

International Project

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AMERO

TRIP REPORT - SOMALIA

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PURPOSES

- 1) To determine the present status and goals of family planning strategy in Somalia.
- 2) To explore the government's attitude toward voluntary surgical contraception.
- 3) To arrange minilaparotomy training and assess training sites. To look into suitable sites for possible future programs in minilaparotomy service.
- 4) To examine the MCH and women's organization infrastructures with a view toward future VSC information dissemination.

KEY CONTACTS

USAID/Mogadishu

Mr. Charles Habis, Health Development Officer

Ministry of Health

Dr. Ruqiya Seif, Director, Family Health and Family Planning

Dr. Fatuma Haji Mohamed, Training Coordinator, MCH/FP Programs

Dr. Asha Haji, Under Director MCH Program

Benaadir Hospital

Dr. M. Warsame Ali, Director (and Program Director, JHPIEGO Project)

University of Mogadishu

Dr. Khalif Bile, Dean of Faculty of Medicine

Madina Hospital

Dr. Hawa Abdijama, G.P.

World Health Organization

Dr. A. Amini, Program Coordinator

REDSO/EA

Ms. Barbara Kennedy, Regional Population Officer

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OUTLOOK FOR VSC IN SOMALIA

I. SOME COUNTRY BACKGROUND FACTS

Somalia is a roughly 150-mile wide band which runs along the coast of the Horn of Africa, boomerang shaped, bordered by Djibouti, Ethiopia and Kenya, the Gulf of Aden and the Indian Ocean. Thus it has the advantage of a long (1,700-mile) and strategic coast with good deep-water ports of Mogdadhishu, Berbera, and Kismayo, but has the disadvantages of vast distances between cities, largely along unsurfaced roads, and an absence of railways. The economy, mainly agricultural in a country of frequent droughts, is dependent on outside financing. A revolutionary military regime has been in power since 1969, and much of the country's budget has gone to support wars waged against neighboring states in an attempt to unite Somali-inhabited territories with the republic.

II. HEALTH AND POPULATION

Being a young, underexploited country with military priorities, Somalia is just recently, with the aid of intensive United Nations and other external support, beginning to concentrate on developing its health infrastructure.

Among the most urgent health concerns are communicable and other diseases (malaria, bilharzia, diarrhea, leprosy, and venereal diseases), female circumcision (almost universal, and of the radical type) with its complications, and the health of mother and child.

Infant mortality is high (147), with 25 - 33% of live-born children dying before the age of five. Malnutrition and gastroenteritis are widespread. With a fertility rate of 6.1, maternal mortality is high, most often caused by illnesses and complications related to multiparity, repeated abortion and lack of antenatal care.

Population in mid-1982 was an estimated 4.6 million. At the current natural growth rate of 2.6% that figure will double in 26 years. Thirty percent of the population is urban.

A population policy has been drafted but is not yet finalized. Generally, there is a feeling that with low population density (19/square mile) the country has adequate space for more people. But the Government has now recognized the health benefits of family planning and has agreed to its gradual introduction through maternal/child health centers.

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Nearly all population activity has taken place within the past year, with the establishment of the Family Health/Family Planning Department of the Ministry of Health. This Department is responsible for the 95 MCH centers which have been created throughout the country. Few of these are fully operational because of the lack of trained personnel, insufficient equipment and supplies, and logistic problems. Nineteen centers offer family planning services, and these are urban.

III. SITE VISIT FINDINGS

Preparatory Activities in Family Planning

The goal of the World Health Organization in Somalia is to integrate family planning into the MCH system, through inclusion of nutrition, primary health and immunization in its program. WHO is addressing the trained manpower problem by directing its major efforts toward a multi-level training program for health professionals, from the traditional birth attendant (TBA) through the public health nurse to the physician. Medical officers and public health nurses are trained in the administration and management of health activities in their regions. The 1982-84 work plan of the WHO includes training 1,220 TBAs and 366 nurses.

Sterilization is included in the curriculum along with other family planning methods, but this alone does not provoke requests for VSC. The WHO representative feels that the terrain must be prepared from both the provider side and the acceptor side. He feels that convincing the providers to support a VSC program is the crucial part. Once this is done and programs are underway, he assured us, he will be delighted to refer VSC acceptors to our programs.

Several other agencies are contributing, as well, to the training of health care personnel in family planning concepts.

A joint AID-MOH program called Family Health Initiatives has begun in five of Somalia's 16 regions. Dr. Ruqiya Seif is the Program Director.

Clinical training has been carried out by IPPF for nurse-midwives, including IUD insertion and prescription of oral contraceptives, but current policies permit only gynecologists to perform these services.

INTRAH has had some input in training by selecting suitable MCH workers and upgrading their knowledge. This has been entirely non-clinical.

Since JHPIEGO's project began in 1980 at Benaadir Hospital, about 80 physicians and 15 nurses have been trained in primary health, MCH and reproductive health. About 80 more physicians and 15 fourth year medical students are currently taking these courses at Benaadir, but with a stronger emphasis on clinical practice. Priority is given to candidates from the five regions involved in the AID-MOH Family Health Initiatives program.

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Westinghouse is embarking on a survey of contraceptive prevalence, including male and female VSC, in Somalia.

Ms. Barbara Kennedy, Regional Population Officer from the REDSO East Africa headquarters in Nairobi, and Ms. Gladys Gilbert of AID/W Africa Bureau, were visiting Somalia at the time of our site-visit, and we had the opportunity to have a glimpse of future bilateral USAID involvement in Somalia. There was a two-week visit for the purpose of assisting the MOH in designing a multi-sectoral family planning program. They were at the stage of indentifying program priorities. Preliminary projects will probably include training, both in-country, regionally, and in the United States, family life centers under the Ministry of Education, inclusion of a family planning component in the training programs of the Somali Women's Democratic Organization, a model family planning clinic in Mogadishu, and a retail contraceptive sales projects.

Status of VSC in Somalia

Sterilization has not been made explicitly legal, along with family planning in general, since no official statement has been made on any aspect of population policy. However, the Ministry of Health, specifically Dr. Ruqiya Seif, Director of Family Health and Family Planning, is all for initiating voluntary surgical contraception services just as quickly as possible as an integral part of family planning promotion. She lost no time in requesting and following through with a minilaparotomy training program after hearing from AVS during the Regional Arab Federation of Associations for Voluntary Fertility Control conference in Khartoum in December 1982 that such training was being offered.

Because of her dynamism, the introduction of family planning is being achieved at an accelerated pace, even in the absence of an official population policy, which would lead one to conclude that her judgement and her word are respected by the government. Considering her conviction and her ability to implement action programs, the future for VSC programs in Somalia looks bright.

Another encouraging discovery was that the Somali Women's Democratic Organization is presently recommending VSC to women of para 7 and over. With a membership of 80% of Somali women, this organization has already accomplished three important legal reforms; the abolition of polygamy, equal pay for women, and equal inheritance rights for women. During our visit, an SWDO representative requested I&E materials on family planning and sterilization, either directly or through the MCH/FP program.

Except for the SWDO efforts, sterilization as an elective method of family planning is virtually unknown, both by the health care community and the general public.

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It would appear that this positive attitude toward VSC by Family Health/Family Planning Director and the politically powerful Somali Women's Democratic Organization could be AVS's cue that it is natural now to introduce sterilization as an integral part of family planning and family health, rather than hesitate and lose the opportunity to present it in its proper place. This way, attention will not be drawn to VSC as it would be if were presented alone.

Projected AVS Activity in Somalia

AVS can begin with a minilaparotomy training program, probably for two or three physicians, to increase the service capability for VSC for medical indications, and begin in a small discreet way to offer elective surgical contraception, first in Mogadishu, then expanding to Hergeisa and Kismayo, if conditions are favorable. In order to begin at all, referrals from MCH/FP centers are necessary, and these cannot be achieved if medical and MCH/FP personnel are not aware of the concept. Thus, the next step is to have the health rationale for family limitation and information on VSC included in the training program of physicians and MCH/FP personnel, possibly by adding a VSC component to training at Benaadir Hospital (the only teaching hospital in Somalia), and possibly by integrating it into MCH/FP personnel training programs.

MINILAPAROTOMY TRAINING AND PROGRAM SITE ASSESSMENT

Two hospitals in Mogadishu were visited in order to assess the facilities for minilaparotomy training.

Benaadir Hospital is the major OB/GYN and Pediatric hospital in Somalia. Built seven years ago by the Chinese, it is modern, well-designed, and well-built. Of a total 300 beds, 160 are in the OB/GYN section, one ward for obstetrics and two for gynecology. It is staffed by nine Chinese physicians, 40 Somali physicians and two Italian teaching physicians. Four of the gynecologists work only in family planning. The gynecological operating room is large and very well equipped, except for a few minor items which we recommended Dr. Zein Khairullah of the World Federation, who will conduct the training, bring with him from New York. The hospital handles 18,000 deliveries per year. There is a separate room available where laparoscopy once took place, with an adjacent recovery room, but the laparoscope has since been removed to another city. Another will be provided by JHPIEGO.

There is a large conference room where lectures for students and doctors take place, including JHPIEGO's training course, and films are shown (with a borrowed projector). Dr. Warsame Ali, Director of the hospital, expressed the desire to have a projector for the hospital itself, and we agreed to furnish one.

Dr. Warsame said he could easily have 30 minilap patients available by the last week of May, when the training was requested, and gave the names of the doctors to be trained by Dr. Khairullah.

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Dr. Seif suggested we also look at Madina Hospital as a possible program site. However, at the time our visit was scheduled there was no one in authority with whom we could speak. All three OB/GYNs were absent as well as the hospital director. However, a general practitioner, who was not knowledgeable about the hospital services, showed us the facilities. There are two operating rooms; one for minor surgery such as D&Cs, and one for major operations. The major operating room was completely equipped with the best and latest equipment, with an adjacent sterilization room equipped with large autoclaves and sterilizing equipment. There would be nothing lacking for carrying out a service program at this hospital.

Hospital services include OB/GYN, general surgery and orthopedics. There are 160 beds, of which 18 are assigned to gynecology. About 2000 deliveries are attended per year. The hospital is located on the outskirts of Mogadishu, and services four surrounding villages.

Both hospitals are well suited to minilap training and service programs. Benaadir has the advantage of being more central and serving a larger population. It was unfortunate that Dr. Seif was ill on the day of our final meeting when possibilities would have been discussed, and decisions made. This will now be done by mail. From our preliminary discussions, we learned that Dr. Seif felt that since there is no private medical practice in Somalia, physicians' allowance should be included as part of the program budget. We checked this out with Ms. Barbara Kennedy, and learned that this is the practice with other agencies, including AID, since physicians are not allowed to work other than for the government, and salaries are very low. In addition, there is a shortage of physicians; only 42 gynecologists in the entire country. The temporary nature of the support will be made very clear and emphasized, and a phase-out date agreed upon.

The only question we would have concerning Benaadir Hospital would be whether it has the administrative capability to handle a VSC program and the JHPIEGO program simultaneously, since each requires adherence to periodic reporting requirements. There is a strong possibility that this capability has improved recently with the change in directorship of both the hospital and the JHPIEGO program. This will have to be verified with Dr. Seif.

CONCLUSIONS AND RECOMMENDATIONS

1. Family planning is in its preliminary stages, and the Government of Somalia, recognizing its health benefits, is encouraging its incorporation into maternal/child health programs, even though official population policy is still in draft form.

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2. The Director of Family Health and Family Planning is moving swiftly in initiating family planning programs, and wishes to do the same with voluntary surgical contraception. Having requested and arranged minilaparotomy training, she wishes to follow through with VSC services. Maternal and child health conditions in Somalia indicate a serious need for these services.
3. A new VSC program will need patient referral, which can best be realized by educating the medical and paramedical community in the concept, health rationale and procedures of VSC. Thus, complementary information and education programs directed at physicians, students, and MCH personnel, and service programs should be developed simultaneously. This will be followed up with Dr. Ruqiya Seif. It will be determined how VSC training components can be inserted into existing family planning training, which would be preferable to their being carried out separately.

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