IEC	Information, Education, Communication
IPPF	International Planned Parenthood Federation
IWE	Institute for Women's Education
KAP	Knowledge, Attitudes, Practices
LOE	Level of Effort
LOP	Life of Project
MING	Ministry of Information and National Guidance
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOI	Ministry of Interior
MOJRA	Ministry of Justice and Religious Affairs
MONP	Ministry of National Planning
NGO	Non-Governmental Organization
NLT	No Later Than
OR	Operations Research
OJT	On The Job Training
PACD	Project Activities Completion Date
PID	Project Identification Document
PL	Public Law
PP	Project Paper
PPSD	Public and Private Sector Office
RMO	Regional Medical Officer
SES	Socio-Economic Status
SFHCA	Somali Family Health Care Association
SWDO	Somali Women's Democratic Organization
TA	Technical Assistance
UNDP	United Nations Development Program

UNFPA United Nations Fund for Population Activities  
UNICEF United Nations Children's Emergency Fund  
URC University Research Corporation  
USAID/S United States Agency for International Development  
Somalia  
WB World Bank  
WHO World Health Organization

## EXECUTIVE SUMMARY

### A. PURPOSE AND METHODOLOGY

The purpose of this evaluation is to review the performance of the Family Health Services (FHS) Project to date. It represents a final evaluation for the Project based on a Project Activities Completion Date (PACD) of December 31, 1989. An underlying purpose was to provide USAID/S with insight into options for project extension and a future follow-on project. The report presents findings, conclusions and recommendations on 12 topics, supported by more detailed annexes.

The methodology used was a review of the extensive documentation available on the Project, amplified by formal and informal interviews with GSDR officials, Implementing Agency (IA) Directors, USAID/S staff and contractor personnel. Field trips were made to Bay and Lower Shebelle regions to observe service delivery and IEC activities at the town and village levels. A concerted effort was made to expose the team to all Project components in rural and urban areas. Observations and interviews were conducted by the team jointly and individually. An internal Mission review of a draft of the report was held on March 29, 1989 and appropriate revisions were incorporated into the report. The report was then shared with the Director General of the Ministry of National Planning and the implementing agencies.

### B. FINDINGS AND RECOMMENDATIONS

Project personnel and Mission staff view the Project very positively. It fills an important gap in donor assistance in Somalia and complements activities of the other donors who are active in health and population. Agency support for project activities should continue.

It is estimated that \$1,750,000 will remain in the FHS Project as of December 31, 1989, the current PACD. These funds could be utilized to finance an extension of the Project. Local currency support will total approximately 127 million Ssh this year. Except for the overall issue of personnel compensation, this level appears to be adequate. Contracting issues make the role of URC beyond the present PACD problematic.

The Project's technical approach towards planned targets is sound, although original targets may have been somewhat ambitious. Cooperation is manifest in the joint activities of the Somali Family Health Care Association (SFHCA) and other Somali Implementing Agencies.

Important progress towards policy reform in family health, family planning and female circumcision can be attributed to Project efforts. Although a formal national policy is not yet in place, compared to the situation four years ago, progress is remarkable.

Project activities have been diverse, and more time and effort could have been devoted to strategic planning. More contractor and USAID/S efforts in this regard would have been worthwhile and should be highlighted in the future.

Although coordination at the implementation level has progressed well, too much verticality still exists. Higher levels of coordination are also needed, and further integration of service delivery and IEC is of paramount importance. Focused linkages between service delivery and IEC efforts in the five IEC regions (Benadir, Bay, Middle Shebelle, Lower Shebelle, Lower Juba) is also clearly needed, but the assessment of regional training needs represents an important step toward improved coordination between Ministry of Health's central and regional offices.

Commodity support has been significant and includes transport, computers, materials production equipment, spare parts and maintenance contracts. Future maintenance is a critical issue.

Contraceptive social marketing (CSM), although appealing, may not enjoy a critical mass of commodity demand. However, this should be explored in more detail.

Somali politicians, religious leaders and citizens appreciate the need to improve the well-being of mothers and children, and perceive Project activities in these terms. Future Agency programming in family health (if approved) should consider this perception in their DFA accounting.

Targets set during the project period have no discernible empirical basis and cannot be endorsed by the team. A revised set of benchmarks should be established which include policy reform, training, strategy development, IEC/service delivery links, and implementation of a regional focus.

Management information has focused on the development of forms and data collection. However, the data are not used for decision-making. This must be addressed in the future.

Operations research has fallen short of its expectations. Future efforts should solely concern the design, execution, analysis and reporting of a KAP/FH survey.

The overseas training plan submitted for FY 89 is overly ambitious. Future overseas tours/training should focus on policy reform and management.

The resource center at SFHCA is under-utilized and should be incorporated into the center at the Institute for Women's Education. Needed renovations are planned and budgeted for the MOH, IWE and CDC.

Major recommendations concerning these findings are as follows.

- o Extension of the PACD - The PACD of the FHS Project should be extended through December 30, 1991, with funds available in the Project used to finance the extension.
- o Project Focus - A more focused set of activities should be pursued which highlight policy development, revised IEC strategy (urban/rural linkages), assessment of awareness of FH, long-term strategy development for implementing agencies, targeted training, and a five region focus for coordination of IEC and service delivery efforts.
- o Policy Development - Efforts towards policy statements in family health/family planning and elimination of traumatic female circumcision should be continued and emphasized throughout the extension period.
- o Strategy Development - The FHS Project should attempt to develop a strategy which links routine project implementation (i.e. service delivery, IEC, training) with long-term policy/program planning.
- o Project Coordination - A new committee structure for family health should be established consisting of a Family Health Policy Coordinating Committee, a Family Health Program Coordinating Committee, and an FHS Project Implementing Directors' Committee.
- o Sustainability - Short-term TA should be provided to the IAs during the FHS Project extension period to assist them in the development of strategies for sustaining their family health activities, and, proposal preparation and submission to other funding organizations.

- o IEC Strategy - Within the framework of the overall strategy for the development of the national family health program, the implementing agencies need to develop a clear IEC strategy defining the population groups to be targeted, the messages to be delivered to these groups, and the methods of delivery.
- o Project Orientation - Current emphases regarding population, health, and child survival are appropriate.
- o Project Indicators - A revised set of indicators to measure achievements throughout the project extension period should be established.
- o Information Management - Short-term technical assistance and training should be provided to evaluate the current MIS and to assist FH providers and managers in the collection and use of family health data for planning, monitoring, supervision, contraceptive distribution and general decision-making.
- o Operations Research - The OR component of the FHS Project should concentrate solely on the development and execution of a region-wide KAP/FH survey. This should include close cooperation with external short-term advisors.
- o Equipment Maintenance - Detailed arrangements need to be made for the installation, routine maintenance and repair of all major equipment purchased through the Project. USAID/S should explore the maintenance of the CSD system and site with CALWANG, UNFPA and the GOI to discern how the contracting and training issues will be addressed.

II. DESCRIPTION OF THE PROJECT

A. **OVERVIEW** - The Family Health Services (FHS) Project was authorized July 8, 1984. The life of project commitment (LOP) was \$10.1 million with a PACD of December 31, 1989. The purpose of the Project is to strengthen the capability of Somali institutions to promote, support, coordinate and sustain family health programs. Four major components were included in the project paper. They are: 1) collection and analysis of demographic data; 2) information, education and communication (IEC); 3) delivery of clinical services; and 4) operations research. Planned USD contributions from USAID/S were anticipated as follows: \$4.3 million for technical assistance (TA); \$4. million for training; \$4.3 million for commodities; \$1.1 million for contingency. It was anticipated that the GSDR would contribute the equivalent of approximately \$10 million in local currency. As of March 15, 1989 the FHS pipeline totalled \$1,754,000 (Annex I).

Central to the Project's activities have been efforts to establish a coordinating entity within the Somali health care system which emphasizes family/maternal health through child spacing. Six Somali institutions are recipients of Project support. The Somali Family Health Care Association (SFHCA) coordinates the family health activities of five other Somali institutions; i.e. the Somali Women's Democratic Organization (SWDO), the Institute for Women's Education (IWE), the Family Health/Family Planning Division (FH/FP) of the Ministry of Health, the Curriculum Development Center (CDC) of the Ministry of Education, and the Central Statistics Department (CSD) of the Ministry of National Planning (MONP). The Project also supports an advisory unit through a contract with the University Research Corporation (URC). This unit supports two full-time staff which provide technical, procurement and administrative assistance. The grant is administered by the MONP's Director General.

B. **BACKGROUND** - The rationale for USAID/S's investment into the FHS Project is anchored in high rates of maternal and child mortality and the inverse relationship between population growth and economic development. Today, as in 1984, maternal mortality and high population growth continue to hamper the economic development of Somalia. Since negative attitudes regarding reduced fertility permeate Somali society, the Project's approach to promotion of family health as a vehicle for improved child spacing was (and remains) appropriate.

Project efforts have directly contributed to subtle changes in perceptions of the value of family planning on the part of Somali religious and political leaders, and to some extent the population at large. Albeit this directly relates to policy trends, to date no official policy has been derived. By virtue of the Project's design, an array of project outputs were anticipated (Annex II). Unfortunately, the total realization of each project output wanes somewhat in relation to the difficulties facing effective service delivery and the inability of the GSDR to support commodity and service delivery without external assistance. However, important progress has been made in improving indigenous skills, gathering of census data, cooperation among implementing agencies, development/production of educational materials, and improved awareness of family health. Present project activities require focus in key areas such as assessment of impact, policy development, strategic planning, service delivery and program management.

C. MAJOR ISSUES - Major issues associated with implementation in the past and future concern the ability of the GSDR to support development efforts (including recurrent costs) given the present state of the Somali economy. It is likely that additional donor support in most sectors will be required well into the 1990's. However, specific issues should be addressed during the extension period of the FHS Project to improve the success and enhance sustainability over the long-term. These issues are as follows.

- o Policy Development - Family health (particularly family planning) awareness of political and religious leaders has increased significantly since the project's inception. An official national family planning/child spacing policy would greatly enhance all aspects of family health in Somalia.
- o Project Objectives - Project contributions to training, institutional strengthening and political awareness are noteworthy and should be encouraged. However, the scope of the Project's family planning objectives might be refocused in light of cultural mores concerning use of family planning methods, difficulties in assessing project impact on general awareness, and other maternal/child health priorities.
- o Sustainability - The FHS Project can be proud of its success in institutional strengthening. However, implementing agencies, particularly the SFHCA, should

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explore additional means of support for operations. Some of the implementing agencies will require moderate support in the future (Curriculum Development Center (CDC), Central Statistics Department (CSD). Some will require continued (and possibly enhanced) support (IWE).

- o Commodity Procurement and Distribution - Effective health service delivery depends on an adequate system to deliver, monitor and resupply outreach centers with commodities. Insufficient stocks and inadequate delivery hamper the provision of services and consequently may depress user rates. Future emphasis on management training and institutional strengthening in this area is important.
- o Service Delivery - Health Service Delivery in Somalia is difficult given sizable nomadic populations, logistic difficulties, civil strife and recurrent cost burdens. The FHS project, through the implementing agencies, need to discern how to become more involved in the development of a more focused service delivery strategy in the regions its serves.
- o Census/Demographic Data - It is likely that an analysis of the census data will not be available until 1991. Assurance of the application of these data in national policy planning is of paramount importance. Maintenance of the system throughout the project extension period must be assured
- o Donor Investments (Gaps Filled by USAID/S) - Regrettably, it is unlikely that the progress made in family health can be maintained solely by the GSDR in the foreseeable future. Since other donor commitments in this area are marginal, future USAID/S support may be a critical element to the maintenance of the entire program and eventual progress toward sustainability.

### III. DEVELOPMENT BENEFITS TO DATE

- A. **OVERALL PROJECT IMPACT** - The Project can be viewed as a successful development venture. It can be safely stated that without the FHS Project, awareness of family health issues and services would have been significantly less than what exists today.
- B. **POLICY REFORM**
- o **Policy Trends** - Although a formal National Family Planning Policy is not in place, the Project has made remarkable strides in sensitizing political and religious leaders to issues related to child spacing, maternal health and family planning.
  - o **Increased Awareness** - Awareness of family health/family planning issues has been impressive at the central level. Outreach to rural areas is beginning to emerge, but actual levels of awareness are difficult to assess. Community mobilization in terms of maternal education is progressing and, if continued, will have important implications in future family health care delivery.
  - o **Female Circumcision** - Female circumcision has been traditionally practiced in Somalia for centuries. It may be directly and/or indirectly responsible for a significant amount of maternal and infant mortality and morbidity. Project efforts to give women of child bearing age an informed choice concerning the circumcision of their children are progressing well. This issue has been addressed at the highest level of government and has been discussed in relation to Muslim Law. Although social reform will take time, progress to date is a noteworthy accomplishment of the Project.
  - o **Census Data Collection** - The Project has supported the computerization of the Statistical Department of the MONP for census data collection, entry and analysis. The division has hardware, software, and data entry personnel in place.
  - o **Population Conferences** - A second national population conference was held in Somalia in 1985 and was well attended. Proceedings were published and distributed by the Project in 1988. These included presentations of numerous macro and micro-population

perspectives on Somalia now and for the future. Recommendations concerning the management of fertility, maternal and child mortality, status of women, social and economic planning, migration and urbanization were presented.

- o National FH/FP Conference - The first National Conference on FH/FP was held in Somalia in February 1988. The Chairman of Social Affairs of the Central Committee of the SRS Party, the Minister of Health, Vice-Ministers of Health and Interior, donors, the U.S. Ambassador, and professionals from various fields attended.

### C. INFORMATION, EDUCATION AND COMMUNICATION

- o Human Resource Development/Training - In the five implementing agencies, many categories of personnel have been trained to reach the community with family health information (including breastfeeding, the benefits of child spacing and the need to eradicate female circumcision). SWDO and IWE are the lead agencies for training district leaders and communicators who then add those topics to their local outreach program. Nurses and TBAs have also been trained to carry these messages to their pre- and post-natal clinics.
- o Materials Production - Each of the five implementing agencies has an IEC Unit engaged in materials production. SFHCA takes the lead in the variety (print materials, audio-visual shows, etc.) and the content (e.g. breast-feeding, eradication of female circumcision, etc.). SFHCA also cooperates with the other IAs in their materials production, both in form and content.
- o Curriculum Development (CDC) - Text books on family health (which include information on child spacing and female circumcision) have been completed for Grades 1-6. A manual/textbook adapted from "Where There is No Doctor" has been developed. The teacher-training curriculum has been expanded to include family health topics. Some materials for in-service training have been developed. A nurses' training curriculum has also been started.

- o **Communications Strategies for Target Audiences -** Two of the implementing agencies have established constituencies to which training and educational efforts are directed. IWE and SWDO, through their respective family life centers and tabella leaders, help to convey messages to local audiences and can contribute to the development of communications strategies to expand their activities on the community level. At present, strategy elements include: a) training for community workers (to enhance their communication capabilities); b) female circumcision; c) breastfeeding, and d) child spacing.
  - o **Resource Center and SFHCA Materials Production Unit -** Equipment for producing pamphlets, brochures, posters, flip-charts, radio programs and audio-visual shows is in place at SFHCA. Graphic artists are hired through SFHCA on a contract basis. The SFHCA also hires poets, dramatists and song-writers to produce child spacing and family life messages for artistic works.
  - o **Community Level Campaigns on Health Issues -** SWDO cooperated with the IWE and MOH in three community level IEC campaigns. A fourth is being planned. The issues included female circumcision and breastfeeding.
  - o **Family Planning Compendium of Terms -** A dictionary of Somali health words is being developed to facilitate communication. Family planning terminology will be included.
  - o **Somali Fair -** The Project participated in the annual Somali Fair where it presented an exhibit on Family Health in Somalia. This exhibit enjoyed wide attendance and won second prize at the 1988 Fair.
- D. SERVICE DELIVERY**
- o **Availability of FH/FP Services -** Until the recent emergency in the north, FH/FP services were available in 55 MCH clinics within 8 regions of Somalia. Two or more staff at each clinic have received clinical skills training and periodic updates. Quarterly supervision and commodity distribution visits are made by the FH/FP Division. In addition, 30 private physicians and nurses in Benadir region have been trained in FP and supplied with contraceptives.

- o **Clinical Training Site Development** - A clinical training site is being developed at Benadir Hospital. Two additional clinics are being targeted for development as training sites in 1989. The purpose is to have high quality service delivery/training available for health providers (including physicians and nurses) at pre-service and in-service levels.
- o **FH/FP Training Center** - The FH/FP Training Center was renovated in the Offices of the FH/FP/MOH Division. The Center has opened and is stocked with training aids, charts and models. The existing inventory is being catalogued and additional materials and publications are being sought.
- o **Clinical Monitoring System** - A clinical monitoring system has been initiated in the MCH clinics for the evaluation of FH/FP services. Supervisory checklist are in place to monitor OJT training and patient care delivery.
- o **Logistics System** - The MOH has the beginnings of a system in place to determine contraceptive needs and to manage procurement, storage and distribution of contraceptives to MOH service delivery sites.
- o **Family Planning MIS** - The MOH has developed procedures and forms for the monthly recording of information on the number of family planning clients and contraceptive utilization. Forms are completed by most of the MCH clinics in the five project regions and transmitted to the FH/FP Division at the central MOH. Individual client record cards have been designed and a pilot test is being conducted in one region. Collaboration with the MCH Division is also underway to develop an integrated, monthly MCH reporting format which includes family planning data linked to other MCH service indicators.
- o **Commodity Procurement** - The Project has procured a wide range of commodities for the implementing agencies. This has improved institutional capabilities, increased outreach capacity and improved general awareness.
- o **Renovation of MOH** - In 1988, a newly-renovated MOH compound became the FH/FP Division's offices. A storeroom and training resource center has also been established in that compound.

E. OPERATIONS RESEARCH

- o Operations Systems Analysis - Three studies analyzing how four IAs relate to each other in the project regions have been completed by the OR Unit of SFHCA. This data has been used for guiding IEC activities within the regions and should be helpful for regional planning purposes.

F. SUSTAINABILITY

- o Agency Coordination - Project support to the SFHCA and implementing agencies has given rise to a coordinated effort for the promotion of family health in Somalia. Urban and rural activities enjoy cooperation among participating agency personnel and to some extent shared resources. Although not perfect, intra-agency cooperation has been established and can be refined to become more effective.
- o IWE Family Health Activities - Teaching family health is now an integral part of IWE's functional literacy program for adult women in the Project's five IEC regions. Curricula and training modules have been developed and tested for breastfeeding, child spacing, nutrition, ORS and female circumcision. These modules have been used to train villager-selected community women leaders. The leaders then relay these messages to women in their home villages through weekly sessions which combine family health presentations and literacy training. More than 50 villages now have active family health IWE programs. Due to the integration of the FH messages into IWE's other educational programs, to IWE's reach into the villages, and to their network of family life centers throughout the country, the likelihood of IWE's family health activities being sustained beyond the PACD is enhanced.

IV. PREVIOUS EVALUATIONS

The only previous evaluation of the FHS Project was conducted February 28 - March 29, 1987. Major themes of the evaluation were that the Project should:

- o Stress private sector service delivery - through private practitioners and community-based distribution (CBD) channels. It was recommended that experience with different CBD modes would guide a later decision on whether to pursue a contraceptive social marketing program;
- o Focus major effort on IEC materials development - as the greatest area of need at that stage of the project. The sensitization of political and religious leaders should be a major target.
- o Give priority to improving clinical training - through attention to developing of practical skills and improving pre- and in-service training materials;
- o Encourage periodic reviews of the Project strategy - by convening meetings of the IAs, URC and USAID staff to discuss progress and to make necessary adjustments to focus and IA roles;
- o Develop the OR component of the Project - by increasing the staff of the SFHCA OR Unit and conducting small scale OR studies to evaluate FH performance and inform FH programming decisions.

V. FINDINGS AND RECOMMENDED ACTIONS

A. ACHIEVEMENT OF PROJECT OBJECTIVES AND FUTURE DIRECTIONS

A.1 Realization of Project Objectives/Programming Options

Finding - The team observed that the FH capabilities of the implementing agencies (SFHCA, FH/FP/MOH, IWE, SWDO, CDC/MOE, and CSD/MONP) have increased significantly. Five of the organizations focus on an active promotion of family health (increased awareness and/or service delivery). The sixth, CSD, has established a computerized system to enter, analyze and apply information on the National Census and to project demographic trends in Somalia. FH IEC outreach has been expanded in five regions of Somalia (Lower Shebelle, Middle Shebelle, Bay, Lower Juba, and Benadir) (Annex IV). The incorporation of FH materials into primary school curricula (through CDC) and the integration of FH training into the ongoing programs of SWDO and IWE are a lasting effort directly attributable to project investments. The FHS Project has supported a wide variety of training, TA and commodities to strengthen the participating institutions. Both urban and rural populations have benefited. Inter-agency cooperation has been a hallmark of the FHS Project and reflects the commitment and determination of the implementing agencies as well as the GSDR. Less success has been realized in service delivery, including the planning and monitoring of clinical services. The development of operations research capabilities has also not progressed rapidly and existing information should be viewed with caution.

In summary, the FHS Project's strengths have been in building a strong foundation of political and religious support, increasing general awareness, support of training, and the development of educational materials. However, much remains to be done to improve service delivery and strengthen linkages between the service delivery and IEC efforts in both urban and rural areas, and link FH/FP/MCH/PHC activities. Awareness building is only the first step towards use of a service and/or commodity. Much time is required beyond awareness building for attitudes to change. Additional time is then required to create substantial demand. Actual levels of change in awareness and use of FH/FP issues/commodities since 1985 are conjecture. An articulated national policy remains elusive. A more detailed description of achievements versus the PP's Logical Framework is presented in Annex II.

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**Conclusions/** - The team concludes that progress towards the Project Purpose: "to strengthen capabilities of Somali institutions to promote, support and coordinate family health programs..." has progressed well. However, continued efforts are needed to improve the linkages between service delivery and IEC efforts, enhance cooperation between the MOH's FH/FP, PHC and MCH divisions, promote policy development, conduct pertinent operations research, increase awareness (and use) and improve service delivery. The decision to proceed with a follow-on should be based on project performance in these areas during the extension period. Suggested benchmarks for the project extension period are presented in Section H.1.

**RECOMMENDATION** - The PACD of the FHS Project should be extended through December 30, 1991.

#### **ACTIONS**

**Implementing Agencies** - The GSDR/MOF should guarantee in writing that: if USAID/S local currency generations are available through the DDD, FHS allocations will receive priority consideration. The implementing agencies (IAs) will approve the recommendations (narrowed focus) in this report and submit a revised workplan to USAID/S to cover the extension period by September 1989.

**USAID/S** - USAID/S will submit a list of requisite benchmarks for the project extension period to the GSDR and IAs by June 1989.

**URC** - URC will provide external TA, as appropriate, to the IAs to assist in the development and finalization of their workplans for submission to USAID/S by September 1989.

## A.2. Comparative Options - Funded Extension vs Follow-On

**Finding** - The team observed that an extension and/or follow-on project is highly desirable for institutional strengthening by the GSDR and IAs. It was also observed that USAID/S fills an important gap in donor assistance at present in FH awareness building, institution building, and service delivery. For these reasons a follow-on project at this point in time is premature, since local currency support is questionable and US dollars remain in the pipeline which could be used to focus present activities. Thus, planning for a no-cost extension is more reasonable, but longer-term planning for a follow-on is inappropriate at present. From the team's point of view, it will be valuable to have evidence of refocused efforts and enhanced service delivery prior to a follow-on design (or a costed extension) (see Section H.1). Furthermore, Mission priorities in FY 1992 may be altered as may interest/commitment by other donors. This would also influence the components of a follow-on as well as its LOE.

Since the Mission's position is unclear as to whether a follow-on project is appropriate (now or in the future), in view of the sector's moderate priority, and, because of the uncertain availability of local currency, a prudent course at present is a no cost extension for the Project. It is presumed the FY 1989 CDSS will further clarify these issues.

**Conclusion** - Extension of the Project with a more narrowed focus is more appropriate than a follow-on project. Deobligation is not appropriate because the Project has generated a great deal of momentum towards policy reform related to family planning and female circumcision. This momentum will be lost if A.I.D. deobligates the remaining project funds. Furthermore, much remains to be done in policy reform, IEC and service delivery to improve family health in Somalia. The foundation is in place, but continued investment is required to foster further progress and move towards a sustainable GSDR FH program. A costed extension at this time is also difficult to justify since a significant amount of refocus is recommended in this evaluation and it is estimated that enough dollars are available to continue through December 1991. Mention of a follow-on could be included in the FY 1989-1991 CDSS which could be carried over into the FY 1992-1995 CDSS (when/if a decision for a follow-on is made). If project benchmarks are achieved, the Mission would have a firm justification for pursuing a follow-on project.

**RECOMMENDATION** - A non-funded extension should be pursued at this point in time.

#### **ACTIONS**

**Implementing Agencies** - Initiate discussions to act upon the recommendations in this report.

**USAID/S** - Accept this recommendation and inform appropriate agencies.

**URC** - Provide technical assistance to the IAs for the initial actions required to address the recommendations in this report.

#### **A.3 Future Directions of the FHS Project**

**Findings** - The team observed that FHS activities are too diverse and may have compromised the overall impact of the Project, especially concerning service delivery. Logistic difficulties are common both within Mogadishu and in other regions. Difficulties associated with storage, inventory, distribution, transportation, and cultural mores are pervasive and hamper outreach and impact. Training has apparently been progressing in the five project regions, but also requires improved coordination among the IAs. Service delivery has been slow to materialize due to lack of outreach, difficult communications between the regional and central offices, and the responsibility for covering more than the five project regions by the FH/FP Department. Focusing the service delivery component of the project in the five IEC regions is needed to improve delivery, identify problems and determine demand. Emphasis on policy development is also a logical pursuit given the need for an articulated national policy. A region-wide KAP survey to assess progress is reasonable. The development and execution of long-term plans of action for the IAs, including securing external support, reflects sustainability. Targeted training for IEC, service delivery, and CSD personnel remains appropriate in relation to revised strategic plans. Evaluation of the appropriateness of CDC materials will also require further investment.

**Conclusions** - The team concludes that the PP design suffers in relation to the breadth of outputs and consequent diversity of tasks and activities mandated. Greater focus is needed.

RECOMMENDATION - Within the project extension, a more focused set of activities should be pursued which highlight policy development, revised IEC strategy (urban/rural linkages), assessment of awareness of FH, long-term strategy development for implementing agencies, integration of MOH department activities, targeted training, and a five region focus for coordination of IEC and service delivery efforts.

#### ACTIONS

Implementing Agencies - The IAs should develop workplans and budgets for the two year extension period which emphasize a strategy for linking IEC and service delivery to ongoing regional efforts conducted by the MOH and respective donors. The MOH should take the lead in this effort and integrate MOH Department directions/activities with those of the IAs. The IAs should present a draft workplan to USAID/S and appropriate donors for review by September 1989.

USAID/S - USAID/S should participate in the development of the regional focus strategy by attending scheduled meetings and providing input regarding FHS priorities and benchmarks.

URC - URC should assist the MOH through its Technical Advisor and other external expertise in the preparation of the strategy statement and plan(s) of action. Initial and follow-up TA should be scheduled NTL May 1989 to address this issue.

#### A.4 Core Contract Extension

Findings - The contracting procedures regarding the extension of the URC contract for 24 months may be problematic. In effect, a 24-month extension represents a significant addition to the original contract. Although the project extension would be "no cost" an extension of the core contract would entail a shifting/adding for funds to the URC contract. Mission options are limited to the current person-month level of effort. Under an extension, an increased LOE would be required. Limited competition may be feasible if the Mission chooses to exercise FAR 6.302-2, "Unusual and Compelling Urgency", or AIDAR 706.302-70(b)3(3)i, "Impairment of Foreign Assistance Objectives". The other option which could be considered is to access short-term TA via buy-ins to central projects, hire resident PSC for the COP, and other long-term advisor positions. However, increased management burden, decreased continuity, increased cost and loss of momentum argue against this latter approach.

Conclusions - The contracting options for extension of the core contract will take time and may slow progress significantly. It is imperative that momentum be maintained, particularly in light of the recommendations contained in this evaluation. The present URC COP has demonstrated an outstanding ability to coordinate efforts and resources through the IAs. Mutual confidence and familiarity have been established which would take a significant amount of time to rebuild. Simply stated, the Project is working and long-term advisors are required. The risk of disturbing continuity within the operation should be taken into account when addressing the maintenance of long-term advisors through a core contractor. However, the rationale for continuing with a contractor versus a buy-in/PSC mechanism, should also be examined.

RECOMMENDATION - Mission direction on the issues concerning the contract within the FHS Project should be finalized NLT April 1989.

#### ACTIONS

Implementing Agencies - No action is required.

USAID/S - The Mission should formulate it's position on this contracting issue by April 1989 and the necessary documentation should be developed by June 1989 to allow adequate time for award prior to the PACD. Another option to consider is extension of the URC contract for a short period time so existing funds need not be deobligated and more time is provided for contract solicitation. USAID/S must also consider the appropriateness of the present Nurse Trainer and Education Advisor positions in light of funds available and the refocused direction of the Project.

URC - URC should provide exact figures for remaining contract resources NLT May 1989. Other fiscal data should be provided as appropriate.

#### B. FHS ORIENTATION: POPULATION/HEALTH/CHILD SURVIVAL

##### B.1 Continuation of Family Health (Family Planning) Objectives

Finding - The team observed that the FHS Project is filling an important gap in donor assistance. The potential for additional donor interest in family health (including child spacing) is moderate (UNFPA and possibly WB). Family planning is a relatively new concept in Somalia, one which is viewed by many as contrary to religious and traditional practices. However, as stated earlier, opinions are changing. The team observed that the key to future success is emphasis on family health, i.e. child spacing as a health issue, and not a population issue. In practice, this has been occurring throughout the project period.

It is difficult to provide a list of prioritized child survival and health options to be included in the project extension and possible follow-on. However, it is clear that for the short-term, the extension should focus on the five IEC regions and integrate FH activities to MCH service delivery. More information and training in pre- and post-natal care would also be worthwhile. Encouragement to mothers regarding immunizations, particularly among nomadic populations would also be relevant. Operational coordination with other donor efforts in the H/CS sector is paramount. To date, efforts in training village communicators have incorporated much health/child survival information regarding ORT, personal hygiene, immunizations and parasitic diseases. This approach should continue to be reinforced within the family planning information curricula.

Conclusion - The team concluded that the FHS Project should concentrate on family planning, but incorporate its goals and objectives into the general MCH system of Somalia. Project activities are in concert with the A.I.D. Health Policy and Child Survival Strategy. Thus, future USAID/S DFA support (i.e. in a possible follow-on project) could be allocated to address a more diverse use of Agency resources. A justifiable breakdown by sector/subsector could be: 50% population, 25% health, 25% child survival. This scenario would relate the importance of the FHS Project to the health sector, and also reflect Agency priorities and GSDR/MOH directions. However, the rapid expansion of activities into the H/CS should be delayed for the moment. The Project has to do more to develop a strategy for regional focus and to strengthen linkages with the MCH service delivery system. This is an appropriate focus. Based on progress during the extension period, a more diverse set of H/CS activities could be contemplated in a follow-on project. The project amendment design should consider these issues.

RECOMMENDATION - It is recommended that Project efforts regarding population, health, and child survival continue. A greater emphasis on health and child survival should not be pursued during the project extension period.

#### ACTIONS

Implementing Agencies - Coordinate appropriate strategy discussions.

USAID/S - Endorse this recommendation and provide insight into Mission priorities related to continued efforts to integrate FH into the GSDR MCH system.

URC - Work with the IAs to develop project extension activities which will facilitate incorporation of FH activities into the GSDR MCH system.

#### C. ROLE OF THE FHS PROJECT IN POLICY REFORM

##### C.1 Awareness of Family Health, Female Circumcision, GSDR Health/Population Policy

Finding - USAID/S, the GSDR and the IAs can be proud of their accomplishments in policy progress to promote FH and eradicate female circumcision. Progress is manifested in the open manner by which Government, Party and religious leaders discuss family health and female circumcision. National conferences on Population, Family Health and Female Circumcision have been held and supported in part by Project resources. Public statements by political and religious leaders have articulated the interest in improving the well-being of Somali women and avoiding unnecessary morbidity and mortality.

Several conditions can be identified which have contributed to this progress. First, there exists a critical mass of competent and energetic individuals who are able to reach high levels of Government to explain and discuss the technical, political and social issues related to FH policy reform. Second, the FHS Project has been a conduit for these energies by: a) supporting Party organizations such as SWDO; b) providing assistance in educational materials production; c) conducting study tours; d) training key personnel, e) providing vehicles for outreach; f) developing ministerial capabilities for data collection and analysis; and, g) establishing a group of cooperating agencies which can speak with one voice to politicians, religious leaders, Party leaders, ministry officials, regional medical officers and villagers. Third, the health concepts linked to child spacing and female circumcision are in concert with the GSDR long-term development objectives.

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It is clear that Somalia has a very long way to go towards the realization of changed behavior regarding family health and female circumcision. Tradition is strong in Somali culture and, respectively, circumcision as well as family planning may take generations to be universally eliminated and accepted. Women, men, and children have firm ideas about family size and the cultural stigmas associated with uncircumcised females. Using improved health as a rationale for child spacing and to encourage more symbolic forms of circumcision has been the vanguard of Somali policy development. The team recognizes that this is an appropriate approach. Movement towards continued political, religious and social awareness can be emphasized in the project extension period. However, it should be recognized that expectations of too much, too soon, may be counter-productive.

**Conclusion** - The FHS Project has significantly contributed to progress in policy development related to improved family health and elimination of traumatic circumcision. The approach pursued by the IAs, URC and the GSDR has been appropriate. Improvement in this approach should stem from increased coordination among IAs and greater sensitization of leaders. Somalia must approach these issues on their own terms and in their own timeframe. USAID/S should be a catalyst for policy discussions through the Director's Office and the PPSD Office as appropriate. Suggested policy benchmarks are presented in Section H.1.

**RECOMMENDATION** - Efforts towards policy statements in family health/family planning and elimination of traumatic female circumcision should be continued and emphasized throughout the project extension period.

#### **ACTIONS**

**Implementing Agencies** - Policy reform issues should be addressed at both Program Coordinating Committee meetings and Policy Coordinating meetings (Section D.1). The IA Directors should routinely discuss policy development strategies at their monthly meetings. The IAs should be involved in the planning, reporting, and publication of results for the 1989 Somalia Population Conference. If possible, the SFHCA should report quarterly to the IAs and donors on progress towards policy development in family health and female circumcision.

USAID/S - USAID/S should be supportive of policy development activities in Somalia. They should assume a role of facilitator, rather than a prime mover. Central project support for technical advisors should be encouraged. A RAPID program might be developed and assistance from the Options Project should be considered. Both could assist the MONP in the development of Human Resource models which could be used as tools to promote the importance of population trends in the long-term development needs of Somalia. The Mission should make every effort to obtain central funding for this/these activities.

URC - URC should assume the role of a catalyst for activities in policy development. It should assist the IAs and committees in outlining issues and formulating strategies for pursuing policy reform. URC should access TA as appropriate to support these efforts.

## C.2 Program Implementation and Policy Development

Finding - The team observed that there is a reasonable balance within most of the IAs concerning policy development and project implementation. This is particularly evident in SWDO and SFHCA, and to some extent within the FH/FP/MOH. URC has placed most of its energies (and resources) in implementation than in policy development. As stated in C.1, policy development should proceed at a pace appropriate for Somalia, however, more emphasis on policy development could be incorporated into the Project during the extension period.

Conclusions - The team concludes that more attention to policy reform issues should be considered. The enhancement of URC's role as an advisor in this respect is imperative. URC should assist in setting appropriate policy benchmarks with the IAs through the provision of TA. The advisory role should be expanded within the URC contract and the COP should access additional URC resources to assist in developing clear strategies for policy reform.

RECOMMENDATION - The FHS Project should place more emphasis on policy and program directions to achieve more focus in implementation.

## ACTIONS

Implementing Agencies - The IAs should discuss this concept at their upcoming IA Director's Meeting. They should work with URC to identify appropriate external TA to address FH policy issues throughout the extension period. IWE, CDC, and CSD should outline options which enhance their impact on FH policy development in Somalia.

USAID/S - Mission views on this issue should be expressed by the Project Officer to the IA Directors. The Mission should follow-up with appropriate benchmarks regarding policy development.

URC - In conjunction with the IAs, URC should prepare a workplan for policy development activities. This should be included in the project extension workplan to be submitted by September 1989. A separate statement by URC on its advisory capacity/role during the extension period should be developed by June 1989 for submission to USAID/S. This should include priorities, objectives, expected achievements, anticipated TA required, and budget.

### D. FAMILY HEALTH PROGRAM MANAGEMENT

#### D.1 Effectiveness of Project Coordination

Findings - Without exception, all participants in and observers of the FHS Project have commented on the remarkable degree of cooperation and collaboration achieved by the IAs. This has been evidenced by: (a) the regularity of coordinating meetings and the high level of attendance; (b) the joint participation of IA staff (in training events, IEC materials development and campaigns); and (c) the development of a consolidated 1989 Project workplan and budget. Collaboration has been strongest in the area of IEC with each of the participating IEC Institutions (SFHCA, SWDO and IWE) being able to bring their own particular organizational strengths to bear on project activities. SWDO has contributed a far-reaching network of influential women leaders for the support and transmission of family health messages; IWE has provided a mechanism for linking the concepts of family health to womens' development through their functional literacy training in the villages; and SFHCA, with the flexibility afforded by its NGO status, has been able to respond rapidly and supportively to implementation needs. Additionally, SFHCA staff clearly articulate that their role within the project should be to facilitate overall performance. With this approach they have encouraged cooperation rather than competition. Finally, the present URC COP has ensured that Project resources are equitably allocated. Clearly this has had a significant influence on the degree of collaboration achieved.

The coordination of IEC activities with service delivery has been less successful. Representation of the MOH on the existing FHS Committees has been limited and IEC activities are not closely related to MOH plans for service delivery.

Conclusions - Through the combined efforts of all of the implementing institutions, a firm collaborative foundation has been established amongst FH IAs. The Project should build upon this and try to increase its audience of GSDR decision-makers with a view to: a) encouraging FH and population policy development; b) supporting the development of a national FH program with an integrated approach to service delivery and IEC; and c) provide high level endorsement for the activities of the FHS Project. The team thus recommends that the Project Coordinating Committee be dissolved and a new Committee structure be established as follows:

- o Policy Coordinating Committee - A Family Health Policy Coordinating Committee, under the Chairmanship of the Director General of the MONP should be established. The purpose of this Committee will be to involve chief Government officers in the FH/FP debate, to keep them informed of initiatives in this area, and to promote FH policy development at high Government levels. Membership would consist of the Director Generals of the MOH, MOE, MING, MOJRA, MOI, and MOF; the Chairman of the SFHCA Board; and a representative from SWDO. This Committee will meet semi-annually. The Executive Director of the SFHCA should be the Secretary, and the SFHCA should provide the secretariat. Representatives of relevant donor organizations could be invited to attend as observers when deemed appropriate by the Committee.
  
- o Program Coordinating Committee - A Family Health Program Coordinating Committee should be established to develop strategies for the implementation of the GSDR national family health program within the policy framework established by the Policy Committee. This Committee will ensure that all Agency and donor efforts are coordinated and will provide technical guidance. Membership of this Committee will consist of one Director from each of the following institutions/units: FH/FP/MOH; SFHCA; SWDO; IWE; CDC; CSD/MONP and URC resident advisors; together with the RMO and the Regional Education Officer from each of the FHS Project regions and a representative from each relevant family health donor. This Committee should meet quarterly, with the chairmanship rotating between the Somali Directors every six months. The SFHCA would provide the Secretariat, and facilitate the preparation of agendas.

- o Project Implementation Committee - The Implementing Directors' Committee should be renamed the FHS Project Implementation Committee. It should meet monthly with the chair rotating among IA Directors every three months. The role of this Committee will be to coordinate the implementation of FHS Project activities within the technical guidance provided by the Program Coordinating Committee. Membership of the Committee should consist of one Director from each of the FHS IAs, and the URC resident advisors. The SFHCA should provide the secretariat.
- o Technical Task Forces should be created as necessary for planning and coordinating specific activities of the FHS Project. Examples of such Task Forces include the current IEC Committee, the Core Trainers Group and the PHC/MCH/FH/FP Divisional meetings of the MOH. These groups would report on their plans and progress to the FHS Project Implementation Committee.

RECOMMENDATION - A new committee structure for FH should be established consisting of a Family Health Policy Coordinating Committee, a Family Health Program Coordinating Committee, and a FHS Project Implementing Directors' Committee.

#### ACTIONS

Participating Agencies - The SFHCA should obtain approval from the Director General of MONP to establish the new committees. SFHCA should prepare the necessary documentation including committee constitution, membership and terms of reference. The Secretariat should establish a meeting schedule and should convene the first meeting of the Policy Coordinating Committee by July 1989.

USAID/S - USAID/S should support the establishment of the new committee structure in discussions with MONP and should regularly attend the meetings of the Family Health Program Coordinating Committee. USAID participation on the Policy Coordinating Committee would also be an important indication of support for policy initiatives.

URC - URC should assist SFHCA in the procedures required for the establishment of the new committees and in the preparation of the necessary documentation. TA for agenda development should be provided as appropriate.

## D.2 Project Management Information System Capabilities

**Findings** - The FHS Project has followed a regular cycle of annual workplan development and quarterly reviews/documentation of progress. The quarterly reviews are consolidated semi-annually. All reports are discussed by the IAs and distributed to the MONP, MOF and USAID/S. Each IA develops and monitors its own budget for the FHS Project (these were consolidated for the first time in 1989). It was intended that each IA (except SWDO, which already has its own computer) would be provided with a micro-computer for use in document production (word-processing) and budgetary management, and would be trained in the use of the software. However, due to difficulties with the electrical supply in IWE and the MOH, their computers have not been installed, but are currently being held at SFHCA. A wind generator has been installed in SFHCA and the FHS Project is supporting the training of local engineers in its maintenance. CDC already has its own generator. Training of the IA Directors (in word processing) and the IA Accountants (in word processing and Lotus 123) has just commenced.

**Conclusions** - In order to reinforce the systematic planning and monitoring activities of the IAs, efforts should be made to install back-up power supplies at the MOH, SFHCA, and IWE to enable the installation and use of the computers purchased for these institutions. Unless this occurs, the training provided to the Directors and Accountants from those institutions will serve little purpose.

**RECOMMENDATION** - Alternative power supplies should be installed at IWE, SFHCA, and FH/FP Division of the MOH so that the computers purchased for them can be installed and used. Training of staff from these IAs should be postponed until the computers are available for them to make use of this training.

### ACTIONS

**Participating Agencies** - IWE, SFHCA, and the FH/FP Division should identify staff to receive training in the maintenance of the generators.

**USAID/S** - USAID/S should approve and facilitate the procurement of the generators.

**URC** - URC should pursue the purchase and installation of generators at IWE, SFHCA, and FH/FP Division and the training of local engineering staff in the necessary maintenance. Spare parts should also be procured. URC should access TA to assist in the determination of appropriate power supplies.

### D.3 Regional Focus/Decentralization of FHS Efforts

**Findings** - There have been significant changes in the social environment for family health in Somalia since the inception of the FHS Project. At the same time, progress to date on the different components of the project has revealed some weaknesses, both in the original design and in strategy development. Targets for the expansion of services were over-ambitious given the capacity of the central MOH. Despite declarations that family health must be promoted as a component of MCH, integration is far from being a reality either at the central level or at the periphery. Staff of the FH/FP Division are currently responsible for all FH provider training, supervision, contraceptive distribution and program monitoring throughout the country. No clear responsibility for these functions has been delegated to peripheral service managers.

**Conclusions** - Integration of family health into MCH services needs to be emphasized both at the central and the peripheral levels of the MOH. Responsibility for the planning, coordination and oversight of all health activities at the periphery rests in the regional office. Thus, the FHS Project should work with the regional health officers to promote and integrate FH/FP into the overall health delivery system. IEC efforts should be guided by regional FH service delivery plans. The extent of regional level FHS activities must be dictated by the IA's capacity to provide the necessary central support and coordination. In order to facilitate the development of FH services at the periphery, a vehicle should be made available to each of the participating regions. This should be achieved by either the permanent relocation of one of the 17 existing Project vehicles, or through a strategy for the sharing of a vehicle between a region and a central IA office.

**RECOMMENDATION** - All service delivery and IEC activities under the Project should be restricted to the original five Project IEC Regions, (Benadir, Bay, Middle Shebelle, Lower Shebelle, Lower Juba). The planning and implementation of activities within a region should be coordinated at the regional level by the Regional Medical Officer with the explicit objectives of integrating family health activities within the primary health care system and linking IEC to service capabilities. A relocation of Project vehicles might be effected such that each participating region has access to transport.

## ACTIONS

**Implementing Institutions** - The MOH should discuss the implications of the regional FHS focus with the Directors of the PHC and MCH Divisions and seek their approval. The MOH should coordinate with the PHC and MCH Divisional Directors in notifying and discussing the decision with the RMOs of the participating regions.

**USAID/S** - USAID/S should endorse the implementation of focused project activities at the regional level and the relocation of Project vehicles in writing to the Director General of the MONP by the end of April 1989.

**URC** - URC should assist the MOH and the IAs in the approval process and regional/central cooperation.

### D.4 Strategy Development

**Findings** - The energy and enthusiasm invested by all those participating in the FHS Project has clearly been considerable. However, in all long-term endeavors, there is the need to periodically re-evaluate goals and targets to ensure their continued relevance and realism, and to adjust strategies and implementation plans accordingly. It is clear that the environment for the family health program has seen significant change since the Project's inception. At the same time, not all Project components have shown the same progress or success. Although the team has gained an impression of vigorous activity, a sense of strategic direction was cloudy.

**Conclusions** - The IAs need to reformulate their strategies to guide implementation activities through the PACD and extension period. Specific components of regional strategy should include:

- a) the types of FH services to be provided;
- b) the sites at which FH services will be delivered;
- c) how FH and MCH services are to be integrated into the PHC system;
- d) the staff/volunteers who will deliver FH services;
- e) the regional responsibilities for FH supervision;
- f) the components of the contraceptive logistics system;
- g) the FH reporting system and information flow;
- h) the collaborative IEC activities to be conducted;
- i) how different donor activities within the region will be coordinated.

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Once the strategic plan is in place, a regional training needs assessment should be conducted and a training plan developed (including management, supervision and service delivery). Regional strategy development and implementation should be phased to ensure that adequate central level support can be provided. Since it can be difficult for those involved closely with the day-to-day implementation of a program to focus on strategic direction, short-term technical assistance should be provided to assist both the IAs and the RMOs in strategy development for the overall family health program and its implementation through the regional health teams. This refocusing, (inclusive of the integration of FH and MCH/PHC services), may increase options for continued support of FH through the MOH and possibly attract other donor support.

**RECOMMENDATION** - A phased approach to regional FH strategy development should be adopted for the extension period. Each regional strategy should include plans for the delivery of integrated FH/MCH/PHC services. Based on each regional strategy, a comprehensive training needs assessment should be conducted and a regional training plan developed. TA should be provided to assist the IAs and the RMOs in the strategy development.

#### **ACTIONS**

**Implementing Institutions** - The FH/FP Division, in collaboration with the PHC and MCH Divisions and the IAs, should provide technical support and guidance to the regions to: a) develop regional FH strategies; b) conduct the regional training needs assessment; and c) develop regional training plans. The IAs should work with the regions to define the respective roles and responsibilities of the regional and central MOH within the FH program, and should cooperate and assist each project region in strategy implementation.

**USAID/S** - USAID/S should endorse the inclusion of the necessary short-term TA in the URC budget for strategy development. USAID/S should also facilitate a flexible approach to the allocation of Project funds in support of regionally-oriented FHS implementation activities.

**URC** - URC should provide the necessary short-term TA for strategy development at both the national and regional levels. URC Resident Advisors should participate in and facilitate the strategy development process and regional training needs assessments. SOWs for the TA should be submitted to USAID/S by end of April 1989. URC should ensure that the strategies are reflected in the development of future workplans and the allocation of resources.

## D.5 Institutional Sustainability

**Findings** - Each of the IAs have relied almost entirely upon FHS Project resources to maintain their involvement in family health activities. When FHS Project funding ceases (unless other donor support is committed), the sustainability of family health activities in Somalia is questionable. Each of the IAs needs to seek alternative sources of financial support for the continuation of their family health activities. In the case of SFHCA, FHS Project funds represent 40% of their total operating budget and their continued existence will be severely compromised unless they can diversify their funding sources. None of the IAs has a strategy for seeking funding, nor much experience in proposal development.

**Conclusions** - Sustainability of the activities initiated under the FHS Project is highly unlikely unless the IAs can attract other donor support. Most of the IAs have little experience in the development of "sustainability" strategies, the identification of potential donors, or in proposal development. During the FHS Project extension period, assistance should be provided to the IAs to help obtain additional support.

**RECOMMENDATION** - Short-term TA could be provided to the IAs during the FHS Project extension period to assist them in the development of strategies and plans for sustaining their family health activities, and, preparation and proposal submission to funding organizations.

### ACTIONS

**Implementing Institutions** - The IAs might participate in the development of strategies and plans for the sustainability of family health activities during the extension period. Following local training in proposal development, they might actively pursue funding proposals with donor agencies.

**USAID/S** - USAID/S could promote sustainability of the Somali family health program by approving the provision of TA for strategy and proposal development and identifying organizations where additional support might be obtained.

**URC** - URC could arrange for the provision of short-term TA in sustainability strategy development and proposal preparation/ submission. SOWs could be developed by July 1989 and submitted with the project extension workplan. Follow-up TA could also be provided to encourage the IAs in the further development and marketing of proposals.

## E. PROGRESS IN FAMILY HEALTH SERVICE DELIVERY

### E.1 Overview

From the outset, the likelihood of success in this component of the Project was compromised. The MOH, with limited resources, was required to provide training and technical guidance to the IEC component, develop family planning curricula and provide in-service and refresher training for several tiers of providers. Data on total contraceptive visits for the five project regions indicate an increase in the Benadir region, but a decrease in the other four regions. The reasons for this decrease needs to be assessed, but may relate to problems with commodity supply, lack of adequate supervision, and limited attention to specific regional training needs. Other aspects of service delivery which affect progress include: a) the client reporting system; b) the contraceptive logistics system; and c) commodity support.

### E.2 Family Health Client Reporting System

**Findings** - At the present time, only limited FH/FP client data are collected or summarized monthly for reporting to the central MOH. The MCH Division is in the process of designing a new, integrated monthly MCH reporting format. This will include all necessary data required for the monitoring of the FH/FP program. The team did not find evidence to suggest that the data presently available are actually used for decision-making by the FH/FP/MOH.

**Conclusions** - The revised client reporting system represents a improvement. However, care should be taken to ensure that data collection is restricted to what is really necessary. Previous experience in Somalia and elsewhere indicates that the design of new reporting forms is relatively easy. Problems lie in the local maintenance of the system, in the flow of information to those who require it, and in the use of the data for decision-making. The FH/FP Division will have to ensure that adequate training and continued supervision is given to clinic staff in the proper recording of data. In addition, the FH/FP/MOH Division should ensure that managers at each level of the delivery system (particularly RMOs) receive the data and central support they need to fulfill their management and service delivery responsibilities. Staff at all levels will need training and assistance in how to use the information collected for monitoring and decision-making.

**RECOMMENDATIONS** - Short-term technical assistance/training should be provided by the Project to evaluate the current reporting system and to assist FH providers and managers at all levels of the delivery system in the collection and use of family health data for planning, monitoring, supervision and decision-making.

## ACTIONS

Implementing Agencies - The FH/FP Division of the central MOH should take the lead (with TA), in the assessment of the FH reporting system, training of staff, and follow-up/ supervision of the reporting system's implementation and use.

USAID/S - USAID/S should assist URC in identifying appropriate sources of short-term technical assistance (including existing centrally-funded projects) and should expedite the necessary arrangements for the acquisition of such services.

URC - URC should identify appropriate TA to assist in the refinement of the client reporting system. The URC LTA to the MOH should be closely involved in TA activities and should be made responsible for follow-up of the training and system implementation. Decisions regarding the utility, restructuring, training and future activities associated with the client reporting system should be incorporated into the Project extension workplan by both the IAs and URC.

### E.3 Contraceptive Logistics MIS

Findings - Each MOH contraceptive distribution point maintains an inventory control card for each type of commodity. Monthly summaries of available stocks are compiled and sent to the FH/FP/MOH Division. The team found that the inventory forms are reasonably accurate. Commodity data are collected from the clinics during tri-annual supervisory visits of FH/FP/MOH staff, who, at the same time, deliver contraceptives. Thus, the contraceptive resupply mechanism is based upon a tri-annual review of the physical inventory and on-site review of utilization trends. Difficulties arise when the supervisory/re-supply visits of FH/FP/MOH staff are delayed or postponed due to impassable roads and/or transportation problems. There is also uncertainty as to how the monthly contraceptive utilization data can be used to guide timely decisions about national procurement needs.

Conclusions - The contraceptive logistics system itself requires revision to improve the effectiveness of the MIS. Contraceptive supplies should be held at the regional level and the RMOs should be responsible for supplying the family health clinics within the region. The FH/FP/MOH Division should be responsible for supplying the regional contraceptive stores and for nation-wide procurement of commodities. The logistics MIS should be designed to improve: a) inventory control at the clinics and at the regional and central stores; b) the resupply of clinics from the regional stores; c) the distribution of supplies from the central to the regional stores; and, d) central procurement from donors.

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RECOMMENDATION - Short-term technical assistance should be provided for the review and amendment of the current contraceptive logistics MIS to meet the management requirements of a regionally-based clinic supply system. (This TA should be linked to reporting system TA suggested in E.2.)

#### ACTIONS

Implementing Agency - The MOH FH/FP Division (with TA), should work with the RMOs from the Project regions on the review and redesign of the contraceptive logistics MIS. The FH/FP Division should also take the lead in the training of regional and clinic staff in the new procedures.

USAID/S - USAID/S should assist URC in identifying appropriate sources of short-term technical assistance (including existing centrally-funded projects) and should expedite the necessary arrangements for the acquisition of such services.

URC - URC should identify appropriate TA and develop appropriate SOWs.

#### E.4 Adequacy of TA/Commodity Support to Date

Findings - The opportunity to provide TA for the service delivery has not been fully utilized. A total of 1.5 person-months of short-term TA has been provided to date for management system development. Two training needs assessments have been conducted, but none has addressed the inappropriateness of the FH service goals or the lack of a clear program development strategy. Commodity support by the Project has been concentrated on the central level. Of the 17 Project vehicles, only one has been allocated to the periphery (to Hargeisa Region in the north). While procurement of commodities is characteristically slow, increased attention must be paid to utilization of data for appropriate procurement planning.

#### CONCLUSIONS

Insufficient attention has been paid over the LOP to support the FH service delivery component. The PP targets were over-ambitious and the TA devoted to strengthening service provision and management has been limited. The success of the proposed regional focus will depend on sound decision-making based on valid and current information from the regions. Specific areas to consider are: training needs assessment; evaluation of training;

logistics management; data analysis; and, program monitoring. Financial and commodity support will be required at the regional level. Regional contraceptive stores and a distribution mechanism should be established. Considerable upgrading of MCH clinics throughout Project regions is needed. A Project vehicle should be re-assigned to each of the Project regions, either on a permanent or time-sharing basis (with one of the central IA offices). The RMO will need financial support for the maintenance of proper supervision, reporting and program monitoring activities.

**RECOMMENDATION** - A comprehensive plan for each of the five recommended Project regions should be developed following the preparation of the phased regional strategies. Priority should be given to strengthening the FH management systems and the management and supervisory skills of regional service delivery staff.

#### **ACTIONS**

**Implementing Agencies** - Logistics/commodity/MIS issues should be addressed in the regional strategy. FH/FP/MOH should develop concise logistic/commodity/MIS elements for that strategy.

**USAID/S** - USAID/S should review and comment on a revised plan.

**URC** - URC should provide TA as appropriate.

#### **E.5 In-Country Pre-Service Training**

**Findings** - Little effort has been devoted to date on the development of pre-service FH curricula. Manuals and references are out of date. Faculty shortages and the lack of incentives have also delayed progress in curriculum development. Short-term TA has been provided for nursing and midwifery training, but medical school curricula are still deficient. In addition, the FH/FP/MOH Division has assisted in the development of a training/referral site at Benadir Hospital. URC's long-term Nurse Training Advisor has begun to address this need. However, more work is required.

**Conclusions** - Pre-service training in FH should be established in nursing and midwifery schools. URC's resident Nurse Training Advisor should provide assistance in curriculum and materials development, and procurement of donated reference materials. Incentives for faculty involved with this effort should be considered. The development of additional training clinics should not be attempted during the FHS project extension period. Support to the Benadir site should be maintained.

RECOMMENDATION - The URC Nurse Training Advisor should give priority to the development of pre-service FH curricula.

#### ACTIONS

Implementing Agencies - The MOH should provide technical support to the Basic and Post Basic Nursing Schools to develop FH curricula.

USAID/S - USAID/S should endorse this emphasis and consider the provision of incentives to nursing school faculty developing the curricula.

URC - The workplan of the Nurse Training Advisor should be revised to prioritize her attention to this issue. Completion of the curriculum development should occur NLT December 1989.

#### E.6 Contraceptive Social Marketing/Private Sector

Findings - The PP included a recommendation that the feasibility of implementing a contraceptive social marketing program in Somalia should be investigated. Two studies, conducted with short-term TA, found that despite some interest on the part of drug sellers, there are many policy, legal and regulatory issues which would need to be addressed before any CSM program could be introduced in Somalia. Since the last TA study, a group of 30 pharmacists/drug-sellers from Mogadishu have been trained by the MOH and given samples of condoms and oral contraceptives. Furthermore, 35 private physicians have been trained and supplied with contraceptives.

Conclusions - Despite apparent changes in attitudes towards family health in Somalia since the start of the Project, opinion remains strongly divided on the current level of acceptability of family planning and contraception. The team questions the readiness of the country for a highly visible form of contraceptive distribution (such as a CSM). However, during the latter part of the Project extension period, TA should be provided to further investigate the feasibility of some form of CSM and the preparatory steps that would need to be taken for a pilot activity. Supplying trained private physicians with contraceptives should continue, but further efforts to involve the private sector in contraceptive marketing is premature. However, based on information gathered during the Project extension period, a follow-on Project (if approved) might include a health care financing component as a means of income generation and private sector development.

RECOMMENDATION - TA should be provided to the Executive Director of SFHCA to further explore the feasibility and desirability implementing a CSM program in Somalia.

ACTION

Implementing Agencies - SFHCA and other IAs, with TA, should participate in a CSM feasibility study.

USAID/S - USAID/S should assist URC in the identification and procurement of the appropriate TA for an updated CSM feasibility study.

URC - URC should identify appropriate sources of TA for the conduct of an updated CSM feasibility study.

F. FUTURE PRIORITIES FOR IEC

F.1 Findings - IEC activities have been pursued by SFHCA, CDC, IWE, SWDO and the MOH, and coordinated by SFHCA. At the start of the Project there was little capacity in Somalia to address IEC FH issues. Today, the IAs represent a group which can promote FH issues at all levels of Somali society. A summary of the IAs' IEC objectives is presented in Annex IV.

Coordinating mechanisms have been established and will probably be sustained beyond the life of the project. The role of SFHCA as the keystone of the IA Committee has been, and will continue to be, vital. The SFHCA has facilitated an orderly process of planning and organization of IEC efforts. However, having established the ability to cooperate and coordinate activities, the five IAs still need to define more clearly their roles and have yet to develop an overall strategy for their activities. There needs to be more coordination between IEC efforts and those of the MOH. The team observed that the IAs' mandate to increase to 50% the awareness of all Somali couples was too vague an objective to serve as a guide for implementing activities. In addition, SFHCA's ability to serve as the principal resource for message design and material development, as envisaged in the project design, is questionable. At present they have neither the accommodations nor the personnel to fulfill this role.

Conclusions - The plan for the five IAs to cooperate and coordinate their IEC activities has begun to work well. However, the IEC component lacks revised and focussed objectives. The overall strategy for the extension period should provide an improved operational framework for the IEC component. The proposed KAP survey, (Section J), whose results should be available by January 1991, will help the IAs further determine key target groups. In the near term, the IAs should draw up an IEC strategy and list

the activities necessary to reach each group. Decisions should be made on the role and the contributions required from each IA and appropriate messages and materials should be developed accordingly.

**RECOMMENDATION** - Within the framework of the overall strategy for the development of the national family health program, the IAs need to develop a clear IEC strategy defining the population groups to be targeted, the messages to be delivered to these groups, and the methods of delivery. The role of each of the IAs should be clearly defined.

#### **ACTIONS**

**Implementing Agencies** - The IAs should develop a comprehensive IEC strategy within the framework of the overall FH program goals/strategy.

**USAID/S** - USAID/S should endorse the IEC strategy developed by the IAs and, as appropriate, promote the allocation of local currency funds for its implementation.

**URC** - URC should provide TA and guidance to the IAs' IEC staff in the development of an IEC strategy, the design of effective IEC messages, and IEC materials development. URC should also support and guide CDC in the testing of new text books and the development of in-service teacher training.

#### **F.2 Resource Center Investment**

**Findings** - A resource center has been set up at SFHCA and serves as a repository for IEC materials, printing and audio-visual equipment. The accommodations available for this resource center are poor. At present it is under-utilized and serves essentially as a storage space for materials produced by the Project. IWE also has an existing and spacious IEC resource center with two large rooms available for further expansion, a full-time librarian, and considerable amount of A/V and printing equipment provided by UNFPA. It is the team's impression that the IWE resource center is more frequently utilized than that of SFHCA.

**Conclusions** - The SFHCA resource center as presently organized does not serve the purpose envisaged in the project design and significant investment would be required to upgrade its function. IWE already has the space, the staff and the interest in housing and managing the Project's IEC resource center.

RECOMMENDATION - The IEC Resource Center and the A/V technician currently on loan to SFHCA from the MOE should be relocated to IWE.

#### ACTIONS

Implementing Agencies - IWE should provide a written guarantee that the relocated Resource Center will serve the needs of all IAs. SFHCA should make the necessary arrangements for the transfer of the A/V technician to IWE. Both IWE and SFHCA should cooperate in planning and moving the Resource Center as soon as IWE is ready to accommodate the additional materials and equipment. The move should be completed by December 1989.

USAID/S - USAID should endorse the relocation of the Resource Center to IWE and promote the allocation of local currency Project funds for the minimal renovation of the two additional rooms available to the Center.

URC - URC should assist IWE and SFHCA in preparing and moving. URC should continue to provide TA to the Resource Center in its new quarters.

#### G. IMPROVED OPERATIONS RESEARCH

##### G.1 Focus on Operations Research in the FHS Project/Need for KAP/FH Survey

Findings - Operations Research (OR) has not progressed as anticipated in the project design. Opportunities were missed due to difficulties concerning logistics, personnel and clear strategic planning. Furthermore, the tasks set forth in the PP appear overly ambitious. Although a number of OR activities were pursued, results have been produced slowly and their application on a national scale is conjecture. Institutional capacities beyond the SFHCA have not been fully explored, thus contributing to decreased output in this component.

Conclusions - Efforts in OR for during the project extension period should be restricted to the development, execution, analysis and reporting of a region-wide KAP/FH survey for Benadir, Middle Shebelle, Lower Shebelle, Bay, and Lower Juba. The SFHCA should coordinate the survey. However, external assistance should be provided on a recurrent basis by the core contractor. Formal research collaboration should be explored with indigenous

institutions such as the Faculty of Medicine and the Academy of Arts and Sciences. Implementing agencies such as IWE, CSD and FH/FP/MOH should be included in the design and execution of the survey. A specific task force should be established within the IA directorate to outline the components of this survey. Logistic issues such as vehicle use, personnel time, and per diems must be addressed early on. The use of CSD enumerators should be explored as a means of data collection. The CSD's computer analysis capability should be viewed as an important resource. Reporting forms should be developed to assess priority indicators of Project achievement and adjusted for differences in urban, rural and nomadic populations as appropriate. The option for obtaining external assistance for this survey should be explored through the development of a detailed protocol and submission to appropriate funding agencies. The entire process concerning the survey should include external TA to guide and monitor design, data collection, analysis and preparation of the final report. A statistically valid sample must be derived with commensurate control over data collection, entry, analysis and reporting.

**RECOMMENDATION** - In coordination with the MONP, the OR component of the FHS Project should concentrate solely on the development and execution of a region-wide KAP/FH survey. This should include close cooperation with external short-term advisors. (Planning for the KAP/FH survey should be completed by June 1989, with a final protocol developed by September 1989. Implementation should commence by 1/90. It is estimated that the entire process will be completed by January 1991).

#### **ACTIONS**

**Implementing Agencies** - The IAs should discuss the KAP/FH survey in their next meeting and develop an action plan. They should also establish a taskforce including other expertise from ministries and organizations.

**USAID/S** - USAID/S should participate in the design discussions regarding the KAP/FH survey and recommend priority components. The Mission should inform the Office of Population of this survey and request one of their staff to provide input throughout the KAP/FH exercise. A.I.D. central project resources for planning, execution and analysis should be canvassed to assure a wide exposure of survey design and conduct.

**URC** - URC should provide TA as required. The URC interface with AID/W central projects and ST/POP personnel should be established early on in the exercise.

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## H. RATIONALITY OF TARGETS/FUTURE BENCHMARKS

### H.1 Achievability of Targets

Findings - The Project Paper stated that by the EOP, the contraceptive prevalence rate would have increased from an (estimated) level of less than 1% nationwide to 8%. Given the social environment that existed for family health at the beginning of the Project, the team believes that this CPR target was unrealistic. Later targets established for the project's IEC efforts stated that by the EOP, 50% of couples would be aware of all forms of contraception and that awareness would have increased by 10% for each of: modern methods of contraception, the deleterious health effects of female circumcision, and the benefits of ORS. The team has been unable to identify the baseline upon which these targets were based. Accordingly we cannot endorse these targets and suggest they be obviated. Part of the problem concerns the scarcity of baseline data. Neither the 1983 family planning KAP survey (conducted on 738 ever-married women in 5 cities) nor the 1985 IEC Baseline Study (conducted on 425 persons in the 5 project IEC regions) provides sufficient data to draw conclusions applicable on a national or regional scale. Although some mini-surveys have been conducted during the LOP in relation to IEC campaigns in the Benadir region, there has been no attempt to carry out a second KAP survey on a scale to measure regional changes in family health awareness over the last 6 years. Thus, actual change in family planning awareness, attitudes and use remain conjecture.

Conclusions - It is concluded that the Project's achievements should not be measured against the contraceptive prevalence rate and awareness targets established at the start of the Project nor during the Project period. A revised set of indicators should be established and monitored and against which the success of the Project during the extension period will be measured. These should include indicators relating to: (a) policy reform; (b) FH KAP; (c) service delivery; (d) training; and (e) strategy development. Suggested benchmarks for the Project extension are as follows (A timeframe for their achievement is included in Annex X).

## SUGGESTED BENCHMARKS FOR PROJECT EXTENSION PERIOD

### POLICY AND DATA COMPONENT

- National Population Policy approved
- National Policy on female circumcision developed
- 3rd National Population Conference held and reports distributed
- 1986 census completed and results distributed
- Local site maintenance of CSD computer facilities achieved
- Local maintenance of CSD computer system achieved

### PROGRAM MANAGEMENT & COORDINATION

- New FHS Committee structure established
- National strategy for FH program developed linking service delivery and IEC activities
- Strategic plans completed for 5 regions
- Decision-making on FH program implementation decentralized to the regional level
- 5 regional training needs assessments completed
- In-country training plan developed based on regional strategies
- Overseas training/study tour plan developed
- In-country management training plan developed
- Computers installed at IWE and FH/FP and being used
- Maintenance manual/compendium developed for all major items of equipment
- 3 proposals for external financing developed and submitted to donors (2 SFHCA, 1 IWE)

### IEC

- Secondary school syllabus completed
- Textbooks for grades 1-8 printed and distributed
- Primary school teachers trained in use of textbooks for grades 1-8
- Evaluation of textbooks for grades 1-8 initiated
- IWE regional facilities upgraded (including incentives such as hoes, sewing machines, cloth, etc.)
- 15 IWE village community centers refurbished
- CDC printing press operational and maintained
- IEC Resource Center established at IWE
- FH policy awareness-videos developed for DGs (2 on female circumcision, 2 on FH/FP, 1 on FHS Project activities)

#### SERVICE DELIVERY

- FH/FP integrated into MCH/PHC system (as evidenced by integrated reporting systems, supervisory mechanisms)
- Fully-functioning FH/FP services provided at all MCH centers in the 5 Project regions
- Contraceptive stores established in each of the five Project regions
- Monthly FH reports (on client numbers and contraceptive use) produced for all FH clinics in the Project regions
- Contraceptive distribution based on monthly returns from all FH clinics in the Project regions
- Job descriptions available for all regional and central staff with responsibility for FH/FP
- Change in CPR from 6/89 - 9/91 assessed
- Clinical standards of practice developed and implemented for FH/FP services
- A FH clinical procedures manual developed and implemented
- FH pre-service training curricula developed

#### OPERATIONS RESEARCH

- KAP study completed in 5 Project regions
- Analysis of maternal mortality and morbidity due to female circumcision completed at Benadir hospital

RECOMMENDATION - A revised set of indicators to measure achievements throughout the Project extension period should be established. Short-term TA should be provided to assist the IAs and USAID/S in this task.

#### ACTIONS

Implementing Agencies - Following the development of strategies for the future direction of the Somali family health program, all IAs should participate in the development of a revised set of performance indicators. These performance indicators should be incorporated into their planning/monitoring process.

USAID/S - Following approval by USAID/S of a reformulated set of activities for the FHS, USAID/S should arrange for the provision of short-term TA to help revise achievement indicators for the FHS Project. USAID should adopt the indicators established as the basis for measuring EOP achievements.

URC - URC should participate in the development of a revised set of indicators to be used for the evaluation of EOP achievements.

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## I. ADEQUACY OF PROPOSED TRAINING PLAN

Findings - Since early 1986, the FHS Project has sponsored Somalis on study tours, short-term training overseas and attendance at international conferences. The PP called for a total of 106 person months for these activities; the Project to date has completed 52 person months (49% of the target). At the present time, the plan contains proposals for an additional 58 person months of overseas training/study tours related to IEC, operations research, program management, and clinical service delivery. Given the progress made to date on component implementation and the team's recommendations for the future, the training plan needs to be revised to ensure that it is based upon Project needs. The team's opinion is that no further training in OR should be provided given the lack of OR personnel within the IAs. In terms of IEC, only a small amount of training is still required in graphic design, audio/visual techniques and production management. For the remainder of the Project, emphasis should be placed on sensitizing leaders (religious and government) and strengthening the management skills of those responsible for the planning, implementation and evaluation of family health programs.

Conclusions - No further training or study tours should be provided by the Project in the area of OR. A maximum of six person months of overseas training should be provided for the IEC component. Person months for study tours should be limited to a maximum of 10 through the LOP and reserved for religious and government leaders. A rational quota for attendance at relevant professional conferences should be derived. Criteria should be established for participation in overseas training and study tours. Selection of candidates should be based upon Project priorities and conditional upon explicitly meeting criteria.

Management development should be a priority for senior and mid-level IA staff, including the participating RMOs. Provision of in-country management training, in lieu of overseas training should be considered.

RECOMMENDATIONS - For the remainder of the FHS Project, in-country training should be improved, and study tours should be restricted to senior religious and government leaders and should not exceed a total of 10 person months. Short-term overseas training should be limited to five person-months for IEC, together with management training for those who cannot be trained in country. Attendance at professional conferences should be considered when deemed essential.

## ACTIONS

**Implementing Agencies** - The IAs should participate, with URC, in the determination of priorities for study tours and overseas training within the framework laid down for the FHS extension period.

**USAID/S** - USAID/S should review and endorse a revised plan for the achievement of these targets by the end of April 1989. USAID/S should assist the IAs in the formulation of criteria and selection of overseas training candidates.

**URC** - URC should prepare revised targets for the number of person months of overseas training/study tours to be sponsored during the extension period by April 1989 and submit a revised plan to USAID/S by May 1989. In preparing the revised plan, URC should investigate the options for in-country management training. URC should also take the lead in determining priority candidates for overseas study and will be responsible for making all the necessary arrangements.

## J. MANAGEMENT/MAINTENANCE OF RENOVATIONS & EQUIPMENT

**Findings** - The Project has funded major renovations to provide upgraded offices for the FH/FP Division which were completed in late 1988. Current plans for building renovations include a proposal from IWE to develop a materials production room (for film development and document printing), and the provision of adequate facilities for the printing press at CDC (strengthening of the floor, and the provision of water and electricity). Budgetary submissions for this work have been approved by the MOF. Once funds are released, the work will be contracted out to local engineers/builders under the supervision of the respective IA Directors. Major equipment purchases made under the Project include: a) computers (the mainframe at CSD/MONP and the laptops for the other IAs); b) printing press for CDC; c) A/V equipment (video cameras and monitors at the Resource Center of SFHCA). TA will be needed for the installation of the large printing press at CDC and for training CDC staff in its operation and routine maintenance. TA will also be required to set up the dark room and small printing press at IWE. A maintenance contract with CALWANG, Nairobi for the CSD is in place, but this expires in 1990. No other maintenance contracts have been

arranged. Local maintenance capability exists for the small computers and possibly for the A/V equipment. Any significant repairs to the CDC printing presses would have to be procured from Nairobi.

**Conclusions** - The maintenance and repair of major equipment purchased by the Project is a source of concern. Local capabilities are limited. TA should be provided for the training of IA staff in the routine maintenance and minor repair of all the equipment, in addition to assisting in the installation and use of the printing presses and A/V equipment at CDC and IWE. Sufficient dollar funds should be set aside to purchase a 24 month supply of spare parts for the major equipment items. Maintenance contracts with Kenyan companies should be negotiated for the printing presses, and with local companies for the micro-computers. For all other equipment, an instruction manual needs to be compiled providing details on whom to contact for maintenance, repair and spare parts and distributed to each IA Director.

**RECOMMENDATION** - Detailed arrangements need to be made for the installation, routine maintenance and repair of all major equipment purchased through the Project.

#### **ACTIONS**

**Implementing Agencies** - The IAs should identify staff who will assume responsibility for equipment maintenance.

**USAID/S** - USAID/S should allocate dollar funds from the Project for the purchase of spare parts and, wherever possible, for maintenance contracts for all major equipment.

**URC** - URC should develop an equipment plan including a) TA requirements for installation and IE staff maintenance training; b) a 24-month supply of spare parts; c) details of maintenance contract to be negotiated; and, (d) a list of companies to be contacted for maintenance and repair where no maintenance contracts are anticipated. URC should help prepare a compendium for the IAs containing an inventory of all major Project equipment together with details of all maintenance arrangements/instructions.

## K. FUTURE INVESTMENTS IN THE CENTRAL STATISTICS DEPARTMENT

**Findings** - The team observed that important progress has been made in the establishment of the data management center at the CSD. Maintenance of the computer mainframe is a major concern. The present contract with CALWANG, Nairobi expires in April 1990 and maintenance of the system beyond that date is unclear. The maintenance contract represents a \$60,000 annual expenditure. The CSD also faces a problem with site maintenance. The site maintenance contract expires within one year and presently local technicians are being trained. Whether they will be ready to assume full site maintenance responsibility prior to the end of the contract is questionable. Four computer programmers have received training in the U.S. and Holland. Two of the four have also received additional system analysis training at BUCEN. BUCEN also provides training for data management and analysis. CALWANG has trained an additional four persons in basic programming. To date, CALWANG has not provided training in maintenance of the system.

**Conclusions** - Maintenance of the system and site established at CSD is imperative. It is unlikely that sufficient training and experience can be accrued by local engineers for the maintenance of the system within the next twelve months. However, site maintenance expertise may be developed within that timeframe if appropriate OJT training is established. These issues should receive priority attention by USAID/S, UNFPA, the GOI and CALWANG and be included in the extension design.

**RECOMMENDATION** - USAID/S should explore the maintenance of the CSD system and site with CALWANG, UNFPA and the GOI to discern how the contracting and training issues will be addressed.

### ACTIONS

**Implementing Agencies** - CSD should prepare a list of priority concerns regarding the future maintenance of the computer system and present it to USAID/S by May 1989.

**USAID/S** - USAID/S should address the issue of maintenance of the CSD computer system within the Project amendment. This should be based on discussion with UNFPA and the GOI. Discussions with UNFPA and the GOI should focus on the extension of the site maintenance contract and future investments in improving the Somali capability to sustain the site.

**URC** - No action is anticipated.

## L. USAID/S MANAGEMENT

### L.1 General Backstopping

**Findings** - The team observed that the FHS Project requires substantial backstopping from USAID/S. It has been implied that the Mission has been slow to react to commodity requests and on their input into specific issues. The FSN's backstopping of the Project is notable. Regrettably, his DH Supervisor is overburdened and cannot devote full attention to the specifics of the FHS Project. Thus, the Project suffers from a lack of technical and policy direction coming from USAID/S. For example, many of the issues raised in this report should have been addressed through routine Mission management. It is recognized that there is little HPN technical depth in the Mission. It is further recognized that mission priorities and staffing patterns cannot (at this time) justify an HPN position. Thus, the dilemma.

**Conclusions** - Issues of strategy development, regional focus, policy development, outcome analysis, redirection of priorities, training, etc. all represent routine backstopping components of an A.I.D. CTO. A high level of direct hire personnel involvement is an important component of sound project implementation. The team recognizes that personnel time has necessarily been diverted because of priorities associated with the emergency. However, over the long-term, development programs should prevail. If USAID/S decides to maintain investments in FH, adequate in-house management/implementation capability should be assured.

The team concludes that USAID/S needs to reconsider its overall management of the FHS Project. More of an advisory role should be assumed to provide administrative as well as technical direction. In-house technical capability should be strengthened. More direct-hire time should be devoted to the management of the FHS Project.

**RECOMMENDATION** - USAID/S should examine its management of the FHS Project to increase its role as a technical and administrative advisor.

### **ACTIONS**

**Implementing Agencies** - No action required.

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USAID/S - USAID/S should review its staffing pattern and the SPAR for the GDO replacement. If future directions in family health are to be pursued, the Mission should recruit a direct hire with demonstrable technical skills to manage the FHS Project and advise the IAs.

URC - No action required.

## M. FINANCIAL ANALYSIS

### M.1 Overview

As of December 31, 1989, it is estimated that \$1,750,000 will remain available in the Project's pipeline. It is estimated that the Project requires approximately 150,000,000 Ssh. annually for implementing agency operation (thus, approximately 300,000,000 Ssh would be required to support the IAs throughout the Project period. The team estimates that the Project can function through December 1991 with the dollars presently available (assuming a refocused effort is pursued). The availability of local currency is more difficult to estimate. However, if the FY 1987 ESF tranche is released in FY 1989, and, if a proportion of the FY 87 ESF and PL 480 funds are committed to the Project by the DDD/MOF, a 24-month extension is feasible. If local currency is not made available, prospects for effective continuation of the Project are minimal. The team also notes that other donor investments in FH/FP are marginal, with the exception of IPPF and UNFPA interests in service delivery and to some extent IEC. It should be recognized that sustained progress will require continued donor support.

### M.2 Dollar Funding

Findings - Total obligations for the Project were \$10.1 million. Of this amount, \$1.6 million is currently unearmarked. An additional amount of \$.18 of earmarked funds are unlikely to be expended by the end of the Project. Together, these amounts total \$1.754 million that is available for de-obligation or for reprogramming. The team has prepared an estimate of the costs of a two year extension which totals \$1.755 million. A more detailed analysis of dollar and local costs is contained in Annex I.

Conclusion - That dollar funds will be available at the end of the project to finance a two year extension, as recommended elsewhere in this report.

RECOMMENDATION - That the Mission utilize the \$1.7 million which will be available at the end of the current Project, to fund a no cost extension for two years, as set forth in Annex I.

### M.3 Local Cost Financing

**Findings** - Local currency support is essential to the successful operation of the Project in terms of personnel incentives, vehicle and other operating costs, and operating activities. There are two issues, both of which go beyond this Project, that affect local currency funding. The first is the authorized level of personnel incentives. The Mission is aware of this problem and is addressing it. However, the system currently has created an imbalance in the salaries for SFHCA employees that needs to be addressed.

There is also a current problem of the overall availability of A.I.D. generated funds. The funds apparently available will not support current operations.

The projected annual budgets for FHS Project A.I.D. generated funds is estimated at Sh. 169.4 million in FY 1990 and Sh. 183.3 million in FY 1991.

**Conclusion** - Local currency support is essential to the success of the Project. If local currency generations are not available, then the Mission should consider diversion of dollar funds to purchase the necessary local currency.

**RECOMMENDATION** - That the Mission make every effort to sustain the approved budget levels for FY 1989, in the short term and support the salary levels requested by SFHCA, but at the level of a 50 percent increase. The Mission should program its local currency generations in FY 1990 and FY 1991 to support the levels recommended in Annex I. Finally, the Mission should pursue its efforts to reconcile the incentives currently being provided by the various donors.

## VI. LESSONS LEARNED

Overview - The FHS Project has been successful because it achieved a significant amount of inter and intra-agency cooperation and motivation. There was little in place regarding family planning activities in Somalia, and basically new ground could be broken. The Project had/has the support of political, technical and administrative agencies and organizations, and has been flexible in its commodities and training components. Equity among the participating agencies both at the central and regional levels has been pursued, and has been perceived as a major unifying force of the Project. Some specific lessons learned follow.

- o Core Contractor - Interpersonal as well as technical skills play an important part in successful implementation. Future long-term and short-term advisors should be screened accordingly. (It should be noted that the present URC COP has performed admirably.)
- o Political Will - Political will, although intangible, has much to do with the Project's success. At present, intense policy pressure on the GSDR for a formal FH policy could impede progress.
- o Vehicles - American-made vehicles required in the Project represents a serious mistake in investment. Vehicles cannot be maintained and are not well suited for the terrain. Annual maintenance approaches purchase price. This practice should be avoided in all future Agency programming in Somalia.
- o Policy Development within Project Assistance - The progress in development through the Project is notable. USAID/S (and AID/W) should embrace the opportunities for policy development in project assistance.
- o Maintenance of Equipment - This issue pervades all aspects of project sustainability. Serious concerns exist regarding the maintenance of the CSD computer hardware, software and site. This issue needs to be dealt with prior to the design of the extension.

- o Policy/and Technical Level Coordination - It is important that policy makers are sensitized to the critical technical issues related to policy reform. Although the Project made excellent progress in this area, more could have been done by USAID at higher levels of government.
- o Strategic Planning - The Project could have placed more emphasis on strategic planning for policy reform, IEC and service delivery. USAID/S could have been more active in this regard either through its own offices, REDSO/ESA or AID/W. URC also requires further depth in this area and should schedule TA accordingly.
- o Sequence of Events - As mentioned in Section V.A.3, Somalia must move at its own pace in policy development. A reasonable sequence of events for implementation might be: political will-awareness-service delivery-behavioral change-use.
- o Project Objectives - One of the shortcomings of the Project design is that it focused too much attention on family planning and not enough on family health. The Project approached family planning service too vertically, and more linkage among MOH and donor MCH and child survival activities is recommended. Shared accounts (perhaps 50% population, 25% health, 25% child survival) for a follow-on might be considered if/when a follow-on project is designed.
- o Flexibility - Part of the Project's success has been a degree of flexibility for TA, commodities and local currency expenditures. This should be maintained as appropriate.
- o Investments in Management - A long-term management advisor may not always fulfill management needs. Specific management benchmarks should be set and monitored from the beginning of a project.
- o Advisory Role of URC - The Project promoted the core contractor apparently more as an implementor than advisor. A clear distinction should be made in future USAID/S programs. Appropriate emphasis should be placed on each.

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- o **USAID Responsiveness to Commodity Request** - Through interviews, it was implied that Mission response to commodity requests could have been more rapid. This issue might be explored further during the extension design.
- o **Sustainability in Somalia** - The Project could have done more to institute sustainable components within the implementing agencies and MOH. Future efforts might include TA for proposal writing and submission to various donor and nongovernment organizations. Generally speaking, sustainability in Somalia will be very difficult in the foreseeable future due to economic stress and civil strife.
- o **Awareness vs Use** - There is a large gap between awareness and use. Project investments should set realistic targets base on social mores and local priorities.
- o **Difficulties of Service Delivery Outreach** - Somalia is a rugged country and logistics are often difficult. This needs to be taken into account.

ANNEX I

FINANCIAL ANALYSIS

A. STATUS OF DOLLAR FUNDS

Table I-1 provides a forecast of dollar funds available at the end of the FHS Project. It is based on the status of available funds as of March 21, 1989. A total of \$10,100,000 has been obligated for the project. The current status of these funds is set forth in the following paragraphs.

Earmarked funds total \$8,529,000, leaving an unearmarked balance of \$1,571,000, almost entirely in commodities. Most of these funds were initially programmed for contraceptives. They have not been utilized because of delays in the start-up of the project, and because demand has not materialized as rapidly as expected, despite the relative overall success of the project. The current procurement of contraceptives should be sufficient to carry the project through to completion, so that these funds will be available for reprogramming at the PACD.

The uncommitted, earmarked balance is currently \$1,447,278, but it is of little value in assessing end of project fund availabilities. It includes \$746,747 for a URC contract amendment that is in process, and \$276,300 in funds earmarked for the FSU, but not yet committed. These funds will ultimately be committed and expended.

Table I-2 contains a forecast of expenditures between now and the end of the project by category, by PIO. The forecast indicates that \$182,774 of earmarked funds will not be expended. Almost half of this amount is in training funds for URC, which were deleted by the recent contract amendment.

In summary, Table I-1 shows a total of \$1,754,000 available for reprogramming when the project is completed. It consists of the unearmarked funds currently available, and the estimated balance of earmarked funds that will not be expended. Potential utilization of these funds for a no cost extension of the project is discussed in the following section.

B. DOLLAR COSTS OF EXTENSION

This report recommends a two year, no cost extension of the Family Health Services Project. The costs of such an extension are shown in Table I-3. They total \$1,754,540. The person months of effort on which these costs are based are shown in Table I-4.

## C. LOCAL CURRENCY COSTS

### C.1 General

This section deals only with A.I.D. generated local currency funds which are managed jointly by the mission and the Domestic Development Department (DDD) of the Ministry of Finance. These are not the total local costs of the project, which include funds provided under regular budgets of the organizations involved. It was not feasible in the time available for this evaluation to track these regular budget costs. However, the DDD funds are essential to the operations of the FHS Project. Project activities cannot be sustained without this additional local currency support, at least for the foreseeable future. This issue of sustainability will need to be addressed in the consideration of any follow-on project, although it is a problem common to development projects in a LDC, like Somalia.

### C.2 Budget History

Table I-5 presents the budget history for the DDD funds, by line item, by agency and in total. This table does not include the budgets of the MONP, because the high expenses of the census in FY 1987 would distort the overall comparison. The data for MONP are shown in Table I-6. Both tables show actual expenditures for FY 1987 and FY 1989, and the approved budgets for FY 1989. However, the FY 1989 budgets have been adjusted for the reduced amounts for personnel compensation, an issue that is discussed below.

The budget patterns in Table I-5 clearly reflect the growth of project activities that has taken place. Overall, the non-census activities' recurring budgets have more than doubled from FY 1987 to FY 1989. While all categories of expense have increased, the great majority of this increase has occurred in the categories of training and project implementation. These categories fund the operating activities of the project. They are complementary, and to a degree, fungible. Together, training and project implementation have increased from Sh. 19.1 million in FY 1987 to Sh. 42.1 million this year. Sh. 13.1 million of this increase occurred in the MOH alone.

The budgets for the FHS Project for FY 1989 total Sh. 127.4 million. This is a substantial reduction from the original requests, which totalled Sh. 182.8 million. During the budget revisions, the budgets were subjected to an inter-agency review process led by the URC Team Leader. Budgets were shared among agencies, and agreement was reached on work plans and common cost factors for items such as fuel consumption. As a result, aside from the personnel compensation question, the approved budgets appear to be reasonable estimates of the budget requirements for the participating institutions for this year.

### C. 3 Budget Issues

There are two major issues with regard to the local currency budgets, neither of which is unique to the FHS Project. The first is the level of personnel compensation. The Ministry of Finance required all agencies to adhere this year to the allowances established in July 21, 1986 by the Committee for Economic Affairs. The effect of the resulting reductions is shown in Table I-7. They total Sh. 8.3 million, 25.3 percent of the personnel line item. This overall figure is understated, because the MOH's budget was not reduced. When the Ministry learned that the 1986 guidelines were to be applied, it revised its budget to adhere to them, using the savings (some 2 million) for fees for lecturers to women's groups in Mogadishu, and compensation for additional regional personnel.

In this process, the DDD eliminated salary increases of 100% requested by SFHCA. However, the IPPF, which pays the salaries of about half of the SFHCA employees, has granted 50% salary increases for this year. This disparity needs to be eliminated, if possible, and the increase of 50% appear reasonable in light of the salary increases which the Mission recently granted to its own local employees.

The second issue concerns the shortage of A.I.D. generated shillings, as a result of Congressional restrictions on the expenditure of ESF funds, and reduced PL-480 levels. If currently available shillings are distributed on a straight pro-rata basis in the second quarter of this year, the FHS Project's share would be about Sh. 5.7 million per month. Since the direct operating costs of the agencies involved total Sh. 5.5 million per month, there would be virtually no funds available for the critical training and project implementation activities.

### C.4 Future Fund Requirements

The FY 1989 budgets for the participating agencies include Sh. 16.4 million for capital improvements. These amounts are based on engineering estimates and appear to be reasonable, and the work to be necessary. None of the agencies identified additional capital needs at this time.

Table I-8 shows the approved budgets for FY 1989, and the forecasts for FY 1990 and FY 1991, by line item, by agency, and in total. The budget projections are based on the following assumptions:

- The reductions in personnel compensation made this year will be restored in FY 1990, except for SFHCA, which will be granted a 50 percent increase that year, to equalize the salary structure of their employees.

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- All costs, except personnel are inflated by 40 percent in 1990.
- An additional Sh. 16.5 million has been budgeted for SFHCA in FY 1990, and are included in the line item for project implementation. These funds are for the local costs of the recommended KAP survey, and it is anticipated that they will be distributed among the agencies participating in the survey, when the FY 1990 budgets are actually prepared.
- All costs are inflated by an additional 20 percent in FY 1991.

These assumptions result in a fairly straight line projection of the local cost budgets for the FHS Project, assuming that the forecast inflation materializes. This method is reasonable, since the agencies will not have significant personnel or equipment changes in the next two years. It is most problematic with regard to training and project implementation. The level of activities in these two categories may well increase further in the next two years. However, these costs are built up from detailed plans for specific, often relatively small activities. Future year work plans for these activities, which would be needed for a more precise estimate, are not available.

In summary, Table I-8 shows a total requirement of Sh. 169.4 million in FY 1990, and 183.5 million in FY 1991. As noted above, the availability of these funds is critical to the success of the proposed project extension.

TABLE I-1

FAMILY HEALTH SERVICES PROJECT  
FORECAST OF FUNDS AVAILABLE END OF PROJECT  
(\$000)

CATEGORY	OBLIGATED	EARMARKED	UNEXPENDED BALANCE	EXPEND FORECAST	BALANCE AVAILABLE
TECH ASSIST	5,320	5,303	1,571	1,556	32
TRAINING	530	513	119	30	106
COMMODITIES	4,250	2,713	893	814	1,616
TOTAL	10,100	8,529	2,583	2,400	1,754

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TABLE I-2  
EXPENDITURE FORECAST - FAMILY HEALTH SERVICES

	PIO	SUBJECT	UNLIQUIDATED EARMARKED	FORECAST EXPENDITURE	EOP BALANCE
TA	40025	FSU	36	36	0
	40069	FSU	2,170	2,170	0
	40075	PSCSeidma	3,310	0	3,310
	40091	MID EVAL	287	0	287
	40095	INPLAN	11,000	0	11,000
	50061	MID EVAL	77	0	77
	40069	FSU	219,109	219,109	0
	50026	FSU	42,447	42,447	0
	50021	BUCEN	74,910	74,910	0
	90001	FSU-89	196,465	196,465	0
	50007	URC	755,930	755,930	0
	60068	SFHA	190,655	190,655	0
	60077	FIN EVAL	70,222	70,222	0
	PO007	KANYARE	4,104	4,104	0
		Subtotal	1,570,722	1,556,048	14,674
TRAINING	50007	URC	119,370	30,098	89,272
COMMODITIES	40042	FSU	625	625	0
	40067	VEHICLES	65,881	47,811	18,070
	40073	CAL WANG	71,175	57,285	13,890
	50078	VEHICLES	67,097	67,097	0
	50089	COMPSUP	28,800	28,800	0
	60001	COMMOD	18,780	0	18,780
	60040	CLIN SUP	28,088	0	28,088
	60046	CLIN COMM	291,950	291,950	0
	60056	PHARMA	112,360	112,360	0
	50007	URC	207,814	207,814	0
		Subtotal	892,570	813,742	78,828
TOTAL			2,582,662	2,399,888	182,774

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TABLE I-3  
 FAMILY HEALTH SERVICES PROJECT  
 FORECAST DOLLAR COSTS OF TWO-YEAR EXTENSION

CATEGORY	LOADED UNIT COST	QTY	YEAR 1 \$	YEAR 2 QTY	\$	TOTAL
HOME OFFICE SUPPORT						
Project Manager	6,000	4	24,000	3	18,000	42,000
Admin. Assistant	3,600	4	14,400	3	10,800	25,200
LONG TERM TA						
Team Leader	11,750	11	129,250	11	129,250	258,500
Nurse Trainer	8,500	11	93,500	7	59,500	153,000
ALLOWANCES (30%)			33,413		28,313	61,725
FSU SUPPORT	5,500	24	132,000	18	99,000	231,000
LOCAL STAFF	990	12	11,880	12	11,880	23,760
SHORT TERM TA						
	13,000	15	195,000	10	130,000	325,000
TRAVEL & TRANSPORT						
Long Term Staff	3,840	4	15,360	4	15,360	30,720
Home Office	3,840	1	3,840	0	0	3,840
Transport	7,000	2	14,000	2	14,000	28,000
OTHER DIRECT COSTS						
Communication, etc	1,200	12	14,400	9	10,800	25,200
Local Costs	2,500	12	30,000	12	30,000	60,000
COMMODITIES						
Computer Maint.	60,000	1	60,000	1	60,000	120,000
Secondary Textbook	130,000			1	130,000	130,000
Contraceptives	60,000	1	60,000	1	60,000	120,000
PARTICIPANT TRAINING						
Study Tours	5,000	10	50,000	5	25,000	75,000
INFLATION					41,595	41,595
TOTAL			881,043		873,498	1,754,540

TABLE I-4

FAMILY HEALTH SERVICES PROJECT EXTENSION  
PERSON MONTHS OF EFFORT

<u>CATEGORY</u>	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>TOTAL</u>
Long Term TA	22	18	40
Short Term TA	10	10	20
Home Office Support	8	6	14
Participants	10	5	15

These person months have been costed in Table I-3 using loaded monthly rates (i.e. rates that include fringe, overhead, G & A and fee), on the assumption that the extension will be executed by an institutional contractor. Additional assumptions underlying Table I-3 are as follows:

- Costs for FSU support are based on the FY 1989 level for the current contract.
- The maintenance contract for the census computer at the Ministry of National Planning will be extended for two years.
- 100,000 copies of the textbook, "Where There Is No Doctor" will be published, based on the previous publication costs for Nairobi.
- An inflation factor of 5% is added to all costs in year 2.

In summary, the estimated total costs of the proposed extension, by category are:

Technical Assistance	\$1,230,790
Training	\$76,250
Commodities	<u>\$447,500</u>
Total	\$1,754,540

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TABLE I-5

FAMILY HEALTH SERVICES PROJECT  
LOCAL CURRENCY BUDGET HISTORY (Sh000)

LINE ITEMS	TOTAL				
	FY 1987	FY 1988	% CHANGE	FY 1989	% CHANGE
Personnel	6,721	7,970	19%	19,842	149%
Per Diem/Trvl	1,472	3,187	117%	3,940	24%
Bldg/Maint	1,487	3,064		3,904	27%
Office	5,352	4,824	-10%	11,749	144%
Vehicles	6,064	6,506	7%	13,066	101%
Subtotal	21,096	25,551	21%	52,501	105%
Training	5,193	1,642	-68%	13,190	703%
Proj Impl	14,809	14,208	-4%	29,076	105%
Total Recur	41,098	41,401	1%	94,767	129%
Capital	750	2,662	-	16,402	
TOTAL	4,848	44,063	-	111,169	

LINE ITEMS	IWE				
	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	1,095	1,683	54%	2,364	40%
Per Diem/Trvl	163	425	161%	756	78%
Bldg/Maint	0	0	-	0	-
Office	127	359	183%	417	16%
Vehicles	1,956	1,756	-10%	2,715	55%
Subtotal	3,341	4,223	26%	6,252	48%
Training	4,024	986	-75%	2,844	188%
Proj Impl	0	2,331		3,228	38%
Total Recur	7,365	7,540	2%	12,324	63%
Capital	0	0		5,000	
TOTAL	7,365	7,540		17,324	

LINE ITEMS	CDC				
	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	841	1,190	41%	1,014	-15%
Per Diem/Trvl	0	90		0	-100%
Bldg/Maint	0	0		0	
Office	0	0		25	
Vehicles	414	253	-39%	706	179%
Subtotal	1,255	1,533	22%	1,745	14%
Training	0	0		0	
Proj Impl	2,277	806	-65%	8,260	
925%					
Total Recur	3,532	2,339	-34%	10,005	
328%					
Capital	0	1,100		5,729	
TOTAL	3,532	3,439		15,734	

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TABLE I-5 -

LOCAL CURRENCY HISTORY (Sh000)

LINE ITEMS	SFHCA				
	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	2,284	1,730	-24%	2,871	66%
Per Diem/Trvl	465	143	-69%	144	1%
Bldg/Maint	1,487	3,064	106%	3,544	16%
Office	763	994	30%	1,137	14%
Vehicles	1,252	1,802	44%	5,203	189%
Subtotal	6,251	7,733	24%	12,899	67%
Training	0	656		91	-86%
Proj Impl	5,233	2,978	-43%	5,854	97%
Total Recur	11,484	11,367	-1%	18,844	66%
Capital	0	0		0	
TOTAL	11,484	11,367		18,844	

LINE ITEMS	SWDO				
	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	627	931	48%	2,800	201%
Per Diem/Trvl	0	411		336	-18%
Bldg/Maint	0	0		0	
Office	873	927	6%	3,961	327%
Vehicles	1,324	814	-39%	2,150	164%
Subtotal	2,824	3,083	9%	9,247	200%
Training	0	0		1,716	
Proj Impl	6,621	6,641	0%	5,304	-20%
Total Recur	9,445	9,724	3%	16,267	67%
Capital	0	0		0	
TOTAL	9,445	9,724		16,267	

LINE ITEMS	MOH				
	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	1,874	2,436	30%	10,793	343%
Per Diem/Trvl	844	2,118	151%	2,704	28%
Bldg/Maint	0	0		360	
Office	3,589	2,544	-29%	6,209	144%
Vehicles	1,118	1,881	68%	2,292	22%
Subtotal	7,425	8,979	21%	22,358	149%
Training	1,169	0	-100%	8,539	
Proj Impl	678	1,452	114%	6,430	343%
Total Recur	9,272	10,431	13%	37,327	258%
Capital	750	1,562		5,673	
TOTAL	10,022	11,993		43,000	

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TABLE 1-5  
LOCAL CURRENCY HISTORY (Sh000)  
MINISTRY OF NATIONAL PLANNING

LINE ITEMS	FY 1987	FY 1988	CHANGE	FY 1989	CHANGE
Personnel	1,912	4,347	127%	4,700	8%
Per Diem/Trvl	133,364	0	-100%	0	
Bldg/Maint	0	0		0	
Office	13,563	1,441	-89%	2,000	39%
Vehicles	26,122	5,313	-80%	6,645	25%
Subtotal	174,961	11,101	-94%	13,345	20%
Training	1,999	861	-57%	144	
Proj Impl	505	1,326	163%	2,040	54%
Total Recur	177,465	13,288	-93%	15,529	17%
Capital	0	0		677	
TOTAL	177,465	13,288		16,206	

TABLE I-7

FAMILY HEALTH SERVICES PROJECT  
REVISED PERSONNEL COSTS FY 1989  
(Sh 000)

AGENCY	BUDGET	CURRENTLY APPROVED	DIFFERENCE	% DIFFERENCE
IWE	3,456	2,364	1,092	-31.6%
CDC	2,280	1,014	1,266	-55.5%
SFHCA	5,780	2,871	2,909	-50.3%
SWDO	4,056	2,800	1,256	-31.0%
MOH	10,793	10,793	0	0.0%
MNP	6,496	4,700	1,796	-27.6%
TOTAL	32,861	24,542	8,319	-25.3%

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TABLE I-8  
 FAMILY HEALTH SERVICES PROJECT  
 LOCAL CURRENCY BUDGET FORECAST (Sh000)

TOTAL			
=====			
LINE ITEMS	FY 1989	FY1990	FY1991
Personnel	24,542	32,861	39,433.
Per Diem/Travel	3,940	5,516	6,619
Building Maintenance	3,904	5,466	6,559
Office	13,749	19,249	23,098
Vehicles	19,711	27,595	33,114
Subtotal	65,846	90,687	108,824
Training	13,334	18,668	22,401
Project Implementation	31,116	60,062	52,275
Total Recurring	110,296	169,417	183,500
Capital	17,079	0	0
TOTAL	127,375	169,417	183,500

IWE			
===			
LINE ITEMS	FY 1989	FY 1990	FY 1991
Personnel	2,364	3,456	4,147
Per Diem/Travel	756	1,058	1,270
Building Maintenance	0	0	0
Office	417	584	701
Vehicles	2,715	3,801	4,561
Subtotal	6,252	8,899	10,679
Training	2,844	3,982	4,778
Project Implementation	3,228	4,519	5,423
Total Recurring	12,324	17,400	20,880
Capital	5,000	0	0
TOTAL	17,324	17,400	20,880

CDC			
===			
LINE ITEMS	FY 1989	FY 1990	FY 1991
Personnel	1,014	2,280	2,736
Per Diem/Travel	0	0	0
Building Maintenance	0	0	0
Office	25	35	42
Vehicles	706	988	1,186
Subtotal	1,745	3,303	3,964
Training	0	0	0
Project Implementation	8,260	11,564	13,877
Total Recurring	10,005	14,867	17,841
Capital	5,729	0	0
TOTAL	15,734	14,867	17,841

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TABLE I-8

LINE ITEMS	SFHCA		
	FY 1989	FY 1990	FY 1991
Personnel	2,871	5,780	6,936
Per Diem/Travel	144	202	242
Building Maintenance	3,544	4,962	5,954
Office	1,137	1,592	1,910
Vehicles	5,203	7,284	8,741
Subtotal	12,899	19,819	23,783
Training	91	127	153
Project Implementation	5,854	24,696	9,835
Total Recurring	18,844	44,642	33,771
Capital	0	0	0
TOTAL	18,844	44,642	33,771

LINE ITEMS	SWDO		
	FY 1989	FY 1990	FY 1991
Personnel	2,800	4,056	4,867
Per Diem/Travel	336	470	564
Building Maintenance	0	0	0
Office	3,961	5,545	6,654
Vehicles	2,150	3,010	3,612
Subtotal	9,247	13,082	15,698
Training	1,716	2,402	2,883
Project Implementation	5,304	7,426	8,911
Total Recurring	16,267	22,910	27,492
Capital	0	0	0
TOTAL	16,267	22,910	27,492

LINE ITEMS	MOH		
	FY 1989	FY 1990	FY 1991
Personnel	10,793	10,793	12,952
Per Diem/Travel	2,704	3,786	4,543
Building Maintenance	360	504	605
Office	6,209	8,693	10,431
Vehicles	2,292	3,209	3,851
Subtotal	22,358	26,984	32,381
Training	8,539	11,955	14,346
Project Implementation	6,430	9,002	10,802
Total Recurring	37,327	47,941	57,529
Capital	5,673	0	0
TOTAL	43,000	47,941	57,529

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TABLE I-8

LINE ITEMS	MNP		
	FY 1989	FY 1990	FY 1991
Personnel	4,700	6,496	7,795
Per Diem/Travel	0	0	0
Building Maintenance	0	0	0
Office	2,000	2,800	3,360
Vehicles	6,645	9,303	11,164
Subtotal	13,345	18,599	22,319
Training	144	202	242
Project Implementation	2,040	2,856	3,427
Total Recurring	15,529	21,657	25,988
Capital	677	0	0
TOTAL	16,206	21,657	25,988

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ANNEX II

FHS PROJECT BENCHMARKS

PROJECT OUTPUTS/INDICATORS

PROJECT ACHIEVEMENTS

PROJECT PURPOSE

To strengthen the capabilities of Small Institutions to promote, coordinate & sustain FH programs.

PROJECT SUB-PURPOSE

A) To strengthen capabilities of Small Institutions to collect, process, analyze and apply population data:

- Central Statistics Department has improved computational technology
- FH Institutions have improved technical & management skills to produce, analyze & apply FH and pop'n data

Software developed for tabulating & editing census data, 8 programmers trained in its use & entry of census data commenced. The WANG hardware handed over to GSDR 6/88

One demographic study completed during LOP. 9 studies of FH practice also conducted & data used to plan IEC activities

B) To increase the operational capability & effectiveness of Institutions involved in the delivery of FH IEC services:

- Increased IEC programs supporting FH services
- FH services personnel have greater effectiveness to motivate couples to adopt family health practices

24 radio programs on FH have been aired. House-to-house campaigns were conducted by In Mogadishu SWDO. SFHCA sponsored 1 day seminars for religious & political in 4 regions. 62 instructors for family life centers, have been trained by IWE to provide FH training in villa. Several songs, poetry & television dramas have been developed and aired

Work begun to incorporate FH into basic nursing and post basic midwifery curriculum. All staff receiving training in FH (630 persons) receive FH motivation/communications skills training

C) To strengthen the capabilities of Small Institutions to plan, implement & evaluate clinical FH services:

- Clinical FH services of MOH will be updated and extended

The number of clinics offering FH services has increased from 20 to 55. Clinic record keeping forms have been simplified. Increased efforts to improve integration of FH & MCH services are being made. FH Training/referral site established at Benadir Hospital.

ANNEX II - FHS PROJECT BENCHMARKS (PAGE 2)

PROJECT OUTPUTS/INDICATORS

PROJECT ACHIEVEMENTS

C) To strengthen the capabilities of Small Institutions to evaluate FH program Implementation, to Investigate & Identify the most effective delivery approaches, & to assist in planning and Implementation:

- Personnel who are implementing FH programs will have improved knowledge & skills related to OR
- FH programs will be guided by an effective operations research program

- A number of OR workshops/seminars have been conducted for FH staff. 1 person at SFHCA has received training & participated in O/S study tours related to OR.
- The OR Unit at SFHCA has one staff member. The targets for this component have not been fully realized.

OUTPUTS

1. Upgraded computer hardware & software:

- One system operating

- VS 100 mainframe computer, peripherals and software (CENTS 4) operational.

2. Population census:

- Population counts for all persons & tabulations for 10% of the population

- No counts available (Census data collected & data entry commenced. Total analysis to be completed 1/91)

3. Report of analysis of 1980 population survey:

- One report

- No report available (Census data collected & data entry commenced. Total analysis to be completed 1/91)

4. Demographic studies:

- Two studies

- One study completed for Wadajir District

5. Workshops on data analysis & planning techniques:

- Four workshops

- 5 OR workshops, 2 OR orientation, 1 data analysis & 1 planning techniques seminar

6. National population conferences

- Two conferences

- One conference held; 2nd conference planned for 1989

7. IEC Baseline data report

- One report

- IEC baseline survey & report completed in 1986

8. Annual workplans which integrate FH IEC activities:

- One workplan & four annual plans

- Integrated IA workplan produced for 1989. Annual workplans produced by each IA for each of 4 years

9. Establishment of IEC Unit and Resource Center:

- One Unit and one Resource Center

- IEC unit & Resource Center established at SFHCA

10. Trained IEC staff and FH personnel:

- 585 people trained

- 245 IEC staff/FH personnel trained from MOH, IWE & SWDO. 1594 SWDO Tabelle Leaders trained

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ANNEX II - FHS PROJECT BENCHMARKS

PROJECT OUTPUTS/INDICATORS

PROJECT ACHIEVEMENTS

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| <p>11. FH curriculum &amp; classroom materials developed:<br/>- 100 sets A-V materials &amp; 1 FH curriculum</p> <p>12. Implementation activities increased:<br/>- 100,000 pamphlets, 30,000 posters, 2 sets of slides, 2 weekly radio features</p> <p>13. Improved cadre of FH trainers, In-service &amp; pre-service training programs:<br/>- 20 trainers, 30 nurse tutors &amp; 480 personnel trained</p> <p>14. FH MCH Training Center established:<br/>- One center operating</p> <p>15. Special FH services established<br/>- 3 hospitals provide voluntary surgical sterilization, infertility services, &amp; STD services</p> <p>16. Management systems for clinical FH services:<br/>- Management system in place</p> <p>17. Expansion of FH services:<br/>- 60 MCH centers and 20 hospitals providing FH services</p> <p>18. Operations Research Unit established:<br/>- One unit operating</p> <p>19. Seminars on operations research methods:<br/>- One seminar</p> <p>20. Operations research reports:<br/>- Three reports</p> <p>21. Family Health survey:<br/>- One survey report</p> <p>22. Monitoring systems for FH programs established:<br/>- Five program monitoring systems</p> | <p>- 21 sets A/V materials, 6 primary school curricula, and 1 FH curriculum for training IWE Family Life Instructors for Family Life Centers in 62 villages</p> <p>- 75000 pamphlets, 30000 posters, 1 set of slides, &amp; 24 weekly radio features</p> <p>- 20 trainers, 10 nurse tutors, &amp; 395 personnel trained</p> <p>- 1 FH training/referral centre established (Benadir Hoop)</p> <p>- One hospital providing specialist infertility &amp; STD services (Benadir)<br/>(Provision of VSC services illegal in Somalia)</p> <p>- Logistics, MIS &amp; supervisory systems designed &amp; operating in MOH</p> <p>- 49 MCH centers, 35 private physicians and 6 hospitals providing FH services (9 further MCH centers in the north have been closed services disrupted due to the emergency)</p> <p>- One operations research unit established at SFHCA</p> <p>- One seminar held in 10/87, a second held 3/88</p> <p>- 9 OR reports completed</p> <p>- No survey conducted</p> <p>- FH clinical record, client statistics, contraceptive logistics, training registration systems in place</p> |
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ANNEX III

COMPONENTS OF A REGION-WIDE KAP SURVEY

RATIONALE - Given the scope of IEC activities which have occurred during the last several years, particularly concerning female circumcision, child-spacing and breast feeding, it is essential to know what kind of impact has been made, and where and how the IEC program has been most effective. Thus, a knowledge/Attitudes/Practices (KAP) survey during the extension period is in order to accurately assess project achievements regarding awareness and use of contraceptives. It should be designed by the end of 1989 and concluded by the end of 1990.

Available Data - While several small surveys have been done on narrow segments of the population, to the best of the team's knowledge, no information based on a broad representative sample of the general population is available. The KAP survey suggested in this evaluation should be confined to the five IEC regions, with possible control samples taken from contiguous regions. Some baseline information is available in the 1983 KAP Survey, which was done only in five urban areas of Somalia. A 1985 baseline survey of a very small sample, but obtained through in-depth interviews, contains much insight into Somali KAP. This latter survey has never been tabulated in a statistical format. Little seems to be known about the general health status of the Somali population, other than crude estimates of maternal/child mortality. A Demographic Health Survey could be useful to the Ministry of Health in the future, possibly if USAID/S approves a follow-on project for the 1990s.

Groups Included - Because of the differences in urban/rural/nomadic life styles and the trends in rural/urban migration in Somalia, these categories should be emphasized in the proposed KAP survey. A breakdown by socio-economic status (SES) variables may include:

physicians	teachers
educated elites,	long-term urban dwellers
recent rural migrants	pregnant women (urban/rural)
recently delivered women	urban youths
(urban/rural)	rural youths,
urban men with families	rural men with families
women of child-bearing age	religious leaders

A complementary option to consider is a RAPID Analysis. However, at this point in time the team recommends a focused KAP to assess project impact among the diverse population groups in Somalia. The team notes that a RAPID presentation would fit well into project activities regarding policy development, particularly if the social costs due to accelerated population growth can be demonstrated to the GSDR. A brief outline of the KAP workplan is presented below.

COMPONENTS OF WORKPLAN

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ITEM	DESCRIPTION
Timeframe:	(6/89-12/90)
Technical Assistance: (12 person-months)	1) Design of Study (2pm) (6/89) 2) Conduct of Study (6 pm) (9/89-6/90) (2x3m visits) 3) Data Analysis (2 pm) (7/90-9/90) 4) Results/Report (2 pm) (10/90-12/90)
Potential Somali Participation:	1) SFHCA (OR Unit) 2) IWE 3) CSD 5) MCH (Dr. Asli) 4) Faculty of Medicine 6) Academy of Arts & Letters
Mechanism:	Buy-In to Central Project (FHI/other) URC Resources CAFS Project (?)
Estimated Cost:	\$200,000

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ANNEX IV

REVIEW OF IMPLEMENTING AGENCY  
IEC ACTIVITIES

I. Somali Family Health Care Association (SFHCA)

Findings - SFHCA oversees a comprehensive IEC program that involves training communicators, designating target audiences, developing and evaluating messages, and designing and testing materials. They also chair an IEC Implementing Committee that includes CDC, IWE, SWDO, and MOH. A small staff of eight includes an IEC Director and an assistant, a training officer and training assistant, a librarian, and an audio-visual expert on loan from MOE. A graphic artist is hired as needed and serves the needs of all participating institutions.

Training in IEC techniques has been implemented and coordinated by SFHCA. A team of core trainers, with a member from each IA mentioned above, trains regional trainers who in turn, are responsible for district level training. For work at the community and/or village level, IWE and SWDO have the most effective means of communication with input from MOH and CDC, and coordinated by SFHCA. Training manuals and materials have been developed for these groups and have been put to use in the regions.

As a result of TOT training sessions, which included workshops, technical training abroad and study tours, a wide variety of cadres are capable of understanding the health benefits of child spacing and breast feeding, as well as the morbidity and mortality associated with extreme forms of female circumcision.

Target groups, as set up by the IEC strategy paper, comprise mostly those who influence and/or formulate policy, both within government and without, as well as IAs. The general population has not been broken down much beyond Family Life Center students (women), other women reached through orientation centers, out-of-school youth and adult men. While this strategy was appropriate at the start of the Project, sufficient progress has been made to decide on more specific target groups.

Materials development has consisted of producing manuals, pamphlets, flip charts, etc. that are useful in training.

Some pamphlets and posters have been designed for the public and slide shows have been well received. Audio-visual equipment is available and some television shows have been produced, but have reached a very limited audience. In a nation with a strong oral tradition, SFHCA can exploit more effectively Somali love of drama, song and poetry by supervising and encouraging among the five IA's the production of these artistic approaches.

Previous studies have shown that a great deal of misinformation and ignorance exists about modern methods of contraception. They also have shown that as much as 50 percent of the public may approve of the use of contraception. However, these data should be viewed with caution. Some messages, both oral and written should be tried to increase specific knowledge and approval of modern methods of family planning. Some observers also believe that growing hardship from scarcer food supplies and falling literacy rates may be beginning to have an effect on attitudes toward population growth.

Conclusions - With the variety and complexity of tasks assigned to SFHCA, plus the small size of the staff, it is safe to say that it is fully occupied with its role in coordinating training and materials development. Its ability to undertake research and do surveys to gain better access to target audiences has been hindered by a lack of personnel, space, and by competing interests.

The TOT phase of the Project has resulted in a significant turn-around in attitudes. While no firm figures are available, the team observed instances of effective communication with village women. A more precise measurement of the change in opinion among leaders and the general public in Somalia must await the results of a follow-up KAP. Nevertheless, there are pockets of dissent or lack of knowledge which are noticeable to observers, and which can be addressed at this point. As one informant put it, some religious and political leaders need further attention to convince them of the merits of Project goals, particularly some sheiks. It is believed that fear of the Sheik's opposition to Project activities hinders progress in achieving more wide-spread acceptance of family health and child spacing messages.

To maintain the momentum in changing public attitudes toward the issues the Project raises, SFHCA should continue to conduct workshops and arrange a study tour to other Islamic countries for political and religious leaders. Physicians in general have had little workshop exposure and technical training in family health/family planning issues and methods. Other training could include Red Crescent volunteers who are reported

to be effective in community work. A new project funded by WHO to train primary health care workers in community work shows promise for coordination with SFHCA. Considering the IEC Implementing Committee's demonstrated success in training field workers, their collaboration with WHO could result in a speedy delivery of family health services in WHO target areas, which overlap in some instances with the FHS.

**RECOMMENDATION** - To maintain the momentum in changing public attitudes toward FH issues, SFHCA should continue to conduct workshops for political and religious leaders, as well as study tours to other Islamic countries, if appropriate. Physicians in general also need workshop exposure and technical training in family health/ family planning issues and methods. Other training could include Red Crescent volunteers who are reported to be effective in community work. Collaboration with a new project funded by WHO to train primary health workers in community work should be considered.

Message content and delivery for specific target audiences in the general public should continue to receive more emphasis. An overall strategy for reaching each group should be devised and the link between interpersonal communication and the mass media should be reinforced. Information about available health services should also be provided. Some messages to test attitudes toward contraceptive use and population issues should be devised for reaching youths and men with families, as well as other groups on urban areas. As results from a second KAP study become available, SFHCA and the Implementing Committee should continue to revise their strategies and retarget their messages.

#### **ACTIONS**

**Implementing Agencies** - The SFHCA should explore possibilities for collaboration with other volunteer groups engaged in community work and investigate how they can coordinate with the WHO program. They should emphasize these activities as priorities, along with coordinating target groups and message design and organizing workshops, and reduce their efforts in actual materials design and production. The SFHCA should also provide leadership to the Implementing Committee to develop an overall strategy to identify specific target groups and design messages, including explicit family planning and population issues, to reach them. This strategy should also be linked to MOH service delivery plans.

**USAID/S** - USAID/S should support this redirection of SFHCA priorities and assure the allocation of local currency funds for its implementation.

**URC** - URC should continue to provide TA to SFHCA and the Implementing Committee in their efforts to develop an overall strategy, and link up with MOH service delivery plans.

## II. Curriculum Development Center (CDC)

Findings - Health education texts for grades 1-8 will be completed by the end of April, 1989. Pre-service curricula for primary and secondary school teachers have been completed and instruction will begin next term. A syllabus for the secondary school curriculum will be completed by the end of 1989. "Where there is no Doctor" will be used as the basic text.

While school curricula have been revised to include family health/child spacing topics, no provisions have been made for sustained in-service training of teachers assigned to teach these new subjects. No materials for this training have been developed. No testing of texts has taken place. A thorough evaluation could take up to four years. Questions on the curricula have not been added to examinations. Printing equipment is awaiting building renovation for installation with local technical assistance. All IAs will have access. Bids are being solicited for printing and distributing texts to schools.

UNFPA supports a project in the Ministry of Education to introduce population education into the school curriculum. No contact has been made with CDC to coordinate mutual interests and efforts.

Conclusions - While much progress has been made in preparing to introduce FH topics in the curricula of primary and secondary education in Somalia, the final stage of actually providing instruction in the schools has not been reached. Furthermore, there should be coordination with the population education project to avoid overlapping efforts and results.

RECOMMENDATIONS - The provision of instruction in the school system and coordination with the Population Education Project should be assured. TA assistance for installation, maintenance and use of the printing equipment should be provided.

### ACTIONS

USAID/S - USAID/S should support continuing assistance to CDC until classroom instruction in FH is assured and coordination with the Population Education Project is achieved. USAID/S should also promote the allocation of local currency Project funds for renovation of the room for the printing press.

URC - If funds are available, URC should consider a limited extension of the contract of the URC Curriculum Advisor to assist with design of in-service teacher training materials; assist with the actual in-service teacher training and

evaluation of this training; / assist with the evaluation design for primary and secondary school texts; assist with the addition of examination questions based on new curricula; continue assistance to IEC strategy and message development to the IEC Implementing Committee as described in Section I. URC should assure the provision of TA to assist with installation of printing equipment and training of the operators and should assist in the preparation of a formal agreement among the five IAs on access to and operation and maintenance of the printing press. URC should also assist with setting up a coordinating mechanism between CDC and the Population Education Project of the Division of Educational Development for mutual assistance and collaboration, and to avoid duplication of effort.

### III. Somali Womens' Democratic Organization (SWDO)

**Findings** - SWDO is one of four social organizations in Somalia that has representatives in all regions of the country. Within the regions, districts are sub-divided on the local level into Tabella (sometimes called Deris) of 50 families each with about seven tabella leaders working in each Tabella. One of the leaders is responsible for health and visits families regularly to monitor health problems. In organizational terms, SWDO is strongest at the moment in Benadir and works most effectively there. They are also drawing up plans to move into the regions. As a member of the IEC Implementing Committee, SWDO took the lead in coordinating neighborhood campaigns against female circumcision and to promote child spacing in three districts of Mogadishu. One report indicates that the campaigns were milestones in demonstrating that the five members of the IEC IAs could work together for a common goal. The strength of each member contributed to the success of the campaigns. SWDO, IWE and MOH jointly prepared training programs for campaign workers which SWDO organized, and used materials from all five institutions.

**Conclusions** - SWDO is an effective organization that works well on the community level, particularly in Benadir. With training, the tabella health leaders can contribute more to upgrading family health.

**RECOMMENDATIONS** - Continue to support SWDO as an effective outreach institution and, in the longer-term, explore the possibility of expanding tabella health leaders' activities to include distribution of non-medical methods of contraception and other simple remedies such as ORS.

## ACTIONS

Implementing Agencies - SWDO should conduct a survey to measure changes in opinion in the Yaqshid, Hodan and Wadajir districts and compare the data with the 1983 KAP study on female circumcision, child spacing and attitudes towards contraceptive usage. (SWDO has already indicated an interest in doing so). SWDO should work more closely with the IEC Committee to develop materials on health themes for use by tabella health leaders. This could be achieved as a collaborative effort within the suggested KAP survey.

USAID/S - USAID/S should continue its support for SWDO health outreach programs and assure the allocation of local currency Project funds for project activities.

## IV. INSTITUTE FOR WOMEN'S EDUCATION (IWE)

Findings - IWE has an institutional commitment to work in the regions at the village level. Every year they train 50 new teachers for their Family Life Centers who are chosen for their interest in community work. The program is about two years old and has established centers in 62 villages in five regions. Thus far approximately 50 instructors trained in family life issues are included in a total of 217 instructors in the four project areas outside Benadir. About 25,000 women with little or no schooling attend the Centers for a two-year period and receive training in literacy, health issues and income generating projects. While largely self sufficient, and with good materials production and training capabilities, IWE would like to see more effective cooperation and coordination among the five participating institutions in the regions. They were pleased with the results of their combined efforts with SWDO and MOH in three districts of Mogadishu, (see SWDO III), and they consider it a promising start. IWE also has most of the equipment for a materials IEC production unit to service all five IA's. There are two very large rooms that could, with minimal renovation, house the Resource Center, now sited in extremely cramped quarters at SFHCA. Furthermore, IWE personnel are available to be trained in design, lay-out and printing of IEC materials, plus the necessary maintenance of the equipment. TA is also ready and available to provide training for these purposes. With the added space and minimal expense, audio-visual productions could be produced for wider audiences by acquiring the capability for putting television productions on film. IWE's regional centers have the capacity for adding these productions to theatrical events that frequently take place at out-of-doors gathering places in the regional districts. These attractions draw attendance from

outlying villages and those who attend will often rent trucks to take them to town for the evening. Such gatherings are ideal for reaching the general public in Somalia, where literacy rates appear to be falling.

Conclusions - IWE has made solid progress in establishing a network of Family Life Centers in regional districts that perform a real service for village women. IWE also has a real commitment to the Family Health project and wishes to see the progress made in cooperating and coordinating with the other IA's. The resources of IWE for quickly expanding IEC activities could easily be exploited and enlarged.

RECOMMENDATIONS - Continue to support IWE in its efforts to upgrade the life of village women, and assist it to expand IEC activities of the FHS by moving the Resource Center there from SFHCA.

#### ACTIONS

Implementing Agencies - IWE should develop, with the other IA's, a written plan for use of the Resource Center and how it would support and service IEC needs of all of them, preferably in cooperative ventures. Expansion and strengthening of their work in the regions should continue.

URC - URC should assist the IA's in their deliberations on moving the Resource Center to IWE and review the possibility of supporting the acquisition of a capability for converting television productions to film.

USAID/S - USAID/S should support the IA's in coming to a decision about moving the Resource Center of IWE, and promote the allocation of local currency project funds for renovation of the two rooms to house the Center.

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ANNEX V

SUMMARY OF RECOMMENDED SHORT-TERM TECHNICAL ASSISTANCE

PURPOSE	MECHANISM	DURATION	COST (\$000)
1. Sensitize policy and religious leaders on FH and population issues & their implications for Somali development. (Central funds)	RAPID present-ation	3 months (Begin) (CY 89)	0
2. Planning and preparation for 3rd National Population Conference. (Central funds)	OPTIONS	1 month (CY 89)	0
3. Assistance to IAs on defining project activities aimed at promoting policy reform.	URC	1 month (1/90)	15
4. Assistance in defining roles/agendas for revised Committee structure.	URC	1 month (5/89)	15
5. Assist IAs/RMOs in FHS program strategy development at regional & central levels.	URC	6 months (Begin) (5/89)	90
6. Assistance to each IA in the development of sustainability strategies and training in proposal development.	URC	3 months (Begin) (CY 90)	45
7. Regional FH management system development (logistics, MIS, supervision, management).	URC	4 months (Begin) (2/90)	60
8. CSM feasibility study.	URC	1 month (Begin) (10/91)	15
9. Development of IEC strategy/message design for urban & rural areas.	URC	2 months (Begin) (1/90)	30

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SUMMARY OF RECOMMENDED SHORT-TERM TECHNICAL ASSISTANCE

PURPOSE	MECHANISM	DURATION	COST (\$000)
10. Assistance to CDC in the TOT & testing/evaluation of the Health Education textbooks.	URC	2 months (Begin) (1/90)	30
11. Revision/development of indicators for project achievements during the extension period.	USAID	1 month (Begin) 6/89)	0
12. Assessment of power supply & maintenance needs for IAs, and training of staff.	URC (local)	1 month	0
13. V P survey (central funds): - initial design (6/89) - final protocol (9/89) - execution (1/90) - analysis/report (12/90)	USAID CAFS	4 months	0
14. Design and conduct of regional training needs assessments.	URC	1 month (10/89)	15
15. Installation, maintenance & training of IEC staff for heavy equipment. (generators, etc.)	URC (local)	1 month (CY 89)	0
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ANNEX VI

IMPLEMENTATION SCHEDULE

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ACTION	DATE	RESPON. AGENCY
- Decision on contract extension strategy	4/89	USAID/S
- Endorsement of regional FHS project strategy/relocation of vehicles	4/89	USAID/S
- TA plan for regional FH strategy dev't	4/89	URC
- Overseas training/study tour plan produced for project extension period	4/89	URC
- CSD computer/site maintenance requirement report	5/89	CSD
- Analysis of remaining contract resources	6/89	URC
- Development of FHS equipment maintenance plan (training, maint.contracts, etc.)	6/89	URC
- Documentation for contract extension	6/89	USAID/S
- New FH Committees established	6/89	MONP/IAS
- URC statement of main TA functions for the extension period	6/89	URC
- KAP Implementation Plan developed	6/89	IAS
- TA plan for Nat'al FH strategy dev't	6/89	URC
- Finalization of benchmarks for FHS project extension	6/89	USAID/S
- TA plan for IA sustainability/proposal development prepared	7/89	URC
- Computers installed at IWE & FH/F	8/89	URC, USAID/S
- 1st meeting of FH Policy Coordinating Committee	7/89	SFHCA

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IMPLEMENTATION SCHEDULE

ACTION	DATE	RESPON. AGENCY
- Textbooks (grades 1-8) printed/distributed	9/89	CDC
- GSDR approval of new benchmarks for project extension period	9/89	IAS
- Revised workplan for extension submitted to USAID/S	9/89	IAS
- Final protocol for KAP survey produced	9/89	IAS
- Nat'l strategy for FH program developed	10/89	FH PROG C. C'TEE
- Preparation & authorization of project amendment	11/89	USAID/S
- Decentralized decision making on FH to regions achieved	11/89	MOH
- Completion of equipment maintenance instructions (compendium)	12/89	URC
- Report of 3rd National Population Conference distributed	12/89	MONP
- Clinical FH standards produced and implemented	12/89	MOH
- FH clinical procedures manual in use	12/89	MOH
- IEC strategy for extension period developed	12/89	IAS
- Pre-service training curricula developed	12/89	URC, MOH
- IEC Resource Center established at IWE	12/89	IWE
- Maintenance manual for all major equipment produced/distributed to IAS	12/89	URC
- 5 regional FH strategic plans completed	1/90	IAS
- Primary teachers trained in books for 1-8	1/90	CDC
- Secondary school HE syllabus completed	2/90	CDC, URC

IMPLEMENTATION SCHEDULE

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ACTION	DATE	RESPON. AGENCY
- CDC printing press operational	2/90	CDC
- Preparation of TA plan to support implementation of regional FH strategies (logistics, supervision, MIS, etc.)	2/90	URC
- SOWs for TA for regional training needs assessments	2/90	URC
- 5 regional training needs assessments completed	3/90	URC, MOH
- 5 Regional contracting stores established	3/90	MOH
- Job descriptions produced for all FH staff	3/90	IAS
- In-country training plans completed based on regional strategies	4/90	URC/MOH
- Monthly FH reports regularly produced for all MCH clinics in project regions	6/90	MOH
- Local site maintenance of CSD computer facilities achieved	6/90	MONP
- IWE regional facilities upgraded	6/90	IWE
- 15 IWE village community centres refurbished	6/90	IWE
- 3 proposals for donor funding produced by IAS	6/90	IAS
- FH/FP integrated into MCH/PHC	9/90	MOH
- Local maintenance of CSD computer system achieved	12/90	MONP
- Contraceptive distribution based on monthly utilization reports from clinics	12/90	MOH

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IMPLEMENTATION SCHEDULE

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ACTION	DATE	RESPON. AGENCY
- Evaluation of textbooks for grades 1-8 in process	1/91	CDC
- KAP study completed in 5 Project regions	1/91	USAID/S
- 1986 Census completed and results distributed.	6/91	MONP
- CSM Feasibility study completed	9/91	URC
- 5 FH policy-awareness videos produced	9/91	IAS
- National Policy on Female Circumcision	12/91	FH POL C'TEE
- National Population Policy Approved	12/91	FH POL C'TEE
- FH/FP services fully provided at all MCH centres in project regions	12/91	MOH
- Study on Mortality/morbidity due to female circumcision completed	12/91	IAS

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ANNEX VII

PERSONS CONTACTED

USAID/Somalia

Lois Richards	Mission Director
Charles Gordon	Deputy Mission Director
Marion Warren	General Development Officer
Rose Marie Depp	Program Officer
Farah Abokar	Acting Project Officer

University Research Corporation (URC), Somalia FHS Project

Mary Ann Abeyta Behnke	Chief of Party
Linda Andrews	Nurse Advisor to MOH
Mike Savage	Consultant to CDC/MOE

Ministry of Health - Headquarters

Raqia H. Duale	Vice-Minister of Health, Preventive Services
Khasim A. Egal	Director General
Sharif M. Abbas	Director, Preventive Health Services
Osman M. Ahmed	Director, Community Health Division
Abraham Kore	Director, PHC Division
Abdi Kamal	Director, MCH Division
Ahmed M. Muhamed	Director, Ed. & Nursing Services Division
Rukiya M. Seif	Director, FH/FP Division
Asha A. Muhamed	Deputy Director, FH/FP Division
Halima M. Sheikh	Head, Public Sector Section, FH/FP Division
Maryam M. Abdulle	Head, Private Sector Section, FH/FP Division
Adar A. Fiido	Head, Regional Section, FH/FP Division
Maana O. Gedi	Head, General Services, FH/FP Division
Omar Y. Ashir	Accountant/Administrator, FH/FP Division
Mahad H. Gelle	Head, Epidemiological Surveillance & Statistical Unit

Ministry of Health - Benadir Hospital

Warsame Ali	Director
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Ministry of Health - Nursing Schools

Zeinab M. Afrah	Principal, Post-Basic Nursing School
Zeinab A. Sheikh	Principal, Basic Nursing School

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**Ministry of Health - Benadir Region**

Khadiyo C. Elmi	Head Nurse, Hodan MCH Center
Faduma A. Elmi	Staff Nurse, Bondhere MCH
Helana M. Hassan	Staff Nurse, Bondhere MCH

**Ministry of Health - Bay Region**

Iglan Maxomed	Head Nurse, Harseed MCH Center (Regional MCH Supervisor & SWDO Communicator)
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**Ministry of Health - Lower Shebelle Region**

Hersi Abdi	Regional Medical Officer
Faduma H. Ali	Regional MCH Supervisor
Abdullahi Warsame	District Medical Officer, Korirole Dist.
Marian O. Elmi	Head Nurse, Merca MCH Center
Fadumo Barako	TBA, Hadun Village, Korirole District

**Somali Family Health Care Association**

Ahmed M. Shire	Executive Director
Shukri A. Jama	Program Officer/IEC Director
Abdi R. Nero	Director, Operations & Research
Hinda A. Hassan	Manager, Resource Center
Faduma H. Muhammed	Training Officer
Muhammed Sahal	Accountant
Madhareyni M. Alawi	Nurse, SFHCA FH Clinic

**Institute of Womens' Education (IWE), Ministry of Education**

Faduma Sharief	Director
Zahra Siad	Deputy Director
Marian S. Hussein	Regional FLP Implementation Unit
Fatima Farah	Regional IWE Coordinator, Bay
Muhidin M. Yarow	Trainer, Bay Family Life Center
Saido H. Ali	Reg'al IWE Coordinator, Lower Shebelle

**Somali Womens' Democratic Organization (SWDO)**

Morayo Garad	President
Abdullahi I. Good	Coordinator, SWDO FHS Project
Rhoda A. Muhamed	Deputy IEC Director
Zahra M. Nur	Regional SWDO Officer, Lower Shebelle
Osob G. Farah	Regional SWDO Officer, Bay

Curriculum Development Center (CDC), Ministry of Education

Hassan D. Obsiye	Director
Zahra. Jibril	Head, Training Section

Ministry of National Planning

Hussein Elabe Fahiye	Director General
Awil M. Farah	Director, Central Statistics Dept.
Abdullahi M. Yayie	Director, Human Resources Department

Other Organizations

Ismail Farah Jama	District Commissioner, Korirole District
M. A. Barzgar	WHO Representative
Faiza J. Muhamed	National Program Officer, UNFPA
Thomas McDermott	UNICEF Representative
Deirdre Lapin	Planning Officer, UNICEF
Brian H. Falconer	World Bank Resident Representative
Carel T. van Mels	UNTCO Senior Data Processing Advisor to MONP

ANNEX VIII

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