Integrated Health Care Programme (IHCP)

Baseline Survey Report

Somali Red Crescent Society (SRCS)

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Contents

Acronyms

AIDS	Acquired Immune Deficiency Syndrome
AWD	Acute Watery Diarrhoea
BEmONC	Basic Emergency Obstetric and New-born Care
BMOC	Basic Medical Obstetric Care
CBHE	Community-based Health Education
D&C	Dilation and Curettage
EPHS	Essential Package of Health Services
EPI	Expanded Programme of Immunisation
FGD	Focus Group Discussion
FSNAU	Food Security and Nutritional Analysis Unit
FP	Family Planning
HQ	Headquarters
IYCF	Infant and Young Child Feeding
IHCP	Integrated Health Care Programme
IFRC	International Federation of Red Cross and Red Crescent Societies
MCH	Maternal and Child Health
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
OPD	Outpatient Department
OTP	Outpatient Therapeutic Programme
PSU	Primary Sampling Units
RAMP	Rapid Mobile Phone-based
RCM	Red Cross/ Red Crescent Movement
SRCS	Somali Red Crescent Society
TBA	Traditional Birth Attendant
STI	Sexually Transmitted Infection
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organisation

1. Background

The Somali Red Crescent Society (SRCS) is an independent, non-political humanitarian organization that was founded in 1963 and was established with presidential decree in 1965. The Society has been providing humanitarian services, including health care, to the most vulnerable people in Somalia throughout the conflict and insecurity over the last two decades. It is currently the largest indigenous humanitarian organization with branches in all 19 regions of Somaliland, Puntland and South and Central Somalia and a network of approximately 5,000 volunteers.

The integrated health care programme (IHCP) has been the core programme of the SRCS since 1992 and has been supported by both Red Cross/Crescent Movement (RCM) partners and non-movement partners such as the United Nations Children's Fund (UNICEF), the World Health Organisation (WHO), the World Bank and recently the World Food Programme (WFP). The IHCP comprises a network of Maternal and Child Health/Out Patient Department (MCH/OPD) clinics and related mobile outreach and community based activities. The National Society has increased the number of the MCH/OPD clinics it operates, from 20 clinics in 1992 to 69 static and 26 mobile clinics in 2011.[1] However the numbers keep fluctuating, particularly in South/Central Somalia due to the activities of the "difficult authorities" or the Al-Shabab militant group ordering the closure or opening of some of the clinics at will in areas under their control. As such as at the end of December 2013, the SRCS was operating a total of 60 active static MCH/OPDs and 23 mobile health clinics.

The SRCS network of MCH/OPD clinics is able to offer a range of health services in line with those defined by the Essential Package of Health Services (EPHS) for the country.[2] Services include the Expanded Programme of Immunization (EPI), therapeutic and preventive nutrition services, case management of childhood and common ailments, safe motherhood (antenatal, delivery and post-natal care, provision of micronutrients, clean delivery kits) and the referral of complicated cases to regional hospitals. The SRCS also supports community-based activities through trained volunteers. These include a range of preventive and promotive activities as well as awareness creation on HIV/AIDS and other stigmatized and harmful traditional practices including female genital mutilation and cutting (FGM/C) and the promotion of Fundamental Principles and Humanitarian Values of the Red Cross/Crescent Movement.

2. Rationale for baseline survey

Due to the emergency circumstances surrounding its set up in 1991, the IHCP did not include a baseline study and has never had a comprehensive evaluation conducted since its establishment. Some project specific evaluations have been carried out on components of the IHCP, such as the Qarhis Project (Community-Managed Health Care Service Provision Model) supported by the World Bank in 2004. Similarly, there have been various multilateral and bilateral evaluations conducted on specific projects under the broader IHCP.

It was decided by the SRCS and the IFRC Somalia Country Representation together with other Movement partners to conduct a baseline study on the IHCP. It is envisaged that the study will provide inputs for the development of partner proposals for the coming years as well as providing a basis for measuring programme impact and service delivery of the clinics over time. It will also provide inputs for refining and developing SMART[3] indicators in operationalizing the SRCS Health Strategy 2013-2017. Furthermore, it will allow SRCS to identify areas of divergence in order that services are of high quality and uniformly delivered across the three zones.

[1] SRCS 2012. The Somali Red Crescent 2011 Annual Report.
[2] Essential Package of Health Services, April, 2009.
[3] Specific, measurable, achievable, relevant and time-bound.

The study focused on 16 MCH/OPDs in Somaliland and Puntland as well as 10 in South/Central zone of Somalia. Annex 1 provides information on the distribution of MCH/OPD clinics that have been purposefully selected for inclusion in the baseline study.

3. Methodology

The Terms of Reference for the baseline survey are provided for in Annex 1. The baseline survey employed a mixed method design involving the use of both qualitative and quantitative data collection instruments. A household survey (Annex 2) was administered using the Rapid Mobile Phone-Based (RAMP) technology.

A team of two consultants were responsible for the overall execution of the baseline survey and worked in close consultation with the RAMP experts and a technical team comprised of SRCS and Movement partners both in Nairobi and at Somalia zonal level. The consultant team developed the three qualitative survey instruments and oversaw their administration. They were responsible for the collection of qualitative data, the data compilation, analysis and report writing. The qualitative survey included: 1) interviews with SRCS clinic staff: 2) facility checklists and 3) FGDs with Community Health Committees as well as male and female community members. Senior and supervisory SRCS staff was not surveyed for the baseline. However, staff members were actively involved in the training, the supervision of enumerators and in qualitative data collection. The survey instruments have been reproduced in Annex 3.

The core household survey questionnaire had been developed by a consultant originally contracted to conduct the baseline. This was subsequently revised in consultation with Movement partners. Similarly, the qualitative survey instruments were prepared and revised by the consultant team in consultation with staff and partners. Field work for the administration of the baseline survey began 16thNovember, 2013 with a brief training of enumerators prior to testing the survey instruments at a clinic site close to Hargeisa, Somaliland.

As discussed in Section 3.5, events beyond the control of the consultant team affected the planned training and testing schedule which was to have taken place over a four-day period. In the event, the training of the enumerators and testing of the quantitative and qualitative instruments was conducted 16th-17th November, 2013. The first training of enumerators (SRCS volunteers from the survey sites) for the household survey and of staff members for the FGDs was conducted jointly with the RAMP consultant 18th-21st November, 2013 at the Maansoor Hotel, Hargeisa. South/Central staff training for the qualitative study took place 26th -28th November 2013 at the Shamo Hotel, Mogadishu while that for the enumerators for the quantitative component took place between 6th and 10th December. Training of staff from Puntland who were undertaking the FGDs and selecting enumerators for the Household survey took place at the 30th November -2nd December 2013 at the SRCS training room in Garowe. That for the enumerators for the quantitative data collection on the other hand took place at the New Rays Hotel in Garowe between 12th and 16th December 2013. An outline of the training can be found in Annex 4.

Table 1 Training schedule

Activity		
Training for piloting data collection tools	16 November 2013	Consultant
Piloting of data collection tools	17 November 2013	Consultant
Training on data collection tools – HH survey and qualitative.	18 – 21 November 2013	Consultant
RAMP training for Somaliland	18 – 21 November 2013	RAMP Expert
Training on qualitative data collection in Mogadishu	26 – 28 November 2013	Consultant
RAMP training South/Central Somalia	06 – 10 December 2013	RAMP Expert
Training on qualitative data collection for Puntland	30 – 02 December 2013	Consultant
RAMP training for Puntland	12 – 16 December 2013	RAMP Expert

3.1 Selection and training of enumerators

SRCS took the decision to draw enumerators from their corps of volunteers and from staff at their branch offices. It was felt that the baseline survey provided an opportunity to build the research and enumeration skills of SRCS staff and its volunteers. Branch offices were asked to select volunteers for the administration of the household survey on the basis of their language and literacy skills. Branch Health Officers were selected to conduct the focus group discussions (FGDs).

It had been intended that the training of the volunteer and staff enumerators for both qualitative and quantitative data would be conducted at the same time in each of the three zones. Due to a localised emergency, this proved to not be possible in Puntland and South/Central Somalia. However, the initial round of training in Somaliland was conducted by one member of the consultant team and by the RAMP specialist. Although the planned training programme could not be followed due to some technical difficulties, the process provided some key lessons for the administration of the survey and for the training of enumerators and in the other two zones (See section 3.5, Limitations). The content of the training included participants understanding the purpose of baseline surveys, understanding and becoming familiar with the various survey instruments and practicing administering the instruments and, for the volunteers administering the household survey, practicing keying and sending data with the mobile phones provided. An outline of the content of the training workshops is given in Annex 4.

It is emphasised that not only was care taken before and during the training to ensure that the household survey questionnaire was carefully translated into Somali but time and attention was given to ensuring that supervisory staff and enumerators in the three zones agreed on the translations and any local variations, slang or vernacular particularly in case of delicate topics such as birth spacing methods. It is also noted that the questionnaire was designed to allow respondents to respond in their own language without prompts.

3.2 Household survey

The Household survey component was conducted in the three zones over the period beginning on the 25thNovember 2013 and ending on the11th January 2014. Operationally, the survey was conducted as three separate surveys. In survey terminology, there were three domains--Somaliland, Puntland and South/Central Somalia. Health facility catchment areas were the primary sampling units (PSUs).

The sample size of households for each domain (zone) was based on precision of plus or minus 10%, prevalence of 50%, and design effect of 1.5. This yielded a total of 145 households per zone. A non-response rate of 10% and a design effect of 2.0 were assumed in this survey thus the number of households to be sampled increased from 145 to 180-200 for each zone.

In Puntland and Somaliland half of the health facilities were selected based on probability proportional to estimated size (PPES) sampling. For Puntland 10 of the 20 health facilities were selected and in Somaliland 6 of 12 health facilities selected. Site selection was random; however, some sites were not included in the random selection process due to security and accessibility issues in those areas. In South/Central Somalia only 10 out of 25 health facility could be accessed securely and all the 10 facilities were included in the sampling frame. The 15 inaccessible health facilities were not included in the sampling frame. The selected PSUs were mapped and divided into 2-10 segments depending on their sizes and using natural boundaries. In Somaliland, one segment was selected from each PSU using simple random sampling (SRS); in Puntland, two segments per PSU, and in South/ Central, one segment was selected per PSU. Mobile phones were used by the interviewers to enter the survey data using Magpi software in real-time during the interview.

Once a segment was selected, all households were mapped and numbered and households to be interviewed were chosen by simple random sampling. The sample included 20 households per each of the 10 PSU in Puntland (200 households in total); 30 household in each of the 6 PSU in Somaliland (180 households total) and 20 household in each of the 10 PSU in south and Central (200 households in total). One of the qualifying criteria for the selected house was the presence of a child below 5 years, where the household selected didn't have a child below 5 years it was dropped and a new selection done.

If no one was at home after three visits to a household that was selected to be interviewed, then this was recorded and no replacement was made. **Tables 1 -3** provide descriptive information about the survey for the three zones. The estimated total population in the sampling frame for Puntland, Somaliland and South/Central Somalia was respectively 170,533, 127,200 and 439,733.

Table 2: Survey description and key information - Puntland

	n	%		N	%
Sample domain (pop)	170,533		**No. households**	200	
Sample domain (houses)	23,995	divided by 5.29	**No. households interviewed**	196	98%
No. clusters	10 of 20		**No. persons (all ages)**	1,393	
No. HH per cluster	20		**Average HH size**	7.11	
			No. children <5 y	446	32%
			Av. sample weight	122.4	

Table 3: Survey Description and key information - Somaliland

	n	%		N	%
Sample domain (pop)	127,200		**No. households**	182	
Sample domain (houses)	24,045	divided by 5.29	**No. households interviewed**	180	99%
No. clusters	6 of 12		**No. persons (all ages)**	1,407	
No. HH per cluster	30		**Average HH size**	5.29	
			No. children <5 y	410	29%
			Av. sample weight	133.6	

Table 4: Survey description and key information – South/Central Somalia

	n	%		N	%
Sample domain (pop)	439,733		**No. households**	200	
Sample domain (houses)	60,343	divided by 7.29	**No. households interviewed**	195	98%
No. clusters	10 of 10		**No. persons (all ages)**	1,421	
No. HH per cluster	20		**Average HH size**	7.29	
			No. children <5 y	458	32%
			Av. sample weight	309.5	

3.3 Facility checklists and health provider interviews

The facility checklist was designed to be administered in a short period (no more than an hour) with the minimum inconvenience to staff and patients. It was recognised that the checklist was not comprehensive particularly with regard to drugs and equipment. The health provider interview guide was also designed to be administered in under an hour and to the cover key areas affecting clinic operations.

The checklists and staff interviews were administered in all three zones. In Somaliland and Puntland, the checklists and staff interviews were conducted by one of the team of external consultants with the assistance of local interpreters. In South/Central Somalia, due to logistical issues, insecurity and distance, the checklists were administered and interviews conducted by a number of different but independent local consultants. Again due logistical and organisational challenges, field work in South/Central Somalia did not begin until the end of January, 2014.

Table 5: Clinics surveyed in Somaliland, Puntland and South/Central

Somaliland	Code	Puntland	Code	South Central	Code
Sheikh	1.4	**Baadweyn**	2.3	**Adado**	3.1
Allaybaday	1.5	**Kalabeyr**	2.5	**Bundowein**	3.2
Dilla	1.6	**Jallam**	2.6	**Balad**	3.3
		Haafo	2.8	**Farjano**	3.4
				Baidoa	3.5

Health facilities were selected using the same sample frame as the household survey. Three of six facilities were selected in Somaliland and five of ten selected in Puntland for the qualitative survey. Unfortunately, insecurity during the field work in Puntland resulted in only four facilities being surveyed. Five of ten facilities were surveyed in South/Central Somalia.

3.4 Focus group discussions

Focus group discussions (FGDs) were held in three locations in Somaliland, four locations in Puntland and five locations in South/Central Somalia over the period November 2013 to February 2014. For the purpose of triangulation and efficiency, the discussants were from the same sites as those selected for the household and clinic surveys. Three separate FGD guides were administered to men and women from the community as well as male and female members of the Community Health Committees (CHCs) of the MCH/OPDs. In total 299 discussants participated including male community members (n = 102); female community members (n=140); and CHC (male-female) members (n = 57)[4]. Table 5 presents the number of participants by location and group. Transcripts have been compiled and are available in a supplementary document to this report.

Table 6: FGD participants by location

	CHCs				Women						Men				
Location	**Total**	**F**	**M**	**Total**	**20-29**	**30-39**	**40-49**	**>50**	**Age not given**	**Total**	**20-29**	**30-39**	**40-49**	**>50**	**Age not given**
Cadaadley (1.2)	9	5	4	14	1	4	3	2	4	7	0	2	0	5	
Sheik (1.4)	9	2	7	12	3	5	1	0	3	11	5	3	0	0	3
Dilla (1.6)	9	5	4	17	7	2	4	3	1	9	0	0	5	4	
Baadweyn (2.3)				12	3	2	1	2	4	9	1	1	3	4	
Kalabeyr (2.5)	8	3	5	13	3	4	1	0	5	9	1	1	2	5	
Jallam (2.6)				9	3	3	3	0		9	3	4	2	0	
Harfo (2.8)	9	4	5	11	7	1	2	0	1	6	3	1	1	1	
Balad (3.2)	0	0	0	7	3	1	1	2		13	1	2	3	4	3
Beletweyn (3.3)	0	0	0	9	5	4	0	0		8	3	1	0	4	
Isha (3.7)	0	0	0	10	5	5	0	0		9	4	3	2	0	
Farjano (3.9)	9	4	5	16	9	5	2	0		4	1	1	1	1	
Adado (3.10)	0	0	0	10	2	3	5	0		8	4	2	2	0	

3.5 Limitations

A number of challenges and limitations were faced during the preparation and the administering of the components of the survey.

Household survey

Site selection: Although the process of site selection was random, the security situation in South/Central Somalia in particular and to a lesser extent Puntland and Somaliland meant that certain clinic sites were excluded from the selection process. Additionally, the inaccessibility of certain sites meant that it was not feasible to organise the

[4]The age structure of FGD respondents is unreliable. In some instances, the allocation across age cohorts does not add up to the total number of FGD participants. This is attributed to poor recording.

survey in those areas. Thus, there was random selection of sites from those that **were considered to be safe and accessible** for the purposes of conducting the Household Survey, the clinic survey and the FGDs.

The selection and training of household survey enumerators: Although branch offices were given criteria for the selection of volunteers, in Somaliland several of the selected enumerators proved to be very young (sixteen and seventeen years old) and somewhat not suitable for interviewing given the sensitivity of some of the question and Somali culture. Limited literacy and poor comprehension leading to the need to have a translator slowed the training. In Puntland and South/Central, Branch Health Officers were trained prior to the RAMP training of volunteers. With a better understanding of the survey methodology and purpose, they were able to assist in the selection of appropriate volunteer enumerators.

No standardized household survey tool: The household data collection questionnaire used in Somaliland where the survey commenced posed a lot of challenges during data analysis necessitating its change for use in consequent data collection in South/Central and Puntland. Some important variables missed in the initial questionnaire hence for some question comparative analysis could not be conducted across the 3 domains

Insufficient pre-testing of the survey instrument: Due to unanticipated delays in the commencement of the field work, the baseline survey tools were insufficiently pre-tested. Training of the enumerators to conduct the pre-testing was reduced to half day training with one facilitator compared with the recommended one day training with two facilitators. Pretesting was limited to one site and time constraints did not allow for a full review and revision process. Consequently, poor questions formulation and difficulties of data collection did not emerge until after the household survey began. This adversely affected the survey data and findings for Somaliland, the first zone to be surveyed.

Unanticipated delays: Uncertainties in planning- from security to flights – affected all aspects of the baseline survey. However, it was most felt in the administration of the survey in in South/Central Somalia. Logistics such as transportation difficulties delayed the household data collection exercise and severely limited monitoring and supervision of the exercise. Data quality in South/Central Somalia may have been compromised as a result of the inability to supervise the exercise.

Mobile Phone technology: Mobile phone and their compatibility with the local phone networks posed a major challenge, particularly in Somaliland where the training of enumerators on the technology for the quantitative data collection commenced. The tested mobile phone type that was procured for the training and actual data collection was found not to be compatible with the local network in Somaliland. The RAMP Expert leading the training spent some considerable time off the training schedule to identify a compatible phone at the local market to enable the enumerators to be trained on the technology. With the lesson learned in Somaliland, both Puntland and South/Central Somalia had to buy and test sample phone compatibility with the respective local phone operators before bulk procurement was made for the training and conduct of the data collection.

Network availability proved another challenge. Not all sites that quantitative data was collected had network and therefore data collected could not always be sent out to the data manager as planned at the end of each day. In some cases, data collectors had to travel to locations where they could eventually send out data collected at the end of the day. In South/central Somalia, the ban on the use of the internet in some parts for a period affected progress in data collection. The delay in data submission posed a threat in early data errors detection, notification and correction.

Interviews with key informants: Although the consultant was able to meet with personnel from the Ministries of Health in all three zones as well as key informants from UNICEF and WHO. Insecurity and time constraints meant it was not possible to meet with the range of agencies and individuals working in primary health care delivery that had been originally anticipated.

Facility checklists and health provider interviews

The checklists and health provider interviews as part of the qualitative data collection were conducted by the same consultant in clinics in Somaliland and Puntland. However, these were conducted by a number of SRCS staff trained for the purpose in South/Central Somalia. The levels of detail and approach varied resulting in significant inconsistencies and incomplete data sets in a few of the clinics. It was apparent from the data, that two of the

interviewers had a poor grasp of English and did not understand all the questions and so some questions were not answered or the reporting of the answers was overly short and unnuanced. In Somaliland and Puntland, health provider interviews were conducted in groups. Thus staff members at each clinic were interviewed jointly and the findings reflect a consensus view. In South/Central Somalia, health providers were interviewed separately and perceptions between individual care providers in a clinic varied.

The administration of the qualitative survey tools in South/Central Somalia was only completed in late February/ early March, 2014 resulting in data for the zone being analysed after the Somaliland and Puntland data had already been analysed and written up. A lack of consistency in the data collection and transcription and the lateness of its inclusion into the report meant that it was not possible to fully integrate all of the South/Central Somalia qualitative data into the body of findings.

Another consequence of the foreshortened pre-testing of instruments, and hastily trained enumerators, was that the structural differences between the zones e.g. the content of the drug kits etc. were not factored into the revision of the facility checklist.

Despite guidelines for the administering of the instruments to consultants in South/Central Somalia, there were inconsistencies in the completion of the checklists and in the health provider interview findings. The quality and the depth of health provider interview data were impaired. Of necessity different consultants were employed at the different clinics. Either due to poor written English skills or because greater depth of information was not sought, the findings are limed.

Focus Group Discussions

Good facilitation and enumeration takes time and practice. Despite the training and the commitment and enthusiasm of the SRCS staff, a lack of practice and experience in conducting FGDs meant that some of the discussions lacked depth and penetration. Invariably there were limitations in individual skills and capacities to conduct the FGDs. In some instances, discussion was stilted suggesting that rapport had not been adequately established. Additionally, as SRCS staff members and/or volunteers were used to facilitate the discussions, there were likely biases introduced, particularly those questions specifically related to the SRCS. This included questions from the FGD guide being skipped or modified for no clear or apparent reason.

Age distribution of FGD participants was uneven across sites. In some instances, age was heavily skewed to older age groups (e.g. > 50 years of age), particularly amongst male FGD participants. It is not possible to break down FGD participants by sex or age as these questions were not consistently recorded by all interviewers.

4. Survey findings

4.1 Household Survey

Table 7: Somaliland - Gender, marital status and age of respondents

Gender of respondent %		Marital status %		Age of respondent %	
Male	6	Married	96	15-29	29
Female	94	Divorced	2	30-39	55
		Widowed	2	40-49	16
		Single	0	50+	1

Of the 180 respondent interviewed, majority 94% of them were female and 96% were married. Twenty nine percent (29%) of respondents were 15-29 years old and 55% were 30-39 years old. Only one percent of respondents were 50 years old or older.

Table 8: Puntland - Gender, marital status and age of respondents

Gender of respondent %		Marital status%		Age of respondent %	
Male	15	Married	98	15-29	44
Female	85	Divorced	2	30-39	40
		Widowed	1	40-49	12
		Single	0	50+	3

In Puntland 198 respondents were interviewed, eighty-five percent of them were female and nearly all (96%) were married. Forty-four percent of respondents were 15-29 years old and 40% were 30-39 years old. Only three percent of respondents were 50 years old or older.

Table 9: South/Central Somalia - Gender, marital status and age of respondents

Gender of respondent %		Marital status %		Age of respondent %	
Male	15	Married	92	15-29	51
Female	85	Divorced	4	30-39	39
		Widowed	4	40-49	6
		Single	0	50+	4

In South/Central Somalia 195 respondents were interviewed, Eighty-five percent were female and 92% were married. Fifty-one percent of respondents were 15-29 years old and 39% were 30-39 years old. Only four percent of respondents were 50 years old or older.

Table 10: Distance to nearest SRCS MCH/OPD clinic

Puntland		Somaliland		South/Central Somalia	
Distance	***%***	***Distance***	%	***Distance***	***%***
<= 1 km	28	<= 1 km	13	<= 1 km	23
2 km	8	2 km	13	2 km	26
3-4 Kim	7	3-4 Kim	7	3-4 Kim	33
5-9 km	7	5-9 km	17	5-9 km	3
10-19 km	10	10-19 km	30	10-19 km	4
20+ km	36	20+ km	20	20+ km	0
Mean	15.6	**Mean**	11.7	**Mean**	3
Median	10	**Median**	8.5	**Median**	

Fifty percent (50%) of households in Puntland were more than 10.0 km from a health facility. In Somaliland, fifty percent of households were more than 8.5 km from a health facility. In South/Central Somalia, 90% of respondents lived less than 5km from a health facility. Eighty-two percent of households were within 4 km of a health facility.

Table 11: Puntland household characteristics

Av. number of persons per household/compound	Av. number of children (age not specified) per household	How long lived in this area	
7.0	**4.3**	<1 year	7%
		1-4 years	18%

		> 4 years	75%

The average number of persons per household in Puntland was 7.0. The average number of children per household was 4.3. Seventy five percent of the (75%) respondents had been living in that location for 4 or more years. Very few (7%) had lived there for less than 1 year.

Table 12: Somaliland household characteristics

Av. number of persons per household/compound	Av. number of children (age not specified) per household	How long lived in this area	
7.8	5.19	<1 year	3%
		1-4 years	17%
		> 4 years	80%

The average number of persons per household in Somaliland was 7.8. The average number of children (age not specified) per household was 5.19. Most (80%) respondents had been living in that location for 4 or more years. Only 3% of respondents had lived there for less than 1 year.

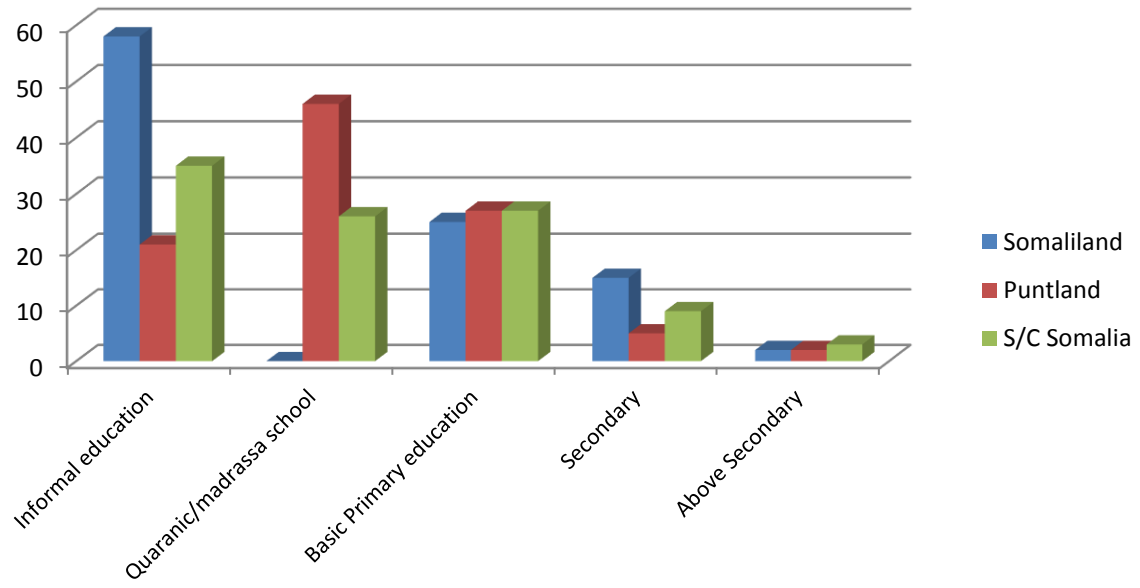
Table 13: South/Central Somalia household characteristics

Av. number of persons per household/compound	Av. number of children (age not specified) per household	How long lived in this area	
7.1	4.45	<1 year	11%
		1-4 years	25%
		> 4 years	64%

The average number of persons per household in South/Central Somalia was 7.1. Most (64%) of respondents surveyed in South/Central Somalia had been living in that location for four or more years and 11% had lived there for less than 1 year.

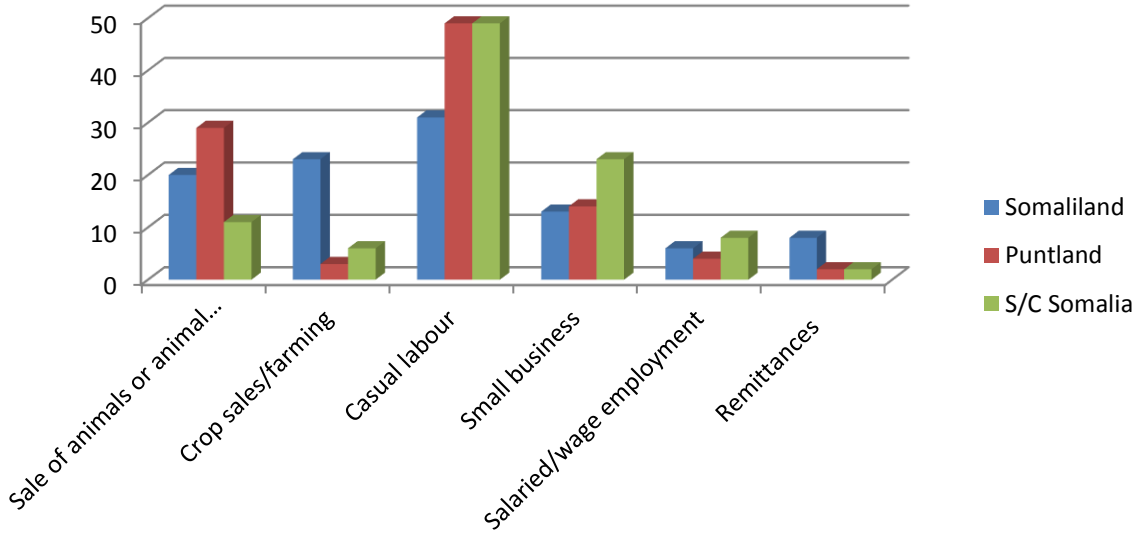
The following charts and graphs describe the socio-economic characteristics of household survey respondents in the three zones.

Figure 1 – Educational status in percentage (%)



Fifty-eight percent (58%) of respondents in Somaliland had only informal education[5] Twenty-five percent (25%) had basic primary education. Sixty-seven percent (67%) of all respondents in Puntland had only an informal education (21%), Qur'anic/madrassa schooling (46%). Twenty-six percent (26%) had basic primary education. There are not significant differences in levels of education between respondents in the three zones.

Figure2 - Household's main source of income - %

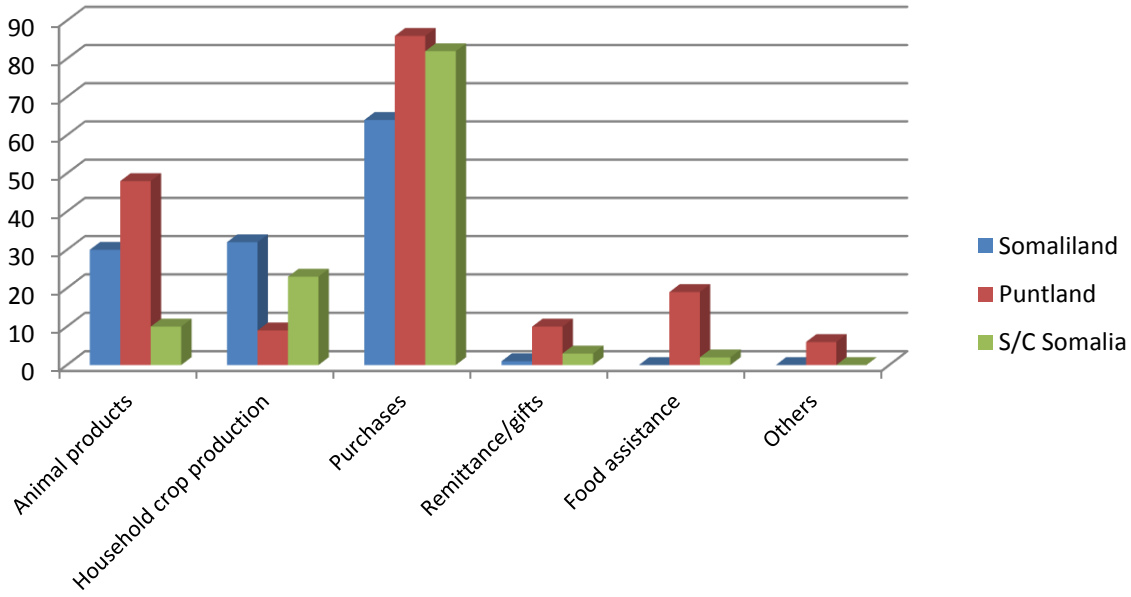


In Somaliland, households reported their main source of income as follows: sale of animal products (20%), farming (23%), or casual labour (31%). Twenty-nine percent (29%) of households in Puntland and only 10% in South/Central Somalia reported sales of livestock as their main source of income. Casual labour was the main source of income in both South/Central Somalia

[5] The Household survey finding in Somaliland did not differentiate between informal and madrassa education.

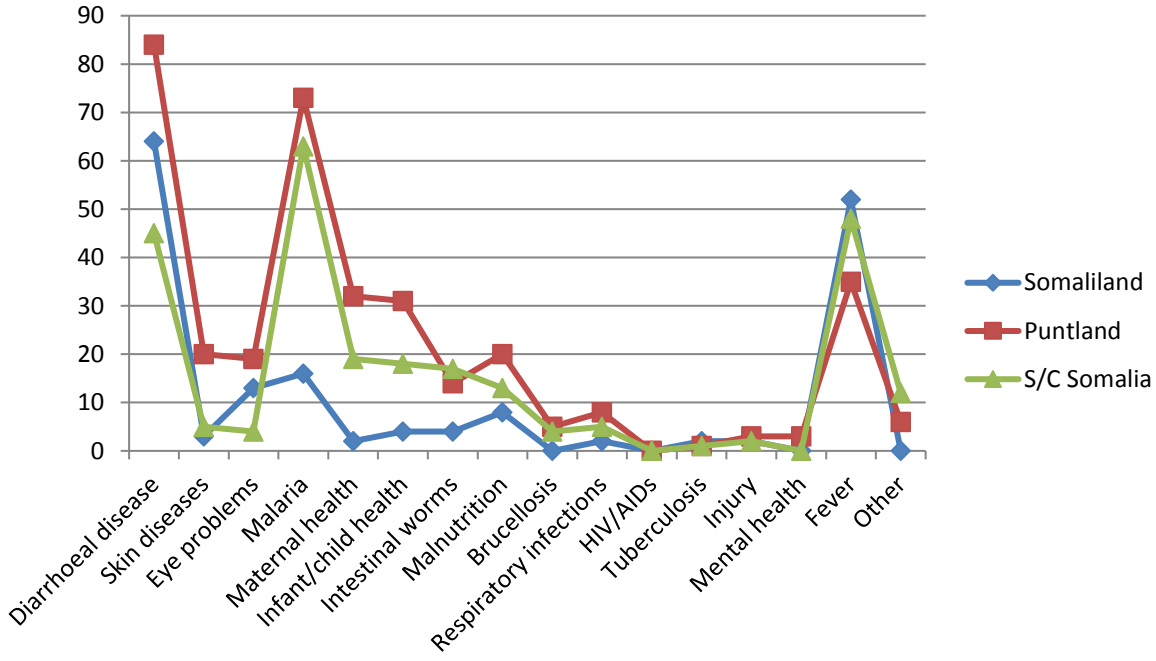
and Puntland. Only 6% reported wage employment in Somaliland. Wage/salaried employment were equally low in Puntland (4%) and South/Central Somalia (8%). Eight percent (8%) of respondents in Somaliland reported remittances from relatives as their income source compared to two percent in Puntland and South/Central Somalia.

Figure 3 - Where do you get food from? (multiple selection)



In all three zones, households purchase most of their food needs. In Puntland, forty-eight percent (48%) sourced animal products from their own production compared to 30% in Somaliland and only 10% in South/Central Somalia.

Figure 4: Five key health concerns in the past month



The top health concerns identified by respondents in Somaliland were diarrhoeal disease (64%), fever (52%), malaria (16%), eye problems (13%), and malnutrition (8%). Other health concerns were expressed by <5% of households. In Puntland, the top health concerns were identified as diarrhoea (84%), fever (35%), and malaria (73%) followed by maternal health and infant child health. Malnutrition was a concern for 20% of respondents. The top health concerns in South/Central Somalia were diarrhoea (45%), fever (48%), and malaria (63%). Malnutrition was a concern for 13% of respondents. It is noted that the rate of malaria (73%) in Puntland was unusually high due to a recent outbreak at the time of the survey. It does not reflect malaria endermicity (hypo-dermic) in the zone. It is further noted that the low rate of reported respiratory disease does not reflect clinic data where respiratory tract infections are most common.

Evidence of positive knowledge and attitudes on the benefits of ANC/PNC

This section shows data on knowledge, attitudes and practices with regards to reproductive health.

Table 14 : Puntland - Reasons for attending ANC

Reasons why pregnant women go for ANC check-ups (multiple selections		How often do you think pregnant women are supposed to go for an ANC check-up	
To get immunisation	82	1	2
To check mother's health	76	2	8
To check baby's health	53	3	23
To get vitamins or micronutrients	62	4 or more times	62
To get clean delivery kit	33	Do not know	6
To get counselling	23		

In Puntland, the reason most frequently given for attending was for immunisation (82%), the second was reason was "to check mother's health" (76%), and thirdly to 'get vitamins or micronutrients' (62%).

Table 15: Somaliland - Reasons for attending ANC

Reasons why pregnant women go for ANC check-ups (multiple selections		How often do you think pregnant women are supposed to go for an ANC check-up	
To get immunisation	56	1	11
To check mother's health	87	2	17
To check baby's health	50	3	37
To get vitamins or micronutrients	34	4 or more times	35
To get clean delivery kit	19	Do not know	4
To get counselling	16		

Eighty-seven percent (87%) of respondents in Somaliland gave the purpose of ANC visits as to "to check mother's health", 50% "to check baby's health" and 56% to get immunisation.

Table16: South/Central Somalia - Reasons for attending ANC

Reasons why pregnant women go for ANC check-ups (multiple selections		How often do you think pregnant women are supposed to go for an ANC check-up	
To get immunisation	79	1	5
To check mother's health	56	2	16
To check baby's health	30	3	59

To get vitamins or micronutrients	34	4 or more times	14
To get clean delivery kit	17	Do not know	5
To get counselling	12		

Seventy-nine percent (79%) of respondents gave immunisation as the reason women go for ANC check-ups. Fifty-six percent (56%) of respondents in South/Central Somalia knew that the purpose of ANC visits was "to check mother's health".

Table 17: Puntland - ANC attendance by mothers and delivery by skilled personnel

During last pregnancy, was antenatal care sought?		Where did you/she go for antenatal care?		How many antenatal visits during last pregnancy		Who assisted with the delivery of your last child?	
Yes	79	SCRS facility	83	0	23	TBA	57
No	21	MOH	1	1	4	Skilled health worker	42
		Private	16	2	8	Unskilled relative	1
		TBA	0	3	18	No one	1
		Other	0	4	27		
				5+	20		

ANC services were sought during the last pregnancy for 79% of the Puntland respondents while 21% had no ANC visits. Sixty-five percent (65%) had 3 or more ANC visits and 47% had 4 or more visits. A skilled health worker attended the delivery of the last child in 42% of cases; traditional birth attendants (TBAs) attended the birth in 57%. The survey did not capture reasons for ANC service selection. As distance was given as a reason why someone would choose to use a facility or not, it is assumed that this would be a reason affecting ANC visits. In the FGDs with women, the lack of transport and an ambulance service was given as a reason for not utilising services. TBAs, according to the FGDs, are very highly regarded and the decision to deliver in the MCH clinic is taken by the TBA and/or husband.

Table 18: Somaliland - ANC attendance by mothers and delivery by skilled personnel

During last pregnancy, was antenatal care sought?		Where did you/she go for antenatal care?		How many antenatal visits during last pregnancy		Who assisted with the delivery of your last child?	
Yes	97	SCRS facility	72	0	3	TBA	50
No	3	MOH	15	1	8	Skilled health worker	47
		Private	10	2	18	Unskilled relative	1
		TBA	1	3	42	No one	2
		Other	2	4	19		
				5+	9		

ANC services were sought during the last pregnancy for 97% of Somaliland respondents. Seventy percent (70%) had 3 or more ANC visits and 28% had 4 or more visits. A skilled health worker attended the delivery of the last child in 47% of cases; traditional birth attendants attended the birth in 50% of cases. Nearly three quarters of

respondents, seventy-three percent (72%) attended an SCRS facility for antenatal care. Fifteen percent (15%) attended an MOH clinic with 10% attending private clinics.

Table19: South/Central ANC attendance by mothers and delivery by skilled personnel

During last pregnancy, was antenatal care sought?		Where did you/she go for antenatal care?		How many antenatal visits during last pregnancy		Who assisted with the delivery of your last child?	
Yes	87	SCRS facility	91	0	17	TBA	59
No	13	MOH	4	1	5	Skilled health worker	34
		Private	4	2	15	Unskilled relative	12
		TBA	1	3	51	No one	1
		Other	0	4	12		
				5+	2		

ANC services were sought during the last pregnancy for 87%of South/Central Somalia respondents while 13% had no ANC visits. Sixty-five percent (65%) had 3 or more ANC visits and 14% had 4 or more visits. A skilled health worker attended the delivery of the last child in 34%; traditional birth attendants attended the birth in 59%. Nearly all respondents, 91%, reported attending an SRCS facility for antenatal care.

Location of last delivery

Table 20: Location of last delivery

Location	SRCS facility	Other facility	Home
Puntland	35%	5%	60%
Somaliland	29%	18%	53%
South/Central Somalia	9%	18%	73%

More respondents report having delivered in a SRCS facility in Puntland than in Somaliland or South/Central. Home deliveries were most prevalent in all three zones but more pronounced in South/Central Somalia[6].

Table21: Puntland–Self-reported child deaths and post-natal care

Have you ever lost a child?		If yes, what was the age of the child?		How soon after the birth of a child should you go for a PNC check-up?	
Yes	33	Miscarriage	22	Before 6 weeks	19
No	67	Less than 1 year	50	At 6 weeks	62
		1-5 years	16	After 6 weeks	1
		More than 5 years	6	Do not know	18
		Do not know	6		

Thirty-three percent (33%) of respondents in Puntland had lost a child. Of those, 22% were due to miscarriage while 50% of deaths occurred in the first year of life. Nineteen percent (19%) of respondents believed women should have a PNC check-up before six weeks, 62% at six weeks. (See Chapter 5)

[6] Only one SRCS facility had dedicated delivery and maternity suite

Table 22: Somaliland - Self-reported child deaths and post-natal care

Have you ever lost a child?		If yes, what was the age of the child?		How soon after the birth of a child should you go for a PNC check-up?	
Yes	36	Miscarriage	25	Before 6 weeks	16
No	64	Less than 1 year	49	At 6 weeks	?
		1-5 years	11	After 6 weeks	55
		More than 5 years	5	Do not know	29
		Do not know	9		

Thirty-six percent (36%) of respondents in Somaliland had lost a child. Of those, 25% were due to miscarriage and 49% of deaths in the first year of life.

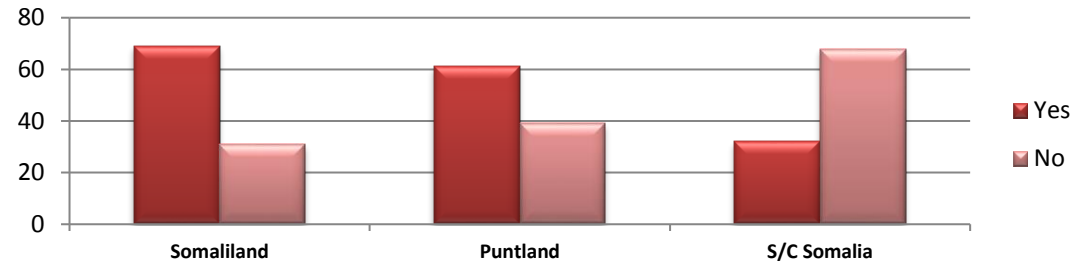
Table23: South/Central Somalia - Self-reported child deaths and post-natal care

Have you ever lost a child?		If yes, what was the age of the child?		How soon after the birth of a child should you go for a PNC check-up?	
Yes	28	Miscarriage	15	Before 6 weeks	15
No	72	Less than 1 year	55	At 6 weeks	60
		1-5 years	26	After 6 weeks	3
		More than 5 years	4	Do not know	23
		Do not know	2	Before 6 weeks	

Twenty-eight percent (28%) of respondents in South/Central Somalia on the other hand had lost a child. Of those, 15% were due to miscarriage and 55% of deaths in the first year of life.

4. Questions related to expressing positive views on birth spacing

Figure 5: Have you heard of birth spacing? - %



In Puntland, thirty-nine (39%) percent of respondents had not heard about birth spacing. Of those who had heard about birth spacing, the method(s) that they knew about were LAM (53%), pills (37%), injectable (37%), and periodic abstinence/rhythm method (8%). IUDs were known by 2%.

In Somaliland, thirty-one percent (31%) of respondents had not heard about birth spacing. Of those who had heard about birth spacing, the method(s) that they knew about were LAM (63%), pills (25%), injectable (15%), and periodic abstinence/rhythm method (8%). None had heard about implants.

In South/Central Somalia, Sixty-eight percent (68%) of respondents had not heard about birth spacing. Of those who had heard about birth spacing, the method(s) that they knew about were LAM (22%), pills (18%), and injectable (17%). IUDs were known by 3%.

Figure 6: Of respondents who had heard of birth spacing, those methods known in percentages.[7]

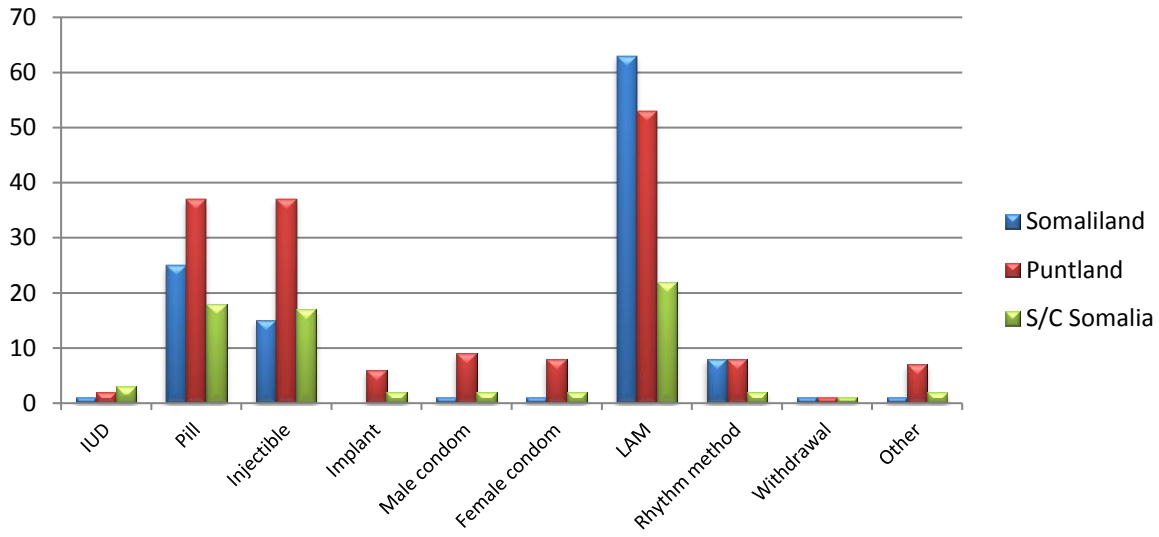


Table 24: Puntland - Current or intended use of birth spacing

Are you using birth spacing now? (female respondents)		If yes, what birth spacing methods are you using? (multiple selections allowed)		If not using birth spacing now, would you consider using birth spacing?	
Yes	37	Intra Uterine contraceptive device	0	Yes	11%
No	63	Pill	2	No	87%
		Injectable	1	Do not know	2%
		Implant	0		
		Male condom	0		
		Female condom	0		
		Lactational amerhorrea method (LAM)	19		
		Periodic abstinence/rhythm method	0		
		Withdrawal	0		
		Other	0		

In Puntland, 37% of respondents said they were using birth spacing. Of those that use some birth spacing, 19 were using LAM, 2 the pill and 1 injectable. Of those that were not currently using birth spacing, only 11% would consider using any form of birth spacing.

[7] The different denominators (not known) for each zone make comparisons problematic

Table 25: Somaliland - Current and intended use of birth spacing

Are you using birth spacing now? (female respondents)		If yes, what birth spacing methods are you using? (multiple selections allowed)		If not using birth spacing now, would you consider using birth spacing?	
Yes	37	Intra Uterine contraceptive device	0	Yes	11%
No	63	Pill	2	No	78%
		Injectable	0.5	Don't know	11%
		Implant	0		
		Male condom	0		
		Female condom	0		
		Lactational amerhorrea method (LAM)	0[8]		
		Periodic abstinence/rhythm method	0		
		Withdrawal			
		Other			

Of those that had heard about birth spacing, 11% would consider using birth spacing

Table 26: South/Central Somalia - Current and intended use of birth spacing

Are you using birth spacing now? (female respondents)		If yes, what birth spacing methods are you using? (multiple selections allowed)		If not using birth spacing now, would you consider using birth spacing?	
Yes	37	Intra Uterine contraceptive device	1	Yes	11%
No	63	Pill	2	No	78%
		Injectable	0	Don't know	11%
		Implant	0		
		Male condom	0		
		Female condom	0		
		Lactational amerhorrea method (LAM)	14		
		Periodic abstinence/rhythm method	0		
		Withdrawal	0		
		Other	0		

In South/Central Somalia, 37% of respondents said they were using birth spacing. Of those that were using some birth spacing, 14 were using LAM, 2 were using the pill and one using the IUD. Of those that were not currently using birth spacing, only 11% would consider using birth spacing. Seventy-eight percent (78%) would not consider using birth spacing methods.

5. Child information

This section provides information on children in the household.

Table 27: Puntland –Number of children and knowledge on childhood diseases

How many children (5 and under) are in	Name the childhood diseases that can be prevented through immunisation /

[8] Missing data

this household?		vaccination? (multiple selections)	
None	2	Tuberculosis	64
Only one	22	Whooping cough	76
Two	35	Pertussis (same disease as wh. cough)	71
Three	36	Diphtheria	53
Four	4	Polio	90
Five	1	Measles	89
More than five	0	Do not know	12

In Puntland, thirty-six percent (36%) of respondents had three children, 35 % two children and 22% only one child. The most commonly known childhood diseases prevented by immunisation were polio (90 respondents) and measles (89 respondents). Whooping cough and Pertussis were known to be prevented by 76 and 53 respondents respectively, TB by 64 respondents and diphtheria 53 respondents.

Table 28: **Somaliland –Number of children knowledge of childhood diseases**

How many children (5 and under) are in this household?		Name the childhood diseases that can be prevented through immunisation / vaccination? (multiple selections)	
None	13	Tuberculosis	49
Only one	48	Whooping cough	59
Two	35	Pertussis (same disease as wh. cough)	41
Three	2	Diphtheria	59
Four	1	Polio	92
Five	0	Measles	93
More than five	13	Do not know	7

In Somaliland, forty-eight percent (48%) of respondents had one child, 35% had two children and 2% had three children. Thirteen percent (13%) had no children in their household. The most commonly known childhood diseases prevented by immunisation were measles (93 respondents) and polio (92 respondents). Whooping cough and diphtheria were known by 59 respondents respectively and TB by 49 respondents.

Table 29: South/Central Somalia - Number of children and knowledge of childhood diseases

How many children (5 and under) are in this household?		Name the childhood diseases that can be prevented through immunisation / vaccination (multiple selections)	
None	2	Tuberculosis	40
Only one	21	Whooping cough	42
Two	40	Pertussis (same disease as wh. cough)	33
Three	27	Diphtheria	31
Four	6	Polio	75
Five	2	Measles	77
More than five	2	Do not know	15

In South Central Somalia, twenty-one percent (21%) of respondents had one child, 40% had two children and 27% had three children; 2% had no children in their household. The most commonly known childhood diseases prevented by immunisation were measles (77 respondents) and polio (75 respondents). Whooping cough and

Pertussis diphtheria were known to be prevented by 42 and 33 respondents respectively, T.B. by 40 respondents and diphtheria by 31.

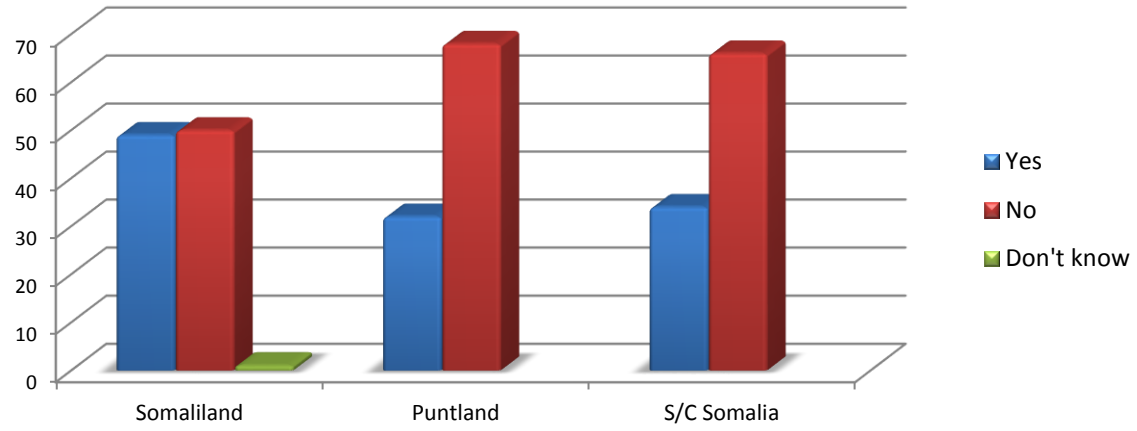
6. Vaccination status

This section shows vaccination status for children <5 years old

Table 30: Number of children under 5 in households surveyed

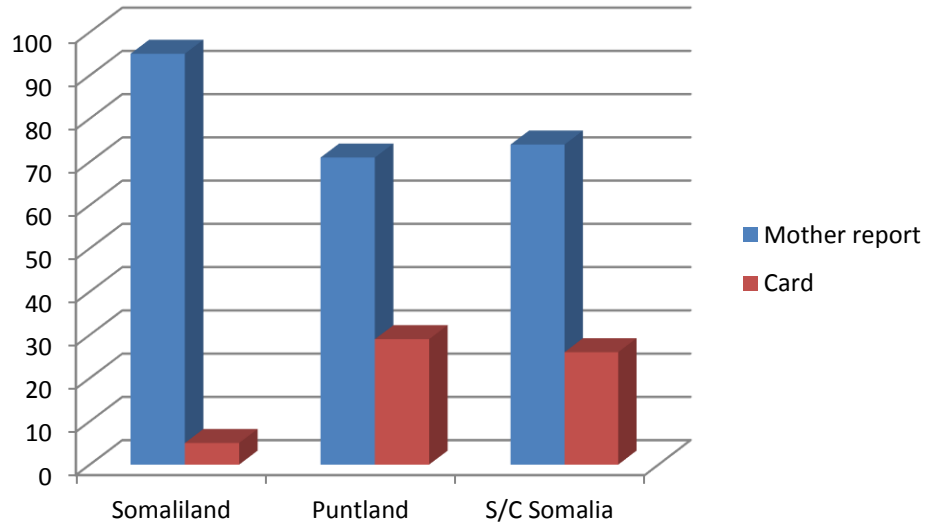
	Puntland	Somaliland	South/Central Somalia
Children <5	446	410	458

Figure 7: Do you have a card or child health booklet for the child?



Thirty-two percent (32%) of respondents in Puntland, forty-nine percent (49%) of respondents in Somaliland and (34%) of respondents in South/Central Somalia stated that they had cards that showed vaccination information.

Figure 8: Vaccine verification



Unexpected difficulties with the administration of the HH questionnaire and the digital data entry of vaccination status in Somaliland led to the HH questionnaire being adapted for Puntland and South Central Somalia. Hence the data from health card verification for Somaliland is not included in the analysis of findings. Less than thirty-percent of households were able to produce the vaccination cards.

Table 31: Vaccination status in Puntland and South/Central *

Vaccination status, in those 12-35 months old	Puntland	South/Central Somalia
BCG	78	75
Polio 1	84	82
Polio 2	81	77
Polio 3	83	73
DPT 1	76	80
DPT 2	76	77
DPT 3	76	71
Measles (all children <5)	80	79
Vitamin A in the last 6 months (in those 12-35 months)	74	75
Vitamin A in the last 12 months (those 18-35 months)	77	82

*The above table gives the vaccination status as reported by card verification.

In Puntland, of those children 12-35 months of age, 74% had received vitamin A in the last 6 months and in those 24-35 months. BCG was reported by 78%, DPT1 by 76%, DPT3 by 76%, and measles by 80%.

In South/Central Somalia, BCG was reported by 75%, DPT1 by 80%, DPT3 by 71%, and measles by 79%. In those 12-35 months, 75% had received vitamin A in the last 6 months, 82% in the last 12 months, and in those 24-35

Table32: Puntland - deworming practices

Deworming in the last 12 months (in those 24-35 months)		**59%**	
If yes, how many times %		***If yes, where? %***	
1 time	28	SCRS clinic	93
2 times	72	Other private facility	3
		Private pharmacy	2
		Traditional healer	0
		Buy drugs from pharmacy	2

In Puntland, 59% of infants under 3 years had received deworming medicine. Of that number, 72% had been dewormed twice. Ninety-three percent of infants receiving deworming treatment had done so at a SRCS clinic

Table33: South/Central Somalia - deworming practices

Deworming in the last 12 months (in those 24-35 months)		**68%**	
If yes, how many times %		***If yes, where? %***	
1 time	19	SCRS clinic	91
2 times	82	Other private facility	2
		Private pharmacy	1

	Traditional healer	0
	Buy drugs from pharmacy	7

In South/Central Somalia, 68% had received deworming medicine. Of that number, 82% had been dewormed twice. Ninety-one percent of infants receiving deworming treatment had done so at a SRCS clinic

7. Breastfeeding practices and nutrition

The data provides information on breastfeeding practices and nutrition

Table 34 - Knowledge of signs of malnutrition

Name the signs of malnutrition in a child that would require referral to a health facility or nutrition centre (multiple responses)			
	Puntland	**Somaliland**	**South/ Central Somalia**
Underweight	88	78	68
No fat on the body, ribs are visible	23	22	29
Loose skin around buttocks	34	13	13
Easily irritated	43	23	10
Unusual appetite	56	37	17
Frequent illness	24	16	18
Severe swelling (oedema) on both limbs or both arms	14	4	15
Swollen "moon" face	15	6	18
Damaged skin or different skin colour	21	18	8
Hair colour changes (yellow or reddish)	21	31	8
Hair becomes dry, can easily be pulled out in patches	20	31	11
Do not know	6	7	19

Eighty-eight percent (88%) of respondents in Puntland knew that "underweight" was a sign of malnutrition in a child that would require referral to a health facility or nutrition centre. Knowledge of the other classic signs of malnutrition was recorded by respondents. Seventy-eight percent (78%) of respondents in Somaliland knew that "underweight" was a sign of malnutrition in a child that would require referral to a health facility or nutrition centre. Knowledge of the other classic signs of malnutrition was mentioned by 4-37% of respondents. Sixty-eight percent (68%) of respondents in South/-Central Somalia knew that "underweight" was a sign of malnutrition in a child that would require referral to a health facility or nutrition centre. Knowledge of the other classic signs of malnutrition was mentioned by 11-29% of respondents.

Table35: Utilisation of therapeutic feeding from SRCS

Have any of your children received therapeutic feeding from SRCS?		
Puntland	Yes	51%
	No	49%
Somaliland	Yes	63%
	No	37%
South/Central	Yes	41%
	No	59%

The survey findings suggest that there was fairly consistent use of therapeutic feeding across the three zones with utilisation of 51%, 63% and 41% in Puntland, Somaliland and South/Central Somalia respectively. As this does not

tally with the clinic records, it is possible that the question was misunderstood and referred to food aid/rations. The clinic data does not support these findings. (See Chapter 5 Discussion)

Table36: Breastfeeding practices

How long after delivery should you wait before breastfeeding your child?			
	Puntland	**Somaliland**	**South/Central[9]**
Less than one hour	89	85	32
Less than 3 hours	5	7	27
Less than a day	4	5	16
Less than a week	2	2	11
Never breastfed	0	0	0

Breastfeeding practices are more consistent across Somaliland and Puntland while in South/Central Somalia, there is low early initiation of breastfeeding reported. Exclusive breastfeeding also varies considerably between zones[10].

Only ten percent (10%) of children 0-5 months in South/Central Somalia were exclusively breastfed with 70% given something other than breast milk in the first three days of life. In Puntland 23% of children 0-5 months were exclusively breastfed with 13% given something other than breath milk in the first three days of life.

Table37: Exclusive breastfeeding practices *

	Children 0-5 months that are still being exclusively breast fed (including nothing by bottle in the last 24 hours	**Taken food or liquid by bottle in the last 24 hours**	**New-borns that were given something other than breast milk in the first 3 days of life**
Puntland	23	38	13
South/Central Somalia	10	64	70

* These questions were not asked during the Somaliland survey.

Table38: Introduction of complementary feeding

At what age should you introduce foods other than breast milk to a baby?				Why didn't you breastfeed exclusively for six months? (Number of respondents)			
	Puntland	**Somaliland**	**South/Central Somalia**		**Puntland**	**Somaliland**	**South/Central Somalia**
After 1 year	4%	9%	9%	Relative made decision	2	3	10
After 6 months	77%	79%	32%	Mother unwell	5	14	15
Between 4-6 months	6%	9%	39%	Insufficient milk	15	39	27
Within 3 months	3%	1%	6%	Do not know	8	47	12
Within 2 weeks	8%	1%	9%				
Other	1%	1%	1%				
Do not know	1%	0%	4%				

[9]South/Central information does not tally to 100%.
[10]Information is not available for Somaliland.

There was also significant variation with the introduction of complementary feeding with South/Central Somalia response reporting earlier introduction of complementing feeding compared to Somaliland and Puntland responses. Decisions for stopping exclusive breastfeeding ranged across responses with insufficient milk cited the most across zones.

8. Communicable Diseases

The following tables show shows data about TB, HIV, and malaria.

Table 39: TB and malaria knowledge

Name the symptoms of TB that you know of				How do you prevent malaria in your home environment?			
	Puntland	Somaliland	South/ Central Somalia		Puntland	Somaliland	South/ Central Somalia
Cough that last a long time (more than 3 weeks)	80%	79%	69%	Mosquito nets	98%	78%	95%
Coughing up blood	48%	48%	37%	Mosquito repellent	73%	18%	63%
Fever	75%	50%	50%	Clear bushes around homestead	21%	13%	14%
Pain in the chest	39%	16%	15%	Drain stagnant water	42%	9%	15%
Night sweats	46%	34%	17%	Cover body with long clothing	11%	2%	6%
Rapid weight loss	46%	57%	31%	Do not know	7%	20%	0%
Loss of appetite	34%	32%	15%				
Feeling tired	10%	6%	23%				

For TB, 80%, 79% and 69% of respondents in Puntland, Somaliland and South/Central Somalia knew that "cough that lasted a long time (more than 3 weeks)" was a symptom of TB. Knowledge of malaria prevention methods ranged across settings with Somaliland respondents knowing fewer means of prevention.

Table 40: Knowledge of HIV and AIDS

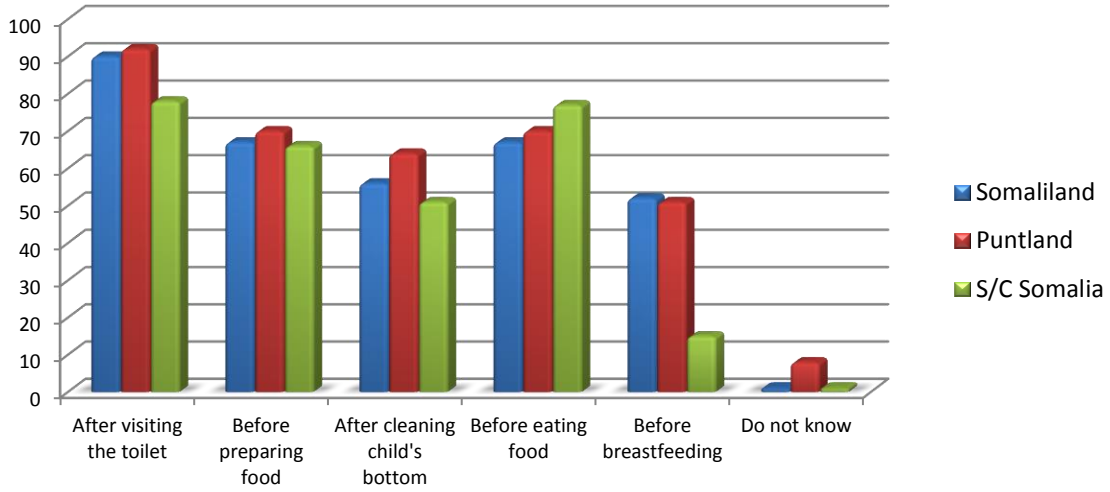
What are the ways that you know of that HIV/AIDS can be transmitted? (Multiple selections)				What are the ways in which HIV/AIDS can be prevented? (Multiple selections)			
	Puntland	Somaliland	South/ Central Somalia		Puntland	Somaliland	South/ Central Somalia
Unprotected intercourse with an infected person	83	78	51	Abstinence from sex	63	54	45
Shaking hands with an infected person	24	2	5	Being faithful to a partner	69	56	34
Sharing needles with an infected person	73	47	36	Using a condom	33	0	4
Mother to child transmission	60	17	8	Sterilizing surgical tools	71	33	25
Contact with infected blood	40	33	12	Do not know	25	28	46
Do not know	16	26	46				

Knowledge levels of HIV/AIDS varied across zones with respondents in South/Central Somalia tending to be less informed about how HIV/AIDS is transmitted than their counterparts in Somaliland and Puntland. While the FGDs with women suggested that infected individuals would be cared for, they also confirmed some ignorance and prejudice with some respondents suggesting that those affected should be isolated.

9. Water and sanitation

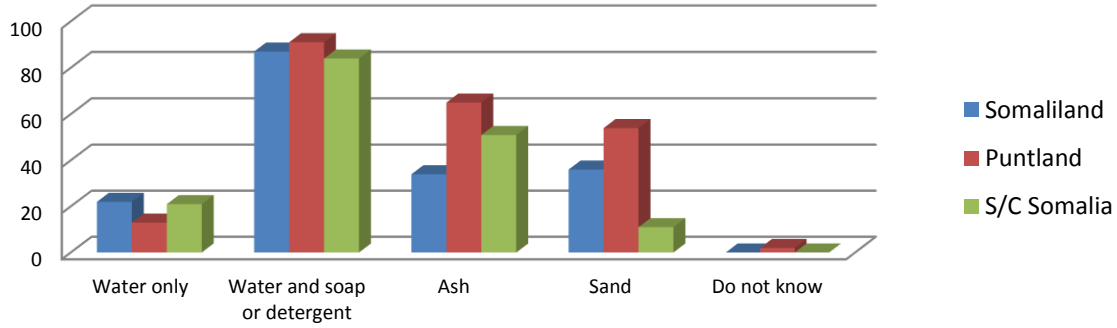
The three charts below show hygiene knowledge and source of water in the three zones.

Figure 9: When do you think that people should wash their hands?



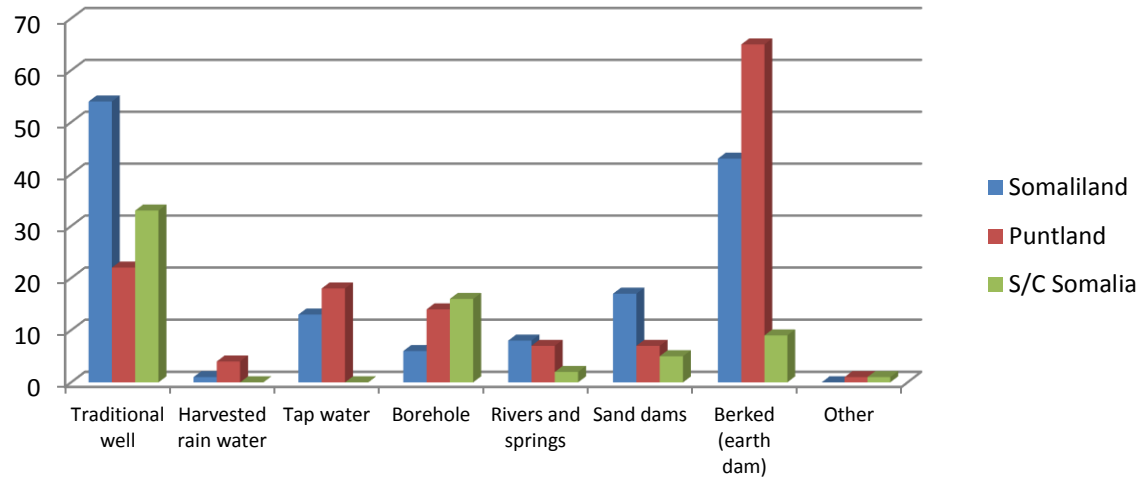
Ninety-two percent of Puntland reported "after visiting the toilet" for when people should wash their hands compared to 90% of respondents in Somaliland and seventy-eight percent (78%) of respondents in South/Central Somalia. The other recommended times were reported by 51-70 % of respondents in Puntland, 52-67% in Somaliland and 15-77% of respondents in South/Central Somalia.

Figure 10: In your opinion, how should you wash your hands?



Ninety-one percent (91%) of respondents knew to wash their hands with soap/detergent and water in Puntland, 84% in South/Central Somalia and 87% in Somaliland.

Figure 11: What is your usual source of water for drinking? (Multiple selection)



The survey allowed for respondents to give one or more answers to the question: 'What is your usual source of water for drinking?' Responses in the three zones demonstrate that respondents utilise a number of different water sources. In South/Central Somalia, only seventeen percent of respondents reported an unprotected water source (not tap water or borehole) as their usual source of water compared to eighty percent (80%) in Puntland and sixty-eight percent (68%) in Somaliland.

Table 41: Water treatment

Do you or any of your family members do anything to treat your drinking water? %				If yes, how?			
	Puntland	**Somaliland**	**South/Central Somalia**		**Puntland**	**Somaliland**	**South/Central Somalia**
Yes	39	17	44	Boiling	32	10	26
No	61	82	56	Chlorination	33	6	96
Do not know		1		Ceramic water filters	17	9	20
				Other filter/sieve	13	10	9
				Other	4	0	0
				Do not know	1	0	0

Sixty-one percent (61%), 82% and 56% of all respondents reported not treating their drinking water in Puntland, Somaliland and South/Central Somalia respectively. For those who reported treating their water, methods ranged across zones. In South/Central Somalia the majority of respondents (96) chlorinated their water, compared with thirty-three (33) in Puntland and six (6) in Somaliland. Although respondents in South/Central Somalia were utilising protected water sources (tap and borehole water), a greater proportion were treating their water than Somaliland and Puntland. This may be a function of poor quality tap and borehole water.

Table 42: Puntland - Sanitation practices

Where do you and members of your family go to the toilet? %		In your opinion, what are the reasons people might use a latrine?		What happens or where do you put children's faeces?	
Outside/bush	12	Privacy	93	On the ground/outside	17
Near river	0	To prevent disease	72	Put in latrine	82
Communal latrine	28	Clean environment	80	In potty	11
Household latrine	60	Other	14	Other	3
Other	0	Do not know	3	Do not know	4

In Puntland, eighty-eight percent (88%) of the households use latrines; either communal or household and only 12% use the bush for toilets. Eighty-two percent (82%) put child faeces in the latrine. Privacy was cited as the main reason (93%) for using a latrine followed by clean environment (80%) and disease prevention (72%).

Table 43: Somaliland - Sanitation practices

Where do you and members of your family go to the toilet?		In your opinion, what are the reasons people might use a latrine?		What happens or where do you put children's faeces?	
Outside/bush	48	Privacy	91	On the ground/outside	49
Near river	0	To prevent disease	44	Put in latrine	53
Communal latrine	9	Clean environment	50	In potty	16
Household latrine	43	Other	0	Other	0
Other	0	Do not know	5	Do not know	0

About half (52%) of the family members in Somaliland use latrines and almost half (48%) use the bush for toilets. Forty-nine percent (49%) put child faeces on the ground or outside. Only forty-four percent (44%) of respondents gave preventing disease as one of the reasons for using a latrine compared to 91% for reasons of privacy.

Table 44: South/Central Somalia - Sanitation practices

Where do you and members of your family go to the toilet? %		In your opinion, what are the reasons people might use a latrine?		What happens or where do you put children's faeces?	
Outside/bush	6	Privacy	82	On the ground/outside	9
Near river	1	To prevent disease	57	Put in latrine	90
Communal latrine	30	Clean environment	54	In potty	7
Household latrine	63	Other	6	Other	0
Other	0	Do not know	1	Do not know	1

Ninety-three percent (93%) of the households in South/Central Somalia use latrines and only 6% use the bush for toilets. Ninety percent (90%) put child faeces in the latrine. Eight-two percent (82%) of respondents gave privacy as the reason for using a latrine compared with 57% to prevent disease and 54% for a clean environment.

Table 45: Puntland - Knowledge on diarrhoea causes and prevention

What do you think are the causes of diarrhoea?		What do you think are the ways of preventing diarrhoea?		What did you do last time your child or a family member had diarrhoea?	
Germs and diseases	77	Using a latrine/disposal of faeces	87	Took them to nearest health facility	79
Dirty dishes and utensils	67	Washing hands with water and soap	78	Gave homemade sugar-salt solution	13

Teething	40	Eating food while it is hot	64	Used traditional medicine	23
Contaminated water	78	Drinking clean water	58	Gave ORS sachet	9
Contaminated food	59	Other	8	Stopped giving breast milk	3
Do not know	6	Do not know	7	Gave more fluid based food	5
				Other	9
				Do not know	7

Seventy-eight percent (78%) reported contaminated water as a cause of diarrhoea, 77% reported germs and diseases, 67% dirty dishes and utensils.

Using a latrine/disposal of faeces and washing hands with soap and water were reported as the main ways of preventing diarrhoea in 87% and 78%, respectively. During the last time that a family member had diarrhoea, 79% of the persons went to a health facility for treatment. Twenty-three respondents used traditional medicine for treatment, thirteen respondents used home-made rehydration solution (salt and sugar) and a further 9 used ORS sachets.

Table 46: Somaliland - Knowledge on diarrhoea causes and prevention

What do you think are the causes of diarrhoea?		What do you think are the ways of preventing diarrhoea?		What did you do last time your child or a family member had diarrhoea?	
Germs and diseases	74	Using a latrine/disposal of faeces	76	Took them to nearest health facility	88
Dirty dishes and utensils	59	Washing hands with water and soap	69	Gave homemade sugar-salt solution	4
Teething	11	Eating food while it is hot	33	Used traditional medicine	3
Contaminated water	57	Drinking clean water	41	Gave ORS sachet	2
Contaminated food	32	Other	0	Stopped giving breast milk	0
Do not know	4	Do not know	0	Gave more fluid based food	0
				Other	0
				Do not know	6

Germs and diseases were reported as the main cause of diarrhoea by 74% of respondents. Using a latrine/disposal of faeces and washing hands with soap and water were reported as the main ways of preventing diarrhoea in 76% and 69%, respectively. During the last time that a family member had diarrhoea, 88% of the persons went to a health facility.

Table 47: South/Central Somalia - knowledge on diarrhoea causes and prevention

What do you think are the causes of diarrhoea?		What do you think are the ways of preventing diarrhoea?		What did you do last time your child or a family member had diarrhoea?	
Germs and diseases	70	Using a latrine/disposal of faeces	73	Took them to nearest health facility	75
Dirty dishes and utensils	49	Washing hands with water and soap	68	Gave homemade sugar-salt solution	11
Teething	14	Eating food while it is hot	27	Used traditional medicine	12
Contaminated water	49	Drinking clean water	31	Gave ORS sachet	5
Contaminated food	36	Other	8	Stopped giving breast milk	2
Do not know	10	Do not know	10	Gave more fluid based food	4
				Other	7

	Do not know	1

Germs and diseases were reported as a cause of diarrhoea by 70% of respondents. Using a latrine/disposal of faeces and washing hands with soap and water were reported as the main ways of preventing diarrhoea in 73% and 68%, respectively. During the last time that a family member had diarrhoea, 79% of the persons went to a health facility.

10. Clinic visits, volunteer visits, and communications

The following tables show data about clinic visits, volunteer visits, and communications.

Table 48: Puntland, Somaliland, South/Central Somalia

What can prevent someone from visiting the clinic?				**Where did you last go for treatment when you or your family member was sick or needed other medical services?**			
	Puntland	**Somaliland**	**South/ Central Somalia**		**Puntland**	**Somaliland**	**South/Central Somalia**
Distance	84	77	45	SRCS clinic	56	66	70
Cost	13	16	18	Other health facility	13	22	9
Permission not given from family or other family member	11	4	10	Private pharmacy	22	8	12
Workload	12	7	19	Traditional healer/birth attendant	3	0	5
Insecurity	2	3	8	By drugs from pharmacy	2	2	1
Other	18	0	34	Outreach service	0	1	1
				Do not know	4	2	3

Distance was cited as an issue more frequently in Puntland and Somaliland (84% and 77% respectively) than in South/Central Somalia as a reason why one might not visit the clinic. The mean distance from an SRCS clinic of respondents varied significantly between zones 15.6km in Puntland, 11.7km in Somaliland compared with on 3km in South/Central Somalia which would explain why distance is regarded by respondents as a greater impediment to visiting SRCS clinic in Somaliland and Puntland than South/Central Somalia (See Table 10). Respondents in all locations were more likely to visit the SRCS clinic than another facility although options of other outlets ranged across locations.

Table 49: Satisfaction with SRCS services

	Puntland	**Somaliland**	**South/Central Somalia**
If at SRCS clinic, were you satisfied with the services provided? %			
Yes	66%	85%	84%
No	34%	15%	16%

If yes, why? (among those that responded "yes")				**If no, why? (among those that responded "no")**			
	Puntland	**Somaliland**	**South/ Central Somalia**		**Puntland**	**Somaliland**	**South/Central Somalia**
Free services	58	91	62	Cost of services	4	8	11

Clinic near my home	18	25	21	Distance	28	32	21
Qualified staff	48	47	40	Lack of qualified staff	1	0	0
Friendly staff	35	54	25	Lack of laboratory services	4	16	43
Short waiting period	40	70	49	Not open or staff absent	1	0	0
Availability of drugs or lab facilities	8	32	2	Lack of drugs	3	8	0
Other	6	0	3	Negative staff attitudes	1	40	0
				Long waiting period	0	48	32
				Other	4	0	18

The primary reasons for satisfaction ranged across locations although free services, short waiting periods and qualified staff were the most cited reasons. Drug availability was only frequently cited in the case of Somaliland and may suggest some issues with drug supply in the other locations. The lack of laboratory services was cited in South/Central Somalia as the main reason for not being satisfied with services more so than the other locations.

Table 50: Puntland - Volunteer activity

When was your household last visited by a Red Crescent volunteer?		On what topic have you received any health education/promotion message?		Who delivered the health education/promotion message?	
Less than a month ago	55	EPI/vaccination	81	SRCS health worker	53
1 and 3 months ago	27	Maternal health	52	Government health worker	5
4 and 12 months ago	3	IYCF	36	SRCS volunteer	28
Do not know	4	Malaria	31	Radio	4
Within last 3 months*	82	HIV/AIDS	20	Religious leaders	1
		Water and Sanitation	25	CHW	0
		Hygiene	24	Outreach staff	1
		Other	15	Health committee members	1
				Family member	0
				Friend or neighbour	0
				Other	0

* **This figure represents the total of those household visited in the last month and those visited in the previous two months.**

A Red Crescent volunteer visited the household within the last 3 months for 82%. Health education received (at any previous time) on EPI and maternal health was reported by 81% and 52%, respectively. Health education messages were delivered by SRCS health workers (53%), SRCS volunteers (28%), and government health workers (5%).

Table 51: Somaliland - Volunteer activity

When was your household last visited by a Red Crescent volunteer?		On what topic have you received any health education/promotion message?		Who delivered the health education/promotion message?	
Less than a month ago	12	EPI/vaccination	82	SRCS health worker	51
1 and 3 months ago	34	Maternal health	74	Government health worker	12

4 and 12 months ago	19	IYCF	28	SRCS volunteer	22
Do not know	34	Malaria	27	Radio	8
Within last 3 months*	46	HIV/AIDS	28	Religious leaders	0
		Water and Sanitation	35	CHW	3
		Hygiene	31	Outreach staff	3
		Other	0	Health committee members	2
				Family member	0
				Friend or neighbour	0
				Other	0

* **This figure represents the total of those household visited in the last month and those visited in the previous two months.**

Forty-six percent 46% of respondents reported a Red Crescent volunteer visited the household within the last 3 months. Health education received (at any previous time) on EPI and maternal health was reported by 82% and 74%, respectively. Health education messages were delivered by SRCS health workers (51%), SRCS volunteers (22%), and government health workers (12%).

Table 52: South/Central Somalia - volunteer activity

When was your household last visited by a Red Crescent volunteer?		On what topic have you received any health education/promotion message?		Who delivered the health education/promotion message?	
Less than a month ago	28	EPI/vaccination	62	SRCS health worker	47
1 and 3 months ago	16	Maternal health	37	Government health worker	3
4 and 12 months ago	9	IYCF	13	SRCS volunteer	10
Do not know	48	Malaria	14	Radio	15
Within last 3 months*	44	HIV/AIDS	5	Religious leaders	0
		Water and Sanitation	9	CHW	0
		Hygiene	27	Outreach staff	1
		Other	26	Health committee members	0
				Family member	2
				Friend or neighbour	1
				Other	9

* **This figure represents the total of those household visited in the last month and those visited in the previous two months.**

Forty-four percent (44%) of respondents reported that a Red Crescent volunteer visited the household within the last 3 months. Health education received (at any previous time) on EPI and maternal health was reported by 62% and 37%, respectively. Health education messages were delivered by SRCS health workers (47%), SRCS volunteers (10%), and radio (15%).

4.2 Facility Checklists

The facility checklist was designed to assess the status of the clinic infrastructure, the use and the maintenance of clinic facilities and the availability and use of drugs and equipment (See Annex 3). All the health facilities surveyed as part of the qualitative survey are Maternal and Child Health/OPD Clinics [11]i.e. offering the equivalent range of services. However, Dilla MCH, in Somaliland, is classified as a BEmONC/MCH clinic, one of a small number of clinics

[11] Under EPHS, MCH/OPD clinics will eventually either be upgraded to a Health Centre or become Primary Health Units

providing additional services including 24 hour delivery services. Details of the services provided in BEmONC clinics are described in Annex 5. Twelve facilities were surveyed in Somaliland, Puntland and South Central in total, seven in Puntland and Somaliland and five in South/Central.

Clinic infrastructure

Table 53: Power and lighting

Power source	Puntland and Somaliland	South/ Central Somalia
Functioning local power supply	2	1
Solar power	3	0
Power backup/generator	3	0
Lamps/torches	2	2

The checklist looked at primary and emergency power and lighting. The broad question was whether consultation rooms, delivery rooms and laboratory facilities had adequate lighting and power source for diagnosis, treatment and care of patients. As explained below and shown in Table 53, some clinics had a number of alternate sources of power while others had none.

Somaliland and Puntland Only three clinics surveyed have reliable power supplies supported by solar energy, a generator or local power providers or a combination of the three. Two are connected to local power supplies. One clinic cannot afford to pay for the supply[12], and in the other the local power supply is no longer functioning. A third clinic is due to receive mains power shortly. Emergency lighting i.e. kerosene or battery lamps was found in 3 of the 12 clinics in the three zones. **South/Central Somalia** One clinic has a reliable local mains power supply. Four of the five clinics surveyed had no power supply. Two had lanterns/kerosene lamps for emergency lighting.

Table 54: Water supply

Water	Puntland and Somaliland	South/Central Somalia
Water catchment	1	*
Borehole	2	2
Functional water tanks	6	*
From other water sources	4	*
Mains water	1	1
Hand pump from well	0	1
Other (unspecified)	0	1

Somaliland and Puntland. All clinics have water on site. One clinic is connected to a mains water supply. Two clinics have borehole water. Water is brought by bowser from stop dams or other water sources to four clinics. Only one clinic has a functional water catchment system. The catchment water is used for cleaning. All clinics have concrete water tanks for water storage. However, one clinic`s tank is badly cracked and no longer in use. **South/Central Somalia** No information was supplied regarding the number or state of water tanks in South/Central Somalia. One clinic was reported to pump water from a well.

Table 55: Sewage and waste disposal

Waste and sewage disposal	Puntland and Somaliland	South/ Central Somalia
Sewage system in place	5	1
Cess pit	2	*
External latrines	6	4
Internal latrine/lavatory	7	4

[12] Clinic staff had paid from their own salaries but this proved unsustainable.

Flushable toilets	3	0
Functioning incinerators	3	1
Protected incineration of waste	4	2[13]
Needle and sharps boxes in use	1	1

Somaliland and Puntland Five clinics have functioning, underground and covered sewage systems in place. Two have cess pits. One cess pit showed cracking of concrete and some sinkage. All but one clinic have both external latrines and ten clinics have internal toilet serving the delivery room and maternity ward.

Three clinics had functioning incinerators. None of these had locks but two were protected within the clinic compound. Two were using metal drums as incinerators; one of these was within the clinic compound, the other outside the compound, uncovered and unprotected. The two remaining clinics take their waste and burn it in 'the bush'. One clinic was using sharps boxes.

South/Central Somalia. No information on sewage system provided from four clinics in South/Central Somalia. Four clinics have external latrines and four have internal toilet facilities. There are no flushable toilets.

Table 56: Building structure

Building structure	Puntland and Somaliland	South Central
Glass in windows	3	0
Metal shutters/screens	4	*[14]
Solid floors	7	5

Somaliland and Puntland The facility checklist included only building components which might affect the hygiene and cleanliness of the clinic. Three clinics have paned windows. The four clinics remaining have metal shutters. All the clinics have solid floors either cemented or tiled.

South/Central Somalia. All clinics have solid floors.

Clinic facilities and services

Table 57: Operational facilities[15]

Clinic facilities		Puntland and Somaliland	South/Central Somalia
Waiting area	External	3	1
	Covered/internal	4	4
Separate examining room - ANC		7	2[16]
Separate examining room - OPD		7	3[17]
Separate examining room – Growth monitoring		1	2
Curtained/screened examining couch in all consulting rooms		4	
Private counselling room		1	1

Puntland and Somaliland Designated waiting areas with seating are available in all clinics. Four of seven clinics provide covered waiting areas. Separate consulting rooms for ANC/U5 OPD and for over 5 OPD are found in all clinics. One clinic has a separate growth monitoring consulting room. Curtained and screened examining couches were available in all consulting rooms in four clinics. One of seven clinics had a separate Voluntary Counselling and Testing (VCT) room.

[13] Missing data from one clinic in S/C
[14] Not specified for S/C
[15] Missing data from one clinic in S/C
[16] Missing data for one clinic
[17] Missing data for one clinic

South/Central Somalia Designated waiting areas with seating are available in all five clinics; four of these are covered or internal structures. Two of five clinics have separate ANC consulting rooms. Three have separate OPD consulting rooms. Two clinics have separate growth monitoring consulting facilities.[18]

Table 58: Consulting room equipment

OPD/ANC consulting room equipment in use	Puntland and Somaliland	South/ Central Somalia
Working torch with spare batteries	0	0
Blood pressure cuff or monitor	7	5
Thermometer	7	5
Stethoscope	7	5
Ophthalmoscope/ otoscope	3	4
Tongue depressors?	1	5
Complete small injury kit - scalpels, forceps, needles, sutures	2	5

Somaliland and Puntland All seven clinics have blood pressure cuffs, thermometers and stethoscopes in their consulting rooms. None have working torches. However, three clinics had working ophthalmoscopes/otoscopes. One clinic had tongue depressors in use. Two clinics have complete small injury kits. However, several had partial kits i.e. a scalpel or a pair of forceps.

In **South/ Central Somalia**, five clinics are fully equipped with only one clinic without a working otoscope. No clinics had working torches.

Table 59: Maternity and delivery services and equipment

Maternity and delivery services and equipment	Puntland and Somaliland	South/ Central Somalia
Delivery room	7	1
Bed with stirrups	7	1
Emergency lighting/lamp	3	0
Foetal stethoscope	6	5
Speculum	1	0
Delivery kit (Scissors/thread/clips)	4	3
Separate maternity ward	5	1

Somaliland and Puntland - Delivery rooms are found in all clinics. Five of seven clinics surveyed have separate maternity wards. All seven delivery rooms are equipped with beds with stirrups. Six had foetal stethoscopes in the room, five had delivery kits and one clinic had a speculum. Four of the seven had no emergency lighting/lamp.

South/Central Somalia– Four of five clinics surveyed had no separate delivery room or maternity room. All five clinics had foetal stethoscopes. Three had delivery kits available.

Table 60: Laboratory facility and equipment

Laboratory facility and equipment	Puntland and Somaliland	South/ Central Somalia
Laboratory facility	5	1
Laboratory in use	2	0
Functioning microscope	2	0

[18] There may have been misunderstanding in S/C as separate Growth Monitoring facilities were attributed to a clinic where apparently there is no separate ANC facility

Malaria dip test	7	4
Anaemia dip test/haemoglobin machine in use	3	0
Urine analysis/dip test	2	0
Centrifuge	2	N/A
Sterilisers/ in use[19]	4	3

Somaliland and Puntland Five clinics of seven have a dedicated laboratory facility. Two of the five laboratory facilities are in use. Two have functioning microscopes in use. Seven of seven clinics have malaria tests. Three facilities have haemoglobin machines/dip test in use; two have urine tests available. Two clinics have centrifuges. Four facilities have functioning sterilisers.

South/Central Somalia. Only one of the five clinics has a dedicated laboratory facility. None have a functioning laboratory. No clinic had a microscope. Four of five clinics had malaria bio line tests. Three had functioning sterilisers.[20], [21]

Table 61: Expanded Programme of Immunization (EPI)

EPI	Puntland and Somaliland	South/Central Somalia
Functioning cold chain refrigerator	7	2
Cold chain temp chart completed and up to date	5	2
Kerosene for refrigerator	4[22]	1

Somaliland and Puntland. All seven clinics have functioning cold chain fridges, two of which are solar powered. Five clinics had completed temperature charts for inspection. Four had an emergency supply of kerosene.

South/Central Somalia – Two of five clinics have cold chain refrigeration, one kerosene powered, one electric/solar powered. One has a cold box. Two have no cold chain facility[23]. (South/Central Somalia has been badly affected by Al Shabab blacklisting of the UN agency with primary responsibility for EPI. This has prevented SRCS effectively promoting EPI)

Administration and clinic management

Table 62: Registers and record keeping

Registers	Puntland and Somaliland	South/Central Somalia
EPI register completed	6	4
OPD register completed	7	5
ANC register completed	7	4
Outreach register completed	2	0
Daily registers from previous months	7	5
Patient records filed.	5	5

[19] Sterilisers (or equivalent) in clinics were all purpose (no separate sterilisers for delivery only)
[20] Missing data for sterilisers in two clinics.
[21] No data on whether sterilisers are functional
[22] Two of the cold chain fridges were solar powered.
[23] No information on reason for absence of cold chain facility

Mohr Monthly return forms	7	1

Somaliland and Puntland All seven clinics have completed OPD over and under 5, ANC registers and easily accessible daily registers for the previous month. Two outreach registers were completed and up to date. Patient records were filed in five of the seven clinics. Monthly return records were complete in all clinics.

South/Central Somalia OPD registers were completed in 5 clinics. ANC and EPI registers were completed in 4 of 5 clinics. Daily registers were available in all five clinics. Monthly return forms for HQ in Mogadishu were available in one clinic.[24] This data is shared with ICRS, MOH and UNICEF.

The drug supplies to clinics in the three zones vary and are provided from different sources. IFRC is responsible along with UNICEF and WHO for the provision of drugs in Puntland and Somaliland and ICRC is responsible for South/Central Somalia. This is explained further in the discussion section. The content of the UNICEF MCH Kit can be found in Annex 9. For the purposes of the survey, a compilation of drugs most commonly used by clinicians in Somaliland where the checklist was tested served as the basis for the drug checklist. It is recognised that a more complete list with some zonal specificity would have been helpful.

Table 63: Drug supply

	Puntland and Somaliland	South/Central Somalia
Secure (lockable) pharmacy/drugs cupboard?	7	5
Metronidazole 250gm	7	4
Abendazole	6	4
Vitamin C 250mg	0	3
Ibrufen 400mg	2	3
Erythromycin Stearate	2	3[25]
Benzyl Benzoate	6	5
Micronutrients	6	3
Methyldopa	2	0
Anti-histamine – cream	0	2[26]
Anti-histamine - tablets	5	3[27]
Erythromycin	5	5
Paracetamol – paediatric syrup	2	4
Phenoxymethylpenicillin	2	4
Tetracycline	4	5
Cotrimoxazole – paediatric dosage	2	1[28]
Amoxicillin – paediatric syrup	2	5
Ampicillin -	2	1
Gentamycin	3	0

Somaliland and Puntland All seven clinics have dedicated lockable pharmacy rooms. Metronidazole is the single drug available in all clinics at the time of the survey. Vitamin C and Anti-histamine cream (not supplied) was not available in any clinic. Erythromycin Stearate, Ibrufen 400mg, Methyldopa, Paracetamol – paediatric syrup, phenol-xymethylpenicillin, Cotrimoxazole – paediatric dosage, Amoxicillin – paediatric syrup, Ampicillin were not available in five of the seven clinics surveyed. Six of seven clinics had Benzyl Benzoate and micronutrients. Erythromycin and anti-histamine tables were available in five of seven clinics surveyed. See Annex 6 for Somaliland and Puntland drug list.

South/Central Somalia. Of the five clinics surveyed, all had micronutrients, Benzyl Benzoate, Erythromycin, and Amoxicillin (paediatric syrup), Metronidazole, Abendazole, Paracetamol – paediatric syrup; Phenoxymethylpenicillin was

[24] Due to poor communications and security, direct reporting to the Ministry of Health is not taking place. This was confirmed when meeting with the person responsible at the Ministry. SRCS supplies the government with data for its HMIS
[25] Missing data for one clinic
[26] Missing data for one clinic
[27] Missing data for one clinic
[28] Missing data for one clinic

available in four clinics. Ampicillin was available in one clinic. Methyldopa and Gentamycin was not available in any of the five clinics. See Annex 7 for South/Central Somalia drug list

4.3 Health Provider Interviews

The Health Provider Interviews were held with staff at all twelve clinics in the three zones. A total of 31 staff were interviewed in Puntland and Somaliland – 26 clinical staff and 5 support staff (cleaners and food distribution clerks). The number of staff interviewed varied between clinics and was dependent on staff availability at the time of interview. Members of the clinical staff and clinic managers were interviewed in all clinics. Support staff members were interviewed in three clinics in Somaliland.

In South/Central Somalia, a total of fifteen staff members were interviewed in the five clinics, the interviewers in Farjano and Balad interviewed staff separately rather than as a group. As a result, the findings do not represent a consensus view.

Table 64: Length of staff tenure at health facilities

	Less than a year	1-2 years	3-4 years	More than 4
Somaliland and Puntland	2	9	4	14
South/Central Somalia	4	2	0	9

In Somaliland and Puntland, of the 31 staff interviewed, two staff had been employed less than a year, nine staff for one to two years, and six staff for three to four years. Fourteen staff had been employed for more than four years. The majority of clinical staff had been employed since the clinics had opened or since the facility had changed e.g. from health post to MCH/OPD clinic.

In South/Central Somalia, of the 15 staff interviewed, four staff had been employed less than a year, two staff for one to two years, and nine staff had been employed for more than four years.

Table 65: Availability of job descriptions

	Job descriptions posted	Job descriptions available	Job descriptions not seen
Somaliland and Puntland	3	1	3
South/Central Somalia	-	-	15

Somaliland and Puntland Three of seven clinics had staff job descriptions posted on consulting room walls. The interviewer was shown one job description in one clinic. In three clinics, staff could not show their job descriptions. In one clinic, staff was not clear about difference between their contracts and their job descriptions.
South/Central Somalia. All fifteen staff interviewed claimed to have job descriptions but this was not verified by the interviewer.

Table 66: Staff qualifications and training

	Qualified nurses	Qualified nurses with midwifery	Auxiliary nurses	Lab tech	Pharmacy
Somaliland and Puntland	11	7	8	1	1
South/Central Somalia	6	3	4	0	0

Somaliland and Puntland All clinics in Puntland and Somaliland had a staff member with a midwifery qualification. Nurses had received at least two years nursing training. The length of formal training varied between two and three years depending upon the institution attended. One clinic had a formally trained laboratory technician and pharmacist.

South/Central Somalia - Of the fifteen staff interviewed in South/Central Somalia, thirteen received some form of training in clinical skills, nutrition and or management. Two interviewees had received no health training but were supporting the delivery of EPI and pharmacy services respectively.

Table 67: In-service training

In-service training	Puntland and Somaliland	South/ Central Somalia
Nursing/midwifery refresher training	6	0
Auxiliary nursing	1	0
Clinic management	3	1
Record keeping/register management	1	0
ANC/PNC	2	
Communicable Disease Control - Malaria, URTIs, Diarrheal disease, AWD (Acute Watery Diarrhoea) , Meningitis, STIs,	8	4
Nutrition and hygiene/OTP	8	6
Management of childhood diseases	1	0
IYCF	12	2
EPI	10	3
BMOC/Safe motherhood	4	1
First Aid/small injuries	2	3
GBV/FGM	12	3
HIV/AIDS	2	2
Drug/stock management	6	0
CBHE	4	0
Laboratory skills	10	0

Somaliland and Puntland All staff in Puntland and Somaliland had received one or more in-house training courses. Of those trainings named by staff the most commonly attended in-house training courses included IYCF (12 staff members), GBV/FGM (12) EPI (10), and laboratory skills. At least one staff member from each of the seven clinics had received training on Communicable Disease Control. All staff stated that they had been offered training of some kind. Training was offered on an annual or semi-annual basis.

In South/Central Somalia, twelve of fifteen staff had received some in-house training. Training in OTP/nutrition was the most commonly attended in-house training course. According to the interview reports, no training was received in a number of areas including drug/stock management, CBHE, and management of childhood diseases.

Table 68: Somaliland and Puntland - Priority health issues as identified by staff interviewed

Disease	1st	2nd	3rd	4th	5th	6th	7th	Frequency
RTIs	3	4						7
UTIs	2	1	1		1			5
Diarrheal diseases	2	1	2	2				7
Small injuries			1					1
Anaemia				3				3
Skin disease		1	1					2

Eye infections	1		1		2
Ear infections	1				1
Malaria		1	1		2
Joint pain/arthritis		1			1
High-risk deliveries				1	1

Respiratory Tract Infections (RTIs) and diarrheal diseases were listed most frequently (x7) as main health issues in clinic catchment communities in Somaliland and Puntland with urinary tract infections third. Anaemia was ranked as the fourth key health issue by three clinics. RTIs were ranked as the number one health issue in three of seven clinics, Urinary Tract Infections (UTIs) and diarrheal diseases in two of seven. RTIs were ranked as the number two health issue in four of seven clinics. These findings vary from those of HH survey which ranked diarrhoeal disease, malaria and fever as the top three health concerns.

Table 69: South/Central Somalia - Priority health issues as identified by staff interviewed

Disease	1st	2nd	3rd	4th	5th	6th	7th	Frequency
RTIs	1	1		4	1			7
UTIs	3		3	2				8
Diarrheal diseases	4	2			1			7
Small injuries					1	1		2
Anaemia	2	1	2					5
Skin disease		1		1				2
Eye infections			1					1
Ear infections								0
Malaria	1	1		1		2	1	6
Joint pain/arthritis					1			1
High-risk deliveries								
Malnutrition		2	1	1				4
STIs		2	2		1			5

Urinary Tract Infections (UTIs) were listed most frequently (x8) as the main health issues in clinic catchment communities in South/Central Somalia with respiratory tract infections and diarrheal diseases listed as the joint second most frequent. Anaemia and Sexually Transmitted Infections (STIs) were listed as key health issues (x5). Malnutrition and STIs were identified as key issue only in South/Central Somalia.

Table 70: Puntland and Somaliland – Staff perceptions of most commonly used services

Service	1st	2nd	3rd	4th	5th	6th	Frequency
ANC/PNC/Maternity	1	2	2	2			7
Food distribution/OTP	2	1	1	1			5
EPI	2		2	1			5
OPD >5	2	2	2	1			7
OPD <5		2					2
Growth monitoring					1		1
VCT						1	1

ANC/PNC/Maternity and over five OPD were listed the two most commonly used services in all seven clinics followed by food distribution/OTP and EPI. Food distribution/OTP, EPI and over 5 OPD were ranked first in two of seven clinics respectively. Staff of three clinics cited distance to clinics and lack of transport as the main barrier to utilization of services. Staff in one clinic cited shortage of vaccines as a barrier to utilization of EPI.

Table 71: South/Central Somalia - Commonly used services

Service	1st	2nd	3rd	4th	5th	6th	Frequency
ANC/PNC/Maternity		2	2	1			5
Food distribution/OTP	7		1	1	1		10
EPI	1	2	5	1			9
OPD >5	2	4	1	1			8
OPD <5[29]		1			1		
Growth monitoring							
VCT							

Staff in South/Central Somalia listed OTP as most commonly used service (x10) followed by EPI (x9) and OPD (x8).

Clinic hours and services – Somaliland and Puntland All seven clinics are open six days a week. Clinic staff stated that all seven clinics provide 24 hour emergency service for maternity services. One clinic offers a 24 hour laboratory service. Three of seven clinics are open 8 hours a day, three are open 7 hours a day and one opens for 6 hours a day. Opening times vary. Six clinics open at 7.00am and close between 1.00 – 3.00pm. One clinic is open from 6.00 am to 12.00 noon, opening again from 2.00-4.00 pm[30]. The EPHS has set the standard seven-hour working day at PHU, HC and RHC levels to operate from 07h30 to 12h30 and 15h30 to 17h30 for five and a half days a week.

Clinic hours and services– South/Central Somalia Clinic hours are from 8 am to 2pm.

Table72: Clinic services available (as listed by staff)

Service	Puntland and Somaliland	South Central
ANC/PNC	7	5
Delivery	7	1
OTP	6	5
EPI	7	5
OPD >5	7	5
OPD <5	7	5
Growth monitoring	7	-
VCT	1	0
Health Education	3	5
Outreach	4	0
Laboratory	1	0

ANC/PNC, Maternity, under 5 and Over 5 OPD, Growth monitoring was recorded by staff as services available in all seven clinics in Somaliland and Puntland. OTP was available in six clinics. Outreach was offered from four clinics, health education in three clinics. VCT was available in one clinic only and full laboratory services in one clinic.

In South/Central Somalia, no clinic was offering laboratory, VCT or outreach services. Growth monitoring was also not mentioned, however clinic data shows that growth monitoring is taking place.

[29]Over or under 5 OPD was not specified in all but two instances.

[30] The earlier opening hours for the latter clinic were requested by the nomadic pastoral community who form the majority of their client load.

Table 73: Services that are unavailable (as noted by staff)

Service	Somaliland and Puntland	South/Central Somalia
Laboratory Service	5	4
Maternity services	-	4
Ambulance Service	1	-
Family Planning	1	-
VCT	1	-
D&C	1	-
Dressing/small injury service	2	3
EPI	1	-

Staff in five clinics in Somaliland and Puntland stated they were not able to offer laboratory services[31]. Reasons given for why clinics were unable to offer laboratory services included: lack of a dedicated space, lack of staff and/or time, damaged or missing equipment, lack of test kits and lack of laboratory skills. An ambulance service, a family planning service, VCT and Dilation and Curettage (D&C) were mentioned variously by staff in different clinics as services they were unable to offer. Other than lack of laboratory services, only the lack of a small injury service was noted by staff from more than one clinic.

In South/Central Somalia, eight respondents stated that they were not able to offer full laboratory and maternity services due to lack of dedicated space and/or infrastructure. Three staff stated that dressing and first aid services were unavailable due to lack of equipment and dressing kits.

The challenges/difficulties experienced by staff at the clinics survey fell into one or more of four categories:

- the supply of drugs;
- laboratory facilities and equipment;
- infrastructure and space;
- staff shortages

Limited and irregular drug supply- Five of seven facilities in **Puntland and Somaliland** complained of regular and extended stock outs of drugs particularly antibiotics. The following concerns were mentioned in relation to the drug supply:

- Lack of paediatric dosages
- Insufficient 1st line antibiotics and no second line[32]
- Insufficient dressing and suture kits
- Insufficient analgesics - paracetamol is the only analgesic provided
- SRCS not supplying drugs to compensate for the reduction in the contents of the essential drug kit

In **South/Central Somalia**, staff in two of the five clinics complained of insufficient drugs and equipment.

- Insufficient 1st line antibiotics
- Insufficient dressing and suture kits
- No drugs for the treatment of hypertension, diabetes and epilepsy
- Insufficient equipment for emergency deliveries

[31] Dip tests were available for malaria.
[32] "Of every 10 patients, we can only treat 3 due to insufficient drugs (particularly antibiotics) and no second line treatment available" Staff member Puntland

Lack of laboratory and diagnostic tests – Staff from five of seven clinics in **Puntland and Somaliland** noted that the lack of functioning laboratory equipment and tests affected services. The lack of sharps and cannulas in three clinics meant that blood could not be drawn for anaemia tests. The lack of working microscopes and kits meant urine analysis was not undertaken in some clinics unless patients purchased their own. No mention was made by respondents of the lack of laboratory or diagnostic kits in **South/Central Somalia**.

Limited and cramped facilities and poor infrastructure- Staff from one clinic in **Puntland** mentioned the lack of a separate maternity unit/delivery room as affecting facility-based deliveries. Lack of electrical power and piped water for the maternity unit was cited by staff of another clinic as a challenge to service delivery. In **South/ Central Somalia,** staff from three clinics complained of the lack of a dedicated maternity facility and the lack of space to provide a private consulting and examination area.

Staff shortages- Staff in two of seven clinics in Puntland and Somaliland mentioned staff shortages as affecting service delivery. Staff shortages meant that one clinic closed during outreach and affected emergency service delivery in another. The lack of qualified personnel (pharmacist) was noted by staff as affecting their work load and drug management. In **South/Central Somalia,** there were no complaints about staff shortages.

Roles and responsibilities - Clinic managers and clinical staff from the seven clinics in Puntland and Somaliland described different arrangements for the management of the workload and sharing of duties. The sharing of duties depended upon the number of staff and the size of clinic. OPD service delivery is shared between staff when one member is absent. The sharing of ANC/PNC depended on gender of team members. There was no standard procedure for sharing duties. Staff from two clinics mentioned volunteers as carrying out clinic duties and sharing tasks (register management, health education).Clinicians from smaller clinics with fewer staff carry a greater number of different tasks than the larger clinics with more auxiliary staff e.g. clinical staff were also carrying out cleaning duties in one clinic. In another clinic, clinical staff was paying for a cleaner from their salaries. Large clinics with dedicated staff for specific service tasks share only on an occasional basis. Dilla, for example, has a 4 person team ANC/maternity team allowing the team to rotate through 24hour shifts. Auxiliary nurses share a greater number of tasks including growth monitoring, health education, EPI and occasional laboratory work.

The sharing of roles and responsibilities of staff members in clinics in **South/Central Somalia** was not well-described. Staff members had a clear idea of their primary responsibility but there was little explanation of how other work was shared neither was there any mention of the work of SRCS volunteers.

Workload - Clinical staff from five of the seven clinics in Puntland and Somaliland found the workload about right except when a staff member is absent. One clinic manager found the work excessive due to the reporting and administrative demands. An EPI auxiliary nurse in one clinic reported being consistently overloaded although supported by volunteers. One staff member noted that workload was excessive when there were a number of maternity cases at once.[33]Only one store keeper (a WFP position) was interviewed and she found her work load heavy without consistent support from volunteers. Staff from one clinic of seven found the volunteer support inconsistent. In **South/Central Somalia**; all but four staff interviewed stated that their work load was about right. Four staff working in either ANC/PNC or OPD complained that their workload was too heavy and that the case load and number of patients was too great

According to the clinic data numbers of OPD consultations vary considerably within and between zones. In South/Central Somalia, the numbers of consultations per day[34] ranged from 17 (Isha) to 63 (Balad), 30-35

[33] Pressure felt partially due to the clinic not having a separate maternity ward

[34] Based on 25 working days per calendar month

consultations per day in clinics in Somaliland and 18-24 per day in Puntland. Other factors include availability of volunteers to support service delivery and staffing levels.

Table 74: Puntland and Somaliland - Perceived training needs

Laboratory skills	EPI- BCG pentavalent	FP training	Drug/stock management	TBA training	Refresher training	First aid/ small injuries	STI management
5	2	1	2	1	2	1	1

Laboratory skills training was regarded to be the most necessary by staff from five of seven clinics. Training in Pentavalent and Drug and stock management was felt necessary by staff in two clinics respectively. Refresher training was wanted by staff in two clinics. Specifically, staff would like to receive extended 2-3 month refresher skill training in their particular clinical field e.g. clinical officer, midwifery etc. rather than refresher training on a particular disease or intervention.

Table 75: South/Central Somalia - Perceived training needs

OTP/Nutrition	Refresher training	Communicable diseases	Case management
1	4	1	1

Staff interviewed in South Central had fewer training requests than those from clinics in Somaliland and Puntland. Refresher training was the most requested (x4). The kind of refresher training was not specified in the South/Central Somalia interviews.

Table 76: Ratio of consultations to other duties

70% : 30%	75% : 25%	80%: 20%	90%: 10%
3	1	4	1

This question was not well understood by interviewees. Of those that responded, four staff reported an average 80% to 20% split between consultations and administrative duties, three a 70%:30%, one 75% to 25% split and one 90 to 10%. It was noted that volunteers carry out a number of administrative duties in all clinics surveyed. Proportion of administration and other duties was not well described in interviews in two of the five clinics in South/Central Somalia. Clinical staff in the three clinics spent approximately 20%-30% of their time on administration and other duties and approximately 70%-80% of their time seeing patients.

Table 77: Somaliland and Puntland - Frequency of supportive supervision

	x4 a month	x3 a month	x2 a month	x1a month	x6 a year	x4 a year	occasional
National Health Officer				2	2	3	
Branch Health Officer	4	1	1	1			
Ministry of Health	1(sms)			4			2

Four of seven clinics in Puntland and Somaliland reported Branch Health Officer visits once a week. Three clinics reported visits three times, twice and once a month respectively. Four clinics reported monthly visits from the MOH. On clinic reported weekly sms exchanges with MOH staff.

Table 78: South/Central Somalia - Frequency of supportive supervision

	daily	x4 a month	x3 a month	x2 a month	x1a month	x6 a year	x4 a year
National Health				No visits reported			

Officer					
Branch Health Officer[35]	1	1	1	1	
Ministry of Health					1

No visits from the SRCS National Health Officer were reported for any of the five clinics. One clinic did not report on SRCS Branch HO visit. Only one clinic reported visits from an MOH official.

Table 79: Puntland and Somaliland - Activities conducted during supportive supervision

Monitoring - registers, - checklists, - drugs - cold chain	Support supervision - support case management	Correct us	Meet with CHC and/or volunteers	Talk to patients	Bring drugs
7	5	2	2	2	1

Table 80: South Central - Activities conducted during supportive supervision

Monitoring - registers, - checklists, - drugs - cold chain	Support supervision - support case management	Inform us
5	2	1

Perceived value of supervisory visits Staff from all seven clinics served in Somaliland and Puntland appreciated visits from by SRCS Zonal and Branch HOs in Somaliland and Puntland. Staff from the clinics valued the supervisory visits for the following reasons:

- "Correction is helpful"
- "They listen to us"
- "They are respectful and give us helpful advice"
- "Very good two-way communication."
- Very open supportive relationship with regular opportunities for feed back to SRCS
- "They support us. We discuss plans"
- "They always wait until we have time to talk and allow us opportunities for feedback"
- "They help us solve problems"

All staff in South/Central Somalia reported opportunities for feedback but this was not qualified or well-described.

How adequate are the guidelines and reference materials? SRCS provides clinics with reference materials including standard treatment guidelines and WHO and UNICEF leaflets, posters and guidelines for staff and clients on specific subjects or diseases. Staff from six of seven clinics in Somaliland and Puntland was satisfied with the guidelines and reference material provided by SRCS. Staff reported receiving WHO guidelines and protocols on a regular basis. Clinical reference books were shown by staff in three clinics but staff were not asked to show reference materials. Staff from one clinic said that they received no reference materials.

All staff in the five clinics in South/Central Somalia found the guidelines and reference materials inadequate and insufficient.

[35]Farjano did not report number of visits

4.4 Focus Group Discussions

Focus Group Discussions (FGDs) were held in all three zones with Community Health Committees (CHCs), and male and female community members. This was an extensive exercise and the process of transcription and analysis took some months. The summary of the findings from the focus group discussions have been grouped under the following thematic areas: Community Health Committees, community health, MCH services, and perceptions of SRCS. Sensitive health issues, such as chewing qaat, FGM, early marriage, birth spacing and HIV and AIDS are also included however these were only discussed in community FGDs and not with CHCs. With all of the FGDs, there were no significant variations in response noted across zones or survey sites. For clarity, the key points raised in the FGDs are noted in bold

Community Health Committees

The CHCs were established by SRCS in all of the communities where there are clinics. Committees are made up of four executive members and five ordinary members. Ideally, one member of the executive (the Vice Chairperson) should be a woman. The selection and training of CHCs took place over in 2002-2003. According to their Terms of Reference, CHCs play a key role in the management of the clinics, resource mobilization, and relationships with donors, government and other agencies and mobilizing the community around health education and key health issues. Membership of the CHC is for a three-year term but members can stand again for re-election.

Membership CHC members tend to be long standing members of their communities (most FGD participants have worked for the CHC for greater than 5 years) and many as long as the MCH/OPD had been established. In most instances **the SRCS initiated the establishment of the CHC** and involved the district authorities and the general public. Once elected to the CHC, it is unclear membership term duration and procedures for re-election. It is also **not clear how representative CHCs are of their communities**. CHC members themselves acknowledge community heterogeneity, particularly in the larger towns, increased by population influx (either due to conflict, loss of pastoral livelihood, urbanization, etc.). **This heterogeneity of the new communities may not be reflected in CHC membership.**

All CHC members are volunteers and take pride in the role that they play for their communities and the SRCS. They **see their work as part of a higher calling for Allah and their communities**.

> *"We work for Allah's reward, we are not paid for our service, neither do we take anything from the organization, we are self-employed and assist the Red Crescent in its free charity work since Allah has sent us white people who want to work for us, we want to prove that we can work for ourselves"* (CHC 1.2).

Community Health Committee (CHC) discussants report that they play an **active role in health management** in their communities. This involves facility management and emergencies such as disease outbreak or emergency deliveries; as noted, *"In case we get a report of an incident we convene a meeting immediately, could it be disease outbreak like diarrhea and malaria, we don't seek for help from outside like from NGO; we don't wait for our absent members, those among the members who are available immediately attend to emergencies …"* (CHC, 1.2).

Structure CHCs tend to follow hierarchical structures and have Executive Committees comprising of a Chairman, Vice Chairman and Secretary. Other members appear to take orders from these members. "*We do have guidelines, rules are informal, we respect the command of our chairman and his vice by working in unity"* (CHC, 2.5). **CHCs meet once a month**; during these meetings issues from the previous month are discussed and plans made for the following month. Meetings are minuted[36]. **CHCs also have written guidelines** although these were not seen by the FGD interviewers or described in any detail. Often, reference to higher orders was made; *"our code of conduct is the Qur'an, and the book of Allah is incentive for us. We do work for the sake of Allah, we also have conduct to be*

[36]Minutes were not reviewed as part of the baseline assessment.

followed that we wrote" (CHC, 1.2). **Each CHC determines a way for ensuring that there is fulltime support for the MCH/OPD**. This may mean having an "on call" system or assigning specific days to individual CHC members. Many stated that they work at the MCH/OPD and are assigned duties by the Manager.

Role CHC **members have been trained on their roles by the SRCS** however details of this training were not provided. CHC members spoke of more recent trainings on an array of health issues. CHC discussants gained from the trainings and note the need for more training, which are viewed as benefitting to the community as exemplified in the following:

> *"Somali proverb says if one is sleeping leaving responsibility to you then you too should not sleep. We the committee are responsible for the people…we do pass training we gained to the community, creating awareness to the community, we inform people on risk issues, causes of diseases, we gather the community or meet them individually"* (CHC, 2.5).

In some instances**, trainings do not appear to be aligned with CHC roles which may create confusion and inefficiencies.** (An outline of the content of CHC training can be found in Annex 8). For example, when probed about trainings, some CHC discussants responded that immunization is done by the CHC while the committee [this may be the executive committee] *"just do other things"* (CHC, 1.2). CHCs have **local recognition and involve themselves in the operation of health services. They wield power as a result.** As noted by one CHC respondent,

> *"This is the committee which brought the hospital where it is now because at that time there was chaos and mistreating new people. We formed this committee with orders of working with good hearted people and anyone found against our orders will give him two to three warnings and we finally take action against him, we can even sack Red Crescent workers if they commit a mistake"* (CHC, 1.2).

This quotation suggests that **greater role clarity and normative procedures may be required for CHCs**. CHC members did not report any current challenges with their work although these have been there in the past. Those mentioned included protection of the MCH/OPD site, community perceptions and resistance from MCH/OPD workers themselves. In one instance this related to the membership of the CHC. As noted,

> *"People fight over the committee and it was decided to dissolve the committee and get fresh members from the market and I am one of those picked from the market. When we convened we were two committees but us we decide to step aside the chair and vice chair of the committee that is how this committee is formed. There was mistrust among members but we overcame it*" (CHC, 1.2).

In some instances, **there is a lack of community understanding that the role of CHC members is voluntary,** *"challenges are many, this community people think we are eating the money of the MCH/OPD so they even call us members of the envelopes"* (CHC, 1.4).

1. Community Health

Questions related to community health were most often answered in relation to **a lack of "higher" (secondary or tertiary) level health care; those mentioned included hospital, laboratory, surgery, ultra-sound, X-ray machine, blood bank and ambulatory services**. All discussants noted the lack of reliable emergency transportation as the biggest challenge for their communities. The main health issues noted related to mother and child health; those for men were primarily related to Qaat or insecurity. Non communicable diseases such as high blood pressure were mentioned in several FGDs (this may also be linked to the higher age of the informants in some FGDs). **There was a preoccupation with emergency services for men linked to injuries (e.g. gunshot wounds, animal bites, etc.) and women linked to delivery.**

Discussants noted that there had been positive changes in their communities. **The SRCS was associated with these positive developments in relation to greater access to health services and better health amongst the population**. It was also noted that there were more people (greater population pressure), urbanization (pastoralists moving to

towns was mentioned) and more businesses/economic diversification. In some instances, urbanization was associated with security (e.g. a safer environment).

The physical presence of the MCH/OPD is associated with progress. As noted by one respondent, *"Where there is health service is not the same as a place with no health facility, so a lot has been achieved for the last five years."* (CHC, 1.2). There is **an over reliance on the health facility for the provision of curative care and less mention of preventive health actions**. When prevention is mentioned, it takes the form of something that is done *for* community members and not *by* them. For example, many refer to being given "awareness creating" suggesting that communication could be made more interactive.

Food insecurity is seen as a major concern in all communities. It is most present during the "famine" (dry) season. It is an urban as well as pastoral issue. **Food distribution and supplementary feeding were mentioned as means of getting food but this was not always seen as transparent**. *"…there is no food distribution here like other areas ,and in 2-3 years what is brought is grabbed sometimes so the needy people did not get something or wealthy people take the food, so needy people are suffering here"* (men 1.4). It is also not so clear why food distribution ends in one location and why it may continue in another.

2. MCH/OPD Services

MCH/OPD services **most often cited by discussants included feeding programmes, immunization, growth monitoring, general consultations and maternity services**. Immunization in particular is recognized as an important preventive service and was identified as such by all focus groups.

Most women respondents in Somaliland and Puntland recognized that they should receive ANC as soon as they realize that they are pregnant while respondents in South/Central Somalia were less specific on when they should attend the first ANC consultation. In contrast, **male discussants noted that it is the man who tends to decide when a woman will visit a health facility.** This is often late in pregnancy with many men mentioning labour as the time to visit. Respondents in all three zones were less clear on when they should attend PNC.

There was overwhelming support for facility-based deliveries in Somaliland and Puntland by both men and women although the use of traditional services was acknowledged. As one respondent noted, *"I have twelve children and all were delivered in the health centre, I find it good and safe"* (women, 1.4). As MCHs are "urban" based, there is a perception of low utilization by communities more remotely located particularly for deliveries. Discussions suggested some variation in service provision and utilization over time i.e. respondents' use of services depended on the age of their children and their changing needs.

In **South/Central Somalia, there was greater support for home delivery with local "midwives" or Traditional Birth Attendants (TBAs).** As narrated by one discussant, *"the normal ones deliver in their houses"* (men, 3.3); and, of a similar vein, women who are sick are thought to deliver in a health facility (women, 3.9). In one instance (Balad, 3.2) the women indicated that they had to use the MCH because there was no TBA. Discussants noted that the decision to refer to the health facility is left to the TBA. *"She [TBA] can keep a woman in labour in the house for three days if she thinks things are right"* (men, 3.3). This suggests that referrals, if they do occur, are late. Although, it needs to be noted that TBAs working with SRCS have been given training to enhance safe delivery.

When referring to nutrition, it was often mentioned as commodities that were given to people and not something that was within one's own control as noted in the following: "*[Health problems] can be prevented when mothers are getting all they need from the health centre including nutrition"* (men 2.6 (2)). While this came up in all three FGD groups (men, women and CHCs), the women's FGDs in Somaliland and Puntland tended to provide more description of a balanced diet as a way of maintaining nutrition. In South and Central Somalia, **there was consistent mention of nutrition commodities, namely Plumpy Nut and biscuits supplied by UNICEF. While**

nutritious foods were mentioned, they were not mentioned in a way that suggested their own nutritional practices i.e. locally grown/produced food stuffs. Consistently across discussants, **there was reference to reduced food intake late in pregnancy**, *"…we Somalis we don't take a lot of food because we believe the baby will grow big and difficult to deliver"* (women, 1.6). Others noted that women needed to eat well to be strong to deliver. Despite the contradictions, these were not challenged within the FGDs.

Birth spacing **There is near universal support with all discussants for birth spacing using lactational amenorrhea method (LAM),** referred to in the discussions as "breast feeding" (it was not clear if discussants understand the requirements of LAM). Birth spacing is viewed as good for the health of the mother and the development of the child. The recognition of breast feeding as a means for spacing births means that men are supportive of women breast feeding up to the age of two years, which was seen as an appropriate interval before a woman had another child.

Besides **breastfeeding, most men were not able to cite other forms of birth spacing** although there was reference made to "medicines" for family planning in several FGDs as noted *"I heard of people using immunization on the arms…"* (Men, 3.9). **Medicine for family planning was not viewed as appropriate by many male FGD participants** although there were a few "positive deviants" amongst discussants. *"There are many methods some give their wives medicine, so 90% of us use breastfeeding because we are Muslims and I would allow my wife to breastfeed to two years, than the medicine which 5% use. Though family planning is good we don't allow"* (men 2.5). Some men acknowledged that women get pregnant when practicing breast feeding. **Men are fatalistic about pregnancy viewing it as the will of Allah** if a woman gets pregnant earlier than intended, as one respondent noted, *"It mostly depends on Allah's will because I have children who their difference is two and others who are almost age mate"* (men 2.3).

Women mentioned other forms of family planning "medicines" and in some instances, gave specific examples (tablets, condoms and injections). Only one female discussant acknowledged to using modern family planning: *"I used family planning and conceived after four years which is good"* (women, 3.3). **Women in all locations perceive that men are not supportive of modern methods of family planning** be they husbands, religious or other community leaders. *"If we tell them we want to use family planning tablets they will not accept and ask it's not necessary. Because they are not the ones to conceive and breast feed they do not care and if consulted will say they have no children to be aborted/or killed"* (women, 1.2). In South and Central Somalia, women themselves tended to voice negative opinions of modern family planning. In this setting in particular, myths and misconceptions appear to be rampant. There was mention of permanent barrenness and miscarriage attributed to modern methods of family planning.

In all FGDs, religion was woven into discussions on birth spacing in a number of ways – as a support for LAM; evoking Allah's will on the number of children conceived and their timing; and, as **a means of discrediting modern methods of family planning** (and their promoters, who were assumed to be outsiders) as exemplified in the following:

> "*Don't make people speak bad and these non-Muslims advocating for the child spacing medicine and injection should not be followed. Some say they want four [children], others two, that is wrong I am creating awareness to girls that Allah provides children and they should not talk of what is beyond their ability" (women, 2.3).*

Based on the dialogue, it is evident that **there was not always consensus amongst women on the merits of modern family planning and that age played a factor** in one's approval of birth spacing. Similarly men also evoked Allah's opinion on the matter. As one noted, Allah would not forgive him if his wife was allowed to space (men, 3.2).

FGM and early marriage: Most women discussants recognized that FGM causes difficulties when delivering. Like men, the "suni" form of circumcision was mentioned as being practiced and accepted. There was general **consensus amongst men and women discussants in Somaliland and Puntland that 'firauni" was no longer accepted or generally practiced**. *"People have civilized from ignorance to professionalism and knowledge; people act according to the teaching of religion so FGM has been stopped and girls are circumcised suni"* (men 2.5). In **South and Central Somalia, the picture was more mixed with many men and women voicing their support of "firauni" and stigmatizing the "suni" form with statements such as *"suni girls become prostitutes"*** (men, 3.9).

Almost all men were of the opinion that their sons should marry circumcised girls as dictated by the Muslim religion. In four male FGDs, there were some men who broke from this mold as exemplified by the following, *"there is no offence leaving the girl the way she was born so I don't mind uncircumcised girls marriage to my son"* (men 2.6 (2)). In a few instances, men noted disagreement with their wives over circumcision. One man mentioned that his wife has refused to circumcise her daughter so he had arranged for the circumcision himself (men 2.3).

Most men felt that girls should be married when they are older than 16 (many cited ages of 18, 19, 20 years) although a number felt that a girl could be married as soon as she starts her menses. Many respondents noted that delaying pregnancy was good as the girl will be more physically able to bear pregnancy but also bear the responsibility. *"…they bear children at the age Allah planned which is 15, but its good at 18 and above because she can handle baby and a family"* (men, 2.5).

HIV and AIDS Women[37] are aware of HIV and AIDS but it is not a topic that is frequently discussed amongst them. This may be due to the low prevalence of HIV and perceived risks. It is viewed as Allah's will if one contracts the disease; it is a *"disease that is passed through act of Allah and through sexual transmission"* (women, 1.2). Female FGD participants were generally accepting of people living with the disease and indicated that they would be taken care of by the community (this may be theoretical rather than based on experience). In some instances, women suggested that people living with HIV and AIDS should be isolated and given morals.

***Qaat* is generally regarded as a negative influence within Somali society. It is associated with insecurity, poor health and a poor economy.** The following excerpts exemplify these issues:

> *"…if someone is an addict and has something for lunch he may use it for qaat instead. So it affects his life, and his dependants` lives, so qaat is the worst problem that this country has"* (men 2.3).
>
> *"In the country there are no jobs and 90% of women sell qaat so they are "ministers of internal and foreign affairs" because they do the housework and selling qaat, they bring some income home while the husband has no job. So qaat has two impacts, one it generates income for women, two it affects men because they spend their income for qaat"* (men 2.3).
>
> "Women have a lot of problem especially for those whose husbands chew Qaat. When their children are sick they are the only ones who are bothered, also they are the bread winners since the husbands can't work." (women, 1.2)

Qaat **is seen as a social, economic and health issue that cannot be resolved**; indeed it does not feature in any of the health campaigns undertaken by the SCRS. While qaat was discussed as something others did in Somaliland and Puntland, there was more self-reflection in the South and Central FGDs.

3. Perceptions of SRCS

In many instances, the SRCS health services are the only services available except for local pharmacies. Private services are costly so not well liked by women. As one respondent stated, in the MCH *"wards are free, medication*

[37]Note, questions on HIV and AIDS were only included in the community female FGD.

is free, drips are free, and even doctors give free consultation so we prefer these but the only challenge is that some might not access, since there is no ambulance" (women, 1.2) **The lack of ambulatory services** was consistently mentioned by discussants. This **affects utilization and access by more remote communities**. As one respondent stated, *"our legs are our vehicle"* (women, 1.2).

The **SRCS is well regarded by almost all discussants in the three FGD groups**[38]. High praise included, *"We thank Allah, Red Crescent work is rated high (100%) because they do work on health, nutrition. Red Crescent is a light that shines on us"* (CHC, 2.5).Others noted, *"Women used to die in their remote residence but now there is telephone hotline and vehicle to transport them to the main MCH"* (CHC, 1.6). In addition to the provision of health services, **many praised the work done by the SRCS on water and sanitation, the provision of food rations and awareness creation.** As one informant noted in relation to awareness creation, *"someone with impaired vision is not same as someone with vision. I mean we have vision now"* (men 1.6).

There are, however**, perceptions of changes in SRCS support over time and between locations**. For example, *"Red Crescent, first they have been working very well in the town and villages, training, buts **nowadays they have decreased their efforts**, it looks like they have increased their efforts in Berbera"* (CHC, 1.2) When probed why this was so, the discussant responded, *"…because we have no relationship and they are not briefing anything"* (CHC, 1.2). In **a number of communities, it was mentioned that programmes had been started and stopped**, or a programme was being implemented in an adjoining district but not theirs; it was unclear to respondents why this was the case. As one noted, *"it's not good when you give someone something and then you stop, so nutrition should be resumed"* (men 1.2). This line of enquiry suggested the need for greater communication between SRCS, CHCs and community members.

5. Discussion

5.1 Household survey

1. Demographic Indicators and key health concerns

Although the three sample groups were largely homogeneous in terms of marital status, the Somaliland sample included significantly fewer men; only 6% percent compared to 15% in both the Puntland and South/Central Somalia groups and was a significantly older group with only 29% under 29 years olds compared to 44% and 51% in Puntland and Somaliland respectively. There were no significant differences in education levels. However, Somaliland's sample included 15% with secondary education compared to 5% in Puntland and 9% in South/Central Somalia.

Health concerns varied slightly between zones with diarrhoeal disease appearing as the major concern with malaria, fever, maternal health and infant /child health ranked in the top five. The Somaliland survey also ranked diarrhoeal disease as the major health concern followed by fever, malaria and eye problems. The South/Central Somalia sample group ranked malaria as its major concern, followed by fever, diarrhoeal disease, maternal health and child health. The absence of maternal health as one of the top five health concerns in Somaliland is notable with only two respondents rating that as one of their concerns. As 94% of the sample was women of child-bearing age, one might have expected it to have been raised as a key concern. It suggests that mothers give priority to the health issues that most affect their children and do not prioritise their own health. Future surveys might include questions which would clarify this.

[38]In two FGDs (men, 3.3 and men, 3.7), there were more negative opinions expressed related to the lack of medicines, doctors and even attribution of infections to the MCH.

2. Evidence of positive knowledge and attitudes on the benefits of ANC/PNC

There was evidence of small but significant gaps between knowledge and attitude to the benefits of ANC/PNC and practice most notably in Puntland. The percentage of births that had 3 or more ANC visits was moderate (65%) (compared to Somaliland 70% and S/C Somalia 65%) despite 85% of respondents stating women should attend three or more ANC check-ups. Most respondents in all three zones accessed SRCS facilities for ANC care with highest number (91%) in South/Central Somalia and the lowest (72%) in Somaliland. This most likely reflects the choices available to women in the survey areas[39]. Antenatal care was sought by the greatest number of respondents in Somaliland with 97% of women seeking care.

The Somaliland and Puntland Multiple Indicator Cluster Survey (MICS) reports the number of women attending 3 or more ANC visits as 26% and 11.5% respectively. Table 82 shows SRCS clinic data for 3+ ANC visits for Somaliland and Puntland showing higher rates than the zonal average but considerably lower rates than those reported in the household survey.

Table 81 Percentage of 3+ ANC visits in ANC visits [40]

	Puntland clinics (4)	Somaliland clinics (3)	S/C Somalia clinics*(5)
% 3rd +ANC Visits	27	49	10
	24	25	13
	37.5	41	53
	33		41
			24

*** South Central Somalia clinic data only records revisits**

Somaliland reported the largest number of facility-based deliveries at 47% of births (29% at SRCS facility). Puntland reported the second largest number at 40% (35% at SRCS facility). This compared favourably with the Somaliland Multiple Indicator Cluster Survey (MICS) that found only 30.6% of births were facility-based. In Puntland, the MICS recorded only 12.7% of live births taking place at a health facility and South/Central Somalia reporting the fewest with only 27% of respondents delivering in a facility[41]. Clinic data for Somaliland reports facility-based normal deliveries of 36%, 73.5% and 99.5% (Dilla BeMONC). Clinic data[42] for facility-based deliveries for Puntland reports facility based deliveries of 4.8% and 50% (The latter clinic recorded all but one of its facility-based deliveries in the Sept-Nov period after the completion of its new delivery and maternity suite). Only one of the five clinics surveyed in South/Central Somalia has a dedicated delivery room. Thirty-five percent (35%) of all deliveries were reported as facility based at this clinic.

The factors affecting the numbers of facility-based deliveries did not form part of the household survey. However, distance, one reason given for dissatisfaction with SRCS services, could be considered a proxy indicator. The facility checklist highlighted the fact that some clinics are not able to offer facility-based deliveries e.g. in South/Central Somalia and the standard of delivery room and maternity ward facilities varied between facilities. It is worth noting a KAP study[43] conducted in Puntland identified ”lack of privacy” (71% of respondents) as the main reason for not wanting to deliver in a health facility.

[39] For example, in South/Central Somalia has fewer NGO and private service providers as compared to either Somaliland or Puntland.
[40] SRCS clinic data June – November 2013
[41] There is no comparable data for South/Central Somalia. A MISC was not undertaken and there are no recent NGOs surveys or MOH data available on facility-based deliveries
[42] Two clinics only.
[43] KAP Survey on Maternal and Child Health in Karkaar Region of Puntland, Somalia Save the Children October 2012

The findings of the facility checklist and the health provider interviews suggest that the lack of dedicated maternity facilities in SRCS clinics in South/Central Somalia in particular would have a bearing on the figures. In South/Central Somalia, seventy-three percent (73%) of the previous births occurred at home and a skilled worker was in attendance for only 34% of those deliveries. The relatively low rate of facility-based deliveries suggests that the food rations offered as an incentive have had limited effect. This is discussed further under the Health Provider interview section.

The baseline evidenced that use of TBAs is high. – The EPHS standard is for 'skilled in-facility attendance at birth with BEmONC for all deliveries'. However, it also includes within the standard a 'companion of the woman's choice at birth and flexibility of delivery position' thus not excluding the presence of TBAs but also not officially recognising their role. SRCS has a history of working with and supporting TBAs. They represent a link with the community and support attendance. According to interviews with clinic staff, it is the TBAs that provide information on births and bring women in labour to the clinic for facility-based deliveries. The FGDs in Puntland and Somaliland showed widespread support for facility-based deliveries. However, it is noted that the discussants in the FGDs in the two zones were drawn from the populations in the immediate or near vicinity of the SRCS clinic. FGDs in South/Central Somalia discussants believed facility-based delivery was for "sick" women (complicated deliveries and that the decision as to whether to deliver at home or at a facility is made by the TBA.

Approximately thirty percent (30%) of respondents reported the loss of a child in all three zones. Of that number approximately half the deaths occurred in the first twelve months of life – 50% in Puntland, 49% in Somaliland and 55% in South/Central Somalia. Rates of miscarriage varied slightly with South/Central Somalia recording 15%, Puntland 22% and Somaliland 25%. A potential area for reducing child, neonatal, and maternal mortality [44]is increasing knowledge of danger signs and a facilitated referral process.

In all three zones, attendance at a PNC clinic before 6 weeks after the birth or a child was thought necessary by fewer than 20% of respondents. The latest WHO protocol[45] recommends three neonatal visits during the first 7 days of life to reduce neonatal deaths from infectious diseases such as sepsis, pneumonia, and meningitis. Clinic data does not disaggregate PNC consultations by date. However, with the exception of clinics in Somaliland, the number of PNC consultations at SRCS clinics was comparatively low compared to live births and ANC visits.

3. Questions related to expressing positive views on birth spacing

Knowledge about birth spacing was generally weak in all 3 zones but particularly in South/Central Somalia where 68% of respondents said that they had not heard of birth spacing. Knowledge of different birth spacing/contraceptive methods was limited with lactational amenohorrea as the best known followed by the pill and injectable. Of the few respondents using a birth spacing method in Puntland and Somaliland[46], five in total, were using either the pill or an injectable. It was noted during the survey of Puntland and Somaliland that there was no evidence of contraceptive pills or devices in the clinic pharmacies visited.

The findings of the FGDs confirmed that there was limited knowledge of other forms of birth spacing particularly from the FGDs with men. Most men did not approve of other forms of birth spacing on religious grounds. FGDs also confirmed that, in theory at least, men decide whether women can use contraception or not and men in

[44] UNICEF estimates for the country as a whole is Maternal Mortality Ratio MMR: 1,200 per 100,000 (2012).
[45] WHO recommendations on postnatal care of the mother and new born 2013
[46] Data missing from Somaliland

general are not supportive. Women in the FGDs had better knowledge of modern contraceptive methods than their male counterparts. However, women in FGDs in South/Central Somalia had a generally weaker knowledge and negative opinion of modern contraceptive methods.

The health provider interviews in South/Central Somalia found that STIs were reported as a major health issue in three clinics. However, no knowledge of condoms was reported during the household survey. The question this poses is whether condoms are promoted by health providers as a means of protection against STIs as well as a birth spacing method. However, it is important to stress the need for STI services including syndromic management and partner notification, particularly in South/Central Somalia given the findings of the survey.

4. Child information and Vaccination status

Knowledge about preventing childhood diseases through immunisation was moderate to high. The greater proportion of respondents understood immunisation as protecting against polio, measles, and whooping cough. Lower rates of knowledge of immunisation were reported in South/Central Somalia. It appears that 20% of the children had not received any vaccinations in South/Central Somalia.[47] In Puntland, seventy-six percent (76%) of children had received DPT3, thus approximately one-quarter of the children had not received their complete set of routine immunizations. In Somaliland half of the children had not received routine immunizations. In contrast, the percentage of the oldest child reported receiving measles vaccine in Somaliland was 85%, so although many received routine or mass campaign vaccinations for measles, it again appears that the routine immunization system is weak.[48] EPI is thus, one of the important areas for attention across the three zones. It is well understood that EPI is the most cost-effective health intervention. The routine system contains several potential antigens (pertussis, Hib, pneumococcal) that can have a substantial impact on child mortality, yet mass vaccination of them is not a cost-effective strategy for delivery. Inhibiting factors for wider immunisation coverage reported by health providers include limited or non-existent outreach services and insufficient supplies of vaccines to all SRCS clinics. These factors combined with the geographically large catchment areas limit SRCS clinic capacity to deliver EPI services. Extending outreach services would improve levels of coverage.

5. Breastfeeding practices and nutrition

Data on exclusive breast feeding was missing for Somaliland. In Puntland**,** exclusive breast feeding (percentage of children 0-5.99 months being exclusively breastfed) was very low (23%) and in South/Central Somalia, exclusive breast feeding was very, very low (10%). In South/Central Somalia, 32% of mothers breast fed in the first hour compared to 89% in Puntland and 85% in Somaliland. In Puntland, the percentage that exclusively breast fed until 6 months would likely be near 15%. Bottle feeding was found to be common—38% In South/Central Somalia; nipple feeding was very common—64% of children 0-5 months in the last 24 hours. Seventy percent gave something other than breast milk in the first three days of life.

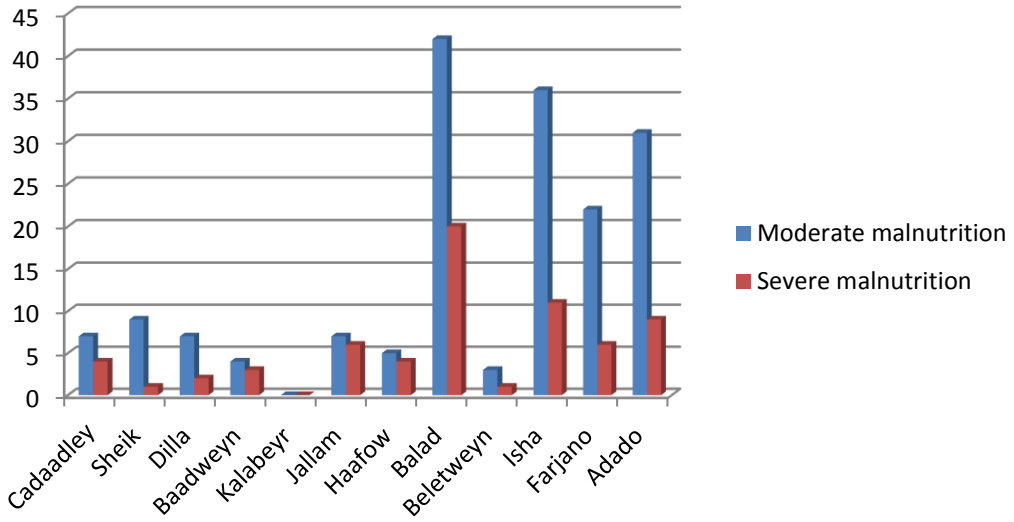
Knowledge of the signs of malnutrition was moderate to high in the three zones. Eighty-eight percent (88%) of respondents in Puntland knew that "underweight" was "a sign of malnutrition in a child that would require referral to a health facility or nutrition centre" compared to 78% in Somaliland and 68% in South/Central Somalia. In South/ Central Somalia, other key signs or symptoms of malnutrition were also not mentioned very often (only by 11-29%).In contrast, malnutrition was only listed as a key health issue in interviews with South/Central Somalia health providers. In all three zones, HH survey respondents identified malnutrition as a key health issue.

[47] There has been a resistance from El Shabab to immunisation in areas they control which may have a bearing on the survey findings.

[48] The recording of vaccination status proved problematic in Somaliland. Changes were made to the data collection for Puntland and S/C Somalia.

The proportion of households where it was reported children had received Supplementary Feeding Programme/Outpatient Therapeutic Programme (SFP/OTP) was high. This data does not correspond with data from the clinics. Clinic data for severe to moderate malnutrition in Somaliland and Puntland is considerably lower than is suggested by HH survey. However, South/Central Somalia clinic data shows high levels of malnutrition. It is noted that no supplementary feeding programmes are currently available in the South/Central Somalia.

Figure 12 Percentage (%) children with severe and moderate malnutrition (Clinic Growth Monitoring data)



Government and the Somali Food Security and Nutrition Unit (FSNAU) base their reports on clinic data so there is no independent nutritional surveillance data in the SRCS areas of operation. At the time of the HH survey, the areas covered by survey nutritional levels were classified as Alert, Moderate, and Critical[49] in the Somaliland, Puntland and South Central Somalia clinic sites respectively. Chronic malnutrition is regarded increasingly as a community education issue by UNICEF and WFP with an emphasis on reducing the relapse rate of children on supplementary feeding programmes.

A substantial opportunity exists to improve the health of infants through adequate feeding practices in this area. Adequate feeding in infants 0-5 months in South/Central Somalia appears lower than in the other two zones. However, WFP is not operation in South/Central Somalia whereas the WFP food ration is available at most of the clinics in Puntland and Somaliland. (WFP had suspended food rations in Somaliland but they are due to recommence). Considerable effort on adequate feeding in the first hour, exclusive breast feeding during 0-5.99 months, and non-use of bottle feeding is likely to be a cost-effective use of health resources. A review of the approach, content and method volunteers and health workers are using for the delivery messages around infant feeding and nutrition would be valuable.

6. Water, sanitation and hygiene

Knowledge of best practices in hygiene and sanitation was moderate to high in the three zones. Ninety-two (92%) percent reported “after visiting the toilet” for when people should wash their hands in Puntland compared to 90% and 78% in Somaliland and South/Central Somalia respectively. Unprotected water sources were reported by 84%

[49] Alert - Low proportion (5 to <10%) Moderate - >10 % and increasing trend, Critical (> 15%) a

of respondent in Puntland, 64% in Somaliland and 45% in South/Central Somalia. It is noted that there appears to be no apparent direct correlation between the reported rate of diarrhoeal disease and unprotected water source. Other factors such as water treatment, distance to water sources, time spent at the water source all have a bearing on the quality of drinking water at household level.

7. Communicable Diseases

Knowledge about many important health concepts was relatively high in all three zones. Greater knowledge of important prevention concepts reflected incidence of certain diseases. Knowledge of malaria prevention, for example, was greater in Puntland and South/Central Somalia where incidence is high as compared to Somaliland where knowledge on malaria prevention was moderate to low due to the low incidence in the latter zone. Although there were important gaps in both Somaliland and Puntland nearly 75% of respondents in the two zones were able to report main elements of important clinical and prevention concepts. Knowledge about modes of transmission of HIV/AIDS was moderate to high. However, 46% of respondents did not know how HIV/AIDS was transmitted in South/Central Somalia as compared to 16% and 26% in Puntland and Somaliland respectively. Reduced access to communities in South/Central Somalia due to curfews, insecurity and the absence of outreach services restricts their access to health education and information and would explain the discrepancies in knowledge around certain important health concepts.

8. Clinic visits, volunteer visits, and communications

The highest proportion of respondents using SRCS services was in South/Central Somalia (70%), with 66% and 56% in Somaliland and Puntland respectively. Possible reasons include fewer options in South/Central Somalia and greater numbers of private, MOH and agency providers in Somaliland and Puntland. For those respondents, it appears that the SRCS health facility system is working relatively well. Eight-five percent (85%) of clients in Somaliland and 84% in South/Central Somalia expressed satisfaction with SRCS clinics. A lower percentage (66%) expressed satisfaction in Puntland. Clients cited a range of different aspects of services as the reasons for their satisfaction. Free services was the primary reason given in all three zones followed by short waiting times and qualified staff. Of those clients who expressed dissatisfaction, the primary reason was distance to clinic in Puntland, long waiting period in Somaliland and lack of laboratory services in South/Central Somalia. The findings of the FGDs confirm that distance and lack of transportation is the principle reason for respondents not availing themselves of SRCS services. It is difficult to assess to what extent long waiting times are a factor. From the clinic data for Somaliland and Puntland, (see Health Provider Interviews), on average, the maximum number of clients seen in OPD is 35 a day and lowest 18 a day which does not appear an unduly heavily client load. However, the numbers of OPD consultations per day in South/Central Somalia are considerably higher. This may be a function of fewer facilities available to the population or alternative a greater burden of disease due to a variety of environmental and socio-economic reasons.

Eight-two percent (82%) of respondents in South/Central Somalia and Puntland reported receiving visits from a Red Crescent volunteer within the last three months compared to 46% of households in Somaliland. However, across the three zones, the primary source of health education/promotion messages was SRCS health workers.

5.2 Health Facility Checklist

The findings of the Health Facility checklist suggest that in Somaliland and Puntland, the SRCS clinics were built to house the range of services under the rubric of an MCH/OPD facility. The MCH/OPD clinic designation has been replaced by the EPHS health centre. This is discussed further in section 5.3. However, variations were noted between and within zones, in the quality of the infrastructure and its maintenance, the equipment and the supplies. It is apparent that different levels of service were envisaged when the clinics were built. For example,

three of the four clinics visited in Puntland had large rooms intended for laboratory facilities, while those in South/Central Somalia had been built without laboratory or maternity facilities. Even within zones variations exist. The findings from South/Central Somalia suggest that clinics vary considerably in size, some with only one room for all consultations. However, in Puntland and Somaliland, MCH/OPD clinics all had separate consulting rooms for OPD and ANC and >5 OPD, however several clinics (2/3) did not have separate rooms.

Significant differences in power supply and the availability of emergency lighting were noted. There appeared to be no obvious correlation between the lack of a reliable and constant power supply and the presence of functioning emergency lighting or torches. Most clinics (9) have no reliable uninterrupted power supply and only four clinics have an emergency source other than personal torches (not found at the clinics but claimed to be used by staff). This raised two key questions around a) the examination of patients and b) lighting during facility deliveries:

- How and how frequently are physical examinations conducted on patients i.e. checking throats/ears/etc. where torches and/or ophthalmoscopes are not available?
- Likewise, how are clinics able to offer 24 hour maternity and delivery services without functioning lighting?

This has implications for diagnosis and treatment particularly as many of the examining rooms are not well-lit by daylight.

The cold chain refrigeration was either solar or paraffin powered therefore vaccines were not at risk.

Water sources vary between and within zones and are dependent upon the immediate climatic conditions and level of local infrastructure in an area. Four clinics in Puntland and Somaliland rely on bowser water from different and unprotected water sources compared to three that are on mains/borehole water. The baseline survey did not address quality of issues but questions on water sources and water quality could perhaps be included in any future surveys.

Sewage systems or cess pits[50] were in place in all clinics in Puntland and Somaliland. Only one clinic had a sewage system and it is not clear from the data how sewage is managed in the remaining five clinics. Waste disposal and incineration of waste varied between clinics. All but two clinics incinerated their waste in permanent incinerators in metal drums. Two clinics in Puntland disposed of waste in the bush. A lack of standardised waste disposal allows for discrepancies between the management and frequency of waste disposal. Only six clinics have protected incinerators and un-burnt waste remains in unprotected drums or incinerators. The variation in the kind and quality of waste disposal raised questions about how this is monitored and the role of the MOH in setting minimum standards.

Although cleanliness and hygiene indicators were not included on the checklist as assessments tend to be subjective, in the main all the clinics and compounds surveyed in Somaliland and Puntland were adequately maintained and cleaned. However, there were notable variations in order and overall maintenance. Used syringes, vials and other medical waste were found on the ground within one clinic compound. The results of the survey of clinics in South/Central Somalia give no indication of the overall hygiene and cleanliness of the facilities.

Equipment and facilities for maternity and facility-based delivery varied considerably between zones and clinics. One clinic in Somaliland was offering a fully-staffed 24 hour a day service to women with a fully equipped labour ward, incubation if necessary and a maternity ward. The exceptional status of this MCH/OPD however is due to the

[50] It was not clear whether the cess pits were organic pits/septic tanks or not. It is the understanding of the consultant team that most were organic pits/septic tanks and therefore permanent. However, there was evidence of at least one cess pit in Puntland i.e. would need to rest or need to be dug out.

fact that it is on a MoH/UNICEF pilot project, the Basic Emergency Obstetrics and Neonatal Care (BEmONC). Other clinics (5) in Somaliland and Puntland had large delivery rooms and separate maternity wards which were unoccupied, poorly equipped and with little evidence of frequent and regular use[51]. South/Central Somalia clinics lacked separate maternity facilities in four of the clinics surveyed. Uneven services and facilities are likely to discourage facility-based deliveries. The register of births was not included on the checklist but the consultant did spot check a couple of registers. These registers showed delivery data entered some days after the date of birth. On the basis of a survey of the delivery suite and the registers, there appears that there may be discrepancies between the number of births registered as facility-based and the actual number. For example, a clinic in Somaliland where the delivery room was not fully-equipped with little evidence of recent deliveries or any women in the maternity ward registered 247 facility-based deliveries in the previous six months according to clinic records. It is conceivable that clinic staff are under pressure to register home births as facility-based due to the food rations offered as incentives for those who give birth in a facility. It is recognised that it is possible that TBAs may also exert pressure on staff to register home births as facility-based. It is understood that clinic staff rely on the support and goodwill of TBAs and their clients.

The survey found an overall lack of adequate laboratory facilities. Despite most clinics having a dedicated laboratory, only two laboratory facilities were in active use. Only two of twelve clinics, had functioning microscopes that were in use. Equipment for testing for anaemia was only available in three of twelve clinics and urine analysis in two of twelve. However, malaria tests were available in all but one clinic. Again this absence of laboratory testing has implications for diagnosis and treatment e.g. lack of test kits for STIs. It further affects the quality of care and range of services provided at the SRCS health facilities.

The distribution of drugs available was uneven across the twelve clinics. Differences in the content of the drug kits between zones only partially explain the absence of some of the drugs. The ICRC supports the clinics in Central/South Somalia whereas the IFRC supports those clinics in Puntland and Somaliland. As yet, they have not come together to compile a compound drug list. However, this may be a function of the prevailing conditions in the different zones. The absence of certain drugs in most clinics was remarkable either as result of early stock outs or limited supply of certain drugs in the kit. The limited availability of analgesics/painkillers in a number of clinics in Puntland and Somaliland was notable both Ibrufen and Paracetamol syrups were only available in two clinics respectively. Methyldopa was only available in two in clinics in Puntland and Somaliland and not available in any clinics in South/Central Somalia. Paediatric dosages of drugs were not available in any clinics in Puntland. Although contraceptives were not included on the facility checklist, it was noted that there were no oral contraceptives available in clinics in Puntland and Somaliland. This may be due to reasons already described i.e. low demand but staff sensitivity and the fear of being labelled as promoting a practice that the community frowns upon or shies away from may discourage stocking modern contraceptive methods.

The above findings need to be understood in the framework of SRCS current drugs policy and practice. It is noted that current drugs supplied to the clinics meet required international standards and also are in line with the treatment of the most common prevailing conditions. The drug procurement is managed by the IFRC Logistics Service in Geneva and done through International Competitive Bidding (ICB) with a reputable company that meets international standards. Local procurement of drugs has been avoided in all zones of Somalia as a way of maintaining the quality of drugs. Paediatric drugs are not always found in the UNICEF MCH kit or when there are delays, IFRC or ICRC provide supplements. Therefore, these need to be supplied by SRCS and its partners and since the survey was conducted paediatric drug supply is being addressed. It is further noted, however, that syrups, for

[51] Sites the consultant visited

instance, requested by the clinics cannot be supplied due to an explicit policy not to procure and ship syrups to the clinics for reasons of cost of shipment and probability of breakages.

5.3 Health Provider Interviews

SRCS has a stable core of health providers. Half of all personnel interviewed in all three zones had worked at their clinic for four years or more. Most of the health providers were from the area where they worked. Roots in the community appear to encourage greater commitment and loyalty to the community by clinic staff. In several clinics, staff paid from their salaries for drugs or test kits when the drug supply was insufficient. However, greater exposure to different communities and working environments might benefit both staff and their patients.

Of the staff interviewed, twenty-seven had formal professional training in nursing, midwifery and clinical skills although the kind and type of training appeared to vary. In Puntland and Somaliland, qualified nurses might have received either two or three year training courses. For example, some staff who identified themselves as qualified nurses had begun as volunteers and/or auxiliaries and then had gone on to work as 'interns' in hospitals for one to two years before returning to the clinics.

As Table 67 shows, In-service training opportunities appear to be unevenly distributed across the zones with Puntland and Somaliland staff reporting attending 92 courses since beginning their employment with SRCS in compared to 25 courses in South/Central Somalia. Possible reasons for this discrepancy include travel restrictions and the relatively high cost of transportation in South/Central Somalia. Most training courses are organised by the SRCS. However, some training such as HIV/AIDS training are organised and funded by multilateral partners such as WHO. The staff appraisal system did not form part of the baseline survey but training needs could usefully be included in staff annual performance reviews and could form the basis for zonal or national training plans. SRCS could also consider conducting a training needs assessment to inform future training plans. Any training plans would need to be informed by the new Human Resource Development plans outlined in MOH policy.

While the perceived main health issues of HH survey respondents and health clinic personnel largely coincided, there appeared to be a few discrepancies. As HH survey respondents were predominantly women with children under five, it is likely that their perceived main health issues would relate to those diseases most affecting their children. Malaria and fever were more frequently listed as health concern by HH survey respondents than staff.

Morbidity data from the clinics surveyed in Somaliland, Puntland and South/Central Somalia differs somewhat from the perceptions of the health providers interviewed. Although Acute Respiratory Disease was ranked first in most common diseases in all clinic reports for 2013, Diarrheal Disease is ranked only once as in the five most common diseases. UTIs and skin infections were reported as most common diseases in all clinics. Malaria does not appear on any of the reports.

Upper Respiratory Tract Infections (UTIs) were not explicitly included on the list of health concerns for the HH survey. Therefore the frequency in the health provider list is not captured or reflected in the survey findings except possibly under the category of 'maternal health'.

No morbidity or mortality data was available from the respective Ministries of Health. However, Health Management Information Systems (HMIS) are in place in Puntland and Somaliland and the Multiple Indicator Cluster Survey (MICS) for both zones represents a commitment to strengthening health management information. Currently, the MOH in both zones are collecting returns with the assistance of the NGO sector. According to MOH staff in Somaliland and Puntland, HMIS data is now being collected and entered and it is anticipated that they will be able to generate their own morbidity data in the near future.

The lack of equipment and laboratory testing appeared to have a bearing on staff perceptions of health issues. Where clinics were not routinely taking blood and testing at ANC, anaemia was not included on the list of concerns. Similarly tonsillitis was reported only in the clinic where torches and tongue depressors were in evidence.

Significant differences were noted in the services available at clinics as listed by staff. Only one clinic offered the range of services of an EPHS health centre. The MCH/OPD clinic and services are not defined in the EPHS. Impediments to offering a full complement of services included inadequate infrastructure (e.g. buildings too small to house a maternity unit), lack of equipment and/or drugs and test kits, a lack of training, and staff shortages. Staff perceptions about what services they were supposed to offer but were unable to do so were not reflective of current health guidelines as described in the EPHS. Under the EPHS, a health centre provides six core components or programmes:

1. Maternal, reproductive and neonatal health
2. Child health
3. Communicable disease surveillance and control, including watsan promotion
4. First aid and care of critically ill and injured
5. Treatment of common illness
6. HIV, STIs and TB

Staff perceptions of SRCS National and Branch Health Officers were positive. All clinics in Somaliland and Puntland received regular visits from their Branch HOs although the frequency of visits varied from daily to once a month. Similarly in Puntland and South/Central Somalia, all clinics were visited by the respective National Health Officers with the frequency of visits varying between once a month to once every quarter. The SRCS IHCP guidelines for clinic visits are once a month for Branch Health Officers and once a quarter for National Health Officers

Visits by Branch HOs were seen by staff in all 13 clinics as primarily monitoring staff and services. Staff in 7 clinics perceived their HOs as providing support supervision. However, all staff in all the clinics reported being given an opportunity for feedback. Although the findings around SRCS supervision suggest staff satisfaction, the emphasis on monitoring and checking rather than support supervision is not one that empowers staff or builds collegial relations. SRCS might want to consider different approaches to support supervision. Given the differences in the state of clinics both in terms of use and cleanliness and maintenance, clarification of the supervisory function would be important in long-term planning.

Focus Group Discussions

The discussion of the findings of the FGDs forms and integral part of the summary of findings and does not require additional discussion in this section. However, attention is drawn to the following key areas highlighted by the FGDs:

- Clinic governance, CHCs , their quality and value;
- Referral and tertiary services available
- Gender differences in relation to understanding and acceptance of modern birth spacing methods
- Communities' responsibility for their own health – is there an over-reliance on health facilities to manage health and nutrition
- The role of husband's in ANC and facility-based deliveries;
- The relationship between food commodities provided by WFP or UNICEF and good nutritional food
- Perceptions of SRCS services as variable

6. Conclusions

As this was the first IHCP baseline survey and was intended as a learning exercise, issues emerging from the findings and issues related to process are noted here so that subsequent iterations of the survey can benefit from the learning generated through this experience. Despite the many challenges and delays, the IHCP baseline survey can be regarded as largely successful. Much valuable data and background information were collected, collated and analysed. The consultant team recognises that there are elements to be improved upon in future surveys but also much can be learnt from these first baseline survey processes. The limitations and some of the major obstacles are discussed in earlier sections in the report but it is useful to highlight the key issues and how these could be addressed in the future.

Methodology, approach and planning

To conduct a household survey in three zones using new technology (RAMP) supported by a qualitative survey was extremely ambitious. The process required not simply organisation but required the support and consensus of a number of different partners in different locations. It is important to acknowledge these logistical and bureaucratic challenges and the extent to which they had a bearing on the overall process.

There were issues with all of the survey tools to some extent. Although time and effort was dedicated to the development of an HH survey tool that would fully capture the key indicators relevant to SRCS work, insufficient time was available for testing the HH questionnaire and other survey instruments. More rigorous pre-testing would have ensured that they were valid for all the three zones and were sufficiently robust to generate the depth and breadth of information sought. Ideally, the RAMP team and the consultancy team would have had time together to consult and to jointly test the instruments and done so in all three zones. As it transpired, due to the lack of rigorous testing, the instrument on child immunization had to be reviewed for Puntland and South/Central Somalia.

In future, a two-step process could be considered, where household data is collected and analysed and the findings feed into the design of qualitative survey tools, would allow for particular health and nutrition concerns that the HH survey raised to be further explored. For example, exploring in FGDs some of the findings of the HH survey in relation to identified health concerns and health priorities.

The brief training in qualitative and quantitative research methods was regarded as valuable by both SRCS staff and volunteers. However, the use of staff persons to administer the FGDs may have affected the kind and depth of discussion. Questions were sometimes skipped or modified by the interviewers. For example, the question *"Would you allow your wives to use any of the child spacing methods?"* in some instances was not asked. Modified questions replaced this, such as *"Up to how long can a mother wait to get her next pregnancy?"* It suggests that some of the interviewers were not comfortable with the subject matter. Also, in changing the wording of the questions, sometimes their neutrality was lost. For example, the question *"Would you **allow** your sons to marry uncircumcised women?"* is more neutral than *"Do you **accept** your son to marry an uncircumcised girl?"* In this instance, the view of the interviewer as someone who had a relationship with the community may have reduced the likelihood of a respondent stating that they would. External consultants who have no relationship with the communities they are interviewing are better placed to probe more delicate issues.

A related issue is the extent to which the survey instruments are aligned with the IHCP log frame and could be used to develop robust indicators for programming monitoring and evaluation. The IHCP was revisited and the indicators reviewed as part of the baseline survey contract. It is important that SRCS and its partners find the opportunity to consider programme indicators in the light of the findings of the survey.

Recommendations

Quality of communication in general and the quality and kind of community health education in particular. The findings of the baseline survey raise questions as to the effectiveness of community education around key health concepts**.** Awareness and understanding of certain health concepts are in doubt particularly the role of nutrition and an understanding of malnutrition. This was particularly apparent from the findings of the FGDs where there appeared to be partial knowledge and understanding of important health issues but insufficient for generating significant changes in behaviour. This in turn, raises questions about who takes responsibility for community health education at local, regional and national levels. Is there routine monitoring or is health education assumed by a) volunteer reporting and b) rates of consultations/observed behaviour change? While some of these points are touched upon by the HH survey and Health Provider Interviews, future surveys could explore this area more fully.

Roles and responsibilities of SRCS volunteers**.** Greater attention needed to be given to volunteers in the data collection. Through the course of the survey, the presence of a cadre of SRCS volunteers as enumerators and at the clinics visited was profound. Evidence of the importance of SRCS volunteers and their key role in the service, most of the clinics in the survey rely very heavily on volunteer labour not only for health education but for the day to day running of the clinics. This is not well described or articulated within the programme documentation and reporting. Future surveys need to include an assessment of the roles and effectiveness of volunteers and their contribution to outputs.

Training of staff and volunteers. Interviews with health providers demonstrate that SRCS has invested in staff training. All staff had received some training from the organisation from disease management courses, to professional refresher courses, with additionally training to support clinic management e.g. laboratory training. As one would expect, the training opportunities have been appreciated. However, there were evidences of skill and capacity gaps affecting the delivery of services. This gives rise to whether there is an overall training strategy either for the regions or across the country. If there is a training strategy, how has this evolved and how is it monitored? Is training aligned with both the perceived training needs of staff and the clinics and with ensuring the drugs and equipment are available for improving treatment protocols? SRCS might consider conducting a training needs assessment which could also shed light on gaps in clinical skills that may have had an effect on the range and quality of service provision.

Disease management and diagnosis**.** This issue relates to training and drugs/equipment but has broader systemic implications. The interviews and the facility checklists strongly suggest some correlation between reported disease and equipment and drugs available. While there may be insufficient evidence to fully support this finding, it is suggested that there is closer monitoring of morbidity and notable differences between reporting between clinics. At a time when Somalia is working to strengthen its HMIS, supporting better and consistent diagnostic practice is one of the substantial contributions SRCS can make to system strengthening.

Facility-based deliveries. The findings of the baseline survey raise some questions regarding the number of facility-based deliveries. There is an apparent disparity between the proportion of women who said they delivered at a facility in the HH survey, the FGDs and the clinic data. With two or three notable exceptions, (Dilla, Jallam) the state of the labour wards, suggest that there are fewer facility-based deliveries than are reported in the registers. The current incentive of a MCHN food package (25kg of grain/cereal, 5.2 litre oil, 10kg beans & 10kg CSB) for facility-based deliveries may well be the reason for clinics to feel the pressure from TBAs and their clients to record home deliveries as facility-based. Interestingly, in the case of Dilla which has 4 midwives and 24hour service, women are choosing facility-based deliveries despite WFP halting food ration to the district an indication of the

accessibility and quality of services. (It needs to be noted that WFP stopped the food ration programme in the entire district for two reasons. One, there was mismanagement of the food ration by a school. Secondly WFP was running out of funds. Indeed the programme was stopped all over Somaliland. New agreements are being signed and the ration is to be resumed hopefully throughout Somaliland and including the Dilla.

A careful and accurate monitoring of the number of facility-based deliveries together with some frank discussions with TBAs and clinic staff might be helpful and could perhaps usefully inform policy around food aid as a health incentive.

It is recognised that this baseline survey exercise is both to provide bench marking for future surveys and to offer some general recommendations for improving the management and the delivery of health services of SRCS clinics. A baseline survey is not a review thus the recommendations are intended as issues to be reflected upon during any upcoming planning. The recommendations include specific suggestions for activities that could improve health outcomes in the three zones and more general suggestions for improving systems and procedure to strengthen the programme and maximise resources.

From the HH survey data and likely main causes of child death (diarrhoea, pneumonia, neonatal) and maternal death, the following activities might be considered. Suggested activities are listed in order of priority:

1. Improve coverage of EPI and vitamin A, including activities by volunteers to register pregnancies and births and track immunizations and ANC visits. Address 20% of children that are not receiving any vaccines and pregnant women with no or 1 ANC visit.
2. Increase knowledge of neonatal, child, and maternal danger signs
3. Improve knowledge about the signs and symptoms of malnutrition
4. Implement a system of three neonatal visits by community volunteers (as now globally recommended)
5. Consider a community facilitated referral system for danger signs and deliveries
6. Promote use of only breast milk in the first 3 days of life
7. Increase exclusive breast feeding (which will decrease diarrhoea and improve nutrition), including activities and messages directed against the use of nipples
8. Increase point-of-use water treatment, especially for those that that are using unprotected water sources.
9. Consider periodic water quality testing and introduce use of water catchment in the clinic as they have good roof for collecting rain water
10. Promote hand-washing stations for washing hands during the 5 critical times
11. Consider integrated community volunteer case management for pneumonia (amoxicillin), diarrhoea (ORS, zinc), and, if common enough, malaria (RDTs, ACTs)[52]. and increasing community surveillance

Although the focus here is providing practical recommendations for improving programming, it is important to note and recognise the success of the Integrated Health Care Programme (IHCP) in maintaining health services in most areas over a turbulent and frequently extremely violent period. In this context, staff retention, maintenance of a drug supply, and delivering health education and EPI over an extended geographic area are extraordinary and SRCS is to be applauded.

The baseline survey identified several areas of the programme which require attention most notably:

- Management of the quality and supply of drugs and equipment;
- Establishment and maintenance of minimum laboratory facilities
- Empowerment of CHCs and health providers to manage and maintain clinics and services
- Management and monitoring of HMIS
- Standardisation of clinical and staff training;
- Quality and consistency of monitoring and supervision
- Provision of child spacing education and services;

[52] This is being implemented by UNICEF and its partners in parts of Somalia.

- Provision of high impact services

Management of the quality and supply of drugs and equipment - It is recommended that SRCS invest in an assessment of the current drug management system by an experienced pharmacist at all levels of SRCS who can provide practical recommendations on the maintenance of an adequate and appropriate drug supply to all clinics.

Establishment and maintenance of laboratory facilities – Inadequate laboratory facilities are affecting the delivery of services and were identified by both HH survey respondents and health providers as a weakness of SRCS services. In conjunction with an assessment of the drug supply, an assessment of minimum requirements for establishing easily maintained and appropriate laboratory facilities including staff training would be useful. Many of the facilities have the large "laboratories" but do not have the infrastructure, the equipment or the training for them to be put to use. It is also recommended that SRCS consider expanding the range to include basic urine and stool analysis.

Empowerment of CHCs and health providers to manage and maintain clinics and services – Now that many of the clinics have been operational for fifteen to twenty years, the management and responsibility for the clinics needs to begin to devolve to the communities and to the increasingly active MOH. Many of the CHCs are composed of senior members of the community who have been occupying their committee positions since the committee was struck. Encouraging committee elections with greater participation of women, the inclusion of new members and long-term planning with some cost recovery mechanisms where appropriate would support greater autonomy and local empowerment. Women are underrepresented. In order encourage women's greater participation; SRCS might want to consider affirmative action measures i.e. 40-50% of CHC membership to be women.

Provision of child spacing education and services – If SRCS is determined, it will continue to address child spacing. It must adopt a consistent and joined-up approach and service. Health education and child spacing promotion need to be appropriate, neutral and supported by SRCS-provided access to contraceptive methods and education in the rhythm method. Interventions need to take into account the extent to which gender and male authority plays a role in decision making.

Provision of high impact services - In an environment of scarce resources for the provision of a wide range of services at the health unit, SRCS may want to review its priorities in relation to increasing competition from other NGOs and private health providers. This requires SRCS to conduct as scan of the operating environment and reassess what services it should prioritise. The new EPHS includes a number of core programmes (The six core programmes for health centres are outlined in Chapter 5). Initially selecting a core programme such as *First aid and care of critically ill and injured* which will generate perceptible results and one of the four additional programmes such *Eye health*[53] or *Mental health and mental disability.* SRCS may want to concentrate its efforts on one or two with the aim of raising the standard and quality of those particular services offered in their clinics. Retraining staff, reviewing salaries and incentives and building community-based quality assurance mechanism would be required to take this suggestion forward but would be a valuable exercise for health staff in how internal system-strengthening can support MOH initiatives.

[53] The findings of the baseline survey and clinic data suggest this is a priority area

Annexes

Annex 1: Terms of Reference

Background

Somalia has been in civil conflict since the collapse of the central government in 1991. The conflict has significantly contributed to the prevalence of insecurity, breakdown of law and order, particularly in Central/South Somalia and the disintegration of the country into clan-based and territorial enclaves that are to date not recognised internationally. Puntland in the North-East and Somaliland in the North-West however enjoy some relative peace, security and political stability but have weak functioning and grossly under-resourced public institutions, including the health sector. The socio-economic cost of the conflict threw the country into one of the worst humanitarian catastrophes ever, plunging the majority of the 9.6 million Somali population into abject poverty and diminished coping capacity. Cyclical climate change-related disasters such as drought and floods have further compounded the vulnerability of a vast majority of the population with displacements, disease outbreaks, food insecurity, malnutrition and loss of livelihoods.

Today, the Somali Red Crescent Society (SRCS) is reputed to be the largest indigenous humanitarian entity working across Somalia with branches in all the 19 regions of the country and with a volunteer strength of about 5,000. Throughout the two decades of conflict and insecurity that resulted in the collapse of public institutions and services particularly in South-Central Somalia, the Somali Red Crescent Society (SRCS) has continued to provide humanitarian assistance, including basic health care services, to the most vulnerable population in collaboration with the local health authorities and other actors such as UNICEF, WHO and WFP.

The Integrated Health Care Programme (IHCP) has been the core programme of the SRCS since 1991, with the support of Red Cross/Red Crescent Movement and non-movement partners. The SRCS-managed IHCP is in line with the strategic aims of the International Federation of Red Cross and Red Crescent Societies (IFRC) Strategy 2020 and the National Society's Strategic Plan 2010-2014. The SRCS Health Strategy (2013-2017) is equally aligned to these strategic documents.

The IHCP comprises a network of Maternal and Child Health/Out Patients Department (MCH/OPD) clinics and community based activities. The number of MCH/OPDs under the IHCP throughout the country has progressively increased from 20 clinics at its inception in 1991 to 62 static and 26 mobile clinics in 2012.Table 1 below shows the location and source of support for the 62 static clinics currently run by the SRCS.

Table 1: Location and support for static clinics in Somalia (as at 2012).

Location	**Number of static clinics**	**Supported by**
Somaliland	12	8 are supported multilaterally through IFRC
		4 are supported by German Red Cross
Puntland	20	Multilateral support through the IFRC
South/Central Somalia	30	ICRC
TOTAL	**62**	

Over the years, the SRCS has expanded the IHCP in terms of coverage and content. Since 1991, the IHCP has expanded the range of services provided to include primary laboratory services, delivery, and others in collaboration with international partners such as UNICEF[54], WHO[55] and WFP[56]. The IHCP targets an estimated population of 600,000. In order to address the unmet needs and increase access to basic health care services particularly vulnerable nomadic and Internally Displaced Persons (IDPs), the SRCS with support from Movement partners commenced mobile clinic services to reach out to these vulnerable targets, particularly in response to the devastating 2011 drought.

[54]United Nations Children's Fund (UNICEF)
[55]World Health Organization (WHO)
[56]World Food Programme (WFP)

The SRCS network of MCH/OPD clinics offer a basic package of health services including Expanded Programme of Immunization (EPI), growth monitoring of children to assess their nutritional status, management of malnutrition through the Out-Patient Therapeutic Feeding Programme (OTP), case management of childhood and common ailments, provision of Oral Rehydration Therapy (ORT) for the management of diarrheal diseases, safe motherhood (antenatal, delivery and post-natal care, provision of micronutrients, clean delivery kits) and the referral of complicated cases to regional hospitals. The MCH/OPDs in Central/South Somalia in addition provide basic stabilization of casualties.

Community-based activities by trained community volunteers such as awareness on disease prevention, promotion of health and health seeking behaviour, HIV/AIDS & Female Genital Mutilation/Cutting (FGM/C) prevention, water, hygiene and sanitation promotion have been integrated into the IHCP, mainly employing the CBFHA[57] and PHAST[58] approaches. Also integrated into the SRCS-managed IHCP is the dissemination of Red Cross/Red Crescent humanitarian values and principles, with activities focusing on reducing stigma and discrimination against people living with HIV and AIDS, promotion of tolerance and reduction of violence. The community-based activities, including the awareness sessions on HIV and AIDS, anti-discrimination and fighting of harmful practices have been regularly addressed through the CBHFA approach at the community level.

The baseline survey

Due to the emergency circumstances surrounding its set up in 1991, the SRCS` Integrated Health Care Programme (IHCP) did not include a baseline study and has never had a comprehensive evaluation conducted of the programme since. Some targeted evaluations have been carried out at various stages and as components of the IHCP, such as the Qarhis Project (Community-Managed Health Care Service Provision Model) supported by the World Bank in 2004. Similarly, there have been various multilateral and bilateral evaluations conducted on specific projects under the broader IHCP.

In 2013, the Somali Red Crescent Society (SRCS) and the IFRC Somalia Country Representation together with other Movement partners plan to conduct a baseline study into the IHCP based on existing programme indicators. It is envisaged that the study will provide inputs for the development of partner proposals for the coming years as well as providing a basis for measuring programme impact and service delivery of the clinics over time. It will also provide inputs for refining and developing SMART indicators in operationalizing the SRCS Health Strategy 2013-2017 with bilateral and multilateral partners support. Further, it will allow SRCS to identify main differences that exist between health clinics across the country (Somaliland, Puntland, South/Central Somalia) and aim to move towards consistency of health service delivery (including indicators used) by all SRCS clinics.

The planned study will focus on 16 MCH/OPDs in Somaliland and Puntland as well as 10 in South/Central zone of Somalia[59]. Annex 1 provides information on the distribution of MCH/OPD clinics that have been purposefully selected for inclusion in the baseline study.

The baseline survey will involve the use both qualitative and quantitative data collection approaches. The Rapid Mobile Phone-Based (RAMP) technology will be employed in the quantitative component of the study. The quantitative data will similarly be analysed and technical reporting produced by RAMP experts who will work in consultation with the identified consultant. The consultant will work closely with a technical team made up of SRCS and Movement partners both ain Nairobi and the field levels in planning and carrying out the survey. Insecurity in most parts of Central/South Somalia and pockets of Puntland and Somaliland will however restrict access to some

[57]Community Based Health and First Aid (CBHFA)

[58]Participatory Hygiene and Sanitation Transformation (PHAST)

[59] Due to rapidly changing situation in South/Central Somalia these 10 locations will be confirmed shortly before the commencement of the study

sites for qualitative data collection by the identified consultant. Innovative mechanisms will therefore have to be devised to collect the requisite qualitative information in such instances for the baseline study.

Purpose of consultancy

The SRCS/IFRC and partners are seeking the services of a consultant to immediately carry out qualitative data collection on the SRCS-managed IHCP based on the objectives below and indicators of the current programme interventions.

The main objectives of the consultancy are:

- To collect qualitative data/information in line with the SRCS Health Strategy indicators that together with quantitative data collected separately, will establish baseline data that will help measure progress against the set goals, objectives and impact over time.
- Based on the analysed quantitative and qualitative data, recommend pragmatic strategies for the SRCS to increase consistency of the services as well as measuring of progress and impact.

Specific tasks under the consultancy

- Review literature and data on the implementation of the IHCP interventions.
- Produce an inception report which establishes the consultants understanding of the assignment and its requirements with that of the evaluation contractor detailing the approach, methodology, key informants and work plan. The inception report should also indicate any additional requirements for information. The inception report will be reviewed and approved by a technical working group overseeing the survey.
- Review/validate and finalise existing draft tools for quantitative data collection.
- Develop tools for qualitative data/information collection
- Liaise with RAMP experts (located in Nairobi for the field work and Atlanta for data analysis respectively) to obtain a complete overview of the entire study and for the requisite technical inputs for reporting on the study.
- Meet with key Movement partners to exchange and gather additional information
- Meet with relevant partners/stakeholders in the field (Ministry of Health, UNICEF, WFP and WHO) to exchange views and gather information.
- Brief SRCS Coordination Offices and Branch team leaders about the study approach and ensure that they are conversant with the tools to be used.
- Monitor the training of enumerators and data collection in the field (Somaliland, Puntland and Central/South Somalia).
- Train SRCS Health Officers and provide guidelines on qualitative data collection.
- Produce a draft report including findings, conclusions and recommendations that will be shared and comments sought from all stakeholders.
- Present the baseline survey findings and key recommendations to SRCS, IFRC, ICRC and RC/RC Movement partners.
- Provide a final report with recommendations, database and survey tools, both qualitative and quantitative, after incorporating the comments and inputs of the SRCS and its Movement partners.

Consultancy outputs

The consultant shall:

- Produce an inception report, qualitative data/information and validated quantitative data gathering tools within 5 days on being contracted.
- Deliver within 7 days after receiving the technical analysis and reporting on the quantitative data, a draft baseline survey report not more than 30 pages (excluding annexes), with analysed baseline data that are in line with the current programme and SRCS Health Strategy 2013-2017 indicators.

Additionally, key recommendations to improve the IHCP programme and facilitate the realization of programme goals and objectives should be included, within the context of and mandate of the SRCS in the wider Red Cross/Red Crescent Movement.

Methodology

As part of the selection process for the consultancy, candidates will be required to submit a 1 – 2 page outline of the proposed study methodology given the details in this ToR and Annexes. For further information please contact Kwame Darko (kwame.darko@ifrc.org).

Short listed consultants will be requested to provide evidence of their previous relevant and approved studies.

Duration and tentative work schedule

The duration for the consultancy will be **35 days** including field visit and report writing as detailed in the time schedule below:

Time line for the study

S/N	Activity	Responsibility	Remarks
1	Development of inception report, review and approval, desk review of secondary data/information, development of qualitative data collection instruments and provide quality assurance of existing draft quantitative data collection tools.	Consultant	5 days
2	Meeting of SRCS & partners in Nairobi	IFRC	1 day
3	Travel to the field, training of Branch Health Officers on qualitative data collection, qualitative data collection, meeting with key partners (MoH, UNICEF, WHO, WFP) in the field (Hargeisa, Garowe, Mogadishu)	Consultant	20 days
4	Report writing (1st draft)	Consultant	5 days
5	Report writing (final draft)	Consultant	3 days
7	Dissemination workshop	Consultant	1 day

Roles and responsibilities

Various individuals and groups will be involved in conducting the baseline survey and their respective roles and responsibilities are detailed in the table below:

S/N	Actor	Responsibilities
1.	SRCS/IFRC/ ICRC	• Support and facilitate the consultant's travel in Puntland, Somaliland and Central/South Somalia, provide administrative, logistics and security related issues of the consultancy • Facilitate meetings and field visits. • Provide the relevant background materials to the consultant. • Provide security briefings.
2.	Technical Working Group	• Provide technical inputs and support to the consultant
3.	The Consultant	• The consultant will be required to abide by the Red Cross/Red Crescent

		security rules and procedures in place for travel to and within the target communities. • Security briefings will be provided to the consultant in Nairobi and in field locations - Hargeisa (Somaliland), Garowe (Puntland) and Mogadishu (South/Central) • Other responsibilities as itemised in this document
4.	RAMP Experts	• Coordinate with the consultant on the final quantitative data collection • Load the quantitative data on the mobile phones • Plan and train enumerators on the RAMP technology at Garowe (Puntland), Hargeisa (Somaliland) and possibly two locations in South/Central Somalia • Supervise and monitor quantitative data collection and screening • Analyse the quantitative data and provide technical reporting on that
5.	SRCS National Health Officers	• Provide field coordination of the entire exercise • Supervise the data collection exercise, both quantitative and qualitative by SRCS staff and volunteers • Provide translation support to the expats
6.	SRCS Volunteer Enumerators	• Participate in the enumerators training • Participate in the field testing of the data gathering tools • Participate in actual data gathering exercise

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Required qualifications, experience and competencies

The consultant should have the following qualifications, skills and experience:

- University degree in Public Health, relevant Health Specialization, Social Science or equivalent qualification
- Extensive experience in conducting health surveys and knowledgeable in sampling methodologies
- Experience in community based development approaches / participatory methods.
- Excellent communication and reporting skills
- Team Leader experience.
- Computer literate with skills on data analysis software EPINFO, or SPSS.
- Good command of both written and spoken English.
- Familiarity with global technical issues in public health in post conflict situations.
- Familiarity, ability and willingness to travel within Somalia and under armed escort.
- Knowledge and experience with the Red Cross/Red Crescent Movement.

Remuneration and terms of payment

The consultant will be paid in accordance with the IFRC standard contract rates applicable for external consultants. Standard IFRC procedures for hiring external consultants will apply.

The payment schedules will be as follows:

- 25% upon signing the contract
- 50% after submission of first draft report
- 25% after submission of final report satisfactory to SRCS/IFRC

Notes

- *The consultant will be contracted by the IFRC and the standard contractual terms will apply.*

- *Agreed travel expenses will be reimbursed at cost in accordance with in the IFRC's relevant regulations.*
- *Somalia Country Delegation, the IFRC, 20 September 2013.*

Annex 1: Location and details of MCH/OPDs to be included in baseline study (but subject to changes).

Zone	Branch	Data collection by NS	Data collection by Consultant	Remarks
Somaliland	Las Anod	Yaagori		
	Erigavo	Eilafweyn		
	Burao	Odwein		
	Berbera		Sheikh	
	Hargeisa		Allaybaday	
	Boroma		Dilla	
Puntland	Garowe	Eyl		
		Godobjiran		
			Kalabeyr	
			Jallam	
	Galkayo	Galkayo South		
		Jerriban		
		Goldogob		
		Harfo		
	Bosaso	Iskushuban		
			Waciye	
South/Central	Mogadishu (Banadir)	Afgoye		
		Balad		
	Beletweyn (Hiran)	Beletweyn		
	Dhusamareb (Galgaduud)	Dhusamareb Galinsoor Abduwak Adado		
	Baidoa	Isha		
		Hulwadaag		
	Kismayo (Lower Juba)	Farjano		

Submission of applications:

Applications should be submitted by email to hr.eastafrica@ifrc.org; to be received not later than **Monday, 30th September 2013.**

Kindly note that due to large volumes of applications received:

1. Only e-mail applications will be accepted
2. Received applications will be short-listed on an on-gong basis
3. Only short listed candidates will be contacted

Annex 2: Household and Child Questionnaires

Somali Red Crescent Society – Integrated Health Care Programme
Baseline Survey –Household Questionnaire

Somaliland = 1		**Puntland = 2**		**South Central = 3**	
Location	**Code**	**Location**	**Code**	**Location**	**Code**
Erigavo	1.1	Eyl/Baday	2.1	Afgoye	3.1
Adadley	1.2	Godobjiran	2.2	Balad	3.2
Kenya	1.3	Baadweyn	2.3	Beletweyn	3.3
Sheikh	1.4	Jerriban	2.4	Dhusamareb	3.4
Daami	1.5	Kalabeyr	2.5	Galinsoor	3.5
Dilla	1.6	Jallam	2.6	Abduwak	3.6
		Goldogob	2.7	Isha	3.7
		Harfo	2.8	Hulwadaag	3.8
		Qarhis	2.9	Farjano	3.9
		Ufewyn	2.10	Adado	3.10

Region	
SRCS Branch locality name	
SRCS Clinic or community area name	
Name of head of household	
Household distance from SRCS clinic	

Result _____ (1=complete; 2= partially complete; 3=refused to take the survey)
Natiijo_____ (1=dhamaystiran; 2=aan dhamaystirnayn; 3=diiday inuu ka qaybqaato sahaminta

Date of Interview ____/____/___ (Taariikhda la waraysiga)

Name of enumerator: …… (Magaca waraystaha)

INFORMED CONSENT

Hello. My name is _____, and I a volunteer/worker with (**Somali Red Crescent Society**). We are conducting a survey and would appreciate your participation. I would like to ask you some questions about health. This information will help (**Somali Red Crescent Society**) to plan its integrated health care services and assess whether it is meeting its goals to improve community health. The survey usually takes __xx_____ minutes to complete. Whatever information you provide will be kept strictly confidential.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey since your views are important.

Will you participate in this survey?

Respondent agrees to be interviewed { }
Respondent doesn't Agree to be interviewed *{ }*

Signature of interviewer: _____

*Date:*_____

	Question and Filters	Coding Categories	
Demographic and Household Background Information			
1	Gender of respondent (Jinsiga Jawaab bixiyaha)	Male (Lab)……1 Female (Dhedig)……..2	
2	Marital status	Married (Xaas)……1 Divorced (La furay)……2 Widowed (Laga dintay)…… .3 Single (Doob/Ganshaanti)……..4	
3	Age of respondent (Da'ada Jawaab bixiyaha)	15-29……1 30-39…… 2 40-49……3 > 50 years……4	
4	Education status of respondent (Heerka waxbarasho ee Jawaab bixiyaha)	Informal Education …… ……..1 *(Malaha waxbarashada aas-aasiga ah*)……..2 Quaranic/madrassa school……..3 Basic Primary Education ……..4 (*Waxbarashada dugsiga hoose /dhexe)*……5 Secondary……6 *(Dugsiga sare*)……..7 Above Secondary …….. ……..8 (*Kasareysa dugsiga sare*)……..9	
5	Household size (compound) (Qiyaasta guriga)	Total number of people in household…… (Wadarta dadka ku nool guriga)	
6	How many children are there in this household/compound? (Imisa qof ayaa ku nool guriga	Only one (Qof keliya)……..1 Two (Laba qof)……2 Three (Saddex qof)……3 Four (Afar qof)……..4 More than 4 (In ka badan afar qof)……5	
7	How long have you lived in this area? (Muddo intee leg ayaad halkan noolayd)	Less than 1 year (Muddo ka yar 1 sanno)……1 1-4 years (1-4 sanno)……..2 More than 4 years (In kabadan 4 sanno)……..3	

8	Household's **main** source of income? *(Isha dakhliga qoyska*?)	Sale of Animals or animal products……1 (*Iibinta xoolaha ama wax soosarka xoolaha*)……1 Crop sales/Farming…….....2 (*Iibinta dalagga beeraha/ beeraleyda)……..2* Casual Labour……3 (*Xamaalatada/muruqmaalka*)……..3 Small business ……..…….....4 (*Ganacsiga yaryar*)……4 Salaried/wage Employment…..……5 (*Mushahaariga bil'laha mise malinlaha*)……5 Remittances from relatives/Diaspora……..6 *(Lacag looga soodiro dibadaha*)……6 Others(specify)_____ *Kuwa kale*(*sheeg*)_____	
9	Where do you get your food from? (Halkee/Xaggee ayaan ka heshaa cuntadaada)	Animal products from own production…….....1 *(Dhaqashada xoolaha iyo wax soosarkooda)…….*1 Household crop production ……..2 *(Beeraha iyo wax soosarkooda)……..…….....*2 Purchases……..…….....3 *(Soo iibsashada)……*3 Remittance/Gifts…….....4 (*Lacahaga dibada lagasoodiro/hadiyad……4* Food assistance ……..……5 *(Raashinka caawimadka)……..*5 Others(specify)_____ 6 *(Kuwa-kale (sheeg)*_____ 6	

10	What have been the main health concerns in your family in the last six months? (Respondent to identify five key health concerns) (Xannuunadee ayaa ku dhacay/asiibay qoyskaaga lixdii bilood ee ugu dambeeyey)	Diarrhoeal disease (shuban)……1 Skin diseases (cudurada maqaarka)……2 Eye problems (Indho xannuun)……3 Malaria (Kaneeco/Duumo)……4 Maternal health (Xunuunada hooyada)……5 Infant/child (xanuunada carruurta ku dhaca)…..6 Intestinal worms (guuryaan calooleed)……7 Malnutrition (nafaqo darro)……8 Brucellosis (Burusela)…… 9 Respiratory infections……10 (xanuunada sanbaba/feeraha ku dhaca) HIV/AIDS (Aydhis)……11 Tuberculosis (Qaaxo/tiibijo)…… 12 Injury (Dhaawac)……13 Mental health (xannuunada dhimirka)……14 Fever (xumad/qandho)……15 Other (specify) Kuwa kale (sheeg)…… 16	
Questions relating to evidence of positive knowledge and attitudes on the benefits of ANC/PNC			
11	Name the reasons why pregnant women go for ANC check-ups. (circle answers provided) (Magacow sababaha dumarka uurka leh u booqdaan xarumaha caafimaadka) Goobaab jawaabaha lagu siiyey	To get immunization……1 (waa inay ka helaan talaal) To check the mother's health……..2 (waa hooyada caafimaadkeeda la eego) In To check baby's health……3 (waa in caafimaadka ilmaha la eego) To get vitamins or micronutrients……4 (waa in laga helo faytamiino iyo nafaqeeyaal) To get clean delivery kit……5 (waa laga helo dhalmo kaab) To get counseling……6 (waa in laga helo talo bixin) Other (specify)……7 Kuwo kale (sheeg)	
12	How often do you think pregnant women are supposed to go for an ANC check-up with a qualified doctor, nurse or midwife? (Imisa jeer ayey tahay hooyada uurka leh inay booqato dhakhtar, kalkaaliye sare ama umuliso siday u ogaato xaaladda uurkeeda mudada ay uurka leedahay)	1 time (1 mar)……1 2 times (2 jeer)……2 3 times (3 jeer),……3 4 or more times (4 jeer iyo ka badan)……4 Don't know (ma garanayo)……5	
13	During your/your wife's pregnancy with your last born child did you seek antenatal care? *(Xiligaad uurkiisa lahayd ilmahaagii kuugu dambeeyey, ma booqatay xarumaha caafimaadka ee uureyda?)*	Yes……1 *(Haa)*……1 No…… .2 *(Maya)*……2	

14	Where did you/she go for antenatal care? Goobtee/Xaruntee ayaad booqatay si aad xaaladda uurkaaga u ogaato?	SRCS facility (xarunta bisha cas)……1 MOH (xarunta wasaaradda caafimaadka)……2 Private (xarun barayfat ah/shakhsi leeyahay).....3 Traditional Birth Attendant (umuliso dhaqameed)..4 Other (Specify) (xarun kale (magacow)……..5 Nowhere (ma booqan).....6	
15	How many antenatal visits did you/your wife have during your/your wife's pregnancy with your last born child? *(Imisa jeer ayaad booqatey xarumaha caafimaadka xiliga aad uurka ilmahaagii/cunugaa kuugu dambeeyey aad lahayd)*	Number of Visits ☐☐ (*Tirada booqashada*) DON'T KNOW……1 *(Magaranaayo)*……1	
16	Where did you/your wife deliver your last child? (*Xagee ku umushey ilmahaagii/cunugaagii kuugu dambeeyey?)*	SRCS Health Facility……1 (*Xarunta caafimadka bisha cas*)//……1 Other facility……2 (*Xarunta caafimaad oo kale*)……2 Home……3 *(Xaafadda/guriga)*……3 Other (specify) _____ 4 Wax kale(cadee) _____ ____4	
17	Who assisted with the delivery of your last child [CHILDS NAME]? (*Yaa ku caawiyey markaad umulaysay ilmahaagii/cunugaagii kuugu dambeeyey?)*	Traditional birth attendant……1 (umuliso dhaqameed) Skilled health worker ……2 *(e.g. nurse, midwife, doctor)* (qof xirfad caafimaad leh sida kalkaaliso sare, umuliso ama dhakhtar) An unskilled relative ……3 (qof qoyska ka tirsan oo aan shaqaalaha caafimaadka ahayn) No-one ……4 (cidna) Don't know……5 (magaranayo)	
18	Have you ever lost a child? (*Wax caruura oo kaa geeriyooday majiraan?)*	Yes……1 *(Haa)*……1 No…… .2 *(Maya)*……2	If no, skip to 20
19	If yes, what was the age of the child? (*Imisa jir buu ahaa cunuga/ilmaha kaa eeriyoday*)	Miscarriage (dhicis buu ahaa)…… 1 Less than 1 year (1 sanno ayuu ka yaraa)……2 1-5 years (1-5 sanno ayuu ahaa)……3 More than 5 years (5 sanno ayuu ka weynaa)……4 Don't know (magaranayo)……5	

20	How soon after the birth of a child should you go for a PNC check-up? (Xiligee ayey tahay inaad booqato xarun caafimaad umusha ka dib?	Before 6 weeks……..1 (6 Usbuuc ka hor) After 6 weeks……2 (6 Usbuuc ka dib) Six months exactly……4 Don't know ……3 (Magaranayo)	
Questions relating to expressing positive views on birth spacing			
21	Have you heard of birth spacing? (Ma maqashay la dheeraynta ilmaha/carruunta?	Yes (Haa)……..1 No (Maya).……2 Don't know……3	If no, skip to 23
22	If yes, name the birth spacing methods you know or have heard of? (Haddii ay jawaabtu haa tahay, magacow hababka kala dheereynta ilmaha/carruurta ee aad taqaan ama aad maqashay)	Intra uterine contraceptive device……..1 (Kuwa ilmo galeenka/makaanka lagu xidho/xiro) Pill……2 (Kiniin/Kiniini) Injectable……3 (Irbado) Implant……4 (Kuwo jirka/Jidhka la geliyo) Male condom……5 (Cinjarka raga) Female condom……6 (Cinjirka dumarka) Lactational amenorrhea method (LAM)……7 (Naasnuujinta) Periodic abstinence/rhythm method……8 (Ka haayirid/jirid) Withdrawal…… 9 (Caslin) Other (Wax kale)…… 10	
23	(IF RESPONDENT IS FEMALE 15), Are you currently doing something or using any method to delay or avoid getting pregnant? (HADDII JAWAAB BIXIYUHU YAHAY DHEDIG 15 JIR AH), weydii: hadda miyaad isticmaashaa waxaad iskaga ilaaliso inaad uur qaado?	Yes (Haa)……1 No (Maya)……2	

24	If yes which method are you using? Haddii ay haa tahay, habkee ayaad isticmaashaa?	Inter uterine contraceptive device……..1 (Kuwa ilmo galeenka/makaanka lagu xidho/xiro) Pill……2 (Kiniin/Kiniini) Injectable……3 (Irbado) Implant……4 (Kuwo jirka/Jidhka la geliyo) Male condom……..5 (Cinjarka raga) Female condom……6 (Cinjirka dumarka) Lactational amenorrhea method (LAM)……7 (Naasnuujinta) Periodic abstinence/rhythm method……8 (Ka haayirid/jirid) Withdrawal…… 9 (Caslin) Other (Wax kale)…… 10	
25	If no, would you consider using birth spacing? (Haddii ay maya tahay Ma laga yaabaa inaad isticmaasho hababka la dheeraynta carruurta?	Yes (Haa)……1 No (Maya)……2 Don't know (Magaranayo)……3	
Questions relating to childhood diseases & breastfeeding practices			
26	How many children (5 and under) are in this household? (Imisa carruur ah oo 5 sanno ah ama yar ayaa ku nool gurigan)	Only one (cunug kaliya)……1 Two (Laba)……2 Three (Saddex)……3 Four (Afar)……4 Five (Shan)……5 More than five (Shan kabadan)……6	
27	Has [CHILDS NAME] ever received a Vitamin A dose (Waligii cunuga/ilmuha ma la siiyey Faytamin A?)	YES……1 *(Haa)*……1 No……2 (Maya)……2 Don't know……3 (Magaranayo)……3	
28	Name the childhood diseases that can be prevented through immunisation / vaccination ? (Magacow cudurada laga hortagi karo talaal)	Tuberculosis (Qaaxo/Tiibijo)……1 Whooping cough/Diphtheria (Kix/Xiiqdheer)……2 Pertussis (Gawracato)……3 Tetanus (Kojiye)……4 Polio (Dabayl)……5 Measles (Jadeeco)……6 Don't know (Magaranayo)……7	

29	Did [CHILDS NAME] ever receive an injection in the arm to prevent measles? (*Cunugaaga maqaatey talaalka garabka ee Jadeecada*?)	YES……..1 (*Haa)*……..1 NO……2 (Maya)……2 N/A……..3 Loogumatalagalin……..3 Don't know……..4 Ma garanaayo……4	
30	<u>Vaccination schedule up to date?</u>	YES……1 (*Haa)*……1 NO……2 *(Maya)*……..2	
30	Do you have a card or child health booklet for [CHILDS NAME] *(Kaarka caafimaadka cunugaaga ma haysaa*?)	YES……..1 (*Haa)*…… .1 No……2 *(Maya)*……2 Don't know……..3 (Ma garanaayo)……..3	If no, skip to 31
31	IF YES: May I see it please? *(Haa haddii ay tahay, ma arki karaa adoo raali ah?)*	<u>Card Seen?</u> *(Kaarka ma aragtey?* YES……1 (*Haa)*……1 NO……2 *(Maya)*……..2 Refused to show the card……3 (wuu diiday inuu tuso karaka)……3	

32 **List all living children under 5 years with details and immunisation records**
(tax dhammaan carruurta 5 sanno ka yar iyo tallaalka ay qaateen ama la siiyey)

	Vaccinations Given as verified by book / card / scar (BCG only)									
	Tallaalka la siiyey sida ku cad karaka ama calaamadda tallaalka Qaaxada						**DPT before April 2013/ Pentavalent Since April 2013 (Tallaalka DPT ka hor bisha Abriil ama Tallaalka Benta falent ka dib bisha Abriil)**			
	Age (years / months) Da'da	Male=1 Female = 2 Lab/Dhedig	BCG Yes=3 No=4	Polio1 Yes=5 No=6	Polio2 Yes=7 No=8	Polio3 Yes=9 No=10	DPT1 Yes=11 No=12	DPT2 Yes=13 No=14	DPT3 Yes=15 No=16	Measles Yes=17 No=18
Child 1										
Child 2										
Child 3										
Child 4										
Child 5										
Verification of the vaccines by: (Caddeynta talaalka)										
Mother report										
By Card										

33 Name the signs of malnutrition in a child that would require referral to a health facility or nutrition centre.
(Magacow calaamadaha lagu garto ilmo/cunug nafaqo darro hayso oo ay tahay in loo gudbiyo xarun caafimaad ama xarunta nafaynta carruurta)

Underweight (ilmo miisaankiisu hooseeyo)…….1
No fat on the body, ribs are visible……2
(Baruur jidhku ma leh ama feedha ayaa muuqda)
Loose skin around the buttocks……3
(Maqaarka badhida hareeraheeda ayaa jilicsan)
Easily irritated……..4
(Wuu cabanyaa)
Unusual appetite……..5
(Oon xumo ama abitayt xumo)
Frequent illness……6
(Xannuun joogto ah oo soo noqnoqda)
Severe swelling (oedema) on both limbs or both arms……7
(Barar labada lugood ama gacmood ka muuqda)
Swollen 'moon' face……8
(Waji bararsan)
Damaged skin or different skin colour……..9
(Maqaarka oo badalma oo midabkiisu is badalo)
Hair colour changes (yellow or reddish)……10
(Midabka timaha oo isbedela)
Hair becomes dry, can easily be pulled out in patches……11
(Timaha oo qalala oo si fududna u go'a)
Don't know (magaranayo)……12

34	Have any of your children received therapeutic feeding from SRCS? (Carruurtaada ma laga siiyey cuntada nafaynta xarunta bisha cas?	Yes (Haa)……1 No (Maya)……..2	
35	Has your last born chid ever received any treatment for worms in last 1 year Cunugaaga ugu dambeeyey ee aad dhashay, ma la siiyey daawada gooryaan dilaha sanadkan ugu dambeeyey	Yes (Haa)……1 No (Maya)……2	
36	If yes how many times has e received the treatment Haddii ay haa tahay, imisa jeer ayaa la siiyey daawada gooryaanka cunugaaga?	Once (Mar kaliya)……1 Twice (Laba jeer)……2 Don't know (Magaranayo)……3	
37	Where did you get the treatment from (Xaggeed daawadaas ka heshay)	SRCS clinic (xarunta bisha cas)……1 Other health facility (xarun caafimaad oo kale)……2 Private pharmacy (farmasi shakhsi leeyahay)……3 Traditional healer (Qof dawo dhaqameedka wax ku daaweeya)……4 Buy drugs from pharmacy (farmasi ayaa ka iibsaday)..5 Don`t know (Magaranayo)……6	
39	What is the NAME and age in months of your last birth that is still living? Magacii mise bilood ayuu se jire ilmahaaga/cunugaaga ugu dambeeyey ee hadda nool	<1……1 1-2…… 2 3-4……3 5-6……4	
40	Skip questions if child is 6-59 months. If child is 0-5 months, then ask: Are you still breastfeeding your last child born (NAME)? Ka bood su'aalahan haddii ilmuha/cunuga da'diisu tahay 6-59 bilood. Haddiise ay da'diisu tahay 0-5 bilood, weydii: Wali naaska miyaad nuujisaa ilmahaaga ugu dambeeyey (MAGACA)?	YES……1 *(Haa)*……..1 No……2 (Maya)……2	

42	Did (NAME) drink anything from a bottle with a nipple yesterday or last night? Cunugaagu shalay ama habeen hore wax uun ma ka cabay dhalo ama masaasad mu juruc leh?	YES……1 *(Haa)*……..1 No……..2 (Maya)……2	
45	How long did you / will you breast feed your youngest child? Muddo intee le'eg ayaad ilmahaaga naaska siisay ama aad siindoontaa mustaqbalka?		
43	How long did you/your wife wait before breastfeeding your child after delivery? *(Waqti intee la'eg ayaad sugtey inta aadan naasnuujin cunugaaga dhalashada ka dib?)*	Immediately……1 (*Isla markiba)*……1 Less than one hour……2 *(Hal saca wax kayar)*……2 Less than three hours……..3 (*Sadex sacadood wax ka yar*)……3 Less than a day……4 *(Maalin wax ka yar)*……..4 Less than a week……..5 *(Asbuuc wax ka yar)*……..*5* Never breastfed……6 *(Maba naasnuujin)*……*6* Other……..7 Wax kale(cadeey)……7 Don't know……8	
38	Explain exclusive breast feeding to respondent then ask; did you exclusively breastfeed your last born child? (Usharax ka la waraystaha waxay tahay naasnuujinta joogtada ahi, ka dibna weydii: ilmahaagii ugu dambeeyey si joogta ah ma u nuujisay naaska?	YES……1 *(Haa)*……..1 No……..2 (Maya)……2	
46	Why didn't you breastfeed exclusively for six months? *(Maxaa u naasnuujin waydey lix bilood)*	Relative made decision……..1 (Ehelkayga ayaa go'aan ku gaadhay) Mother unwell…… 2 (Hooyada ayaa xunuunsatay) Insufficient milk……3 (Caano ku filan ma leh) Don't know…… ….4 (Maranayo)	

47	At what age should you introduce foods <u>other than breast milk</u> to a baby? *(Goormaad kubilawdey inaad siiso cunugaaga cunooyinka kale aan aheyn caanaha naaska*?)	After 1 year ……1 *(Sanad kadib)*……1 After 6 months ……..2 *(Lix bilood kadib)*……2 Between 4 – 5 months ……..3 *(Inta udhaysa 4-5 bilood)……3* Within first 3 months ……..4 *(Sadexdii bilood ugu horeysey gudahooda)…..*4 Within 2 weeks ……5 *(Labo asbuuc guda hooda)*…….5 Other (specify ……6 *Wax kale(cadee*) Don't know ……7 *(Magaranaayo)……..7*	
44	In the first 3 days after birth did you give your youngest child anything other than breast milk to drink? Saddexdii maalmood ee ugu horeysay dhalashada ka dib, ma siisay cunugaaga ugu yar wax aan caanaha naaska ahayn?	Yes (Haa)……1 No (Maya)……2 Don't know (Magaranayo)……3	
41	Now I would like to ask you about liquids or foods that (NAME) had yesterday during the day or at night. Did your child receive any of the following—plain water, juice or juice drinks, clear broth; milk such as tinned, powered, or fresh animal milk; infant formula, other liquids, yogurt, any solid, semi-solid, or soft foods)? Hadda waxaan jeclahay inaan ku weydiiyo arrimo ku saabsan nooca cuntada ama cabitaanka ee aad cuntay ama cabtay shalay, maalinimadii ama habeenimadii. Cunugaagu ma helay ama ma qaatay biyo caadiya oo aan waxba lagu darin, sharaab/cabitaan, maraq, caano sida kuwa qasacadaha, xoolaha, ama cabitaano kale, cunto adag ama mid jilicsan ama isku jir ah?	YES……1 *(Haa)*……..1 No……..2 (Maya)……2	

		Less than 6 months (In ka yar 6 bilood)……1 6 to 11 months (6 ilaa 11 bilood) ……2 12 to 18 months (12 ilaa 18 bilood) ……..3 19 to 24 months (19 ilaa 24 bilood)……..4	
48	What would be the reasons that you would take your new born to a clinic? (Waa maxay sababa ay tahay inaad ilmahaaga/cunugaaga u geyso goob caafimaad)	Poor suckling or feeding……1 (haddii uu jiqiwaayo and waxba cuniwaayo) Fast/difficult breathing……2 (neeftuur saayida/neefsiga oo adkaaga) Baby feels cold……3 (ilmaha/cunuga oo qarqaryo/qadhqadhyo dareema) Baby too small/too early…….. .4 (ilmaha oon koreyn) Yellow palms, soles or eyes……5 (gacmaha iyo indhaha ilmaha oo huruudnoqda) Swollen abdomen……6 (caloosha oo dibirta ama barbarta) Unconsciousness……7 (miyir doorsoon) Pus or redness of the umbilical stump, eyes or skin……8 (malax iyo caabuq ku dhaca xundhurta iyo indhaha)	
Communicable Diseases			

49	Name the symptoms of TB that you know of. (Magacow calaamadaha Qaaxada/Tiibijada)	Cough that lasts a long time (more than 3 weeks)……1 (qufac muddo dheer socda – in ka badan 3 usbuuc) Coughing up blood……..2 (qofkoo dhiig qufaca) Fever……..3 (xumad/qandho Pain in the chest……..4 (laab xannuun/qaarjeex) Night sweats……5 (dhidid habeenkii yimaada) Rapid weight loss……6 (miisaanka oo deg deg u luma ama u dhaca) Loss of appetite……..7 (abiteytka oo qofka ka luma/xumaada) Feeling tired……..8 (daal/tabcaanimo)	
50	What are the ways that you know of that HIV/AIDS can be transmitted? (Sidee ayuu aydhisku ku fidaa ama lagu kala qaadaa?)	Unprotected sexual intercourse with an infected person……1 (galmo lala sameeyo qof qaba xannuuunka) Shaking hands with an infected person……2 (ayadoo la gacan qaado qof qaba xannuunka) Sharing needles with an infected person……..3 (iyadoo lala wadaago irbado qof xannuunka qaba) Mother to child transmission……4 (hooyadu ilmaheega ayey u gudbin kartaa) Contact with infected blood……5 (ayadoo la taabto dhiig aydhis qaba) Don't know……..6 (magaranayo)	
51	What are the ways in which HIV/AIDS can be prevented? (Sidee ayaa aydhiska lagaga hortagi karaa?)	Abstinence from sex……..1 (iyadoo qofku kafogaado galmo) Being faithful to a partner……..2 (waa inuu qofku koobnaadaa lamaanihiisa) Using a condom……..3 (isticmaalka jinjirka) Sterilizing surgical tools……4 (qalabka qaliinka oo la karkariyo) Don't know……5 (magaranayo)	

52	How do you prevent malaria in your home environment? (Sidee ayaad kaneecada/dhilmaanyada iskaga ilaalin kartaa markaad gurigaa joogto?	Mosquito nets……1 (maro kaneeco/sinsiyeeri) Mosquito repellant……2 (daawada kaneecada/dhilmaayada erida) Clear bushes around homestead……3 (indooga laga jaro guriga iyo agaarkiisa) Drain stagnant water……4 (biyaha oo laga qalajiyo guriga agaarkiisa) Cover the body with long clothing……..5 (dhar dhaadheer xidho) Don't know……..6 (magaranayo)	
		WASH	
53	When do you think that people should wash their hands? (Xiligee ayaa tahay inay dadku maydhaan gacmahooda)	After visiting the toilet……..1 (musqusha/suuliga ka dib) Before preparing food……2 (cunto diyaarinta ka hor) After cleaning child's bottom……..3 (ka dib marka ilmaha laga saxarada la tiro) Before eating food……4 (cuntada intaan la cunin ka hor) Before breastfeeding…… 5 (Naasnuujinta ka hor) Other……..6 (mar kale) Don't know……...7 (magaranayo)	
54	What do you use to clean your hands? (Maxaad isticmaashaa markaad maydhayso/dhaqayso gacmahaaga?)	Water only……1 (Biyo kaliya) Water and soap or detergent……2 (Biyo iyo saabuun) Ash……3 (Dambas) Sand……..4 (Ciid) Nothing……5 Waxba)	

55	What is your usual source of water for drinking? (xaggeed biyaha aad cabaysid ka heshaa?)	Traditional well……1 (ceel gacmood) Harvested rain water……..2 (biyaha jiingadda) Tap water……..3 (Biyaha qasabadda/rubineetada) Borehole……4 (biyaha riiga) Rivers and springs……..5 (biyaha webiga ama kuwa dur-durka) Sand dams……6 (biyaha baliyada/waraha) Berked……7 (biyaha berkedaha) Other……..8 (qaar kale (cadee)	
56	Do you or any of your family members do anything to treat your drinking water? (Adiga iyo ehelkaagu ma daweysaan biyaha aad cabaysaan?)	Yes (Haa)……1 No (Maya)……..2 Don't know (magaranayo)……3	If no, skip to 47
57	If yes, how? (Haddii ay haa tahay, sidee ayaad u daweysaan)	Boiling……..1 (waan karkariyaa) Chlorination……..2 (koloriin ayaa ku daraa) Ceramic water filter ……3 (Biyo miire ayaan isticmaalaa) Other filter/sieve……..4 (waan kala fadhiisiyaa) Other……..5 (wax kale – cadee) Don't know……..6 (magaranayo)	
58	Where do you and members of your family go to the toilet? (Xagee adiga iyo xubnaha qoyskaagu u xaajo tagtaan)	Outside/bush……1 (bannaanka) Near river…… 2 (webiga ama dooxa) Communal latrine……3 (musqul/suuliga bulshada ka dhexeeya) Household latrine……4 (suuliga/musqusha guriyaga) Other……..5 (wax kale – caddee)	

59	In your opinion, what are the reasons people might use a latrine? (Fikir kaaga, dadku maxay u isticmaalaan suuliga/musqusha)	Privacy……..1 (usturaad awgeed) To prevent disease……..2 (si ay cudurada uga hortagaa) Clean environment……..3 (si loo helo deegaan nadiifa) Other……..4 (wax kale – caddee) Don't know……5 (magaranayo)	
60	What happens or where do you put children's faeces? (Xageed ku asturtaa saxarada carruurtaada?	On the ground / outside ……1 (bannaanka ayaan ku tuuraa) Put in latrine ……..2 (suuliga/musqusha ayaa ku ridaa) In potty ……..3 (boo ama baydhman) Other……..4 (wax kale – caddee) Don't know……5 (magaranayo)	
61	What do you think are the causes of diarrhoea? (Maxaad u malaynaysaa inay sababaan shubanka)	Germs and diseases……1 (Jeermis iyo cudur) Dirty dishes and utensils……2 (weel aan nadiif ahayn) Teething……3 (iskaha oo soo baxaya awgeed) Contaminated water……4 (biyo wasakhoobay ama aan nadiif ahayn) Contaminated food……..5 (cunto wasakhowday oon aan nadiif ahayn) Don't know……6 (magaranayo)	

62	What do you think are the ways of preventing diarrhoea? (Sidee ayey kula tahay in lagaga hortagi karo shubanka?)	Using a latrine/disposal of faeces ……1 (in la asturo saxarada oo la isticmaalo musqul/suuli) Washing hands with water and soap ……..2 (in gacmaha lagu maydho/dhaqo biyo iyo saabuun) Eating food while it is hot ……..3 (in cunno cuntada inta ay kulushahay) Drinking clean water ……..4 (in la cabo biyo nadiif ah ama daaweysan) Other……..5 (wax kale – caddee) Don't know……6 (magaranayo)	
63	What did you do last time your child or a family member had diarrhoea? (Markii u dambaysay ee ilmahaagu/canugaagu xannuunsaday maxaad samaysay/fashay?)	Took them to nearest health facility ……1 (waxaan u qaaday xaruntii caafimaad ee iigu dhawayd) Gave homemade sugar-salt solution ……..2 (waxaan siiyey biyo sonkor iyo milix/cusbo leh) Used traditional medicine……..3 (waxaan isticmaalay daawo dhaqameed) Gave ORS sachet……..4 (waxaan siiyey milanka shifo) Stopped giving breast-milk…….5 (waxaan ka joojiyey inaan siiyo caanaha naaska) Gave more fluid based food ……6 (waxaan siiyey cunto jilicsan) Other……..7 (wax kale – caddee) Don't know……8 (magaranayo)	
Health services			

64	What can prevent someone from visiting the clinic? (Waa maxay sababa ay u iman/u soo booqan layihiin dadka xarunta caafimaadka?)	Distance……..1 (way ka fog tahay) Cost……..2 (lacagta la qaado ayaa qaaliya) Permission not given from husband or other family member……..3 (ogolaansho kama haystaan raggooda iyo ehelkooda Midna) Workload……..4 (shaqadaa ku badan oo shaqaaluhu uma haleelayan) Insecurity……..5 (nabadgelyo xumo) Other (specify)..…… .6 (wax kale – caddee)	
65	Where did you last go for treatment when you or your family member was sick or needed other medical services? (Xageed tagtay ama aad markii aad xannuunsatay ama aad geysay markii qof qoyskaagu xannuusaday	SRCS clinic……..1 (xarunta bisha cas) Other health facility……..2 (xarun kale) Primate pharmacy……..3 (farmasii barayfat ah) Traditional healer/birth attendant……..4 (dadka dhaqan iyo dhirta wax ku daaweeya) Buy drugs from pharmacy……..5 (dawaan ka soo iibsaday farmasii) Outreach service……..6 (kooxa caafimaadka ee wareega ayaa i daaweeyey) Nowhere……7 (meelna)	
66	If at SRCS clinic, were you satisfied with the services provided? (haddii aad tagtay ama aad iska soo daaweysay xarunta bisha cas, ma ku qanacday sidii la guugu shaqeeyey?)	Yes (haa)……..1 No (maya)……..2	If no, skip to 57

67	If yes, why? (Haddii ay haa tahay, waayo?)	Free services……1 (bilaash ayaa laygu shaqeeyey) Clinic near my home……2 (xaruntu gurigayga ayey u dhawday) Qualified staff……3 (shaqaale xirfad leh ayaa ii shaqeeyey) Friendly staff……4 (shaqaale soo dhaweyn leh ayaa jooga) Short waiting period……5 (si dhakhso ah ayaa laygu adeegay) Availability of drugs……5 (daawo ayaa laga helaa) Availability of lab facilities……6 (shaybaar ayaa laga helaa? Other……7 (wax kale – caddee)	
68	If no, why? (Haddii ay maya tahay, waayo?)	Cost of services……1 (Qiimaha lagaa qaadayo ayaa qaaliya) Distance……2 (way fog tahay) Lack of qualified staff……3 (shaqaale xirfad lihi ma joogaan) Lack of laboratory services……4 (shaybaar ma laha) Not open or staff absent…… 5 (ma furna ama shaqaalaha ayaa maqan) Lack of drugs……6 (daawo ma taal) Negative staff attitudes……7 (hab dhaqanka shaqaaluhu ma fiicna) Long waiting period……8 (muddo dheer ayaa la sugayaa in laguu adeego) Other……9 (wax kale – caddee)	

69	When was your household last visited by a Red Crescent volunteer? (Goormay ahayd markii ugu horeysay ee mutadawaca bisha cas ahi gurigaaga soo booqdo?)	Less than a month ago……..1 (muddo bil ka yar ka hor) Between 1 month & 3 months ago……2 (muddo laga joogo bil ilaa 3 bilood) Between 3 months & 12 months ago……3 (muddo laga joogo 3 bilood ilaa 12 bilood) Don't know……4 (magaranayo) Not visited by Bisja cas volunteer	
70	On what topic have you received any health education/promotion message? (Fariintee ama macluumaadkee ka qaadatay baarujinta caafimaad ee aad ka qayb gashay?)	EPI/vaccination……1 (arrimaha tallaalka) Maternal health……..2 (caafimaadka hooyada) IYCF……..3 (quudinta ilmaha iyo carruurta yar yar) Malaria……..4 (ka hortagga kaneecada/duumada) HIV/AIDS……..5 (Ka hortagga aydhiska) Water and sanitation……6 (biyaha iyo fayodhowrka) Hygiene……7 (nadaafadda) Other……..8 (wax kale – caddee)	

71	Who delivered the health education/promotion message? (Ayaad ka heshay fariimaha baraarujinta caafimaadka? .	SRCS Health worker……1 (shaqaalaha caafimaadka ee bisha cas) Government health worker ……..2 (shaqaalaha caafimaadka dawladda) SRCS Volunteer……3 (mutadawiciinta bisha cas) Radio……4 (Radiyowga) Religious leaders……5 (culimada diinta) CHW……6 (daryeelaha caafimaadka) Outreach staff……7 (kooxa caafimaadka ee wareega) Health committee members……8 (gudida caafimaadka) Family member……9 (qof ehelkayga ka tirsan) Friend or neighbour……10 (saaxiibkay ama jaarkayga) Other……11 (wax kale – caddee) No health education	

Baseline Survey – Child Questionnaire

Child Questions about EPI, vitamin A, and deworming?		
1.	Cluster ID	
2.	Household ID	
List the last 3 living children under 5 years with details and immunisation records (tax 3 ugu yar oo nool 5 sanna ka yar iyo tallaalka ay qaateen ama la siiyey)		
Vaccinations Given as verified by book / card / scar (BCG only) Tallaalka la siiyey sida ku cad karaka ama calaamadda tallaalka Qaaxada		
3.	Child 1 age in months Cunuga koowaad daàdiisa bileed.	

4.	Gender of child 1 (Jinsiga Cunuga 1)	Male (Lab)……1 Female (Dhedig)……..2
5.	Do you have a card or child health booklet for [CHILDS NAME] *(Kaarka caafimaadka cunugaaga ma haysaa*?)	YES *(Haa)*……1 No (Maya)……2 Don't know (Magaranayo)……3
6.	Vaccine Received child 1 Talaalkaka uu qaatay cunuga 1	- BCG ☐ - Polio1 ☐ - Polio2 ☐ - Polio3 ☐ - DPT1 ☐ - DPT2 ☐ - DPT3 ☐ - Measles ☐ - Not Vaccinated ☐
7.	Card Verification Child 1 Caddeynta talaalka cunuga 1	- Mother Report - By Card
8.	Has CHILD 1 ever received a Vitamin A dose IN THE LAST 6 MONTHS ? Ilmaha 1 waliigiis ma la siiyey Faytamin A 6dii bilood oo ugu danbaysay	YES……1 *(Haa)*……1 No……2 (Maya)……2 Don't know……3 (Magaranayo)……3
9.	Has CHILD 1 ever received a Vitamin A dose IN THE LAST 12 MONTHS ? Ilmaha 1 ma la siiyey Faytamin A 12dii bilood ee ugu danbaysay.	YES *(Haa)*……1 No (Maya)……2 Don't know (Magaranayo)……3
10.	Has chid 1 ever received any treatment for worms in last 1 year Cunugaaga 1 ma la siiyey daawada gooryaan dilaha sanadkan ugu dambeeyey	Yes (Haa)……1 No (Maya)……..2
11.	If yes how many times has e received the treatment Haddii ay haa tahay, imisa jeer ayaa la siiyey daawada gooryaanka cunugaaga?	Once (Mar kaliya)……1 Twice (Laba jeer)……2 Don't know (Magaranayo)……3
12.	Where did you get the treatment from (Xaggeed daawadaas ka heshay)	SRCS clinic (xarunta bisha cas)……..1 Other health facility (xarun caafimaad oo kale)……..2 Private pharmacy (farmasi shakhsi leeyahay)……..3 Traditional healer (Qof dawo dhaqameedka wax ku daaweeya)……..4 Buy drugs from pharmacy (farmasi ayaa ka iibsaday)..5 Don`t know (Magaranayo)……6
	Child 2	

13.	Child 2 age in months Cunuga 2 daàdiia bileed.	
14.	Gender of Child 2 (Jinsiga Cunuga 2)	Male (Lab).....1 Female (Dhedig).....2
15.	Do you have a card or child health booklet for Child 2 *(Kaarka caafimaadka cunugaaga ma haysaa*?)	YES *(Haa)*.....1 No (Maya).....2 Don't know (Magaranayo).....3
16.	Vaccine Received child 2 Talaalkaka uu qaatay cunuga 2	- BCG - Polio1 - Polio2 - Polio3 - DPT1 - DPT2 - DPT3 - Measles - Not Vaccinated
17.	Card Verification Child 2 Caddeynta talaalka cunuga 2	- Mother Report - By Card
18.	Has CHILD 2 ever received a Vitamin A dose IN THE LAST 6 MONTHS ? Ilmaha 2 waliigiis ma la siiyey Faytamin A 6dii bilood oo ugu danbaysay	YES.....1 *(Haa)*.....1 No.....2 (Maya).....2 Don't know.....3 (Magaranayo).....3
19.	Has CHILD 2 ever received a Vitamin A dose IN THE LAST 12 MONTHS ? Ilmaha 3 ma la siiyey Faytamin A 12dii bilood ee ugu danbaysay.	YES *(Haa)*.....1 No (Maya).....2 Don't know (Magaranayo).....3
20.	Has chid 2 ever received any treatment for worms in last 1 year Cunugaaga 2 ma la siiyey daawada gooryaan dilaha sanadkan ugu dambeeyey	Yes (Haa).....1 No (Maya).....2
21.	If yes how many times has e received the treatment Haddii ay haa tahay, imisa jeer ayaa la siiyey daawada gooryaanka cunugaaga?	Once (Mar kaliya).....1 Twice (Laba jeer).....2 Don't know (Magaranayo).....3
22.	Where did you get the treatment from (Xaggeed daawadaas ka heshay)	SRCS clinic (xarunta bisha cas).....1 Other health facility (xarun caafimaad oo kale).....2 Private pharmacy (farmasi shakhsi leeyahay).....3 Traditional healer (Qof dawo dhaqameedka wax

		ku daaweeya)…….. …..4 Buy drugs from pharmacy (farmasi ayaa ka iibsaday)..5 Don`t know (Magaranayo)……6
Child 3		
23.	Child 3 age in months Cunuga 3 daàdiia bileed.	☐
24.	Gender of Child 3 (Jinsiga Cunuga 3)	Male (Lab)……1 Female (Dhedig)……..2
25.	Do you have a card or child health booklet for Child 3 *(Kaarka caafimaadka cunugaaga ma haysaa*?)	YES *(Haa)*……1 No (Maya)……2 Don't know (Magaranayo)……3
26.	Vaccine Received child 3 Talaalkaka uu qaatay cunuga 3	- BCG ☐ - Polio1 ☐ - Polio2 ☐ - Polio3 ☐ - DPT1 ☐ - DPT2 ☐ - DPT3 ☐ - Measles ☐ - Not Vaccinated ☐
27.	Card Verification Child 3 Caddeynta talaalka cunuga 3	- Mother Report ☐ - By Card
28.	Has CHILD 3 ever received a Vitamin A dose IN THE LAST 6 MONTHS ? Ilmaha 3 waliigiis ma la siiyey Faytamin A 6dii bilood oo ugu danbaysay	YES……1 *(Haa)*……..1 No……..2 (Maya)……2 Don't know……..3 (Magaranayo)……3
29.	Has CHILD 3 ever received a Vitamin A dose IN THE LAST 12 MONTHS ? Ilmaha 3 ma la siiyey Faytamin A 12dii bilood ee ugu danbaysay.	YES *(Haa)*……1 No (Maya)……2 Don't know (Magaranayo)……3
30.	Has child 3 ever received any treatment for worms in last 1 year Cunugaaga 3 ma la siiyey daawada gooryaan dilaha sanadkan ugu dambeeyey	Yes (Haa)……1 No (Maya)……..2

31.	If yes how many times has e received the treatment Haddii ay haa tahay, imisa jeer ayaa la siiyey daawada gooryaanka cunugaaga?	Once (Mar kaliya)……1 Twice (Laba jeer)……2 Don't know (Magaranayo)……3
32.	Where did you get the treatment from (Xaggeed daawadaas ka heshay)	SRCS clinic (xarunta bisha cas)……1 Other health facility (xarun caafimaad oo kale)……2 Private pharmacy (farmasi shakhsi leeyahay)……3 Traditional healer (Qof dawo dhaqameedka wax ku daaweeya)……4 Buy drugs from pharmacy (farmasi ayaa ka iibsaday)..5 Don`t know (Magaranayo)……6

Annex 3: Facility Checklist and FGD Guides

Facility checklist			
Facility infrastructure			
		Yes/no	Comment
Power source? Generator? Any kind of power backup (eg lanterns?)			
Water source?	Water catchment?		
	Tanks?		
	Other?		
Latrine			
Separate latrines/facilities for men and women?			
Sewage			
Disposal of waste?			
Disposal of needles and sharps?			
Is the disposal facility/incinerator protected/locked?			
Is there a waiting area	External		
	Inside		
Private examining room?			
Curtained/screened examining couch			
Private counselling room?			
Glass in windows? Screens?			
Solid floors			
Pharmacy/Drugs cabinet? Lockable?			
Supplies cupboard? Lockable?			
Laboratory facility			
Delivery room?			

Delivery room emergency lighting?			
Equipment and supplies			
- Examining room supplies:			
- working torch with spare batteries?			
- blood pressure cuff or monitor?			
- thermometer			
- stethoscope?			
- ophthalmoscope? otoscope?			
- tongue depressors?			
- other equipment - scalpels, forceps, needles, syringes?			
Lab equipment	Microscope		
	Malaria dip test		
	Anaemia dip test		
	Urine dip test		
Sterilizer			
Delivery room	Bed with stirrups		
	Emergency lighting/lamp		
	Foetal stethoscope		
	Scissors/thread/clips for tying umbilicus		
Cold chain refrigerator	Functioning with temp chart completed		
	Kerosene		
Daily register completed for previous day?			
Daily registers from previous months?			
Patient records? Filed?			
Monthly return forms for sending to MoH			
Drugs			
Metronidazole 250gm			
Abendazole			
Vitamin C 250mg			
Ibrufen 400mg			
Erythromycin Stearate			
Benzyl Benzoate			
Micronutrients			
Methyldopa			
Anti-histamine – cream and tablets			
Erythromycin			
Paracetamol – paediatric syrup			
Phenoxymethylpenicillin			
Tetracycline			
Cotrimoxazole – paediatric dosage			
Amoxicillin – paediatric syrup			
Ampicillin -			

Gentamycin		

Health Providers Interview Guide

Instructions to Interviewer: Please write in answer or circle the number next to the response(s) given.

1. Name of Facility: _____

2. Sex of health worker: M____ F_____

3. Are you from this area? Yes_____ No_____(specify)

4. How long have you worked at this facility?

5. Do you have a job description?

6. What is your training background for your position at the facility?

7. Have you received any additional training from SRCS? If yes, what training have you received?

8. What are the major health issues faced by your patients and the community in general?
9. What services are most commonly used at this health facility by the community? (*Probe: Are there barriers faced by the community in accessing the services?)*

10. What are the days/hours that services are offered?

11. What services are offered at this facility:
    - ANC
    - Delivery unit
    - Immunisation

12. Are there services you are supposed to offer but are unable to? (*Probe: If YES, which ones and why?)*

13. What are the difficulties faced in this health facility? (*Probe: Have you had particular difficulties with stock-outs of supplies and equipment? If YES, what supplies and equipment and for how long?)*

14. Do you have outreach services from your health facility? (*Probe: In the area? What types of services are available through outreach?)*

15. What are your roles and responsibilities at this health facility (Probe: Do you share tasks and workload with other staff members or health committee members? If yes, what are those tasks?
16. Is your workload too much/about right/too little? Why?
17. Are there tasks you perform that you feel that you are not adequately trained for? If yes, what tasks are they?
18. During your average week how much of your time is spent carrying out the following:
    - seeing patients
    - doing paperwork/completing returns etc.
    - attending meetings
    - cleaning
    - filing
    - stock checks

19. How frequently do you receive visits from your supervisor/MOH/ other officials?

20. What do SRCS supervisors do where they visit?

21. Do you have opportunities for feedback?

22. How adequate are the guidelines and reference materials?

Focus Group Discussion (FGD Guide): Men

Total Number of Discussants: _____
Directions: For questions 1-6, unless specified otherwise, ask participants to raise their hands to indicate their response. Tally the number of responses for each question.

Thank you all for coming today. All the information gathered here today will be treated in strict confidence. Before we begin our discussion I would like to ask you some general questions about yourselves.

1. How long have you lived in this area?
(imisa ayaad halkan ku noolayd)
1.1 Less than one year **No.:_____**(indicate number)
(sanad ka yar)
1.2 One year-4 years **No.:_____**
(hal sano ilaa afar sanno)
1.3 More than 4 years **No.:_____**
(in kabadan afar sanno)
1.4 Any other _____ (describe)
(wax kale, sharax)

2. Are you resident in this area all year round? Yes___
(halkan miyaad degenayd waligaa) No___

3. What is your age (or estimated age)? (Start from one corner and tally them in the age groups provided here below.) (Da'aadu waa imisa? Calaamada da'da ku haboon ee lagu siiyey)

3.1 20---29 ----------(indicate number) (tiro sheeg)
3.2 30---39 ----------
3.3 40---49 ----------
3.4 50 and above ----------
(50 iyo ka badan)

4. If you have been to school, what level of schooling have you completed?
(Haddii aad dugsi gashay, heerkeed ka gaadhay ama kaga baxday)
4.1 _____ madrassa (madarasad)
4.2 _____ completed primary school (dugsi hoose/dhexe ayaan dhamaystay)
4.3_____ completed secondary school (dugsi sare ayaan dhamaystay)
4.4_____ other (specify): _____
(wax kale – caddee)

5 Have you ever been married? (Waligaa ma guursatay)
5.1 Ever married _____
(waan guursaday)
5.2 Currently married _____
(haddaan xaas ahay)

6. How many of you have more than one wife? (Tally their numbers by asking them to raise their hands.) (Imisa idinka mid ah, ayaa hal xaas ka badan leh?) (qor tiradooda, adigoo weydiinaya inay gacmahooda kor u taagaan)

6. What in your opinion are the major health concerns in this area and in this community? (Probe: *What makes these major concerns? What are the major health concerns for men? For women? For children?)*
(Waa maxay dhibaatooyinka caafimaad ee ugu waaweyn ee haysta bulshadan? (Sii weydii: kuwa dhibaatooyinka u gaara raga? Haweenka ama carruurta?

7. What are the health facilities available to this community? (Probe: *Can you describe the services they offer? Which of those health facilities are most commonly used by the community members? And why?)*

(Waa maxay adeega caafimaad ay haysato bulshadani – sii weydii: adeega caafimaad ay bixiyaan xaruhama caafimaadku, kuweese ay dadku jecel yihiin inay tagaan, waa maxayse sababtu?

8, Do men and women use different health facilities? (Probe: *When you go to a health facility, where would you go? Do you choose different health facilities for different services? If yes, why?*)
(Ragga iyo haweenku xarumo kala duwan miyey tagaan? Sii weydii: xarumaha ay tagaan iyo sababta?

MCH services –

I would now like us to talk about women's health during and after pregnancy and also infant and children's health

9. What are some of the problems that women encounter during pregnancy and childbirth
(Probe *Have any of your wives experienced difficulties during pregnancy and childbirth. Can you describe some of these?)*

(Waa maxay dhibaatooyinka caafimaad ee haysta haweenka xilliga uurka iyo mark ay umulayaan). Sii weydii inay haweenkoodu ay la kulmeen dhibaatooyin xilligii ay uurka la haayeen ama umulayeen. Ha sharaxaan qaar ka mid ah dhibaatooyinkaas.

10. Can you tell us how can some of these problems and the risks be avoided? (Probe; what are the benefits of receiving care at a health facility during pregnancy?)
(Ma noo sheegi kartaa sida looga badbaadi karo qaar ka mid ah dhibaatooyinkaas? Sii weydii: waa maxay faa'iidooyinka ay hooyadu ka heli karto xarun caafimaad xilliga ay uurka leedahay haddii ay booqato?

11. Under what circumstances would you permit your wife/wives to deliver at a health centre (Probe: *Who makes the decision on antenatal care and where your wives deliver*?)
(goorma ayaad u ogolaanaysaa in xaaskaaga/xaasaskaaga ay/ku umushu xarun caafimaad) Sii weydii: Yaa go'aamiya inay hooyadu tagto xarunta caafimaadka si daryeel caafimaad loo siiyo xilliga uurka ama ay ku umusho?

12. To what extent do men take responsibility for their children's health care? (Probe: *Do men ever take their children to the health facility? If there are any costs, is it men or women who cover those costs?*)
(Waa maxay masuuliyadda ragga ka saaran caafimaadka carruurtooda? Sii weydii: raggu ma u qaadaan/geeyaan carruurtooda goob caafimaad? Yaase lacagta bixiya aabaha mise hooyada?

13. In your opinion, how old should a woman be when she has her first baby
(da'dee ayey tahay in inantu/gabadhu uur ku qaado ama uurka koowaad qaado?)

14. What is your opinion about child spacing: (Probe: How long after the birth of a child should a woman wait, before trying to become pregnant again
(sideed u aragtaa kala dheeraynta ilmaha? Sii weydii: muddo intee le'eg ayey hooyadu sugeysaa inay uurkale qaado?

15. Can you name any child spacing methods?
(ma sheegi kartaa mid ka mid ah hababka ilmaha loo kala dheereeyo?
16. Would you allow your wives to use any of the child spacing methods?
(Xaaskaaga ma u ogolaan lahayd inay istimaasho hababka kala dheeraynta ilmaha?)
17. Is the practice of FGM common in your community? *(Probe: What are your thoughts about the practice? Are your daughters 'circumcised'?)*
(Gudniinka hablaha/gabdhuhu ma ku badan yahay bulshadiinan? Sii weydii: Sideed u aragtaa gudniinka hablaha/gabdhaha? Hablahaaga/Gabdhaaga ma la guday?

18. Would you allow your sons to marry uncircumcised women?
(Raali ma ka noqon lahayd haddii inamadaadu guursadaan hablo/gabdho aan gudnayn?)

Community Health Issues

19. In your opinion, do many people in this area experiences food insecurity (Probe: If so, what periods of the year?)

Siday adiga kula tahay, dad badan oo raashin xumo haysaa ma jiraan halkan? Sii weydii: haddii ay jiraan, xilliyadee ayey raashin xumadu dhacdaa sanadkii?

20. Do you think people in this community can adequately feed themselves throughout the year?
(Ma kula tahay inay dadka halkan ku nooli helaan raashin ama cunto ku filan sanadkii oo dhan?

21. To what extent do you think chat and chewing affects food security and productivity in this community?
(Waa maxay waxyeelada qaadku u leeyahay ehelidda cuntada iyo wax soo saarka bulshada?

22. What changes have you noticed in your community that have made a difference to people's lives? (*Who or what has been responsible for these changes?)*
(Waa maxay is bedelada nololeed ee ka dareentay bulshada? Waxaa sababay isbedeladaa?

Perceptions of SCRS

23. What are the benefits that SRCS has brought to the community? (Probe: *Describe and explain those changes*)
(waa maxay faa'iidooyinka ay bisha casi ku oo kordhisay bulshadan? Sii weydii: sharax waxyaabihii isbedelay)

24. Are you satisfied with the services offered by SCRS? What are the services most appreciated and why?
(Miyaad ku faraxsan tahay adeegyada bisha casi qabato? Waa kuwee ku aad ula dhacsan tahay? Maxayse sababtu tahay?

25. What long-term impact, if any has SRCS and its interventions had on this community? (*What are the changes you've noticed?)*
(waa maxay saamayntae adeegyada bisha casi ku yeesheen bulshadan?)

26. What do you recommend to improve the services offered by the SCRC health facility?
(maxaad ku talinaysaa in bisha casi ku darto adeegyada ay bixiso?)

Focus Group Discussion (FGD Guide): Health Committee

Total Number of Discussants: _____

Thank you all for coming today. All the information gathered here today will be treated in strict confidence. Before we begin our discussion I would like to ask you some general questions about the committee and your membership.

1. How long have you lived in this area?
(imisa ayaad halkan ku noolayd)

1.1 Less than one year **No. :_____**(indicate number)
(sanad ka yar)

1.2 One year-4 years **No.:_____**
(hal sano ilaa afar sanno)

1.3 More than 4 years **No.:_____**
(in kabadan afar sanno)

1.4 Any other _____ (describe)
(wax kale, sharax)

2. Are you SRCS volunteers/members, if yes for how long?
- 2 years or less
- 2-5 years
- more than five years

(Ma Mutadawaciinta/Xubnaha Ururka Bisha Cas ayaad tihiin, haddii jawaabtu tahay Haa, intee in le'eg?
- 2 sanno ama in ka yar
- 2-5 sanno
- in ka badan shan sanno

3. Can you describe the committee? (Probe: *How many are you? How many men? How many women?)*
(Sharaxaad ma ka bixin kartaa Guddida? (Sii weydii*: Imisa ayaa tihiin? Imisaa Raga, imisaana dumara?*)

4. How long has there been a health committee in this area?
(Imisa sanno ayay goobtu lahayd guddi caafimaad?)

5. How long have you been a committee member?
- 2 years or less
- 2-5 years
- more than five years

(Imisa sanno ayaad ka tirsanayd guddida caafimaadka?
- 2 sanno ama in ka yar
- 2-5 sanno
- in ka badan shan sanno

6. How was the health committee formed? (*Who or what organisation assisted in its formation*?)
(Sidee ayay guddida caafimaadku u samaysantahay? *(Yaa ka caawiyay ama ururkee ayaa ka gacan siiyay asaaska guddida?)*

7. What training did you receive? What tools did you receive?
(Tababar noocee ah ayaad hesheen? Agab noocee ah ayaad hesheen?)

8. What are the roles and responsibilities of the committee and its members? (Probe: *What do you do and with whom*)
(Waa maxay doorka iyo waajibaadka xubnaha guddidu? (Baadh: *Maxaad qabataan, yaanad u qabataan*)

9. Do you have guidelines and procedures? (Probe: Do you have a Code of Conduct? Do you take minutes of all your meetings?)
(Ma leedihiin wax idin haga ama qaab aad raacdaan? (Sii weydii: *Ma leedihiin Xeer? Ma qortaan shirarka aad yeelataan?)*

10. What role does the committee play in financial management? (Probe: *Describe the role and who makes decisions about the collection and the use of any user fees? Whose interest do you see your selves representing?*)
(Door intee le'eg ayay ka ciyaaraan guddidu maamulidda dhaqaalaha? (Baadh: *Sharax doorka iyo cidda go'aanka ka gaadha waxyaabaha ku saabsan ururinta iyo isticmaalka lacagaha soo xerooda? Dantee ayaa u malaynaysaa in aad u matalayso?)*

11. Approximately how many hours a week do you spend on health committee business? Specify how much time on the various tasks.
(Qiyaas ahaan imisa saacadood ayaa wiigii guddidu ka shaqaysaa hawlaha caafimaadka?)

12. What challenges do you face as a health committee member or duty bearer?

(Maxaa caqabado ku soo waajaha adigoo ah xubin ka mida guddida caafimadka ama qofkii shaqada hayay?)

Health issues in the community (Arrimaha caafimaadka bulshada dhexdeeda)

10. What in your opinion are the major health concerns in this area and in this community? (Probe: *What makes these major concerns? What are the major health concerns for men? For women? For children?)*

(Adigoo fekerkaaga qeexaya waa maxay arrimaha ugu waaweyn ee caafimaad ee bulshadani danaynayso? (Baadh: *Maxaa aad loogu danaynayaa? Waa maxay arrimaha caafimaad ee raggu danaynayaan? Waa maxay kuwa ay dumarku danaynayaan? Waa maxay kuwa caruurtu?)*

11. What are the health facilities other than SRCS available to this community? (Probe: *Can you describe the services they offer? Which of those health facilities are most commonly used by the community members? And why?)*
(Waa maxay adeegyada caafimaad ee ay bulshadu heshaa ee aan ahayn kuwa Bisha Cas? (Baadh: *Ma sharaxi kartaa adeegyada ay bixiyaan? Adeegyadan caafimaad kuwee ayay bulshadu aad u isticmaashaa? Sababtuna maxay tahay?)*

12. How, in your opinion, has the health of the community changed over the last 5 years? (What improvements have you noted? What has got worse?)
(Adigoo fekerkaaga cabiraya wax isbedel ahi ma ku yimid caafimaadka bulshada 5tii sanno ee u danbeeyay? (Horumarkaas maxaad ka xusi kartaa? Maxaa xumaaday?)

13. What are the major challenges that people experience in maintaining good health?
(Waa maxay caqabadaha caafimaad ee ay dadku la kulmaan sidii ay u heli lahaayeen cafimaad wanaagsan?)

Food security (Helidda Cuntada)

14. In your opinion, do many people in this area experiences food insecurity (Probe: *If so, what periods of the year?)*
(Adigoo fekerkaaga cabiraya, dad badan oo goobtan degeni ma la kulmaan cunto la'aan (Baadh: *Hadday sidaas tahay, waqtiyadee ayay sanadka kaga beegantaa?)*

15. To what extent do you think that food insecurity affects the health of the community? Can you describe what these affects might be?
(Heer intee le'eg ayaad u malaynaysaa in cunto la'aantaasi ay saamayn ku yeelato caafimaadka bulshada? Ma sharaxi kartaa waxa ay saamayntaasi noqon karto?)

SRCS – Perceptions (Fekerka Bisha Cas laga haysto)

16. How have SRCS interventions had an impact on the community?
(Siday shaqada Bisha Casi saamayn ugu yeelataa bulshada?)

17. Which interventions have been the most successful and why you do think so?
(Shaqooyinka ay Bisha Casi qabatay kee ugu wanaagsanaa? maxaad ugu malanaysaa?)

18. How could SRCS interventions be improved?
(Sidee shaqaada Bisha Casi qabato loo horumarin karaa?)

19. What, if anything, do SRCS volunteers do in this community?
(Waa maxay, haddii ay jirto, waxay mutadawaciintu Bisha Casi bulshadan u qabtaan?)

Focus Group Discussion (FGD Guide): Women

Total Number of Discussants: _____

Directions:

Before you start the FGD and when the tape recorder is running, state the location, the date and the time the FGD commenced. Remember to state the time the FGD ended.

For questions 1-6, unless specified otherwise, ask participants to raise their hands to indicate their response. Tally the number of responses for each question.

Thank you all for coming today. All the information gathered here today will be treated in strict confidence. Before we begin our discussion I would like to ask you some general questions about yourselves.

1. How long have you lived in this area?
(imisa ayaad halkan ku noolayd)

1.1 Less than one year **No. :_____**(indicate number)
(sanad ka yar)

1.2 One year-4 years **No.:_____**
(hal sano ilaa afar sanno)

1.3 More than 4 years. **No.:_____**
(in ka badan afar sanno)

1.4 Any other _____ (describe)
(wax kale, sharax)

2. Are you resident in this area all year round? Yes (Haa)_____
(halkan miyaad degenayd waligaa) No (Maya)_____

3. What is your age (or estimated age)? (Start from one corner and tally them in the age groups provided here below.) (Da'daadu waa imisa? Calaamada da'da ku haboon ee lagu siiyey)

3.1	20---29	----------(indicate number) (tiro sheeg)
3.2	30---39	----------
3.3	40---49	----------
3.4	50 and above	----------

4. If you have been to school, what level of schooling have you completed?
(Haddii aad dugsi gashay, heerkeed ka gaadhay ama kaga baxday)

4.1 _____ madrassa (madarasad)
4.2 _____ completed primary school (dugsi hoose/dhexe ayaan dhamaystay)
4.3_____ completed secondary school (dugsi sare ayaan dhamaystay)
4.4_____ other (specify): _____
(wax kale – caddee)

5 Have you ever been married? (Waligaa ma guursatay)

Have you ever been married? (Waligaa ma guursatay)

5.1 Single _____
(kali)

5.2 Married _____
(haddaan xaas ahay)

5,3 Divorced
(la furay)

5.4 Widowed
(laga dhintay)

6. How many of you have ever given birth? (Tally their numbers by asking them to raise their hands.) (Imisa idinka mid ah, ayaa carruur dhalay? (qor tiradooda, adigoo weydiinaya inay gacmahooda kor u taagaan)

6.1 _____ever given birth (carruur dhalay)

6.2 _____ never given birth (waligood aan carruur dhalin?

Health issues within your community.

1. What are the main health concerns within your community? (Probe: What are the main health concerns for women? For men? For children?)
   (Waa maxay dhibaatooyinka caafimaad ee ugu waaweyn ee haysta bulshadan? (Sii weydii: kuwa dhibaatooyinka u gaara Haweenka? Ragga? ama carruurta?

2. How would you describe the variety of health facilities in your community? (*Probe: Which of those health facilities are most commonly used by the community members? Why?)*
   (Sidee ayaad u sharixi lahayd adeegyada caafimaad ay haysato bulshadani – sii weydii: adeega caafimaad ay bixiyaan xaruhama caafimaadku, kuweese ay dadku jecel yihiin inay tagaan, waa maxayse sababtu?

3. Have you faced any challenges while trying to access the services offered at the health facility? (*Probe: What would you comment on the distance to the health facility? What mode of transport do the community members commonly use?)*
   (Wax dhib ah miyaad kala kulantaa inaad hesho adeega caafimaad xarumaha caafimaadka)Sii weydii: Ka waran fo'gaanta xarunta caafimaad? Gaadiid nooceeya ayey isticmaalaan bulshadu?

Women's health issues and child health

4. Where do women access health care when they are pregnant? (*Probe: Where do the women prefer to deliver? What are some of the reasons for such preference?)*
   (Xaggee ayey haweenku ka helaan adeeg caafimaad marka uurka leeyihiin? Sii weydii: meesha ay haweenku jecel yihiin inay ku umulaan? Waa maxayse sababaha ay u door bidaan/u jecel yihiin inay ku umulaan goobahaas?

5. In your opinion, when should a woman who is pregnant visit the health centre? (*Probe: For antenatal care, for delivery? If a woman has tested HIV positive and is pregnant, what are her options?*

(Goorma ayey kula tahay in haweenka uurka leh booqdaan xarun caafimaad? (Sii weydii: marka ay uurka leeyihiin iyo marka ay umulayaan? Haddii ay haweenay uur leh laga helo HIV, waa maxay fursadaha u bannaan ee samayn karto?

6. In your opinion, when should a woman who has delivered visit the health centre?
(Rayigaaga, goorma ayey haweenay umushay tahay inay booqato xarun caafimaad?)

7. Is there anyone of you who has ever heard of child spacing? (*Probe: What have you heard about it? (Probe:* How would you describe the practice of child spacing in this community?) (*Probe: What are the thoughts of husbands regarding child spacing in this community?) (Probe: How about religious and community leaders?)*

(Ma jirtaa cid idinka mid ah oo maqashay kala dheeraynta ilmaha? (Sii weydii: maxaad ka maqashay dheeraynta ilmaha? Sideed u sharaxi lahayn siday u isticmaalaan kala dheeraynta ilmaha bulshadani? Waa maxay fikirka ay ka qabaan ragga bulshadani kala dheeraynta ilmaha? Ka waran culimada iyo oday dhaqameedyada?

8. What are the challenges that people, particularly women, face in raising healthy children? Is malnutrition an issue?
(waa maxay dhibaatooyinka ay dadku gaar ahaan haweenku kala kulmaan korinta carruur caafimaad qabta? Nafaqadaradu dhib jirta miyaa halkan?

9. For most people, is there a) enough food all year round b) is there a choice of food items and can people afford them?
(Dadka badankooda, a) raashin ku filan ma helaan sanadkii, b) raashin kala gedisan ma helaan, imise awoodaan inay iibsadaan?

10. What have you heard/ do you know about HIV/AIDS? (*Probe: How would someone get infected? How would someone reduce their risk to infection? How about a pregnant woman i.e. PMTCT?)*
(Maxaad ka maqashay ama ka taqaanaa HIV/Aydhis? Sii weydii: Sidee ayuu qofku ku qaadi karraa HIV? Sidee ayuu qofku u yarayn karraa halista uu ku qaadi karo HIV? Ka waran haweenayda uurk leh iyo ilmaheeda uurka ku jira?

11. How common is it for women in your community to discuss issues such as pregnancy? Child spacing or HIV/AIDS among other health issues. Who do you talk to, where do you get your information from?
(Haweenka bulshadiinu maka wadahadlaan/sheekeystaan arrimaha ku saabsan uurka, kala dheeraynta ilmaha, HIV/aydhiska iyo arrihama kale ee caafimaadka ku saabsan? Kale ee xog u raadsataan ama xaggee ayaa ka heshaan wararka caafimaadka ku saabsan?

12. How would you react to a family member or friend who happens to be HIV positive (Probe – shake hands with the person, share a meal with the person, sleep in the same room with the person, let your child be taught by the person, care for the person living with HIV/AIDS?)
(Sideed u aragtaa haddii qof qoyskaaga ka mid ah ama saaxiibkaa qaado HIV) Sii weydii: in lagu kala qaadi karo is gacan qaadka ama salaanta, wax wada cunidda, qol isla seexadka, waxbaridda iyo in la xanaaneeyo qofka qaba HIV/Aydhis?)

13. Is the practice of FGM common in your community? *(Probe: What are your thoughts about the practice?)*

(Gudniinka habluhu/gabdhu ma ku badan yahay bulshadiina? (Sii weydii: waa maxay fikirka aad ka qabto gudniinka hablaha/gabdhaha?

14. How do girls/women get information about menstruation and menstrual hygiene?
    PROBE: Who provides this information? Are there some things/information missing that you would like to know?
    (Siday u heshaa inantu/gabadhu macluumaadka ku saabsan xaydka (cisada) iyo nadaafaddeeda? Sii weydii: yaa siiya macluumaadkaas? Macluumaad dheerad oo ay tahay inay ogaadaan oo ka maqani ma jiraa?

15. How are you able to get personal menstrual hygiene items? PROBE: How do you obtain the items? Does someone give them to you or do you purchase or make them yourself? If someone gives you the items, are they appropriate? Do you need other items? If you have to buy or make the items, what were the costs? Do you or your family have to sacrifice anything else to get them? What items are you not able to get, but would have liked? Are the items the same as what you regularly use?
    (Sideed u heshaa qalabka loo isticmaalo iska asturidda xaydka (cisada)? Sii weydii: sidaad u heshaan qalabkaas? Ma cidbaa ku siisa? Miyaad iibsataa, mise waad samaysataa? Haddii ay cidi ku siiso, ma yihiin qaar fiican? Haddii ay tahay inaad iibsato ama aad samaysato, waa imisa qiimahoodu? Ma jirtaa wax kale oo adiga iyo qoyskaagu samaysaan si aad u heshaan qalabkaas? Qalab nooceeya ayaad jeceshay inaad hesho mase la mid yihiin kuwa aad goor walba isticmaasho?

16. What do you know about nutrition of pregnant women? Probe to know foods the pregnant women should take and what they should avoid
    (Maxaad ka taqaanaa nafaqaynta haweenka uurka leh? Sii weydii: noocyada cuntada ay tahay inay qaadato hooyada uurka leh iyo kuwa ay tahay inay ka foojidnaato?)

17. What signs should compel a pregnant woman to seek medical attention? Probe to know danger signs that will require a pregnant woman to seek medical attention.
    (Waa maxay caalamadaha ay tahay hooyada uurka leh inay la kulanto dhakhtar ama qof caafimaadka yaqaan? Sii weydii: caaladaha khatarta ah ee ay hooyadu u baahan tahay gargaar caafimaad?)

18. What are the benefits of having children immunized? Probe
    (Waa maxay faa'iidada tallaalka carruurtu?

19. What signs should compel a mother to take a new born for medical attention? Probe to know the danger signs
    (Waa caalamadaha ay hooyadu ilmaheeda/cunugeeda ay tahay inay xarun caafimaad ama dhakhtar u geyso)

Perceptions of SCRS

20. How have SRCS interventions had an impact on the community?
    (waa maxay faa'iidooyinka ama isbedelada ay bisha casi ku oo kordhisay bulshadan?)

21. Which interventions have been the most successful and why you do think so?
    (Shaqooyinka ay Bisha Casi qabatay kee ugu wanaagsanaa? Maxaad ugu malaynaysaa?)

22. How could SRCS interventions be improved?
(Sidee shaqaada Bisha Casi qabato loo horumarin karaa?)

23. What, if anything, do SRCS volunteers do in this community?
(Waa maxay, haddii ay jirto, waxay mutadawaciintu Bisha Casi bulshadan u qabtaan)

Annex 4 Outline of Baseline Survey Enumerator Training

Workshop agenda

- Introductions
- Workshop objectives and expectations
- What is a baseline survey?
- Baseline survey methodology and sampling
- Introduction to Household Questionnaire
- HH Questionnaire - practice

Workshop objectives

By the end of the workshop, participants will:

- Understand the purpose and content of a baseline survey;
- Know and have practiced administering a HH survey;
- Know and have practiced keying HH survey data into mobile phones (RAMP)
- Know and have practiced administering Focus Group Discussions.

What is a Baseline Survey?

- It's a starting point;
- A systematic gathering of data from various sources;
- These sources can include interviews, existing records, observation, questionnaires and electronic devices;
- The process is usually preliminary to statistical analysis of the data.

Qualitative and Quantitative methodology

- The terms qualitative and quantitative describe groups of research methods, rather than being methods in their own right. Any given method of doing research will belong to one or the other.

Quantitative methods

- Quantitative refers to a group of methods whose main focus is on quantities, that is, numbers. Numbers will usually be the main type of **data** that these methods collect, and those numbers will be analysed using mathematical or statistical techniques. Researchers using quantitative techniques usually see themselves as doing science.

- Experiments done in a laboratory will almost certainly be quantitative. In a health care context, **randomised controlled trials** are quantitative in nature, as are **case-control** and **cohort studies.** Surveys (questionnaires) are usually quantitative

Qualitative methods

- Qualitative research takes as its starting point the fact that people understand and can talk about their lives. Qualitative studies try to explain social phenomena in terms of the wider contexts of peoples' lives. The methods used include direct, unstructured interviewing, or observation of real-life settings (**ethnography**). The data that qualitative methods collect tends to be words, rather than numbers, in the form of **transcripts**, or **fieldwork notes**. That data is typically unstructured, and statistical methods cannot be used in its analysis.

Complementarity

- Often research uses either a quantitative or a qualitative approach which gives some people the idea that the approaches are mutually exclusive. However, combining quantitative and qualitative approaches can enhance research. For example, a qualitative study can guide the design of a subsequent quantitative study or by mixing elements of the one approach into the other. **It is more important to match the right design to the right question**.
- Surveys (questionnaires) can often contain both quantitative and qualitative questions. The quantitative questions might take the form of yes/no, or rating scales (1 to 5), whereas the qualitative questions would present a box where people can write in their own words.

What can we learn from a baseline?

- A baseline survey is a description of the circumstances in a place or area before the development project is carried out;
- It provides information against which changes can later be measured;
- It provides the basis for subsequent assessment of how efficiently an activity is being implemented and the eventual results achieved.

Methods and survey instruments

- HH survey questionnaire – RAMP
- Focus group discussions:

Women in the community,

Men in the community

Health Committee members

- Structured interviews – Health Facility staff
- Semi-structured interviews – Community leaders/MoH personnel/other key informants
- Observation – Facility checklist
- Clinic records

Annex 5 Summary of BEmONC services

Staff at health units offering Basic Emergency Maternal Obstetrics and Neonatal Care (BEmONC) receive additional training. The modules include;

1. Administration of parental antibiotic
2. Administration of uterotonic drugs
3. Administration of parental anticonvulsants
4. manual removal of placenta
5. Removal of retained products of conception (DNC)
6. Assisted vaginal delivery
7. Care of the new-born and resuscitation
8. Bold transfusion
9. Caesarean section
10. Focused Antenatal care
11. Use of partograph
12. Prevention of infection
13. Antepartum haemorrhage
14. Postpartum haemorrhage

UNICEF further provides the following:

Delivery sets, Delivery kits, Vacuum extraction equipment, Removal of retained products of concept and Neonatal resuscitation equipment- bag and mask, stethoscope, reliable clock.

Under BEmONC the following activities are carried out by clinic staff:

1. Focused ANC service – identifying high risk mothers and referral to the highest health facility as necessary, encouraging each mother come to ANC at least 4times in her pregnancy

2. Social mobilization among the community on availability of BEmONC service.

3. Assisting deliveries

- using partograph, management APH and PPH,
- do referral for complicated deliveries on time and prevention of infection ;
- referred cases where a caesarean section is performed have are free;
- PNC services - encouraging at least one visit during the PNC period.
- Management of preeclampsia

4. Cash incentives to TBAs for referring expectant mothers to BEmONC units - $5 in each case referred

5. Community health committee were received refreshment in each month during their routine CHC meetings 5$ per person.

6. Provision of supportive supervision for BEmONC services

Provision extra drug related on BEmONC like syntocinon or oxytocin with refrigerator

Annex 6 SRCS OPD kit - Somaliland and Puntland.

No	Item Description	Unit	Quantity
1.	ANC attendance by mothers and delivery by skilled personnel	ANC attendance by mothers and delivery by skilled personnel	100
2.	Benzoic Acid 6% + Salicylic Acid 3% ointment 400mg	Jars	3
3.	Benzyl benzoate 25% lotion, 1 litre bottles	Bottle	1
4.	Aluminium Hydroxide 125 mg + Magnesium Trisilicate 250mg /oofer ANTIACID TABS	1000 tab Jar	2
5.	Amoxicillin 500 mg	1000 tab Jar	2
6.	Ascorbic Acid (250mg) **200**mg	1000 tab Jar	5
7.	Cotrimoxazole 120mg	100 tab Jar	20
8.	Cotrimoxazole 480mg	1000 tab Jar	4
9.	(Ferrous Sulphate 200mg+ Folic Acid 0.4mg)/ **Iron 100mg+Folic Acid 350mcg**	100 tab Jar	60
10.	Metronidazole (250mg) **200**mg	1000 tab Jar	2
11.	Multivitamin	1000 tab Jar	3
12.	Paracetamol 100mg	1000 tab Jar	2
13.	Paracetamol 500mg	1000 tab Jar	4
14.	Phenoxymethyl Penicillin 250mg	1000 tab Jar	2
15.	Salbutamol 4mg	1000 tab Jar	1
16.	ORS 20,5 gr low osmolarity, (1 litre) **500ml sachet**	100 sac/pack	4
17.	Silver sulphadiazine 1% cream, 15gm	tubes	25
18.	Povidone 10%, 500mls	Pcs	1
19.	Urine strips 9 tests /offered **10 parameters**	100 strips box	1
20.	**PAPER** Envelops for dispensing tablets/ capsules	1000pcs pack	2
21.	Gauze Absorbent 90cm x 90m	Pcs	2
22.	Cotton wool 400gm	Pcs	1
23.	Crepe bandage 10cm x 4.5m+	pack of 12	1
24.	Examination gloves latex, medium size@ 100s	Packets	1
25.	Surgical adhesive tape 2.5 cm	Pcs	1

26.	Swab sterile 10x10cm (packet of 5 pieces) /**Gauze swabs sterile 4'x4' 100 p**	Packet	1
27.	Soap 100gm	Pcs	1
28.	Bic Pens (blue or black)	Pcs	3
29.	Note book A6	Pcs	1

Annex 7 SRCS OPD kit South/Central Somalia

ANALGESIC	
DORAPARA1S6	PARACETAMOL (acetaminophen), 120 mg/5ml, syrup, 60ml bottle
DORAPARA10T	PARACETAMOL (acetaminophen), 100 mg, tab.
DORAPARA5T	PARACETAMOL (acetaminophen), 500 mg, tab.
ANTACID	
DORAARTESP10TA	ALUMINIUM HYDROXIDE + MAGNESIUM TRISILICATE, 120 + 250 mg, tab.
ANTIBIOTICS	
DORAAMOX1S1	AMOXYCILLIN, 125 mg/5ml, powder for syrup, 100 ml, btl
DORAAMOC15S6	AMOXYCILLIN + AC CLAVULANIQUE, 125 + 31.25/5ML, powd, 60 ml
DORAAMOX1S1	AMOXYCILLIN, 250 mg, breakable tab
DORACEFI1S10	CEFIXIME 100mg/5ml, suspension, 100ml
DORACEFI4T	CEFIXIME 400 MG, tab
DORACOTR48T	COTRIMOXAZOLE 400 + 80MG tablets (UNTIL STOCKOUT)
DORAZSOK0001	COTRIMOXAZOLE, 200+40 mg/5ml, suspension, 50 ml, btl.(UNTIL STOCKOUT)
DORACIPR5T	CIPROFLOXACINE HYDROCHLORIDE, 500 mg, tab
DORADOXY1T	DOXYCYCLIN, 100 mg, tab.
DORAERYT1S1	ERYTHROMYCIN 125mg/5ml, powder for syrup, 100ml bottle
DORAERYT2T	ERYTHROMYCIN, 250 mg, tab.
DORAPENIV2T	PENICILLIN PHENOXYMETHYL (peni V), 250 mg, tab.
ANTHELMINTIC	
DORAALBE4T	ALBENDAZOLE, 400 mg, tab.(MEBENDAZOLE UNTIL STOCKOUT)
DORAPRAZ6T	PRAZIQUANTEL, 600 mg, tabs
ANTIHISTAMINES	
DORAZLON125	CHLORPHENIRAMIN, 4 mg, tabs
ANTIMALARIAL	
DORAARTESP5TC	ARTESUNATE 50mg + SULFADOXINE/PYRIMETHAMINE, 6tabs+2tabs, Child
DORAARTESP10TA	ARTESUNATE 100mg + SULFADOXINE/PYRIMETHAMINE, 6+3tabs, Adult
DORAQUIN3T	QUININE SULFATE, 300 mg,
DORASULP5T	SULFADOXINE 500 mg + PYRIMETHAMINE 25 mg, tab.
ANTIINFLAMMATORY, ANALGESIC	

DORAACSA3T	ACETYLSALICYLIC ACID, 300 mg, tab.
DORAZLON130	IBUPROFEN, 200 mg, tabs.
ANTIMYCOTIC	
DORANYST1S	NYSTATINE, 100 000 IU suspension, 24ml
ANTIPROTOZOIC	
DORAMETN1S1	METRONIDAZOLE 125mg/5ml powder for suspension 100ml bottle
DORAMETN25T	METRONIDAZOLE, 250 mg, tab.
ANTIVIRAL	
DORAACI2T	ACYCLOVIR, 200 mg, tab.
BRONCHODILATOR	
DORASALB4T	SALBUTAMOL, 4 mg, tab. (UNTIL STOCKOUT)
DORASALB2S	SALBUTAMOL, 0.1 mg/puffs/inhaler
MICRONUTRIENTS/VITAMINS	
DORAASCA5T	ASCORBIC ACID (vitamin C), 500 mg, tab
	FERROUS SULFATE 185 mg + FOLIC ACID 0.4 mg, tab
DORAFOLA5T	FOLIC ACID, 5 mg, tab.
	MULTI MICRONUTRIENT, film-coated tabs
	RETINOL (vitamin A), 100.000 IU, soft gel. caps
DORARETI20C	RETINOL (vitamin A), 200.000 IU, soft gel. caps
DORAYINC20T	ZINC SULPHATE 200 mg. tab.
REHYDRATANT	
DORAORSA1S	ORAL REHYDRATION SALTS (O.R.S.), sachet 27.9 g/1 l
POST RAPE KIT	
	POST RAPE KITS (Combivir, Postinor, Cefixime, Azythromycine, Pregnancy test)
	PREGNANCY TEST
ZZZ OTHER	
MMREBAGPD6	BAG, 6 x 8 cm, for drugs, plastic
	EXTERNAL DRUGS, ANTISEPTICS AND DISINFECTANTS
DEXTBENS6O5	BENZOIC ACID 6% + SALICYLIC ACID 3%, ointment, 400 g, jar
DEXTBENZ2L1	BENZYL BENZOATE, 25%, lotion, 1L., btl.
DASDCHLC1S1	CHLOREXIDINE 1.5% + CETRIMIDE 15%, solution , 1L, btl
DEXTCLOT5T	CLOTRIMAZOLE, 500 mg, vaginal, comp + applicator (REPLACE NYSTATIN)
DEXTGENV1C2	GENTIAN VIOLET, crystal, 25g., btl
DASDIODP1S10	IODINE POVIDONE, 10%, solution, 1 l, btl.
DEXTSULZ1C50	SULFADIAZINE SILVER, 1%, cream, 500 g, jar
DEXOTETR1O5	TETRACYCLINE, 1%, eye ointment, 5 g, tube

	TESTS
DDGTMALRP25	MALARIA TEST, SD BIOLINE Ag Pf/Pan, rapid, kit for 25 tests
DDGTURINM10	URINE TEST,pH/den/prot/gluc/cet/bld/nit/lc/bili/urob,1 strip
	MOSQUITO NET
HSHEMMETRL	MOSQUITO NET, LLIN, rectangular, large 160 x 180 x 150 cm
	CLEAN DELIVERY KIT
KMEDZLON096	CLEAN DELIVERY KIT
	HYGIENE
HHYGSOAP800G	SOAP, laundry, 800g, with 3 cutting marks, piece
	VACCINATION
VACCINES	
	BCG, Bacillus Calmette-Guérin vaccine 1 ml 20 dose vial
	PENTAVALENT (diphtheria, tetanus, pertussis & hep B + haem Inf)
	OPV
	MEASLES
	TT
VACCINATION MATERIAL	
MINSCNTR5C	CONTAINER, SAFETY, for used syringes & needles, 5l.
MINSNEEDH18	NEEDLE, HYPODERMIC, G 18, 1.8 x 40 mm, pink, IV, disp.
MINSSYRD5A	SYRINGE, 0.5 ml, autodestructive, for immunisation campaign
	SYRINGE, 0.05 ml, autodestructive, for BCG
MINSSYRD5	SYRINGE, 5 ml, 2 parts, disposable
COLD CHAIN	
XCOLBOXCO3T	COLD BOX, VACCIN CARRIER, 3 l, Quattro + 8 ice packs 0.41
XCOLCOCA1CE	CONTROL CARD, COLD CHAIN MONITOR
XCOLZLON0003	ICEPACK, 0.3 lt
XCOLZLON0006	ICEPACK, 0.6 lt
XCOLFRIF17KE	REFRIGERATOR 170L/55L, FREEZER, Sibir V170KE, 230 V/kerosene
XCOLTHER1A	THERMOMETER, MOELLER 104614, -40C + 50C
XCOLBOXC22E	VACCINE COLD BOX, LARGE RANGE
	KEROSENE, LITERS IN STOCK
	SRCS MONTH:
	MEDICAL EQUIPMENT & INSTRUMENTS: MEDICAL EQUIPMENT
XSTEAUTO39	AUTOCLAVE, UNICEF, 39L., pressure cooker
XMEQCOUC01	COUCH, EXAMINATION, 193x60x80cm, adj.head rest, and dismounta.
XSTEDRUM2434E	DRUM STERILISATION 24 cm, diam 34 cm, lateral ellipses

XSINMEDI195024	FORCEPS, sponge, Foerster, 24 cm, serreted jaws, staight
XSINMEDI161214	FORCEPS, hemostatic Kocher, Foerster, 14cm/1x2 teeth, staight
XMEQWAFUKIDD	KIDNEY DISH, medium, 250x140x40mm, stainless steel
XSEQSTRE1X	STRETCHER, fordable in width
XMEQWAFUTRAY	TRAY, 320x220x10mm, inox
XMEQWAFUTRDR	TROLLEY DRESSING, 60 x 43 cm, 2 shelves
XSINMEDI474007	JAR, 75 x 175 mm, without lid, stainless steel
	DELIVERY SET, INSTRUMENTS
	MEDICAL EQUIPMENT & INSTRUMENTS/EXAMINATION MATERIAL
EELEBATTLR14	BATTERY, dry cell, alkaline, 1.5V, C (LR14), 26 x 50 mm
XSINMEDI440750	HAMMER, PERCUSSION, 20 cm
XMEQZSOK0154	MEASURING BOARD (PAEDIATRIC)
EMEATAPMTA15	MEASURING TAPE, tailor type, flexible, 1.5m
	MUAC TAPES (NON MARKED)
XSINMEDI440750	HAMMER, PERCUSSION, 20 cm
XMEQOPRI2050B	(ophthalmoscope), BULB, 2.7 V
XMEQOTRI2010B	(otoscope), BULB, 2.5 V
XMEQOPRI2050	OTOSCOPE-OPHTALMOSCOPE (Set)
XMEQSCALAD	SCALE ADULT (Bathroom type) mecanic 0-150kg/0.1kg
XMEQSCABYP	SCALE BABY, Salter, suspended, 0-25kg x 100g inc trousers
XMEQSCALBY	SCALE BABY, with tray, 0-16 kg x 10g.
XMEQSPHYRIA	SPHYGMOMANOMETER, adult, with one cuff 14x54.5 cm, REF:1362
XMEQSTETD	STETHOSCOPE, duplex (dual-head chest piece)
XMEQSTETP	STETHOSCOPE, Pinard
XMEQTHER1M	THERMOMETER, medical, mercury free
MMRETODEW	TONGUE DEPRESSOR, wood, non sterile
XMEQSCABYPT	TROUSER SETS FOR SALTER SCALE
	SRCS MCH/OPD: MONTH:
	MODULE, DRESSING
APACBAGP35	BAG, PE plastic, for garbage, 35L, grey, 0.06mm, 58x60cm
MDREZLON128	BANDAGE, ELASTIC, 10 cm x 5 m, constraining
MDREBANDG08	BANDAGE, GAUZE, 08 cm x 4 m, elastic, non sterile
MDREBTRI136	BANDAGE, TRIANGULAR, 136 x 96 x 96 cm
MDRECOMPG10	COMPRESS, GAUZE, 10 x 10 cm, 8 plys, 17 thr., ster., 2 pcs
MDRECOMPG20N	COMPRESS, GAUZE, 10 x 20 cm, 12 plys, 17 thr., non-ster

MDRECOTW1	COTTON WOOL, 1 kg, 100% cotton, hydrophilic
MDRETATSD06	DRESSING, ADHESIVE BANDAGE, wound plaster, 6cm x 5m, roll
MDRETADSP02	TAPE, ADHESIVE PAPER, 2.5 cm x 10 m, roll
MDRETADSP05	TAPE, ADHESIVE PAPER, 5 cm x 10 m, roll
MSTETAUT1	TAPE, AUTOCLAVE, 19mm x 50m
MMREGLOVEM	GLOVE, EXAMINATION, LATEX, non sterile, medium (7-8)
XSINMEDI061684	FORCEPS, DRESSING, 14.5 cm, English pattern
XSINMEDI402518	SCISSOR, DRESSING, LISTER, 18 cm
XSINMEDI473008	BOWL, ROUND, 100 ml, 80 x 35 mm, stainless steel
	SRCS MCH/OPD: MONTH:
Item Code	**Item description**
	Nutrition Products
FNUTPLMP5002	PLUMPYNUT/EEZEEPASTE (in sachets)
FNUTPLMPSUP	PLUMPY SUPP (in sachets)
FNUTBISCBP05	BP5 (each)
FNUTBISCBP100	BP 100 (each)

Annex 8 CHC Training

Community Health Committees Training Requirements

	Training Subject	Skill based	Knowledge based	Attitude
Community Health Committee	Introduction to the Red Cross/ Red Crescent Movement Principles		•	
	Introduction to the ToR of the Community Health Committees; Understanding the mission, mandate and responsibilities of the Community Health Committees		•	
	Meeting Procedures	•	•	•
	Team work	•		•
	Introduction to Community Health and Development		•	
	Introduction to Governmental (Local authorities) Health Regulations			
	Community Health Planning	•	•	
	Monitoring of Health Practices within the locality	•	•	
	Conflict Management and Problem Solving	•	•	•
Committee	Participatory Leadership	•		•

Chairman and Vice Chairman				
	Management Skills	•	•	
	Chairing meetings	•		•
	Communication Skills	•		
Committee Secretary	Secretarial Skills (Minutes taking, filing, correspondence, reporting, etc.).	•	•	
	Communication Skills	•		
	Correspondence	•		
Committee Treasurer	Basic accounting (book keeping, financial reporting, budgeting, etc.)	•	•	
	Correspondence	•		

Annex 9. UNICEF MCH kit

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Packing details for Kit S9906770 Somalia, PHU Kit (A1)

Total kit consist of 1box marked with part 1 of 1

Total Wgt pr kit 20 Kgs Total Volume 0.080 m3

Material code	Material Desription	Qty	Unit	Packed in Part no:	
S8914100	Carton f/dividers 249 x 140 x 163 mm	1	EA	1 of 1	Wgt 20 Kgs Volume 0.080 m3
S8914101	Divider for S8914100	1	EA		
S1559200	Promethazine 25mg tabs/PAC-100	5	PAC		
S1562040	Salbutamol syrup 2mg/5ml/BOT-150ml	10	BOT		
S0512111	Bandage,gauze,8cmx4m,roll	3	EA		
S0746510	Scalpel blade,ster,disp,no.22	1	EA		
S8941505	Pre-pack Carton, 15 cdm	1	EA		
S1531001	[redacted]				
S1531002	[redacted]				
S1546315	Erythromycin 250mg tabs/PAC-100	10	PAC		
S1560610	Quinine sulfate 300mg tabs/PAC-100	1	PAC		
S1562015	Salbutamol 4mg tabs/PAC-1000	1	PAC		
S1543625	Diazepam inj 5mg/ml 2ml amp/BOX-10 pt	2	BOX		
S1552416	Hydralazine pdr/inj 20mg amp/BOX-5	2	BOX		
S1543803	Water for inj 5ml amp/BOX-50	2	BOX		
S1511500	[redacted]				
S0503025	Bandage,elastic,7.5cmx5m,roll	3	EA		
S9008034	Double-wall ctn.60x40x33.3 cm, 0.08 m3	1	EA		
S1550025	Fe(as fum.)+folic 60+0.4mg tab/PAC-1000	2	PAC		
S1555650	Metronidazole 250mg tabs/PAC-1000	1	PAC		
S1559005	Benz.benzylpeni.pdr/inj 1.44g vl/BOX-50	1	BOX		
S1520011	Benzylpenicillin pdr/inj 3g vial/BOX-50	1	BOX		
S1551960	Gentamicin inj 40mg/ml 2ml amp/BOX-50	1	BOX		
S1559360	Magn.sulph.inj 500mg/ml 10ml amp/BOX-100	1	BOX		
S1555205	Lidocaine inj 1% 50ml vial/BOX-5	2	BOX		
S1543805	Water for inj 10ml amp/BOX-50	1	BOX		
S1523000	Calamine lotion/BOT-500ml	1	BOT		
S1531505	[redacted]				
S1553105	Povidone iodine sol 10%/BOT-500ml	1	BOT		
S1562020	Salbutamol oral inh. 0.1mg/ds 200ds	20	EA		
S0305020	Apron,protection,plastic,disp/PAC-100	1	BOX		

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Packing details for Kit S9906770 Somalia, PHU Kit (A1)
Total kit consist of 1box marked with part 1 of 1
Total Wgt pr kit 20 Kgs Total Volume 0.080 m3

Material code	Material Desription	Qty	Unit	Packed in Part no:	
S8941505	Pre-pack Carton, 15 cdm	1	EA	1 of 1	Wgt 20 Kgs Volume 0.080 m3
S1559200	Promethazine 25mg tabs/PAC-100	5	PAC		
S0512111	Bandage,gauze,8cmx4m,roll	3	EA		
S0746510	Scalpel blade,ster,disp,no.22	1	EA		
S1531001	Azithromycin 500mg tablets/PAC-10	7	PAC		
S1531002	Cefixime 200mg tablets/PAC-56	2	PAC		
S1546315	Erythromycin 250mg tabs/PAC-100	10	PAC		
S1560610	Quinine sulfate 300mg tabs/PAC-100	1	PAC		
S1562015	Salbutamol 4mg tabs/PAC-1000	1	PAC		
S1543625	Diazepam inj 5mg/ml 2ml amp/BOX-10 pt	2	BOX		
S1552416	Hydralazine pdr/inj 20mg amp/BOX-5	2	BOX		
S1543803	Water for inj 5ml amp/BOX-50	2	BOX		
S1511500	Beclometa.oral inh. 0.05mg/ds 200ds	10	EA		
S0503025	Bandage,elastic,7.5cmx5m,roll	3	EA		
S9008034	Double-wall ctn.60x40x33.3 cm, 0.08 m3	1	EA		
S1550025	Fe(as fum.)+folic 60+0.4mg tab/PAC-1000	2	PAC		
S1555650	Metronidazole 250mg tabs/PAC-1000	1	PAC		
S1559005	Benz.benzylpeni.pdr/inj 1.44g vl/BOX-50	1	BOX		
S1520011	Benzylpenicillin pdr/inj 3g vial/BOX-50	1	BOX		
S1551960	Gentamicin inj 40mg/ml 2ml amp/BOX-50	1	BOX		
S1555205	Lidocaine inj 1% 50ml vial/BOX-5	2	BOX		
S1543805	Water for inj 10ml amp/BOX-50	1	BOX		
S1523000	Calamine lotion/BOT-500ml	1	BOT		
S1531505	Chlorhexidine conc. sol. 5%/BOT-1000ml	1	BOT		
S1553105	Povidone iodine sol 10%/BOT-500ml	1	BOT		
S1562020	Salbutamol oral inh. 0.1mg/ds 200ds	20	EA		

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Packing details for Kit S9906771 Somalia, PHU Kit (A2)
Total kit consist of 1box marked with part 1 of 1
Total Wgt pr kit 42 Kgs Total Volume 0.310 m3

Material code	Material Desription	Qty	Unit	Packed in Part no:	
S8941501	Pre-pack Carton, 7.5 cdm	1	EA	1 of 2	Wgt 20 Kgs Volume 0.160 m3
S0575000	Towel,huck,430 x 500mm	2	EA		
S0772000	Scissors,bandage,200mm,str	1	EA		
S0481053	Thermometer,clinical,digital,32-43°C	5	EA		
S0919305	Bottle,plastic,250ml,wash bottle	1	EA		
S0237000	Bowl,stainless steel,180ml	2	EA		
S0514000	Brush,hand,scrubbing,plastic	2	EA		
S9910005	Surg.inst.,dressing /SET	2	SET		
S0721000	Forceps,dressing,standard,155mm,str	2	EA		
S0726000	Forceps,artery,Kocher,140mm,str	2	EA		
S0773500	Scissors,Deaver,140mm,str,s/b	2	EA		
S0983400	Timer,60 min	1	EA		
S0726000	Forceps,artery,Kocher,140mm,str	1	EA		
S0558100	Indicator,TST control spot/PAC-300	1	PAC		
S9016023	Double-wall ctn.80x40x50 cm, 0.160 m3	1	EA		
S5001100	Bag,UNICEF,blue nylon,280x410x170mm	1	EA		
S0361020	Drawsheet,plastic,90x180cm	4	EA		
S0211000	Basin,kidney,stainless steel,825ml	2	EA		
S0270000	Tray,instr,ss,225x125x50mm,w/cover	2	EA		
S0921600	Bottle,plastic,1L,w/screw cap	1	EA		
S0106000	Drum,sterilizing,165mm diam	2	EA		
S2170000	Pail w/bail,handle,polyethylene,10 litre	1	EA		
S5007311	Water cont,PVC/PE,10l,collaps.,w/o logo	2	EA		
S0108000	Drum,sterilizing,290mm diam	2	EA		
S0107700	Drum,sterilizing,260mm diam	2	EA		
S0106000	Drum,sterilizing,165mm diam	2	EA		
S0170000	Stove,kerosene,single-burner,pressure	1	EA		

S0156000	Sterilizer,steam,39L	1	EA	1 of 2	Kgs Volume 0.150 m3

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Packing details for Kit S9906773 Somalia, HC Kit (B2)
Total kit consist of 2 box marked with part X of 2
Total Wgt pr kit 35 Kgs Total Volume 0.212 m3

Material code	Material Desription	Qty	Unit	Packed in Part no:	
S8941100	Pre-pack Carton, 11 cdm	1	EA	1 of 2	Wgt 21 Kgs Volume 0.120 m3
S9910004	Surg.inst.,suture /SET	4	SET		
S9910003	Surg.inst.,delivery /SET	4	SET		
S0567000	Tape measure,tailor's,fibreglass,1.5m	5	EA		
S0385000	Tourniquet,latex rubber,50cm	2	EA		
S0686500	Stethoscope,foetal,Pinard	2	EA		
S0630010	Flashlight,pre-focused	2	EA		
S0660050	Otoscope, set.	2	EA		
S0361020	Drawsheet,plastic,90x180cm	2	EA		
S0211000	Basin,kidney,stainless steel,825ml	1	EA		
S9012024	Double-wall ctn.60x40x50 cm, 0.120 m3	1	EA		
S0141020	Scale,electronic,mother/child,150kgx100g	1	EA		
S0686000	Stethoscope,binaural,complete	4	EA		
S0845000	Resuscitator,hand-oper.,infant/child,set	1	EA		
S0145555	Scale,infant,springtype,25kg x 100g	2	EA		
S0270000	Tray,instr,ss,225x125x50mm,w/cover	8	EA		
S0683200	Sphygmomanometer,(adult),aneroid	4	EA		
S0189000	Weighing trousers/PAC-5	2	PAC		

S0114530	Baby/infant L-hgt mea.system/SET-2	1	SET	2 of 2	Wgt 13 Kgs Volume 0.092 m3