A Continuum of Care Approach to Sexual and Reproductive Health in Somalia

End Of Project Evaluation Report
Cover images

First Row from left
- Mothers attending a community sensitization in a village.
- A new born in Gambool Health Center, Garowe, Puntland.

Second Row from left
- A BEmONC training session for midwives/nurses in Hargeisa, Somaliland.
- Community Health Workers pose for a photo session in the midst of training.

Third Row from left
- A MERLIN/SCI officer handing over a 4x4 Toyota ambulance to Minister for Health, Somaliland.
- Midwives in Dilla HC, Boruma Somaliland referring a client to CEmONC facility.

Fourth Row
- EC-UNICEF logo

This report was produced by
Dr Hassan Adan Ahmed, an independent Consultant contracted by UNICEF.
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Dr. Hassan Adan Ahmed
**Acronyms**

ANC  Antenatal Care  
BEmONC  Basic Emergency Obstetrical Neonatal Care  
CEmONC  Comprehensive Emergency Obstetrical Neonatal Care  
C4D  Communication for Development  
CHC  Community Health Committee  
CHW  Community Health Workers  
EC  European Commission  
EmONC  Emergency Obstetrical Neonatal Care  
EPhS  Essential Package of Health Services  
FGM/C  Female Genital Mutilation/Cutting  
GMC  Gaalkacyo Medical Centre  
IEC  Information, Education, Communication  
JHNP  Joint Health and Nutrition Programme  
MCH  Maternal and Child Health  
MoH  Ministry of Health  
NGO  Non-Governmental Organization  
PMWDO  Puntland Minority Women Development Organization  
PNC  Post Natal Care  
RH  Reproductive Health  
SDRO  Somalia Development Relief Organization  
SGBV  Sexual and Gender-Based Violence  
SLNMA  Somaliland Nurses and Midwives Association  
RMO  Regional Medical Officer  
SOP  Standard Operating Procedures  
SRCS  Somalia Red Crescent Society  
SRH  Sexual Reproductive Health  
TBA  Traditional Birth Attendants  
THET  Tropical Health and Education Trust  
ToT  Training of Trainers  
UNICEF  United Nations Children Funds  

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Section 1

Executive summary

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Executive Summary

The overall purpose of this evaluation was to assess the extent to which the “Continuum of care approach to Sexual and Reproductive Health in Somalia” project has improved access to integrated SRH services among the Somali population. The main objectives of the evaluation were:

a. Evaluate the output/outcomes and impact of the project against its objectives.
b. To provide recommendations, identify lessons learned, generate information and knowledge to shape future such projects in Somalia.
c. To calculate the costs (and effectiveness) of EmNOC provision and compare them with the costs (and effectiveness) of other health interventions in Somalia.

During this period, the 14 Basic Emergency Obstetric and Neonatal Care (BEmONC) facilities supported saw 50,966 women attending their first Antenatal Care (ANC) visit. This means each facility saw an average of 1,200 mothers for first ANC per year, translating to a 40% increase compared to the year 2011, before the intervention. Mothers who attended ANC2 and ANC 3 were 30,290 and 29,328 respectively. Furthermore, facilities supported a total of 34,180 deliveries through skilled birth attendants. This translated to an average monthly skilled delivery of 68 per facility for each of the 14 BEmONC facilities. This marks a 400% increase in facility-based delivery compared to the year 2011, in which the average monthly delivery per facility was 17.

A total of 1,167 referrals were made to Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) hospitals during this period. These referrals were mainly due to obstructed labour leading to maternal distress, Pregnancy-Induced Hypertension (PIH), poor progress in labor, Antepartum Hemorrhage (APH)/Placenta previa and Intrauterine Fetal Demise (IUFD). The facilities saw a total of 29,311 mothers as PNC cases.

This phenomenal achievement is attributed to several factors, discussed in details on the following sections. These include upgraded/rehabilitated infrastructure, capacity building of the health workers, regular and uninterrupted medical equipment and supply, community sensitization and awareness, active participation by the health authorities, local community and implementing partners.

In order to respond to the above assessment questions, five separate yet interlinked areas of review were identified and key findings under each are summarised below.
A. RELEVANCE
Reproductive health indicators in Somalia are among the worst in the world with maternal mortality rates estimated to be 1400/100,000 live births. This, in conjunction with a high total fertility rate of 6.4, translates into a lifetime risk of death during labor of one in ten mothers. Perinatal death rate is also high at 81/1000 live births. The high maternal mortality is mainly a result of a major lack of access to quality Sexual and Reproductive health (SRH) services (skilled attendance and EmONC) coupled with social, cultural and health seeking behaviour practices that are highly unfavourable for SRH. Therefore, the EC/UNICEF co-funded SRH project was and is still relevant to the target group (women of reproductive age) and the beneficiaries (catchment population). These groups consider the need addressed by the project as their first priority. Fixed discussion groups held with some members of Community Health Committee (CHC), the health authorities (Ministry of Health, Puntland) and the mothers attending the Maternal and Child Health Facilities have all confirmed the positive change brought about by the operation. A 100% of the interviewed individuals request the return project because of its immense positive impact on the health of the community.

B. EFFICIENCY
There have been delays in the inception phase of the project but thereafter the project provided inputs and resources on time when needed. The activities were implemented according to the planned budget. The partners at different level monitored the inputs, activities and outputs regularly. UNICEF through its collaborative and implementing partners was able to deliver quality SRH care by upgrading and interlinking a total of 14 health care facilities around 4 functional referral hospitals and through the creation of demand for skilled attendance. UNICEF supported the capacity building of health staff. It was also able to provide essential medical supplies to both BEmONC and CEmONC facilities. All these ensured provision of the services in 24/7 manner.

C. EFFECTIVENESS
All the planned results, indicated in the log frame, were achieved. The quality of the results is good and in line with the project purpose. There are several factors that helped the target group access the results: the skilled delivery attendance, the 24 hrs. services at the facilities, the availability and uninterrupted pharmaceutical and non-pharmaceutical medical supply, the regular community sensitization/awareness programs and the improved infrastructure. All these led to community ownership of the project.

D. IMPACT
Evaluation finds that to a large extent all that was planned was achieved. The intervention had undertaken several activities to realize the results and the objectives of the project. A summary overview of progress towards each result follows below:

Result No.1: Access to quality comprehensive SRH services improved in 14 Health Centers and 4 Referral Hospitals in Somalia
Analysis of narrative reports, HMIS data, facility records, implementing partners’ records all indicate that all the targets under this result were achieved and that 100% of all the activities delivered.

**Activity 1: Medical service delivery human resources capacity enhanced**

UNICEF conducted a human resource and skill gap analysis in both Puntland and Somaliland. THET conducted most of these trainings. The trainings were conducted at different stages of the project and offered to the various levels of the community (CHW), MCH (midwives, nurses and auxiliaries) and referral hospital (medical personnel). In total **76** Community Health Workers (CHWs), **86** qualified midwives/nurses and **58**-community nurse were trained and absorbed into the project. In addition to providing training to health workers in the 14 BEmONC and 4 CEmONC facilities, UNICEF also strengthened the zonal health system by building capacity through Training of Trainers (ToT) targeting various nursing schools and medical institutes. At the end of the program, in 2014, there will be sufficient trainers in Somaliland **(10 ToTs)** and Puntland **(9 ToTs)** especially in BEmONC services.

**Activity 2: Infrastructure and medical equipment upgraded in 14 BEmONC facilities.**

In both Puntland and Somaliland, UNICEF rehabilitated, enhanced and/or constructed all the BEmONC and CEmONC facilities following the needs assessment done prior to the initiation of the project. The upgrading involved construction of maternity wing, elevated water tank and ground water tank, incinerator, placenta pit, pit latrine, and cesspool. The entire infrastructure put in place is in good use and shape.

In addition UNICEF procured medical equipment (hospital furniture, delivery beds, fetal Doppler etc.), midwifery kit (to support 50 deliveries in each BEmONC facility) and surgical/obstetrics kits (designed to perform an average of 100 deliveries, including 50 with complications and surgery)

**Activity 3: Effective referral system for ANC/PNC BEmONC and CEmONC established**

UNICEF repaired an existing ambulance for referrals within Boroma town covering five MCHs and provided three 4X4 Toyota ambulances (Boroma, Bossaso and Gaalkacyo) and five e-Rangers motorbike ambulances (Garowe). In the lifetime of the project a total of **1167 referrals** were made to the 4 CEmONC facilities. The main reasons for referrals were: obstructed labor, Preeclampsia, Antepartum hemorrhage, breech presentation, and intrauterine fetal death.

**Result No 2: Demand for SRH/MNCH Clinical and Family Planning services enhanced in the target population**
Social mobilization and advocacy, one of UNICEF’s comparative advantages facilitated achievements of significant results for the SRH project. This result was critical in effectively addressing the delay in deciding to seek care and was evidenced in the increased demand in pregnant women and their families for intra-partum care in facilities (ANC, PNC and deliveries with a skilled attendant) in target areas. This advocacy was implemented through the Communication for Development (C4D) strategy by addressing issues like social cultural barriers to seeking health care, beliefs and practices surrounding SRH, health and nutrition education etc. Several strategies were employed including establishment of 14 Community Health Committees, radio and television programs and documentaries (reaching the target 300,000 catchment population), mothers’ clubs, TBAs, community mobilization forums, house-to-house contacts with the target groups etc.

E. SUSTAINABILITY

In the original proposal of the project, its sustainability and exit strategy was not well captured. Luckily UNICEF is a key stakeholder in the Essential Package of Health Services (EPHS) under the Joint Health and Nutrition Program (JHNP). The project has been taken over by EPHS/JHNP up to December 2016. The scale-up of the EPHS package includes SRH under its core program - 1 “Reproductive, Maternal and Newborn Health”. EPHS thus continues to support the provision of essential health for pregnant women and newborn.

However, the current EPHS lacks some important components of the SRH project namely: incentives to the CHC, TBAs and community sensitizers, free-of-charge services both at BEmONC and CEmONC facilities, baby gifts to post-delivery mothers, deficiency of some supplies and medicines e.g. MVA kit. The other main problem lies in the sustainability of the project in CEmONC arm, as the current EPHS focuses on primary health care thus leaving out hospital based services.

Conclusion

The SRH project was well planned and implemented as it invested mainly in infrastructure, capacity building, medical supply, community awareness and sensitization and 24-hr facility coverage. This led to increased demand and uptake of reproductive health services among the target population, empowered/informed population and community ownership.

Project Description

The SRH project “A continuum of Care Approach to Sexual and Reproductive Health (SRH) in Somalia” was an EU-UNICEF co-funded project that was managed by
UNICEF and implemented through a collaborative partnership between the Ministries of Health in Somaliland and Puntland, World Vision International, Somali Red Crescent Society (SRCOS), MERLIN/SC, Puntland Minority Women Development Organization (PMWDO), Somali Development Relief Organization (SDRO), Galkayo Medical Center (GMC) and THET. The project was implemented for a period of 44-months, from July 2011 to February 2015.

As well documented in the logical framework of the project, the overall objective was to improve access to integrated comprehensive SRH services among the Somali population. The specific objectives were to

- Improve access and supply of quality comprehensive sexual and reproductive health, including maternal and neo-natal health services in poor and vulnerable populations in Somalia and
- Increase demand for sexual and reproductive health services in poor and vulnerable populations in Somalia.

The project planned to achieve the following two results:

- Access to quality comprehensive SRH services improved in 14 Health Centers and 4 referral hospitals in Somalia. This was to be achieved with the following activities:
  - Upgrade infrastructure and medical equipment.
  - Enhance medical service delivery, Human resource and management capacity.
  - Establish an effective referral system.

- Demand for SRH clinical and Family Planning services enhanced in target population. The following activities were to be undertaken to achieve this result:
  - Provision of incentives to community workers/TBAs for referrals.
  - Training of CHW.
  - Development and dissemination of a communication for development (C4D) strategy for sensitization of the community.

At the end of the project the following were proposed expected outcomes:

- 12,600 women and new-borns provided with skilled delivery and essential newborn care.
- 1,200 women treated for minor obstetric complication.
- 700 women referred and treated for major obstetric/SGBV complication.
- 13,500 pregnant women referred to ANC/PNC.
- 12,000 women referred from community receiving RH care at HC.
- 18,000 couples provided with family planning counselling and a choice of appropriate methods.
- 300,000 people with improved access to quality SRH services.

The project was implemented in two phases: *Inception phase* when gap and demand analysis for all the activities was done and *Implementation phase* when the planned activities were actually carried out. Several reports and monitoring evaluation were also carried out, which formed the basis for this evaluation. The interim reports were done so as to cover 6-months activities of the project.

**Methodology overview**

The evaluation was conducted between 22nd Oct 2015 and 22nd Jan 2016. The final survey was conducted in Puntland (Garowe, Galkaio, Burtinle in Nugal region and
Bossaso in Bari region) and Somaliland (Boroma and Zeila districts). The catchment areas for the Maternal and Child Health (MCH) facilities, the EC-UNICEF co-funded, within these districts was used as the source for getting the qualitative and quantitative data for the survey.

Evaluation questions were based on five criteria (relevance, effectiveness, efficiency, impact and sustainability) and are focused on expected outcomes from the original logical framework as outlined in the inception report of the SRH project. The Results Oriented Monitoring (ROM) Ex Post tool, developed to assess a project's achievement in its lifetime, was adopted and referred to time and again in assessing the project on the mentioned criteria.

This evaluation included a desk-based document review, key informant interviews and focus group discussions in Puntland and Somaliland as well as Skype interviews with key staff from UNICEF, EC, Implementing partners, ministries of health and facilities. Further detail on how these methodologies were implemented follows below:

A. Desk Review

The evaluator conducted a desk review and analyses of all the relevant information and data obtained from UNICEF-Somalia office including but not limited to inception report, final proposal report, interim progress and narrative reports so as to identify key issues and obtain necessary data. In addition to reviewing these data and reports, the evaluator engaged all the key actors in EU, UNICEF and other available officials from implementing partners on the project: WVI, SRCS, and SCI. Those officials who were key in the set up of the project but were not available were contacted via Skype to brief and update the evaluator on the project.

B. Field visits

Field visits were carried over two-weeks period both in Somaliland and Puntland. Unfortunately it is only in Puntland that the evaluator managed to visit the facilities. Two BEmONC and 1 CEMONC facilities were visited. It is during these visits that qualitative (Key Informant Interviews and Fixed Discussion Groups) and quantitative (HMIS and implementing partner reports) data collection was carried out. In addition review of the infrastructure, medical equipment and ambulances was also done.

QUALITATIVE DATA:

- **Key Informant Interviews**

In total 12 key respondents were interviewed: nine in Puntland and three in Somaliland. Respondents included facility in charges, midwives, members of community health committees, and staff of the implementing agents, Ministry of Health authorities as well as UNICEF zonal officers. A standard key informant interview tool was used in this part of data collection and the questions were designed based on the respondent's role in the project. Overall, though the questions covered the five criteria outlined above. The table in Annex 3 shows the breakdown of respondents per organization.

- **Focused Discussion Group**

Two FDG were carried out in two facilities in Garowe, Puntland: Waaberi and Gambool MHCs. In total 14 people including 4 midwives, 3 nurses, 3 CHC
members, 1 Regional Medical Officer, 2 primary health coordinators and one UNICEF EPHS zonal officer were interviewed.

**QUANTITATIVE DATA**

Both HMIS and implementing partner reports were reviewed and analysed so as to get the actual figures and trends over time on both performance and quality indicators of the SRH project.

The evaluation generated the following reports:

1. **Documentation report:**
   A five-page document highlighting the achievements, lessons learnt and challenges.

2. **End line survey report:**
   These include key SRH indicators measured by comparing before and after the intervention. This report was informed by information and data gathered from the field visit.

3. **Impact Evaluation report:**
   Calculation of cost (and effectiveness) of EMONC services in comparison with other health interventions in Somalia.

4. **Final Evaluation report:**
   This is a comprehensive report detailing the achievements of the entire project and its impact on the community. It also encompasses all the above reports.

**Limitations of the Evaluation.**

Although all efforts were made to meet with and talk to as many relevant respondents as possible, and conduct filed visits to all facilities during this evaluation, a number of logistical and practical factors prevented this from being entirely successful:

1. As a result of misunderstanding between UNICEF and MoH, Somaliland, the facilities in Boruma, Somaliland was not visited.

2. The evaluation was conducted when most of the implementing partners had their annual review meetings, and this led to time constraints for proper interview.

3. As a result of external factors like limited armoured vehicles, not enough time was spent in the visited facilities to peruse all the records and data. Effort was however made to conduct FDG and interview the key respondents of the visited facilities.

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**Section 2**
Evaluation Results

- Relevance and Quality of Project Design
- Efficiency Of Implementation
- Effectiveness
- Impact To Date
- Sustainability

A. RELEVANCE AND QUALITY OF PROJECT DESIGN.
The EC/UNICEF co-funded SRH project was and is still relevant to the target group (women of reproductive age) and the beneficiaries (catchment population). The project had a coherent logical framework with Objectively Verifiable Indicators (OVIs) that were realistic and time bound. Almost all the indicators have been achieved and even surpassed. It had a good needs assessment of the target population and the planned activities and outputs were appropriate to achieve the project purpose.

These target group and the beneficiaries at large consider the need addressed by the project as their first priority. This follows the accrued benefit derived from the project namely: increased uptake of the services, increased skilled birth attendance, the free-of-charge services, provision of free facilitated referral both to the MCH and the CeMONC facility, abundant and uninterrupted medical supply, increased number of well trained staff and the 24 hrs coverage of the facility.

Overall the change in the situation of the target group is in the positive direction as brought about by the intervention. There has been significant decline in maternal mortality and morbidity in the community. Fixed discussion groups held with some members of Community Health Committee (CHC), the health authorities (Ministry of Health, Puntland) and the mothers attending the Maternal and Child Health Facilities have all confirmed the positive change brought about by the operation.

A 100% of the interviewed individuals request the return project because of its immense positive impact on the health of the community.

**B. EFFICIENCY OF IMPLEMENTATION**

There have been delays in the inception phase of the project but thereafter the project provided inputs and resources on time when needed. The activities were implemented according to the planned budget. The partners at different level monitored the inputs, activities and outputs regularly. There are project officers of the respective partners who visited the facilities on weekly basis. In addition there are monthly meetings attended by the MoH authority, officers from the implementing partner and UNICEF. UNICEF has coordination officer who oversees the entire project and attends all technical meetings. All these meetings generated technical reports that were shared with the coordinating agency, UNICEF.

All the planned activities of the project were eventually implemented albeit delays in some. For example the CeMONC maternity wing infrastructure though completed in Nov 2014, is of good quality well designed maternity wing that is well equipped to provide quality tertiary SRH services.

UNICEF through its collaborative and implementing partners was able to deliver quality SRH care by upgrading and interlinking a total of 14 health care facilities around 4 functional referral hospitals and through the creation of demand for
skilled attendance. UNICEF supported the capacity building of health staff. It was also able to provide essential medical supplies to both BEmONC and CEmONC facilities. All these ensured provision of the services in 24/7 manner.

Traditional Birth Attendants (TBAs) were vital actors at community level and received incentives (5 USD) for client screened and referred to BEmONC facility. However, with the transition to EPHS and its takeover of the facilities, this incentive is no longer available as EPHS does not cover it. This led to the elimination of TBA services and their role in the project. This, according to midwives at the facilities, has affected some extent the number of cases referred to the facility. A member of CHC for Waberi HC, Garowe Puntland says that in spite of the lack of TBAs’ roles, the facilities are still reaping the fruits of the project especially after intense community awareness and sensitization. There are still some sad incidents reported where TBAs still hold mothers at the community level and refer when it is too late. Recently a mother died while in labour at home because of delay in seeking medical attention as a TBA was managing her at home.

In both Puntland and Somaliland, UNICEF rehabilitated, enhanced and/or constructed all the BEmONC and CEmONC facilities following the needs assessment done prior to the initiation of the project. The referral to the CEmONC facilities was to be offered free-of-charge for emergency cases. However, since sustainability and exit strategy wasn't well captured in the logical framework, the CEmONC facilities have started charging the operative services like C/S., as the current EPHS program does not support the referral facilities. In fact as a case in point, when the maternity wing in Boruma Hospital was completed and handed over in November 2014, UNICEF provided supplies that will run the SRH support to MCHs till April 2015. This necessitated the hospital to charge the cases referred from MCHs. This is a big concern for the partners that the gains made by the SRH project may be reversed.

There is good complementarity and coordination among the implementing partners. For example, Somali Red Crescent Society in Somaliland, after discovering this gap of the operation, has supported the referral with their ambulance. In addition they carry out any maintenance to Dilla HC as well as supplying OPD medicines and laboratory reagents.

C. EFFECTIVENESS

All the planned results, indicated in the logical framework, were achieved. The quality of the results is good and in line with the project purpose. There is several
factors that helped the target group access the results: the skilled delivery attendance, the 24 hrs. services at the facilities, the availability and uninterrupted pharmaceutical and non-pharmaceutical medical supply, the regular community sensitization and awareness programs. All these led to community ownership of the project.

The project has achieved its targets and in some has surpassed the targets for the respective indicators. Until now no unexpected negative effect of the project was found. In fact in one of the facilities (Dilla MCH, Somaliland), the maternity structure constructed by the operation had no perimeter wall. After the community realized the benefit of the project, they fund-raised money and finally erected a perimeter wall. This was a positive effect by the project on this community.

**D. IMPACT**

Evaluation finds that to a large extent all that was planned was achieved. The intervention had undertaken several activities to realize the results and the objectives of the project. A summary overview of progress towards each result follows below:

**Result No.1: Access to quality comprehensive SRH services improved in 14 Health Centers and 4 Referral Hospitals in Somalia**

Analysis of narrative reports, HMIS data, facility records, implementing partners’ records all indicate that all the targets under this result were achieved and that 100% of all the activities delivered.

**Activity 1: Medical service delivery human resources capacity enhanced**

UNICEF, through a hired consultant, conducted a human resource and skill gap analysis in both Puntland and Somaliland. THET was the leading implementing partner in capacity building of the health workers. It did this in collaboration with local institutions and health schools like Somali Medical Association, the Puntland School of Nursing and the Somaliland Nurses and Midwives Association (SLNMA) etc. This collaboration with the ministries of health in the lead, gave local credibility and improved local acceptance and adoption to the curriculum. THET has also conducted a quality assurance evaluation of the trainings conducted to date. This ensured that the skills acquired were applied well and strengthened quality monitoring of the project.

In all the trainings of the various levels, master trainers (ToTs) were first trained following the adoption of the respective curriculum and manuals. These ToTs thereafter trained the respective health workers so as to fill the gap for skilled health work force. In addition these partners also provided SOPs for the smooth running of the facilities. These were endorsed and adopted by the Ministry of Health. These materials are available in the visited facilities and are still in use.

In addition to providing training to health workers in the 14 BEmONC and 4 CEmONC facilities, UNICEF also strengthened the zonal health system by building capacity through Training of Trainers (ToT) targeting various nursing schools and
medical institutes. At the end of the program, in 2014, there were sufficient trainers in Somaliland (10 ToTs) and Puntland (9 ToTs) especially in BEmONC services.

Although the capacity building targeted the health workers in the designated BEmONC and CEmONC facilities, interviewed officers on the ground confirmed that many other health workers in other MCHs benefitted from the regular trainings offered by the project. This illustrates the essential contribution the project made in enhancing the capacity of the health workers in Somalia at large.

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of training</th>
<th>Categories of staff trained</th>
<th>Total Number trained</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td>Pre-/in-service/refresher training on community-based Reproductive Health (RH)/Maternal Neonatal Child Health (MNCH) and referral services</td>
<td>Community Health Workers</td>
<td>76</td>
</tr>
<tr>
<td></td>
<td>Training of Trainers (ToT) for community-based RH/MNCH services and referral</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Health Centre</td>
<td>In-service/refresher training on basic MNCH care and BEmONC.</td>
<td>Midwives, nurses, auxiliaries and lab techs.</td>
<td>456</td>
</tr>
<tr>
<td></td>
<td>ToT on basic MNCH care and BEmONC.</td>
<td></td>
<td>19</td>
</tr>
</tbody>
</table>
During the life of the project implementing partner field teams conducted supportive supervision of BEmONC/CEmONC facilities using standard supervisory tools developed in consultation with MOH; monitored staff performance and provided on-the-job training and technical knowledge to staff, aimed at strengthening the referral system, improving ongoing BEmONC activities and quality of services in these facilities. These supervisory field visits were essential in strengthening the skills acquired in the trainings, and at the same time boosted the morale of the health workers, according to the facility in charges interviewed.

The tables below show the trained technical and CHW staff from Somaliland and Puntland for the Primary Health Units, BEmONC and CEmONC facilities respectively. They include the training of the master trainers (or ToTs as they are popularly known).

<table>
<thead>
<tr>
<th>Referral Hospitals</th>
<th>CEmONC, abortion/post-abortion and SGBV training for medical personnel</th>
<th>Gynecologists, Pediatricians, and medical officers.</th>
<th>8</th>
</tr>
</thead>
</table>

In some of the facilities visited, some of these protocols are displayed on the wall, and the midwives refer to them time and again.

All these trainings, protocols, on-job trainings and supervisions created a skilled workforce that delivered quality EMONC SRH services in the facilities in 24/7. Prior to this, except for the hospitals, the facilities were only operational during daytime. This 24 hrs coverage increased service uptake reduced maternal morbidity and it is hoped contributed positively to national health statistics.

During field visits, all the trained staffs are in their respective facilities, and applying the enhanced skills. There is however lack of supportive supervision, refresher trainings and on the job trainings.

Ministry of Health authorities, Puntland have requested for both refresher courses and fresh trainings for health workers, especially on BEmONC and CEmONC skills. One of the biggest successes of the SRH project has been empowering the skills of the health workers. This had instilled a sense of trust among the community in the health workers, according to a leader of the Community Health Committee of Waaberi Health Centre, Garowe, Puntland.

Activity 2: Infrastructure and medical equipment upgraded in 14 BEMONC facilities.

2.1 Infrastructure

UNICEF hired a civil engineer at the inception phase of the project to carry out assessments of the targeted health facilities in Somaliland and Puntland. The engineer developed architectural and structural drawings, electrical drawings,
water system layouts, placenta pits, a sewerage system, boundary walls, bill of quantities of the selected facilities.

The drawings were endorsed by the Ministries of Health in Somaliland and Puntland and were cleared by the UNICEF technical unit based in Copenhagen. Structural drawings were also discussed with EC Infrastructure Officer. Based on these drawings, bidding documents were prepared and bids were called from Somalia-based construction companies. The assessments also identified the need to construct new maternity wings in most of the facilities.

Depending on the need of the facility, the upgrading involved construction of maternity wing, elevated water tank and ground water tank, incinerator, placenta pit, pit latrine, and cesspool. The entire infrastructure put in place is in good use and shape.

The table below details the required infrastructure upgrading, rehabilitation/construction following assessment at the beginning of the project and the works carried out in each facility by the end of the project.
<table>
<thead>
<tr>
<th>District</th>
<th>Health Facility</th>
<th>Required infrastructure following baseline needs assessment</th>
<th>Infrastructure put in place by the project</th>
</tr>
</thead>
<tbody>
<tr>
<td>PUNTLAND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galkayo</td>
<td>South Galkayo II</td>
<td>Shed for waiting area, rehabilitation of toilet, providing tiles for Post Natal Care (PNC) and its corridor, new store room, placenta pit and incinerator.</td>
<td>DONE</td>
</tr>
<tr>
<td>Galkayo</td>
<td>Gaaldogob MCH</td>
<td>Replaced with Burtynle MCH due to security reasons. No major infrastructure work is required in Burtynle MCH.</td>
<td>Minor rehabilitation</td>
</tr>
<tr>
<td>Galkayo</td>
<td>ISRAA IDPs MCH</td>
<td>New construction (Maternity section, block of three rooms, elevated water tank and ground tank, Incinerator, placenta pit, cesspool, 4 pit latrine)</td>
<td>DONE</td>
</tr>
<tr>
<td>Bossaso</td>
<td>Haji Abdulhi</td>
<td>Due to limited space no rehabilitation. Center will be reassessed in January 2012 to determine construction needs</td>
<td>The MCH was destroyed by fire in January 2013. The building was totally rehabilitated.</td>
</tr>
<tr>
<td>Bossaso</td>
<td>Hro Awar (Horseed)</td>
<td>Maternity section, elevated water tank and ground tank, incinerator, placenta pit, cesspool</td>
<td>DONE</td>
</tr>
<tr>
<td>Garowe</td>
<td>Waaberi</td>
<td>Store room, watchman room, rehabilitating the toilets, maternity wing, and placenta pit</td>
<td>DONE</td>
</tr>
<tr>
<td>Garowe</td>
<td>Gambool</td>
<td>Maternity section, elevated water tank and ground tank, incinerator, placenta pit, cesspool</td>
<td>DONE</td>
</tr>
<tr>
<td>SOMALILAND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boroma</td>
<td>Idhan MCH</td>
<td>New construction (Maternity section, block of four room, elevated water tank and ground water tank, incinerator, placenta pit, 4 pit latrine, cesspool, new boundary wall and gate)</td>
<td>DONE</td>
</tr>
<tr>
<td>Boroma</td>
<td>Ullanjit MCH</td>
<td>Maternity section, elevated water tank and ground tank, incinerator, placenta pit, cesspool</td>
<td>DONE</td>
</tr>
<tr>
<td>Boroma</td>
<td>Korgab MCH</td>
<td>Store room, watchman room, rehabilitation of toilet related to maternity, placenta pit, incinerator</td>
<td>DONE</td>
</tr>
<tr>
<td>Boroma</td>
<td>Ali Jowhar MCH</td>
<td>No major work required</td>
<td>Minor rehabilitation</td>
</tr>
<tr>
<td>Boroma</td>
<td>Sh. Osman MCH</td>
<td>Maternity section, watchman room elevated water tank and</td>
<td>DONE</td>
</tr>
</tbody>
</table>
A case to point out is the newly constructed maternity wing in Boruma hospital. A first of its kind in Somaliland, it has a labour/delivery hall, a postop ward, prenatal ward and is closely connected to the theatre. In addition it is well equipped to offer CEmONC services. It was praised and appreciated by the RMO and representative form the ministry of health, and the UNICEF field officer was given certificate of appreciation.

On 5 January 2013, one of the SRCS-managed BEmONC facilities in Bossaso, Haji Abdullahi MCH, consisting of 6 rooms and two latrines, burnt down and all materials were destroyed. All efforts were made to put out the fire using sand and blankets and no casualties were recorded; the two women who were in the delivery room at the time of the fire were safely evacuated. With UNICEF approval, SRCS hired a rented building nearby and immediately resumed services, in order to continue providing life-saving interventions to the community. In 3 months time, UNICEF in collaboration with EU constructed a new building in the place of the burnt structure.

The infrastructure input by the project was well received by the respective authorities, health workers, beneficiaries and target group. All the structures put up by the project are fully functional and in use by the facilities. The midwife in charge Gambool HC, Garowe Puntland confirmed that maternity wing put up by the project led to increased uptake of the services and at the same time provided them with enough room and space to work. And according to her it is only after the construction of the maternity wing that the facility started operating on 24 hr. basis.

2.2 Medical equipment and supply

During the inception phase, MNCH consultant was hired to carry out a detailed EmONC assessment of selected health facilities (MCH centers, referral hospitals), and to suggest requirements to upgrade these facilities to provide quality sexual and reproductive health services. The assessment examined facility readiness, provider skills, the quality of services, coverage and utilization of EmONC services.
and supply status. One of the key areas assessed was the gap in the availability and supply of medical equipment and supplies. Based on these gaps and the suggestions to bridge them, UNICEF procured the following medical supply and equipment to the facilities:

- **Medical equipment and hospital furniture** like delivery beds, hospital beds, wheel chair, resuscitaire, fetal heart Doppler, pulse oximeter, HBmeter, (see annex for details). All these were a one-time supply and in the few facilities visited they are still in good state.

- **Midwifery kits** for the BEmONC facilities. This contained medicines and non-pharm supply to support 50 normal deliveries. (See annex for details of the kit). After the lapse of the project essential components of this kit is no longer supplied under EPHS. These include oxytocin, universal precaution and infection prevention materials, MVA kit, certain lab reagents etc. And the lack of these essential components has downgraded the services offered at the facilities.

- **Obstetric surgical kits** for the CEmONC facilities: This kit provided medicines and supply that was designed to perform an average of 100 deliveries, including 50 with complications and surgery (with an average of 25 caesarean sections) see annex for details. It was also able to perform laparotomy and other minor surgery in emergency. After the lapse of the project, this kit is no longer supplied, as EPHS does not cover the CEmONC facilities. This has led to CEmONC facilities charging the services including referral from MCHs. This is a concern for the implementing agents that it may reverse the gains made through the SRH project. In Puntland, the ministry has taken upon it to encourage the CEmONC facilities to offer free service. This, according to the authorities may not be sustainable in the long run. SRCS, the implementing partner in Dilla HC, Boruma, Somaliland also registered its concern on this matter. Currently they handle the situation by providing referral with their own ambulance and pleading with CEmONC facility (Boruma Hospital.)

UNICEF, through the MoH and implementing partners, is still supplying essentials medicines and supply under EPHS to the facilities, although devoid of the some essential components of BEmONC. The UNICEF field officer, Hargeisa informed the evaluator that UNICEF has implemented a supply chain management system. This will ensure that facilities will order on need basis preventing wastage, over and under stocking of a particular supply.

An interview with several staff in the upgraded/rehabilitated facilities confirmed that the upgrading, rehabilitation/construction and equipping of these facilities have drastically improved their working environment, boosted their morale and this in turn led to increased uptake of the services by the target group. This, according to them, was one unique thing that made the SRH project stand out among all other health interventions in Somalia.
The uninterrupted supply of medicines, consumables and other vital supplies in the background of rehabilitated facilities and well trained adequate health workforce meant provision of quality, 24-hr reproductive health to the target group. This led to the drastic achievement by the SRH project in its short life span. An FDG with some members of health committee have affirmed the positive changes brought about by this project and they wished it continued or replicated in other parts of the country. The health workers who have gained immensely from this project echoed similar sentiments.

**Activity 3: Effective referral system for ANC/PNC BEmONC and CEmONC established**

The referral system was the most important link between the target group and various facilities in the SRH project. Referral linkages were developed during planning workshops and procured a new 4x4 Toyota ambulance for the facilities in Boruma, Somaliland. It also provided two 4x4 Toyota ambulances for the facilities in Bossasso and Galkayo. In Garowe, five e-Rangers motorbike ambulances were provided that were procured with funding from the Government of Japan and handed over to implementing partners.

A detailed referral system and protocols was developed by each BEMONC facility in a one-day workshop supported by Regional Medical Officer (RMO) and UNICEF and attended by health facility staffs, community members and the respective implementing partners. This collaborative effort focused on establishing referral and transport linkages between community and the health facility (BEMONC) and between the BEMONC facility and referral hospital. The management of the ambulances and referrals was under the implementing partner of the respective BEmONC facilities.

The facility staffs were made to understand that the referral and ambulances was to be done “ON CALL” duty basis. To avoid unnecessary over referrals, weekly audit was also done.

In Garowe, the community turned down the use of the motorbike ambulances. And instead indicated that they would prefer proper ambulances as opposed to motorbike ambulances. As agreed with MoH Puntland, UNICEF has decided to procure an ambulance (Toyota) for Garowe using other resources, while the motorbike ambulance was to be used to refer patients from neighboring IDP camps to the BEmONC facilities. However this did not materialize and on some occasions local vehicles were hired to cater for transport between the community and the MCHs. Up to now the health center in charges, some members of the old health committee and the midwives at the Gambool and Waaberi (both in Garowe, Puntland) expressed their biggest challenge as lack of referral system. This, according to them have hampered the delivery of a good service and also affected their numbers.

The referral system is the most affected component of the project following its discontinuation. According to Dr Abdisamad, Director, Garowe General hospital, one of the main success of the project was the effective referrals system from BEmONC facilities such that cases referred from a BEmONC facility required no further evaluation by the team in the hospital as they were confident that the case
must have been properly managed and by the time of its referral it must have been a complicated case.
Nowadays once a case deserves referral, the client is given referral note and she is advised to go to the hospital by her own means. Unlike previously during the life of the project, a client would be referred with an ambulance in the company of a midwife who would remain with until her time of delivery.

Dr Abdisamad gave an example that in the month of OCT 2015 records in Gambool HC showed that 28 cases were referred to Garowe general hospital for further management. But only 9 cases came to the hospital actually, as the other 19 could not be accounted for. This never happened in the lifetime of the SRH project

Currently all the ambulances are functional and stationed in the CEmONC facilities but not in use for the referral of cases from BEmONC to the hospital. Should a client want to use the ambulance for referral then he or she is tasked with fuelling the vehicle and paying the driver.

In the lifetime of the project 1,167 referrals were made to the 4 CEmONC facilities. The main reasons for referrals were: obstructed labor, Preeclampsia, Antepartum hemorrhage, breech presentation, Intrauterine fetal death as illustrated by graph below.

*Figure 5: Trends of BEmONC facility based delivery in Somaliland and Puntalnd, 2011-2014*
The SRH project has been a success due to setting up well-equipped infrastructure staffed with adequate skilled health workers backed by an effective referral.
system. This has drastically increased service uptake and reduced maternal morbidity and mortality. It is a project praised by the respective health authorities as it has strengthened the fragile health sector of Somalia. The health authority in Puntland have praised the project so much that they want its revival and at the same time expansion to other regions of the state. The vehicle are added assets to the CEmONC facilities.

**Result No 2: Demand for SRH/MNCH Clinical and Family Planning services enhanced in the target population**

In order to maximize the impact of the SRH project, both the beneficiary (catchment population) and the target group had to be brought on board fully. This was done through social mobilization and advocacy that facilitated the tremendous achievement of the SRH operation. This advocacy was implemented through the Communication for Development (C4D) strategy by addressing issues like social cultural barriers to seeking health care, beliefs and practices surrounding SRH, health and nutrition education etc. This initiative enhanced community ownership of the project, created linkages between the community and the health facilities, increased service demand at the facility level, resolved conflicts between healthcare providers and the community and established cordial trust between the two. The initiative was carried at the following levels to increase demand among the population for the services offered at the facilities:

**Establishment of Community Health Committees:**

Community Health Committees (CHCs) consisting of 7 members (3 female and 4 male members) were established and strengthened in all participating BEmONC facilities. Their main role was to enhance community ownership of MCH services. They were established around each BEmONC facility after a 3-day training to support the management of the facilities, advocate for BEmONC services, mobilize community, and strengthen collaboration between the health facility staff and community so as to enhance the latter’s ownership of Health Centre services. They regularly met and together with TBAs played a critical role in the increased uptake of the services. Through out the lifetime of the project, over 100 meetings were conducted across the facilities. In these meetings, they discussed on the services offered at the facilities, how it was to be improved, feed back from the community and at the same time it acted as sensitization meeting for the members. Minutes for the meeting were written and shared with the implementing partner during supportive supervision. Currently due to the lack of incentives for the CHCs no more regular meetings are conducted by the committee. This, according to facility in charges, had had negative impact on the service uptake in the facilities due to reduced community mobilization. A member of CHC, Waberi HC has strongly appealed for the return of SRH or similar projects because “we are still reaping the fruits of the SRH project”.

**Performance based financing:**

A performance-based salary top-up system was introduced according to the EC remuneration scheme and the model used under the Health Poverty Reduction
project in Somaliland. This is because public health servants, as well as community health workers, in Somalia get very low, or no, salaries. The performance-based incentive provided to CHWs/TBAs, Health Centers and Regional Hospitals was based on the number of cases referred from the community to the Health Centre, from the Health Centre to the Regional Hospital, and treated in the hospital. These salary top-up and incentives approaches increased motivation of health workers in the target health facilities and their commitment to longer hours of operation. This was key to having facilities operational round-the-clock and reduced public apathy towards health facilities. In so doing, it ensured that more people accessed SRH services.

But with the advent of EPHS, all these incentives are no longer provided. Health workers interviewed in the visited health facilities confirmed that this affected their morale and hence performance. A case in point is improper and untimely filling of partographs, which lowered the quality of SRH service provided. The delayed salaries of the staff further compound this. For example the staff in Waaber and Gambool HCs have not received their dues for 8 months. The staffs interviewed expressed their demotivation and this is reflected in the quality of work at the facility.

Community mobilization forums and awareness meetings:
During the lifetime of the project, community mobilization and awareness activities were carried out to enhance utilization of the BEmONC and other SRH services. This was done with the following members of the community to increase ownership of the project:

- **Community leaders:**
  Advocacy meeting and awareness on BEmONC services was held for 1,160 religious, political and clan elders. They in turn reached more than 3200 people in the catchment population with simple messages of encouraging the target population to utilize the health facilities. The project provided some little incentives to these leaders as they reached the mass. This is no longer available under EPHS.

- **Community mobilizers:**
  A total of 75 community mobilizers have been trained in both NWZ and NEZ sensitizing the community on the availability and importance of SRH services in the selected BEmONC facilities. They conducted 200 sensitization meetings, eventually reaching 5250 persons in the target community.

- **Traditional Birth Attendants:**
  They were identified, trained and sensitized on their role in referring pregnant mother to the facilities. In turn they were offered an incentive of 5 USD for each delivery referred to the facility. They were also linked to the health facility staff and the CHC where they jointly conducted meetings and reached over 3,500 community members. However, with EPHS in place, their roles as linkage to the community and therefore the incentive have stopped. This has had a negative impact, albeit negligible on the number of cases referred to BEmONC facilities form the community.
Radio and Television Awareness

Radio Dajir (Garowe district), SBC Radio (Bossaso district), Voice of Galkayo (South Galkayo) and Radio Hargeisa (Hargeisa) aired radio magazine programme over a period of 12 months reaching the entire catchment population and beyond. The program was aired 3 minutes three times a day for 20 days in a month. The radio programs also featured health and program officers from the implementing partners/UNICEF.

The topics covered on the radio programmes included SRH and child health services; availability of BEmONC services at the respective health facilities; health education and nutrition. In addition community and clan leaders, as well as satisfied couples recorded and aired as part of the programmes.

In Boruma, Somaliland to maximize the number of people reached through community mobilization sessions, the program enlisted the services of the local TV station (RAYO TV). The station in coordination with SCI/MERLIN developed 10-minute documentaries based on activities in each of the six MCH centers. The documentaries were then aired every night for two weeks, increasing the amount of people reached with key messages. At least 40,000 beneficiaries reached.

Bill boards

At least six billboards were fixed at strategic locations with messages on availability of BEmONC services in respective health clinics. The message was clearly depicted in both English and Somali language. They still stand erected and have caught the eyes of many passers by thus contributing to the increased uptake of services at the facilities. The legacy of these programs is still being felt at EPHS facilities.

Mother Club meetings

Through partnership with TBAs, a total of 22 Mother Clubs were formed with the main objective of reaching pregnant women with key messages on reproductive health with emphasis on safe delivery. The Mother Club meetings also addressed issues on awareness and socio-cultural barriers to seeking effective care and reducing maternal and neonatal mortality. At least 5,300 mothers were reached through these clubs, where through active participation and dialogue many of their fears and questions were addressed.

E. SUSTAINABILITY

In the original proposal of the project, its sustainability and exit strategy was not well captured. Luckily UNICEF is a key stakeholder in the Essential Package of Health Services (EPHS) under the Joint Health and Nutrition Program (JHNPs).
The project has been taken over by EPHS/JHNP up to December 2016. The scale-up of the EPHS package includes SRH under its core program - 1 “Reproductive, Maternal and Newborn Health”. EPHS thus continues to support the provision of essential health for pregnant women and newborns. The same implementing partners remain present and operational in the facilities. This has enabled continuity of the services at the SRH facilities especially the BEmONC facilities. EPHS continues to support incentives to MoH staff in health facilities at district and zonal levels.

However, the current EPHS lacks many components of the SRH project namely: incentives to the CHC, TBAs and community sensitizers, free-of-charge services both at BEmONC and CEmONC facilities, baby gifts to post-delivery mothers, deficiency of some supplies and medicines e.g. oxytocin. The other main problem lies in the sustainability of the project in CEmONC arm, as the current EPHS focuses on primary health care thus leaving out hospital based services.

The JHNP aims to support sustained and improved reproductive, maternal, newborn and child health and nutrition outcomes for Somali women, girls, children and their communities – resulting in measurable impact in reduced maternal and child mortality. It also aims to improve the capacity and leadership of the Somali Health Authorities in managing and coordinating the health sector development.

JHNP supports implementation of the in-country developed policies including Somali Health Policy, Health Sector Strategic Plans, aligned health and nutrition strategies/plans and relevant UN cooperation strategies. The programme’s implementation considers the specific context of Somaliland, Puntland and Central South and ongoing health sector reform initiatives including EPHS framework, Global Fund for AIDS, Tuberculosis and Malaria, GAVI Health System Support, Health Consortium Somalia and the Joint Programme on Local Governance.

The positive gains made by the project may be affected by disappearance of some benefits. For example, in the current EPHS program, TBAs no longer play a role, the role of CHC and community mobilizers not well captured. This may eventually affect the pregnant mothers referred from the community and reverse the gains made so far. The various incentives offered by the project are no longer available. For example a midwife in one of the facilities says that mothers are demanding for the baby gifts that were being given previously.
Section 3

Conclusion

Challenges

Lessons learned

Key Observations and Recommendations
This was well planned and implemented project that invested mainly in infrastructure, capacity building, medical supply, community awareness and sensitization and 24-hr facility coverage. This led to increased demand and uptake of reproductive health services among the target population, empowered/informed population and community ownership. The authority and the community advocate for the return of the project, its sustainability and its expansion in other parts of Somalia.

The overall performance rating was found to be between good and very good. With regard to relevance the project was relevant at the time of its conception as it was based on assessments, universal health indicators and baseline surveys. The overall efficiency was found to be good with some delays during inception phase, the project was very effective where interventions were implemented well by partners, both short term (increased service uptake and awareness) and long term impacts have been realized (infrastructure, skilled personnel, increased number of HCWs and regular medical supply). Sustainability of the interventions is questionable although linked to JHNP and is running under EPHS.

Finally due to the SRH project interventions, more than 300,000 people benefited with increased access to quality sexual reproductive health.

**CHALLENGES**

The project was essentially very successful and achieved a lot. However, it encountered some challenges during its implementation. Some of these challenges raised during an FDG with the various stakeholders (CHC, midwives, health authority, implementing partners) include:

- Lack of sustainability.
- Delayed salaries/remuneration of the health workers.
- Inadequate supply for BEmONC and CEmONC service delivery.
- Lack of performance based incentives for facilities.
- The need for more capacity building.
- Need for CEmONC trainings and refresher courses for the BEmoNC trainees.
- Lack of incentives for the CHC, TBAs and community mobilizers.
- Insufficient salaries to BEmONC staff.
- Lack of proper referral system especially in Garowe, between the community and the BEmONC centers and between the latter and the CEmONC facility (Garowe hospital).

**LESSONS LEARNED**

Some important key lessons learnt in the lifetime of the project are:
- **Strengthened health system:** The project enhanced the capacity of health workers, upgraded infrastructure and equipped the BEmONC facilities. This in turn strengthened a fragile health system in Puntland and Somaliland.

- **Stakeholder (community leaders, TBAs, health authority) inclusivity** was critical in this project. This led to community/health authority ownership of the intervention and increased uptake of the services.

- **Unintended positive use** of some of the outputs of the project: In the process of enhancing service delivery and capacity building several manuals, protocols, SOPs have been developed and locally adopted. These materials continue to serve the ministries as key reference documents.

- **Refurbished, well-equipped health facilities** with regular adequate supply increases demand and uptake of the services provided in these facilities. This in turn boosts the morale of the health workers.

- **Health sector coordination** with clear role sharing among the key stakeholders and implementing partners improves health care delivery.

- **Regular sustained monitoring and evaluation** coupled with supportive supervision also increases quality service delivery and eventually uptake of the service by the target group.

**KEY OBSERVATIONS AND RECOMMENDATIONS**

**UNICEF/Implementing partners:**

1. **Incorporation of HIV services:** Although HIV prevalence is reportedly low in Somalia; Prevention of Mother To Child Transmission is the universal way to eliminate paediatric HIV. It was noted that while the project is a SRH project it lacked HIV component. Therefore there is need to incorporate HIV services in such future project. In addition there is need to provide PMTCT training to the HCWs and supply of PMTCT commodities (Testing kits and ARVs).

2. **Family planning Services:** While implementing partner like Merlin has approached PSI to provide FP services in 6 MCH facilities, the rest of other facilities had no proper regular FP services. It is recommended that provision of FP services be incorporated into such projects in the future and the role of respective partner in FP provision clarified.

3. **Provision of quality neonatal care and resuscitation:** The project laid more emphasis on maternal health while the intertwined neonatal health was somewhat weak. It also recommended that for future such projects, proper neonatal care training be provided to the Health workers in BEmONC facilities so as to tackle the high neonatal deaths in Somalia.

**MoH/UNICEF/EU:**
1. There is need for a comprehensive, consultative meeting to discuss a phase out and sustainability strategy for such successful intervention in the future. Strategies recommended include
   a. Extension of the project duration beyond its planned end date,
   b. Affordable cost sharing strategy,
   c. Sourcing for more donors to be put on board,
   d. Positioning of such successful operation at the heart of the health strategic plans and the Joint Health and Nutrition Program of Somalia,
   e. Dialogue and opinion seeking from the target population and host community.
2. Integration of the successes of this project into and expansion of EPHS to offer comprehensive EMONC services in MCHs.

EU/UNICEF:

1. Extension of the project duration: The impact is so immense that such a project should not have a life span. At least an extension by 2 more years will give the community and the authority an ample time to plan for sustainability of the operation. If extension is not possible, then a gradual pull out is recommended lest service provision is interrupted.
2. Expansion of similar projects in other parts of Somalia.