End of Project Evaluation of the Capacity Building Within HealthCare: Somaliland

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The Evaluation team

- Dr. Peter Memiah- PhD. Lead Consultant
- Dr. Gabriel Mahasi – MD, MPH – Content Expert
- Mrs. Wandia Ikua – MA-Demography – Qualitative Analysis
- Mr. Samuel Kemboi – BSc, MPH – Quantitative Analysis
- Dr. Gerald Oyugi – MD, MPH – Programs Specialist

Acronyms

ADFA	Australian Doctors for Africa
CBH	Capacity Building in Health Care
CCO	Clinical Coordination Office
CMDA	Christian Medical and Dental Association of Kenya
ETAT+	Emergency Triage Assessment and Treatment
EAUH	Edna Adna University Hospital
HBB	Helping Babies Breath
HGH	Hargesia Group Hospital
INGO	International Non Governmental Organizations
KPA	Kenya Pediatric Association
MOH	Ministry Of Health
NICU	Neonatal Intensive Care Unit
NLM	Norwegian Lutheran Mission
NNM	Nooleynta Naruurada Mustaqbalka
SMEA	Scripture Mission East Africa
THET	Tropical Health and Education Trust
ToT	Training of Trainers
WHO	World Health Organization

Executive Summary

Background: Capacity Building within Healthcare (CBH) is a project implemented in Somaliland by the Norwegian Lutheran Mission (NLM) operating under the local name Nooleynta Naruurada Mustaqbalka (NNM). The project has been piloted since 2008/9 in partnership with Somaliland Ministry of Health, Edna Adan Hospital, Hargeisa Group Hospital and the University of Hargeisa Medical Faculty. The evaluation of this project was carried out between October 6th and November 1st 2014.

Methods: The main purpose of the evaluation was to establish the achievements, effectiveness and impact of the CBH strategy as well as take cognizance of the termination process and lessons learnt with regard to empowering health care workers in Somaliland through capacity building and knowledge transfer activities. The evaluation utilized a triangulation approach in data collection. The data collection methods included documentary analysis of all project documents and a purposive selection of 22 key informants was interviewed. The respondents were selected from within the CBH project team (both local and expatriate), partner facilities specifically Edna Adan Hospital and Hargeisa Group Hospital, development partner agencies and learning institutions. Both quantitative and qualitative research methods were applied to enrich the content of the evaluation report. Site visits; the evaluation team also conducted site observations and two focus group discussions with midwives and 5th year medical students.

Findings: The evaluation exercise revealed that the CBH project has greatly contributed in assisting the MOH address its main challenges that pertain to the health workforce by:

- Capacity building of health care workers through trainings in neonatology, ETAT+, HBB, anesthesia and developing a neonatal unit in Hargeisa Group Hospitals
- Supervision of medical students during clinical rotations
- Establishment of a clinical coordination unit at HGH that rationalizes clinical rotations for medical doctor students.
- Mentoring and support to radiology; physiotherapy, pediatrics and obstetrics departments as well as contribution to medical research

CBH has succeeded in improving the clinical knowledge and skills of prospective health care workers and ensuring academic staff are linked to teaching institutions. Additionally, the CBH project has provided health care workers with the requisite competencies to not only deliver good medical care but to also act as change agents that catalyzes and inculcate medical ethics and values.

Recommendations: Several recommendations emanated from the evaluation exercise ad were outlined in the following thematic areas 1) For *capacity building efforts*- implementing a pragmatic approach; a logical framework design for capacity building and; understanding contextual factors 2) For *Future work in Somaliland* – applying an ethnocentric approach and developing a technical expertise within SMEA 3) For *approaches to capacity building*- different approaches for considerations 4) For *data demand information use and quality improvement* 5) For scaling up- use of a diffusion approach and e-learning platforms

Background: Somaliland

Since 1991, Somalia has been without a functioning central government and has experienced a prolonged humanitarian crisis due to a civil war that still affects large parts of the country. The civil war destroyed most of the infrastructure, displaced large populations, and took a heavy human and financial toll on the Somali population (World Bank 2006). In 1991, the Northwest declared the independent state of Somaliland. Several other regions have since declared independence unilaterally and implemented semi-autonomy over their population (Sorbye and Leigh 2009). Since its self-declaration of independence in 1991, Somaliland has against many odds established a system of democratic governance and embarked upon an ambitious development agenda including designing a National Development Plan (NDP 2012-2016).

Based on the initial GDP analysis, which was severely limited by lack of comprehensive data, Somaliland's 2012 GDP was estimated to have been $1.4 Billion with GDP per capita estimated at $347 (World Bank, 2012). In addition to man-made emergencies, Somalia regularly experiences natural disasters: droughts and floods are the two dominant hazards affecting the majority of the country. In 2008, the most severe drought in two decades affected approximately 3.3 million Somalis (EM-DAT), triggering a major humanitarian response.

Health Care Sector in Somaliland

Somaliland is a post-conflict state whose systems remain fragile and susceptible to a multitude of external factors. Without a strong central government or international recognition, Somaliland has lacked the resources necessary to invest in the health of her own people. Its healthcare indicators demonstrate the vulnerability of an entire population and the glaring lack of proper health services coordinated nationally.

The rudimentary health care system in Somaliland comprises of a central Ministry of Health, regional health offices (although few district health management structures exist); volunteer Regional Health Boards (primarily concerned with the financing and management of larger referral hospitals); 1 National referral hospital, 1 National Mental Hospital, 5 Regional Referral Hospitals, 3 District Hospitals, 7 Tuberculosis treatment Centers, 73 Maternal and Child Health Clinics, and about 200 health posts. There also exist medical and nurse/midwifery associations, medical personnel training institutes, a vibrant market of private health care service provision and pharmacies.

However, the extent of skilled health care personnel shortage in the system is unsettling. The healthcare services are largely provided by under-trained, under-supervised, and under-paid staff who, in addition, lack a regulated and organized working environment. The system functions largely on donations from international agencies (such as the UN, NGOs, and Islamic Charity Funds). This under-investment in health services has translated to a large percentage (more than 85%) of the rural population remaining unreached with any service from the public health system with resultant huge health inequalities within the populations. There is therefore an urgent need to build the capacity of the health care system to provide a range of accessible, affordable and better quality services that people need and demand.

Health Indicators

In a bid to appraise the health situation of the population in Somalia, UNICEF supported the Ministry of National Planning and Development in 2006 to conduct a clustered survey on multiple indicators (MICS 2006) across the entire Somalia including the breakaway states such as Somaliland. A similar study was conducted separately for Somaliland in 2011 and provides a fair comparison to her neighbors. The survey provides valuable information on the situation of children and women in Somalia and was based, in large part, on the need to monitor progress towards goals and targets emanating from the Millennium Declaration of the Millennium Development Needs. Among many other indicators, the MICS 2006 (Somalia) and MICS 2011 (Somaliland) study showed that:-

SCOPE	MICS Indicator	2006 for Entire Somalia (including Somaliland)	2011 for Somaliland
Child Mortality	Under-5 Mortality	135/1000	91/1000
	Infant Mortality Rate	86/1000	72/1000
Low Birth Weight	Infants weighed at Birth	5%	
Immunization	BCG Coverage	26%	26.8%
	DPT Coverage	12%	11%
	Measles vaccine coverage	19%	25.8%
	Fully Immunized Children	5%	-
Maternal Newborn Health	ANC Care	26%	
	Skilled attendant delivery	33%	44.1%
	Institutional Deliveries	9%	30.6%
	Maternal Mortality Ratio	1044/100,000	

Background to the CBH Project

From the foregoing discussion, Somaliland has faced innumerable challenges in providing basic healthcare to her population. This is especially so after the civil war of 1988-1991 which in addition to disrupting the daily lives of the people of Somaliland affected the training, recruitment and retention of skilled healthcare workers. The indicators from the MICS 2006 and MICS 2011 showed a deterioration of health at many levels from the pre-war population health status. From early surveys conducted in 2008, it was established that whereas there were many international and local actors providing basic health services to the population in Somaliland, there was little effort to address the skilled health worker shortage. The training institutions relied on poor trained tutors and semi-skilled personnel offered much of the health service. Thus, the **Capacity Building within Healthcare Project (CBH)**, locally operating in Somaliland as **Nooleynta Naruurada Mustaqbalka** (NNM), was conceived by the Norwegian Lutheran Mission (NLM). The main objective of the CBH project was to enable Somaliland to produce better health for the general population by contributing to the development of skilled personnel and teaching institutions that will be self-sustainable.

To accomplish this mandate, the CBH project aimed to:-
Contribute to the development of a new generation of health workers in Somaliland:

a) With sufficient knowledge and skills adjusted to local context to produce the long term goal

b) Through clinical and educational work at the partner institutions, gain experience and insights of typical educational, clinical, financial, relational, cultural and political possibilities and challenges in order to be able to design a broader and more targeted capacity building project within the health care system
c) By communicating and demonstrating the importance of learning (not teaching), accuracy, trust, respect, altruistic care, ethical awareness, equity, justice, the value of the individual and the holistic health approach in the interaction with students and junior health workers

The Design & Implementation of the Project

Preceding the NNM engagement in Somaliland, NLM conducted a fact-finding mission between January and March of 2008 from which the extensive shortage of skilled health care workers and the limited capacity of the training institutions throughout the country was established. Thus, a project to address this health worker shortage was conceived and initially planned to run for a period of between 8 – 12 years, with an initial pilot phase of 2 years. In June 2008, NLM representatives signed formal "Letters of understanding" with five different partners in Somaliland – all of which experienced resource scarcity and a clear lack of teachers. These were Amoud University (AU), Burco General Hospital (BgH), Edna Adan Maternity Hospital (EAMH) and who later became Edna Adan University Hospital, Hargeisa Group Hospital (HgH) and University of Hargeisa (UoH). NLM was at the same time registered as an INGO in Somaliland with the Ministry of Planning and Coordination (MoPC), with a Memorandum of Understanding with the Ministry of Health and Labor (MoHL). To ease local ownership and participation, the organization is registered under a local name, Nooleeynta Naruurada Mustaqbalka Somaliland (NNM/S). Further, the CBH project sought to secure the cooperation of other organizations already working in Somaliland and with which there could be cooperation on common objectives. These organizations included: THET and the MIDA-FINNSOM project. The pilot phase of the project did not start fully until September of 2010 due to a variety of factors including the terror attacks in Hargeisa in 2008 that delayed the initial preparations and financial and personnel constrains in the projects inception year.

CBH Project Beneficiaries

Immediate beneficiaries of the CBH project were intended primarily to be medical and nursing students, clinical workers at partner health facilities and academic staff at health teaching institutions. The institutional strengthening objective incorporated institutional administrators into the project's coverage. The long term beneficiaries, and the ultimate reason for investing in capacity building within the healthcare system in Somaliland, were the general population, particularly mothers and children.

Throughout the project, there has been an emphasis on personal development and awareness of the participant's own values and beliefs about clinical work. Consequently, the curriculum design favored an experiential approach with teaching methods that focus on process-orientated outcomes. In line with the projects strategy of capacity building, other elements such as logbooks, seminars and ongoing support from the facilitators (trainers) were implemented to support the participants following completion of each of the courses.

The Pilot Phase: 2010-2011

The original plan of activities for the Pilot Phase (2010 and2011) included the following:-

PLACE/GOAL	ACTIVITY
Edna Adan (EAMH)	Bachelor course in midwifery, lecturer
	Support Gyn/Obs clinical teaching for community midwifes
HGH/Edna Adan	Short term teams, clinical tutoring/mentoring
UoH Medical faculty	Lecturer, continuous courses
	Lecturers short term, based on current needs
	Clinical tutoring of medicals students
All Institutions	Basic science research course
	Field research experience
	Administration support to HGH
Preparations for next phase of project	Observation and identification
	Development of contextualized capacity building methods
Evaluations	Internal semester end evaluation
	Project evaluation

In as much as letters of understanding were signed by all the project partners, limited available resources and field level personnel made it possible to engage with only 3 out the 5 institutions during the pilot phase, namely: HGH, University of Hargesia and Edna Adan University Hospital, to varying degrees. From the evaluation carried out at the end of the Pilot phase, the following were the achievements:-

Achievements in the 2 year Pilot Phase:

Place / Partner	Activities	Capacity delivered
Edna Adan UH	Bachelor course, lecturer	1 nurse/midwife were involved in planning and teaching of the new group of BSc Midwifery students in integration with the THET leadership and Edna Adan Started the last week of the 1st Quartile. 2 nurses/midwifes taught and mentored nursing and para-clinical health students in the first quartile
	Various courses	External teacher given lectures in TB for nurse, pharma, lab students and staff over 1 week
HGH	Long term staff, Short term teams and volunteers, clinical tutoring/mentoring and teaching, maternal education	1 long term medical doctor ,through clinical tutoring, taught and mentored medical students and interns in gynecology and obstetrics at the maternity ward of the hospital. 1 nurse/midwife taught and mentored midwifery students from IoHS and community midwives from EA. 1 physiotherapist taught nurses in physiotherapy 1 anaesthesiologist , through clinical tutoring, taught and mentored medical doctors, interns and technicians at HGH. He also provided lectures to junior doctors. 1 medical doctor , through clinical tutoring, taught and mentored medical doctors and interns at HGH. He also provided lectures to medical students. 1 Midwife and Community Health Nurse, was doing clinical teaching at HGH with community midwife students, and clinical supervision and

Place / Partner	Activities	Capacity delivered
		teaching on ultrasound at EA. A team of CBH volunteers, in collaboration with nursing students from Edna Aden Hospital, initiated bi-weekly teaching sessions for delivering mothers in issues related to breastfeeding, care of the mother and child post-partum, hygiene etc.
IoHS	Rehabilitation course	Initiated from the director of IoHS, NNM provided a physiotherapist for training one batch of nursing students. NNM also recruited national teachers for co-teaching.
UoH Medical Faculty	Lecturer, continuous courses	1 medical doctor taught research methodology and guided students in practical nutrition research 1 radiologist taught medical students, interns nurses and medical doctors and radiographs practically and theoretically 1 medical professor taught tuberculosis at EA
All institutions	Research training	1 medical doctor recruited and trained field assistants for nutrition research project over 2 months

Challenges in the Pilot Phase included:-

Internally:

- The CBH project suffered from being operative before NNM had been able to establish necessary infrastructure in Somaliland. This affected the volume of capacity building that was offered towards partner institutions in both 2010 – 2011.
- The design of the project was based on the assumption that the required qualified personnel would be available within 3 months' notice. However, this was not possible as recruitment was centralized in Norway and not decentralized at the local level that altogether slowed down the process. Additionally, the salaries offered were not competitive and this impaired the ability of CBH project to meet the needs of partner institutions. The HR challenge was further experienced with the recruitment of short-term workers.
- Delayed start-up of activities due to extensive infrastructural requirements by the CBH project to implement its activities.
- Budgetary constraints.

Externally

- Weaker administrative and coordinative abilities at the partner institutions than anticipated hence the shifting circumstances required frequent changes in the implementation plans i.e. fewer lectures delivered than originally planned
- Poor participation in capacity building activities by the intended participants slowed down planning and delivery of planned lectures.
- Delicate security situation caused by the delayed government elections
- Undue expectations by the other stakeholders including the governmental authorities outside the scope/ability of the project to deliver.

Phase II: 2012, 2013

Following successful completion of the pilot phase, the project received funding to continue with the activities for 2 more years (2012 and 2013), one year at a time. The activities in the pilot phase were continued for the year 2012, but broadened to include administrative capacity

building, more involvement of regional partners and para-clinical training tools. The new activities included the following:-

a) System for Clinical Teaching: - Enabling the HGH and the UoH to constructively organize, implement, monitor and evaluate clinical instruction and teaching of medical students on an annual basis. Use of log books to document clinical experience.

   Indicator: - this was to be measured through:-

   - Narrative on the institutionalization process to enable planning and implementation of a Clinical Instructor teaching activity
   - Final annual plan describing the clinical instructor activity of the UoH and HGH.

b) Teaching of Bachelor of Midwifery for 9 months

   Indicator: - measured through

   - Number of students involved in different topics of the BSc Course
   - Type of subjects and description of capacity building support offered to students and staff during the year.

c) Research Dissemination: - Submission of one Master Thesis to the University of Oslo in collaboration with University of Hargesia and disseminate the results widely.

d) Sandwich Setup (for HGH, EAUH) - Train competent and skilled staff for 3-6 months in anesthesia and scrub nursing as part of future leadership and development of the institutions.

   Indicator:-

   - Number and category of staff trained
   - Narrative on the individual skills acquired and the participation of partner institutions.

   The nurse anesthetist support evolved into an 18 months National Nurse Anesthetist's course hosted by EAUH & Al Hayat Hospital (Amoud University in Boroma) with funding from Fistula Foundation International in collaboration with CBH funding. An experienced Kenyan Nurse Trainer was recruited for EAUH throught CBH.

   Similarly, the scrub nurse training evolved into a 12 month Operation Theater Post-Diploma Nurse Course hosted by Hargeisa Institute of health science and HGH with funding for the training from *Pharo Foundation* and training equipment provided by NNM.

e) Helping Babies Breath course: this is a 12 hour course aimed at improving the skills of staff handling mothers and babies at delivery as well as creating a pool of National Staff capable of transferring knowledge to other staff and students at the two hospitals.

   Indicator:-

   - Number of staff and students trained/number of sessions held

- Narrative on the individual skills acquired and institutional processes enabled at partner institutions through the activity

Highlights arising from Phase II:
This phase responded to some of the recommendations from the evaluation of the pilot phase including:-

- National and International CBH staff in Somaliland, whom have gained increasingly useful experience over the first two years of the project, have formed useful networks critical to the future of the project.
- Ongoing difficult recruitment of skilled personnel as short and long term facilitators for the training program
- Progressive Institutional ownership of the projects activities
- Growing support by the Ministry of Health
- Lack of clear long term plans for the project – causing DIGNI to make decisions that fundamentally affected the ongoing implementation of the project.
- Lack of clear and quantitative indicators hampered measurement of progress and communication of results to donors.

CBH Phase III: 2013, 2014

Following successful implementation of the 2012 period and derivation of a clear long term engagement with the Somaliland government and other stakeholders, a new project was written with anticipation to receive funding for 5 years. This however did not happen as planned and instead the CBH project received another 1-year extension for 2013. The plan was later revised and in the end process of being approved to run from 2014-2018 but put on hold shortly after due to the unique set of circumstances at the end of 2013.
As part of the extension for 2013 and 2014, there was a clear focus to **facilitate institutionalization and coordination of training processes at and between partner institutions and increase their administrative capacity to do so**. This is illustrated in the table below together with the achievements and indicators against each of the objectives.

Objective	Activity name	Indicator	Results/Outcomes
A) Facilitate institutionalization and coordination of training processes at and between partner institutions and increase their administrative capacity	**I. Systems for clinical teaching** of medical students from UoH at HGH	Partners are able to implement the plan that was finalized by end of 2012	I) Full clinical assessment systems and part of the necessary resources for clinical teaching is established for last year medical students.
	II. Hospital management course	Improved managerial capacity and efficiency at partner institutions. Better utilization of external resources	II) HGH have a functional logistic office in their admin department
	III. Hospital management consultants		III) EAUH has improved some necessary systems in the admin finance department and staff is

Objective	Activity name	Indicator	Results/Outcomes
			aware of the needed direction for further improvement.
B) Increase availability of qualified and skilled human personnel at partner institutions relevant to mother and child health.	**IV. Sandwich activity (**from now on called **post graduate nurse diplomas)**	Raised level of performance within operation theater (surgical capacity) in hospitals where workers are offered training	24 scrub/peri-operative nurses and 6 neonatal nurses just graduated and are available for MoH for surgical and neonatal service in the country. 5 additional neonatal nurses doing internship for HGH. 12 nurse anesthetist trainees are now able to do basic (ketamine, spinal, regional) safe anesthesia in hospitals in western part of Somaliland.
	V. Regional health teams support	Students and staff receive added learning by seeing treatment modalities not often offered in S land and team-work -modeling within defined thematic areas	
C) Contribute to clinical skills and competencies amongst the target group particularly relevant to the achievement of the Millennium development goals 4 and 5 – reducing mortality among mothers and children.	**VI. Helping Babies Breathe**	At least 2 per partner institution trained as TOT's. Another 2 training sessions per year expected and 12 students trained so that skills are used in real life situations at partner wards	Three hospitals in Somaliland (EAUH, HGH, Amoud) have nurse/midwife staff with skills to resuscitate newborns well and equipment to maintain skills for staff and students. One hospital (HGH) has a functional neonatal unit operating at the level of WHO neonatal guidelines for LMIC. Last year medical students receive pediatric training at international level.
	VII: Material capacity building support	To provide learning material and basic equipment in order to facilitate the learning process, expecting this activity to improve the clinical and theoretical skills within the institutions	
D) Support implementation of student teaching that encourage learning, accuracy, trust, respect, altruistic care, ethical awareness, equity, justice, the value of the individual and the holistic health approach in patient care	**VIII. General clinical teaching by CBH staff**	a) Students and staff have increased relevant clinical skills and competencies (towards the formal curriculum where existing)	*CBH cannot state results on outcome level here – this will take years to be shown*
		b) Patient friendly attitudes and expression of dignifying human values increases when students and staff are treating patients themselves	

Highlights from the 2013

a) Internal conditions

i) Human resources have been an issue also in 2013. CBH have had high activity due to many short-termers, but the project would have preferred few, long-term staff instead. CBH have during 2013 recruited 2 very skilled national staff that have contributed immensely to the outputs in the project.

ii) A more mature NNM mother organisation has made implementation of activities easier than before.

b) External conditions

i) Withdrawal of Ethiopian partner for "sandwich activity" spurred the development of national postgraduate courses for nurses instead; as a result CBH was involved in training more health workers than expected.

ii) Ongoing requests from HGH prompted CBH to contribute to a whole new unit at HGH, namely the neonatal unit and a training program for neonatal nurses, which was not originally in the PD for 2012-13.

iii) Strong demand of HBB courses from EAUH have made it possible to train all nurse/midwife students at the hospital over a 6 months period.

iv) Deterioration of effective collaboration between NNM and HGH administration starting September 2013 led to termination of CBH training capacity activities in the maternal units from November 2013, withdrawal from teaching of medial students in the maternal wards from October and break down of HBB championship activities for graduate nurse and midwife staff as of September.

Highlights from the 1st half of 2014: (Done/reported Done partly/ possible to report partly Not possible to do/ to report)

Objective	Change to plan	Activities done	Indicator – results or achievability
Objective 1: Finalize nurse anesthetist training	Yes. Amoud have extended their course till January 2015 with own funds.	As scheduled. EAUH running final exams now in July.	After 2Q, 11 students are left (from the 19 that started)
Objective 2: Improve abilities to deliver specialized care for sick and premature neonates among staff, medical students and interns at HGH/UoHMF	Yes. CBH teaching doctor was evacuated and new specialists not given VISA. Alternative input developed.	• Some teaching done by national doctors trained by CBH in 2013. • One national doctor given extra training in Ethiopia in order to be better equipped for teaching students • A contract for HGH neonatal unit signed in March 2014 with 4 stakeholder groups	Only item 3. Has been partly achieved and will be the only item still ongoing for the next 3 months.
	No.	• As scheduled. Final exams for neonatal nurse trainees postponed 1 month due to absenteeism. • Head of ward and 2 neonatal nurses given 1 weeks study tour to neonatal wards in Addis to learn systems	• Nurse spend approximately 180-200 hours teaching • 3 out of 7 trainees at risk of dropping out of course due to poor performance.
Objective 3: Improve knowledge, competencies and skills in **emergency neonatal care** among staff, medical students, postgraduate nurse students	Yes, postponed due to VISA problems for bringing in consultants.	Re-organized the activity with detailed sub-budget and targets, signed implementation contract with EAU. Transferred funds to EAU. Delivered all needed equipment for establishing a HBB center at EAU. Negotiated a contract with Kenya pediatric association (KPA) to follow up the activity during August-November 2014. Ministry of health promised to assist with the VISA issue.	• Expected achievability, but with other staff than anesthetists and scrub nurses. • Assessment will only be done over 3 months due to postponement
Objective 4: Enhance coordination and management of clinical training for medical students at HGH	No	• 7 faculty members trained 2 days in Addis in all parts of the clinical assessment systems. • Regular on-line support by CBH staff in maintaining systems for academic year 13-14.	• In 4th rotation, faculty still need some support, but are improving • Other INGO's has been given all systems developed by NNM
	No	• Log-books filled and data computerized and analyzed. Marks generated. Last data cleaning going on. • Evaluation of Clinical coordination has started and are expected to finish in August • All tools for clinical assessment of medical students systematized and handed over to medical faculty • Financial support from other INGO's emerging. Encouraged to continue the contract with gradual face out over 6 years that CBH developed in 2012	Achieved Evaluation expected achieved Expected achieved
Objective 5: Continued advocacy and facilitation for necessary health systems strengthening	Yes. Withdrawal of NNM health experts from Somaliland makes it very difficult to be proactive and in a position for dialogue	• A concept paper for teaching hospital strategy has been widely distributed amongst national stakeholders • Revision of clinical curriculums during 2014 have been discussed with medical faculty • Drafts of new HMIS variables for maternal and neonatal hospital wards will be given to MoH • A strategic approach to scale up HR for neonatal health has been handed over to MoH, including a complete curriculum for 1 year post-graduate neonatal nurses.	Achievability within 2014 **unlikely**

Changes in conditions for running CBH affecting the project

Between October 2013 and March 2014, a series of dramatic changes in the conditions for running the CBH project in 2014 occurred. One central health worker, teaching students and staff, was deemed “incompetent” by HGH administration and practically unable to do the assigned work from that point in time. The project leader was ordered to evacuate from the country in December 2013 due to a specific threat by elements “willing and able” to carry out operations in Somaliland. One of the rented houses for CBH staff was some few weeks later sealed by the house owner and all assets and personal belongings taken hostage. A painful and resource-demanding process followed, involving the regional court in Hargeisa, elders from Isaaq subclans, Ministry of Interior of Somaliland and the Norwegian Embassy in Nairobi. In February, NNM (that is hosting the CBH project), was ordered to move office on two days’ notice by the Ministry of Interior. Key national staff resigned from their positions. Finally, the country representative of NNM and administrative leader of CBH and the rest of the expatriate staff had to leave the country in March 2014. During first quarter of 2014, it was almost impossible to bring any effective input to the activities in CBH due to the circumstances described and a systematic denial of VISA applications for new CBH expatriate staff. A massive re-organisation of CBH followed with the development of new strategies for being able to finalize ongoing activities. National officers were now put in charge of the activities on the ground with renewed mandate, agreements with national partners were renegotiated (CBH now functioning more as a back-donor for local implementers) and new staff hired on short notice. When the project leader has been in need of meeting beneficiaries face to face, work-shops and study tours have been held in Ethiopia. In short, those activities that national partners have been eager to see come through, has found new ways of coming through, but those who have had lower priority, for one or the other reason, have not been possible to move forward.

Evaluation Methodology

This evaluation is intended to assess the performance against the agreed plan and other procedural and technical health care issues of the project and provide the outcome of the evaluation to the relevant government bodies and to the implementing agency NNM to fill their information gap. In particular the main objective of this end of term evaluation is mainly intended to assess the progress of the project and its achievement and the intended and non-intended consequences generated due to this project intervention and to provide the outcome of the evaluation to the government organization, donors and similar implementing partners.

Evaluation Objectives

The evaluation outlines four key objectives as follows:

1. **Assessment of the main approach and methods applied in relation to the output and overall objectives of the project, including, but not limited to, the following specific assessment areas:**
    - CBH achievements per the planned PD's and objectives
    - Assessment of the needs addressed in relation to the needs expressed by the Government of Somaliland and project partners throughout the project
    - Assessment of the needs addressed by the project in relation to the overall methods and output
    - Assessment of knowledge and resources available to the project, with a specific focus on the assessment of the availability, recruitment, preparations and efficiency of personnel (local and expatriate). Achievements in the project compared to the total number of positions in the project.
    - Assessment of project management, communication and leadership capacity, both at project level and organizational level (SMEA/NLM):
    - Assessment of the strategic choice of the project to be involved in a number of different activities with different cadres of health workers at different partner institutions
    - Assessment of the partnerships involved in relation to local and regional ownership, addressing the needs, establishing the knowledge and resource platform, and implementation context of the project.
2. **Assessment of the CBH project and its staff's impact/spill-over effects beyond the PD expected output in relation to:**
    - Hospitals where CBH staff has been teaching clinically
    - The Ministry of Health
    - Clinical training of health workers in Somaliland
    - Systems strengthening of partner institutions
    - Health research in Somaliland
    - Neonatal care in Somaliland
    - Other dimensions of health care in Somaliland

3. **Explore what opinions stakeholders, partners, beneficiaries and ministries hold in relation to the termination of the new 5 year plan (CBNC) and the withdrawal of all international staff from Somaliland on request from Ministry of Interior.**
    - What was the reason for the termination/breakdown?
    - What did NNM/CBH do well in that process?
    - What could NNM/CBH have done differently?
        - To avoid the situation
        - In crisis management
    - How did the negative attention on NNM affect the partners and the partnerships?
4. **Assessment of the project's overall implementation strategy, impact and challenges in relation to other health capacity building projects implemented through similar initiatives and INGO's in the project area (FINNSOM, THET, KINGS COLLEGE, ADFA)**

Evaluation Methodology

The evaluation employed a mixed-method approach, using qualitative and quantitative methods. Mixed method research is defined as the use of two or more research methods within a single study (Creswell and Plano Clark, 2011). As described below, the varied methods of data collection allowed for different aspects of the evaluation purpose and objectives to be examined. Data was collected using interviews, focus group interviews, emails and documentary analysis.

Quantitative Methodology

The consultants undertook a logical and systematic approach to identify, measure, and document the successes and gaps of the project. Quantitatively the assessment was looking at the issues/recommendations about which there are two evaluation reports. Additional quantitative data was collected through comprehensive literature review of the project reports (key activities; including number of trainings, standardization of current training materials; number of people trained and accredited/specialty; progress documents, communication emails, budget documents, human resources documents etc.). Variables for the study were based on the project objectives and targets as outlined in the terms of reference (ToR) and in the project annual reports. This was further informed by the different project progress documents that were reviewed and observation/site visits in order to assess the specific contribution of the project including the provision of medical or training equipment as per the agreement or at least the minimum standard.

Qualitative Methodology

Qualitatively the evaluation looked at issues relating to the success or challenges of the project both from the implementers', partners and beneficiaries' perspective. The evaluation was participatory, as it sought the involvement and input of all stakeholders in the program. Qualitative methods provided descriptive, non-numeric information. This aimed at providing increased contextual understanding of the project. Qualitative information was compiled from relevant documents, Focus Group Discussion (FGDs) with health care providers who benefited from the program and Key Information Interviews (KIIs) with but not limited to administrators

of host institutions partners of NNM, MOH officials, CCO and similar project implementers. International actors and ex-NNM consultants were interviewed through email communication.

Data Collection Methods

To meet the objectives of the study, data collection instruments were designed by the consultant's team to evaluate the project from the perspectives of the beneficiaries and managers, collaborating institutions and other stakeholders. Contact emails were sent to a sample of past program beneficiaries; employees and other actors. In Depth Interviews (IDI) were conducted to elicit the views of the training facilitators. In depth interviews were conducted with program beneficiaries and other stakeholders. In addition, training curricula and other documentation were analyzed as well as a scoping of the sites supported.

Data Collection Design

FGD and IDI: The tools were divided into five sections:

- Section A: Biographical information
- Section B: Experience of the impact of the program on knowledge, skills, comfort and confidence
- Section C: Impact of the program on capacity building activities (individual, organizational and inter-organizational level)
- Section D: Sustainability of the impact of the program (factors that facilitated and hindered application and sustainability)
- Section E: Overall views of CBH

These open-ended questions allowed respondents to describe their perspectives in their own words. Most importantly, respondents were asked to provide examples of opportunities provided and taken to build capacity at several levels, including within their own practice (changing own and colleagues' practice), within their own institution (e.g. change in policy and priorities), and within the wider community (enhanced relationships between organizations). In addition, respondents were asked to make recommendations for improvements/ best practices and what could have been done better.

For the manager/ administrators several open-ended questions were included to allow them to describe their expectations for the project and whether those were met. They were also asked to provide examples of changes in practice of the staff members, as well as any changes within the institution or between other organizations. Finally, they were asked for any suggestions for changing or improving the project and its supports.

Documentary Analysis: A number of documents were obtained from the Project Manager,

including outlines of the project; project reports; background documents; communication; evaluation reviews; training resources and relevant Microsoft PowerPoint presentations. These were analyzed to formulate a contextual understanding of information pertaining to structure, content and processes involved in the project

Observation and Site Visits: The institutions supported were visited and the Consultants utilized an observation checklist; log frames/faculty logbook; database of those trained; checklist of necessary equipment for obstetric care, neonatal resuscitations and new born care; activity registers etc. to further evaluate the impact of the project at the institutional level.

Sampling of interviewees

A detailed contact list of project focal persons in Hargeisa was availed to the evaluation team. NNM office set appointments for the key informant interviews. The list of key informants is included in the Appendices.

Data analysis methods

Logical and explicit linkages between the different data sources, data collection and analysis were conducted. Data collected from interviews and discussions were transcribed from audio format to form synthesizable themes, patterns and categories. Evaluation findings, conclusions and recommendations were derived from this analysis.

Limitations to the evaluation

There was lack of baseline data and information available that portrays and quantifies the gap in health care human resource, the training gaps and infrastructure in Somaliland- Hargesia prior to the implementation of CBH project. This data would be beneficial in drawing comparable conclusions in regard to the benefit of the CBH project to the health care system in Somaliland- Hargesia.

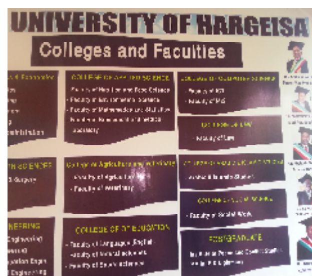
Findings and Discussion

After engaging and interacting with several stakeholders, partners and collaborators of NNM CBH project, it was evident that the CBH project has made enormous positive contributions in improving the skills, professionalism and attitudes of health care workers and the workforce in supported hospitals and institutions. This is outlined in the findings based on the objectives

Objective 1: Assessment of the main approach and methods applied in relation to the output and overall objectives of the project:

To respond to this objective, the evaluation team conducted desk reviews of project documents and reviewed health data from previous health evaluations done in Somaliland (MICS 2006, 2011) as well as Somaliland MOH strategic documents. Interviews were conducted with CBH senior staff, hospital administrators, Hargeisa University faculty officials and Ministry of Health who interacted with the CBH program with the aim of developing an understanding of Somaliland's health and medical education context, CBHs strategic approach, available resources to the project, and to determine the organizational capacity required for successful program implementation.

1.1 Background: Somaliland Medical Education Context.



Medical and nursing Education in Somaliland is in its post war reconstructive phase, with 2 recognized medical schools producing doctors since 2008 and 5 nursing schools. Two facilities are used for teaching medical students and intern doctors; these are Boroma and Hargeisa group hospitals. The number of trained doctors has been gradually rising. As is expected in a post war context, there are few experts/specialists to lecture and teach medical students and recruiting of qualified lecturers is an ongoing challenge.

Evaluation of the medical education context revealed the following:

1. CBH partners especially UoH, HGH and EAUH are willing to provide services but are however severely hampered by lack of core resources-human, financial and training.
2. CBH partners are struggling with many basic institutional issues such as managerial processes, leadership and establishing an organizational culture conducive to collaboration and effective implementation toward their own objectives.
3. There is a lack of clarity of vision and detailed objectives in terms of quality or efficiency development as pertains to future health workers produced and health care services.
4. The managerial processes at the teaching facilities are weak and uncoordinated with few or non-existing mechanisms to ensure a wider ownership and accountability within the organization to facilitate long-lasting change
5. The University of Hargeisa lacks an institutionalized mechanism for ensuring a planned and efficient delivery of training curricula to students.

1.2 CBH achievements.

It is within this challenging context that the achievements of the CBH project have to be evaluated.

Course	Number of people accredited from courses	Type of Course
Helping Babies Breathe	264	Short Course (3 days)
Helping Babies Breath TOT	28	Short Course (3 days)
ETAT+	21	Short Course (6 days)
Neonatology	11	Long Term (12m)
Nurse Anesthetics	11	Long Term (18m)

It is significant to note that there was about 11,000 contact hours of clinical teaching and supervision with approximately 500 health students and staff over the 5 years course of the project, involving around 40 different health teachers. For a country with a shortage of clinical lecturers, the impact of this on the quality of future medical doctors in Somaliland cannot be underestimated.

"The number one challenge is lack of a skilled workforce, which is lack of qualified skilled health workforce..."
MOH

1.3 Project Strategy

Somaliland's Health sector Strategic Plan 2013-2016 recognizes the severe shortage of qualified health staff, with just one doctor for 30,000 people, one midwife per 27,000 and one nurse per 9,000. A skilled provider attends fewer than 20% of births. An important facet recognized by the MOH in this strategic plan is that the performance of the health system in responding to the health needs of the people is poor and that consultation rates for children and adults are very low, with adults visiting a health facility once every ten years and children visiting once every five years in average. Functioning hospitals are underutilized and by far the majority of ill people, if they can afford it and reside in an urban setting, tend to secure treatment from the unregulated private sector. The quality of care provided by private providers is variable and often poor.

Somaliland's health sector therefore faces the two-fold challenge of:

1. Having sufficient numbers of skilled competent health professionals to provide healthcare to its people
2. Improving the quality of healthcare services to enhance health outcomes and increase population confidence to engage the healthcare system.

The CBH project's strategy is extremely congruent in meeting this need, the project therefore sought to improve the quality of health workers, increase the number of a specialist cadre

(nurse anesthesia and neonatology) as well as instill the right values to improve patient care experiences and patient outcomes.

1.4 Project Implementation

The project addressed Millennium Development goals 4 and 5, which are to reduce child Mortality and to improve maternal health by:

1. Coordination of clinical teaching of medical students/interns to ensure future health workers will have the ability to deliver good, evidence based health care to patients
2. Teaching and systems development & strengthening in Maternal ward Hargeisa Group Hospital
3. Conducting Post graduate nurse, intern and medical student training in neonatology
4. Implementing the American Pediatrics Association 'Helping Babies Breathe' course. This taught practical skills towards neonatal resuscitation and contributed towards addressing neonatal mortality
5. Hospital management support through provision of consultancy services at Edna Aden University to ensure that their finance and administrative units are auditable as well as facilitating training in Financial and human resource management, professional ethics and ward management
6. Facilitating the Nurse Anesthetist course which is important in reducing infant and maternal mortality by providing skilled anesthetists for emergency caesarian sections and other surgical procedures
7. Implementing the ETAT+ course, a WHO/KPA program which trains in management of pediatric emergencies and supports reduction of child mortality
8. Advocacy to MOH for better management and coordination of clinical training
9. Supporting Scrub nurse training in collaboration with Somaliland Nursing and midwifery Association (SLMNA) to increase capacity of theatres to manage obstetric emergencies.

As can be seen, the project undertook a multi-pronged approach towards its objectives, with capacity building at the heart of these efforts. It could be argued that capacity building efforts are long term in their nature, are difficult to measure with regards to impact and are only one cog in a multi wheel cog towards improving clinical outcomes.

1.5: Project resources vs Project achievement

1.5.1 Staffing

The CBH project was able to achieve a significant broad base of activities with a mix of about40 short term and 6 long-term expatriate staff (defining long term as more than 1 year duration of contract). Short-term expatriate staff provided technical expertise in medical education throughout the project life cycle. About half of the short-termers have been health workers from the EA region. The number of short-term expatriate staffs who were sourced and were available for the project was an impressive number in light of their non-NNM, concurrent assignments within Somaliland and Somaliland being a fragile, post-conflict state. Short-term expatriates were sourced from NLM generally and specifically from Norway, further increasing the profile of the project.

The engagement of short term expatriates based on the contextual realities of Somaliland can only serve to improve the healthcare system through exposure and interaction with new thinking, ideas and standards however, short termers are limited in their ability to impact change due to the short term nature of their engagement. Implementing long term change is only possible with long term investments on the ground particularly in staff to enable them to interact with, engage and understand the needs of a context which is ever evolving with new players and initiatives.

1.5.2 Assessment of project management, communication and leadership capacity, both at project level and organizational level (SMEA/NLM):

NLM have been undertaking health projects within developing contexts and Africa for the past 60 years. These projects have been essentially focal, donor driven health projects with establishment of rural hospitals, provision of healthcare to local populations and eventual project handover to local authorities. The CBH project appears to be an evolution towards implementation of a different developmental type of health project with interactions with Governments, institutions, local and regional partners from the very start. The previous assessments in 2007 led to an MOU with MOH and various institutions raising expectations of a large capacity building initiative which the program found challenging to deliver. An additional challenge was managing MOH expectations. Consultations with the project team revealed that the project manager faced the challenge of defining the vision and executing the project without strong organizational presence, input, support and guidance. We could not ascertain the adequacy of preparation of expatriate staff but this being a different developing health care context, adequate preparation of expatriate staff to manage expectations and to deal with a less efficient culture would be highly recommended.

Objective 2: Assessment of the CBH project and its staff's impact/spill-over effects beyond the PD expected output

Impact assessment, as a measurement of whether longer-term and sustainable change has occurred from the CBH intervention, was evidently a complex process that we really could not establish. The complexity of impact assessment increases when trying to measure the impact of intrinsically intangible, fluid and iterative processes such as individual capacity building. However, the evaluators attempted to make meaning and correlations based on the project achievements. To respond to this objective, the evaluation team conducted interviews with Hospital administrators, CBH Staff, Hargeisa University faculty officials and MoH who interacted with the CBH program. Site visits; Site observations and focus group discussions were conducted to assess the CBH project impact.

2.1. At the hospital level

The CBH project strategy was to build the capacity of health care workers in selected institutions through short and long-term consultants. Selected trained health care workers were later mentored and supervised to become champions and Trainer of trainers for long-term sustainability.

"...We are privileged to have worked with such a wonderful program...."
EAUH

"...we admire this program"
UoH.

Below are some of the outcomes of the CBH involvement at the hospital level;

- Confidence among program participants in application of acquired knowledge
- Capacity building of health care workers and addressing the needs as outlined in the Somaliland Health Care Strategic Plan
- Resource materials such as the neonatal ward book and labor ward book that are currently being used in the hospitals to manage patients
- Strengthened alliance between CBH program and Edna Adan University Hospital to ensure continuity of the neonatal courses through EAUH
- Improved medical education through introduction of clinical systems to support internship and medical rotations.
- Professional relationships established amongst faculty and CBH teaching staff
- Local Ownership and courses are now being led and cascaded directly through partner institutions
- Being involved in the National internship committee, helping to revise the national program for intern doctors
- Creating awareness at national health meetings about how to establish and use clinical systems for monitoring training among medical students

2.1.1: Clinical coordination Unit (CCO)

Through a consensual agreement among like-minded partners including THET, HGH, ADFA and NNM to strengthen clinical teaching that saw the establishment of the CCO in 2012. The office was set up with an aim of ensuring medical students experienced the best learning outcomes in the wards. Some of the functions of this office with NNMs support include: scheduling of clinical rotations and teaching, scheduling of consultants and lecturers; coordination and supervision of medical students, development of clinical curriculums, systems for formative assessment of clinical competencies and skills and grading of end of year performance.

"...the future health care system depends on these young doctors..."
CCO

2.2 At the Ministry of Health

The MOH is in the process of developing a Health Sector plan that will look into the development of human resource for health care, standardize neonatology training as well as coordinate ad hoc trainings conducted by NGOs. The CBH project has greatly contributed in assisting the MOH address its main challenges that pertain to the health workforce by:

- Number of health cares workers through trainings in neonatology, ETAT+, HBB, anesthesia and developing a neonatal unit in Hargeisa Group Hospitals.
- Supervision of medical students during clinical rotations

- Establishment of clinical coordination unit that rationalizes clinical rotations for medical doctors students.
- Iodine research findings contributing to the discussion of composition of sprinkles (food fortification) to be used in the whole country
- At the time of our field visit- The current CBH National Project Coordinator had been nominated to be the director of the Maternal and Child Health Department under the Ministry of Health

2.3: Neonatal care in Somaliland

Recent studies in Malawi, Kenya, Nigeria and Ethiopia suggest that competency in neonatal resuscitation is critical in the delivery rooms, neonatology units and pediatrics intensive care units to ensure the safety and health of neonates. Neonatal resuscitation is effective only when health professionals have sufficient knowledge and skills however, malpractices by health professionals are frequent in the resuscitation of neonates. In HGH Nurses and midwives lacked the appropriate skills and expertise on resuscitating newborns with respiratory arrest or distress, in February 2013, CBH and Health Poverty Action (HPA) started a neonatal unit in a small corner "Small Box" in the maternity ward in order to address this challenge.

"Before the neonatal unit there was about 70 neonatal deaths in a month after the introduction of the neonatal unit neonatal deaths reduced to 7 deaths per month".
Staff from the Neonatal Unit

The neonatal unit was designed and built in line with the specification document developed so as to cater for triage and resuscitation, Kangaroo care, NICU, isolation rooms, private rooms for laboratory investigations and counseling among others. The building was funded by HPA. Initially 6 nurses were trained in neonatal nursing and placed in the neonatal unit in 2013; an additional 5 were trained in 2013-2014. Two medical doctors were also trained to follow up the ward medically.

"…with NNM, we can go to the moon…"
Staff from the Neonatal Unit

To strengthen their capacity, NNM facilitated the participation of local expertise (4 health care workers) in learning forums such as the International Congress of Tropical Pediatrics organized by Kenya Pediatrics Association (KPA). There was also a study tour to visit 2 hospitals for neonatal health care workers in Addis Ababa, Ethiopia; before the establishment of the neonatal ward, with the main objective of learning how to run a neonatal unit. The unit currently has 2 doctors and 9 neonatal nurses; 11 rooms which can accommodate 3 babies

in each room. In addition to resuscitation of babies; the unit also runs a concurrent program *Keeping Babies Warm*, initiated by previous CBH staff, whereby babies born to needy mothers are provided with a kit that contains diapers and fleece clothing to keep the babies warm.

Previous challenges in neonatal care: Before 2013 there were no place to treat sick newborns in the hospital; lack of documentation hence follow up of clients was difficult***:*** Absence of formal hand-over session or shift end reports to facilitate smooth shift changes***;*** Lack of staff rotation schedules, staff lateness: and lack of adequate resources and equipment to run the neonatal ward

Outcomes of introducing neonatal unit at HGH: 10 midwife/nurses have been trained in neonatology in turn they have become trainers of trainers who are engaged for skills transfer to other health care workers at the group hospitals including medical students in clinical rotations; Internal systems have been developed and strengthened to include proper documentation of the neonatal cases handled at the neonatal ward; improved staff adherence to shift hours and hand-over of reports at the end of the shift; Improved neonatal survival rates due to respiratory complications; Introduction of *Keep Babies Warm* intervention; Payment of salaries for neonatal unit staff; Provision of neonatal health care services at HGH; Provision of essential equipment, supplies and drugs.

2.4: Other health work

As afore mentioned this objective presented particular challenges for assessing impact, not least whether it is possible to demonstrate a causal link between the CBH intervention and a wider process of change; however, other immediate effects to health work in Somaliland included;

- A growing South-south relationships with Somaliland partner institutions through collaboration with CMDA-Kenya, KPA Kenya, University of Nairobi Medical school surgical department, Tikur Ansbessa and Yekatitt 12 hospitals in Addis and Kijabe hospital in Kenya.
- Encouraged SomHealth (drug wholesaler) to start wholesale importing essential neonatal drugs and disposables to Somaliland
- Delivering a whole clinical medicine library worth USD 20000 to medical faculty October 2014
- The recognition of the CBH project at the Ministry of Health despite a small budget. The CBH project was at some point in the duration of the project recognized as the Number 2 performing INGO in Somaliland.

Objective 3: Explore what opinions stakeholders, partners, beneficiaries and ministries hold related to the termination of the new 5 year plan (CBNC) and the withdrawal of all international staff from Somaliland on request from Ministry of Interior.

To respond to this objective, the evaluation team conducted interviews with CBH staff, hospital administrators, Hargeisa University faculty officials and MoH who interacted with the CBH program. Desk reviews were also conducted to evaluate communication and contingency/crisis management plans, which were developed/, occurred during this period.

3.1 Background-Somali Context and culture

Somali context and culture appeared to have a great influence on the termination of the 5 year plan and we therefore sought to develop an understanding of both as we interacted with key stakeholders during our visit to Somaliland.

Religion is very important to people from Somalia and Islam plays an important role in Somali culture. The constitution of Somalia likewise defines Islam as the religion of the Somaliland Republic, and Islamic Sharia and customary laws are retained in many civil and inter-clan matters. Imams and clan elders are particularly influential. Family and by extension one's clan is the ultimate source of personal security and identity with the strength of clan ties providing security in times of need. Clans essentially are tight-knit communities and clan elders hold a disproportionate clout over government affairs. In response to this, and being isolated from the external world during the war and rebuilding, as well as being a deeply conservative country, Somalis appear to be a closed society, wary of foreigners and outsiders that they perceive to want to gain entry into their community.

3.2 Termination

NLM's work in Somaliland took a different approach from other International NGOs. First, they settled in the area of Half London in Hargeisa, which was away from the three areas recommended by the Government of Somaliland for International NGOs as residential areas. Secondly, their residential location was away from their offices and in direct proximity to the surrounding community. Thirdly they took up a large number of houses (6-7) within this area and NNM staff settled in with their families, which was unusual as many INGO positions in Somaliland were unaccompanied positions. Fourth, they did not have the usual security commonly observed accompanying foreigners in Somaliland. They instead moved and interacted freely. Finally, NNM staff learnt the Somali language and was able to freely interact with the Somali population.

From our interactions with key stakeholders whose activities interfaced with the CBH program there appears to be a consensus that the genesis of NNM's problems are traced to propaganda rooted in suspicions of the perceived intention of closely living in and interacting with ordinary Somalis.

"…….because there is a rule in Somaliland which says you don't intermix with the community. Our community don't like foreigners to go in and when I saw them just go in creating friends, ……… So many questions will be asked"

"I know. The false information, I know everything. It is false propaganda……….What I heard was that they were giving some lectures of religion"

"The religious leader was talking every Friday for a whole year about the foreigners. People were stopped from going to those houses because they said they were spreading Christianity"

The situation appeared to slowly evolve and escalated with threats against the NNM Project Manager from religious groups in Hargeisa and denial of visas by the Ministry of Interior to NNM expatriates and visiting clinical consultants. NLM regional leadership decided to terminate the project fearing for safety of their staff as well as perceiving lack of support from the Government of Somaliland despite the tremendous work done in trying to improve healthcare for the people of Somaliland.

The CBH project in pursuit of the goal of improving healthcare within Somaliland, undertook what appeared to be a more direct service delivery improvement approach as opposed to capacity building and involving MOH which was the implementation approach adopted by other NGOs involved in health programs. MOH involvement usually included logistical, administrative as well as financial support. The CBH project also strongly challenged what appeared to be entrenched norms of offering clinical care which were detrimental to overall patient outcomes as well as trying to catalyze change within a health system which was slow to accept efficiency and improvement. The evaluators could not corroborate whether these factors had an influence on the termination of the project, but these came out as significant challenges that the project faced with regards to buy in and ownership by key stakeholders.

3.3 NNM Response and Crisis Mitigation

NNM sought clarification from the Government of Somaliland specifically the MOH and the Ministry of Interior with regards to denial of visas for its project staff. It appears that no suitable movement occurred in the resolution of this matter, and in January and February 2014 an official communication was sent to all partners who were part of the process of implementing the CBH project informing them of the closure of the project within 6 months.

NNM developed a detailed project wind down plan outlining persons responsible for various project components in the absence of the Project Manager and expatriate staff on the ground as well as ensuring continuity of activities and hand over to partners, in particular; the CCO, HGH, Edna Aden Hospital and MOH. The Program Manager provided support from Kenya with visits to Ethiopia to meet project staff and review implementation of activities. Disruption of planned and ongoing trainings was mitigated through engagement of stakeholders to ensure continued sustainability of project components.

It is not unusual for International NGOs operating in different cultures and contexts to face difficult situations which threaten the viability of projects with loss of investments made as well as exposing vulnerable populations to further harm from closure of programs for which there are sometimes no other alternatives. From our interactions in Somaliland, Christian NGOs particularly Caritas and World Vision have faced incidents of a similar nature where accusations were leveled of deviating from their core mandate.

3.5. Effects of termination on partners

3.5.1 Effect on Medical Education

The termination of CBH as a clinical capacity building program had an immediate profound effect especially on the quality of medical and nursing students within Somaliland. The Dean of the University of Hargesia Medical School who has a passion for developing future health workers for Somaliland expressed this during our interviews.

"….. I think the thing, which is very important, is that one of my consultants was lost at the same time the patients, neonatal section, are the ones affected mostly. At the same time the faculty of medicine we were supposed to have 2 sponsors from University of Nairobi, and the process was going on, then this process has stopped now".

3.5.2 Effect on health outcomes

The most profound effect of CBH project termination on health outcomes will be experienced in the neonatal unit. NNM established this unit and initially provided training allowances for 2 doctors and 10 nurses. Health Poverty Action took over renovation and paying for staff salaries but this is destined to end by the end of 2014. Unless new supporters step in within months, it is likely that the neonatal unit will close in the absence of the requisite staff and resources to support purchase of consumables and this will undo the great gains made in reducing neonatal mortality rates.

Objective 4:Assessment of the projects overall implementation strategies, impact and challenges in relation to other health capacity building projects implemented through similar initiatives and INGO's in the project area (FINNSOM, THET, KINGS COLLEGE, ADFA)

To respond to this objective, the evaluation team conducted site visits to HGH, EAUH and the CCO. The team conducted interviews with officials from the MoH and program staff of organizations running medical education capacity building programs in Somaliland specifically THET. We also interviewed hospital administrators and staff of the CCO.

4.1 International NGOs supporting initiatives to improve the quality and capacity of health workers.

From our interactions, we were able to identify four programs supporting clinical capacity building for medical and nursing students as well as for health workers. These were: 1) THET; 2) FINSOMA 3) Australian Doctors (ADFA) and 4) CBH

ORGANIZATION	CLINICAL CAPACITY BUILDING APPROACH
Tropical Health and Education Trust (THET)	Adopts an integrated approach to Human Resources for Health and works at three levels: *1) Individual Health Workers* Through their partnership with King's College Hospital in London, THET supports clinical teaching, continuous professional development and support and supervision in specialties with a special focus on Medical Doctors, Community Health Workers (CHWs), nurses and midwives. *2) Somaliland Training institutions* THET provides support to health training institutes through, refresher courses for tutors, specialist gap filling training, curriculum review and development, examination support and the provision of essential teaching equipment and materials. *3) Somaliland Ministry of Health(Department of Human Resource and Department of Human Planning and Policy)and Professional Associations(Somaliland Medical Associations, Somaliland Nursing and Midwifery Association and Somaliland Medical Laboratory Associations)* THET supports the strengthening of health system governance by providing expert support to develop policies, technical tools, and regulatory frameworks. Institution strengthening support is done through building skills for health managers. THET provides office support and previously supported the salaries for intern doctors from 2006-2011, but this has since stopped. THET is not as extensively involved in direct medical student and medical interns' capacity building as the CBH program.
FINSOMA-International Organization for Migration	The MIDA FINNSOM Health program began in 2008 with an objective of sustaining a well-functioning health workforce to provide quality service to the general populace of Somaliland and Puntland. Through IOM the FINSOMA Program recruits health care workers for voluntary assignments that support the Somaliland Health Sector Strategic Plan 2013–2016 and Puntland Health Sector Strategic Plan 2013–2016. As transferring skills and knowledge to local health practitioners, support professionals and policy makers takes time, the majority of assignments have duration of 18 months.
Australian Doctors	ADFA supports clinical teaching for medical students and interns, as Somaliland has very few specialist doctors to support the teaching of clinical specialties. These are usually short-term assignments of about one-two weeks every 2-3 months.
Capacity Building for Health	Supports undergraduate medical and nursing students increase their knowledge to the expected level described in their respective curriculum guide manuals. Supports the development of Interns and clinical workers at the teaching hospitals to increase their ability to deliver good, evidence based health care to patients. Supports progress towards meeting MDG 4 and 5 by implementing *the Helping Babies Breathe* and *Emergency Triage Assessment and Treatment* courses designed to reduce neonatal and infant mortality. Post nursing Diploma in neonatology and anaesthesia are integrated to support neonatal care as well as emergency obstetric care.

ORGANIZATION	CLINICAL CAPACITY BUILDING APPROACH
	Increases knowledge production through a community health research approach. CBH was more active in directly improving clinical knowledge and skills as well as trying to develop healthcare workers with the requisite competencies to not only deliver good medical care but also act as change agents to slowly catalyse and inculcate medical ethics and values.

4.2. Evaluation of the CBH Strategy:

Somaliland faces enormous challenges in offering medical training to be at par with its regional neighbours. A dearth of medical specialists negatively impacts on the quality of teaching of medical doctors, with implementing partners especially CBH, THET and ADFA filling in this gap by providing specialists for this purpose. CBH (and FINSOMA) was more active in directly improving clinical knowledge and skills as well as trying to develop healthcare workers with the requisite competencies to not only deliver good medical care but also act as change agents to slowly catalyse and inculcate medical ethics and values. The implementing partners had a complementary approach with THET supporting capacity building at training institutions and MOH level to improve medical education by supporting policy development, curriculums review, managerial competencies and regulatory frameworks. CBH however were more concerned with meeting the immediate need for competent and qualified health workers to progressively meet the health needs of the Somaliland population. The different approaches and strategies have been discussed in the lesson learnt and key recommendation section.

Lessons Learnt and Key Recommendations

"I can summarize the strengths as dedication, integrity, knowledge, love for the people, wanting to implement things in already established institutions. Weaknesses: too small? Too many things going on at the same time? Too "white"….. "

NNM- Short-Term Consultant

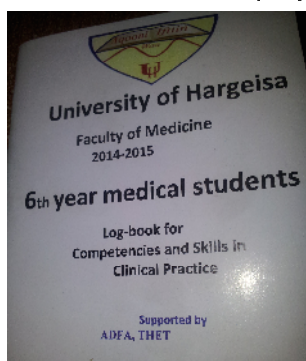
Key Lessons

Relevance: Improvements in maternal and newborn health are key Millennium Development Goals; strategies to achieve them include ensuring skilled attendance at birth and providing emergency obstetric care for women and infants who need it. Improving the capacity of healthcare providers (HCPs) to provide this care is likely to contribute to improved maternal and newborn health.

"There is a change in the way the students are taught but they appreciate the way the teaching is done"
MoH

Measuring Outcomes: In post evaluations of capacity building programs it is impossible to assess the impact on the wider objectives. It is, however, often possible to determine the outputs of the interventions and the effects on the performance of individuals and institutions. Although outputs and effects are often of a qualitative nature, it is usually possible to develop indicators for impact assessment and to collect the necessary information through surveys, interviews, OSCEs and other formative evaluations that show the long-term impact of the intervention. If during the training phase similar information was collected a before-after comparison should be made, which may give an approximation of the net impacts.

Implementation Strategy: By and large the CBH program was quite effective in having met and going beyond its stated objectives. Improving maternal and infant health were the driving factors for the CBH project. Contextually the strategic plan also alluded to the need for skilled workers in the country as well as the gap in addressing maternal and child deaths. Implementation of activities was pegged on institutional as well as individual capacity building. The major achievements include: providing high level expertise; provision of medical equipment and materials; training of trainers; setting up of clinical systems to ensure coordination of clinical teaching of medical students/interns; systems development and strengthening in hospitals; training in neonatology; ETAT+ and HBB; training of trainers; competency based testing; streamlining internship; strengthening of finance and administrative units in hospitals; ensuring collaborations to manage obstetric emergencies



Sustainability and Partnerships: NNM began to take a more 'macro ' perspective in 2012; with more attention was paid to the broader environment in Somaliland in the building of capacity.

More efforts were put in areas as partnerships, integrated planning and inter-organizational coordination. Also, capacity processes were seen to involve complex processes of human behavioral change whose influence governed the more technical considerations with regard to organizational structure and systems. Therefore, the idea of capacity building as a dynamic or a process set in motion came to the front. Also during the exit process plans were made to ensure the efforts were owned and driven by national stakeholders and accepted by them as being in their own interests. Without that commitment and sense of control and ownership, capacity building was simply not viable

Improved Communication and support: The analysis of documents revealed that the Project Manager was involved in both the technical and administrative functions of the project- with "an overflowing" engagement in all other aspects of the project. This makes the organization to be identified by the person and not through its mission or core values. Strengthening individual capacity building of healthcare workers was the core business of NNM in Somaliland, all efforts should have been made to ensure support actions in efficient project administration by SMEA including where necessary provision of equipment and infrastructure.

Key Recommendations

For Capacity Building Efforts

The term capacity building has been used in respect of a wide range of strategies and processes, which have the ultimate aim of improved health practices that are sustainable. The following are key recommendations from this evaluation

Pragmatic Approach: Contracts signed by NLM created expectations in the earlier phases of projects subsequently there was high engagement of the project with numerous stakeholders which also led to the gradual expansion of the scope of work on a "shoe-string" budget. As such the objectives of a capacity building program should always be specific and realistic. This is particularly important in case of a broadly oriented capacity building program, which is the case of the NNM within the framework of Somaliland; vague objectives are a considerable risk factor.

"NNM *wants to give money and know what the money has been spent on"*
MoH

Logical Framework: The CBH Program design should start from a learning theory indicating why and how the interventions will lead to the desired outcomes. Only then useful intervention logic can be developed offering good guidance for the program design. The learning theory underlying the capacity building program should be tested as much as possible prior to the program. The impact of the CBH should be evaluated properly using standard evaluation methodology such as a before-after comparison and a control group approach. The latter is possible if the capacity building program is introduced phase-wise especially for short programs such as HBB.

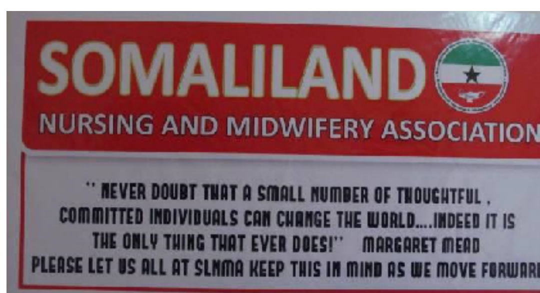
Contextual Factors: For NLM Capacity building efforts should take account of context factors that are likely to affect the outcomes. Such context factors may relate to the political context but also to practical factors such as the availability of people with specific skills needed for interventions this should be determined prior to the program implementation; understanding this would help in identifying what type of skill set to engage in a short-term or long-term consultancy.

For NNM Future Work in Somali Land

Ethnocentrism: Based on our experience the exit process was, and still remains, rarely technical; it was and remains about beliefs and values. Therefore, we must understand both culture and religion as they affect human experiences and lives, and support communities to bring about positive change from within. Each one of us is a product of our own context; it is our individual identities and we often act and react based on how our context labels and stereotypes communities and people. Therefore understanding and investing in finding common ground to ensure that boththe community, religious leaders, clans and ministry embrace and drive NLM efforts is a powerful approach because it takes into consideration that we are dealing with people's most private of human feelings and beliefs. NNM should learn from their country experiences that culture matters. And, therefore, should be committed to deliberately, systematically and strategically institutionalizing a culturally sensitive approach to development.

Technical Support Office: The development of technical expertise is often considered to be essential for organizations so that they can plan, implement and evaluate appropriate health programs and measures. Underpinning this approach is the premise that developing a core of well-trained individuals decreases reliance on external consultants and increases local capacity to sustain efforts when funding ceases. While capacity building may involve further training in a health specialization, broadening the skills of health workers such as training multi-disciplinary teams and not just "specialists/cadres" can also have strategic benefits. This approach focuses on training members of the organization and providing them with skills and knowledge, which is not only beneficial to the individuals, concerned but more importantly to the organization and the wider community. For the approach to be successful the NLM back office should have a highly technical "support office" that can provide "buck-stopping" support to the in-country team.

For Approaches to Capacity Building Efforts



Based on our experience and intensive literature review, we believe that there are four main approaches and within each of these a range of strategies would appear to have potential for capacity building. The four approaches we have identified are: (i) a top-down organizational approach which might begin with changing agency policies or practices; e.g. the WHO way (ii) a bottom-up organizational approach, e.g. provision of skills to staff; e.g. CBH way; (iii) a

partnerships approach which involves strengthening the relationships between organizations; e.g. the THET way and (iv) a community organizing approach in which individual community members are drawn into forming new organizations or joining existing ones to improve the health of community members; e.g. the Caritas Way. NNM should evaluate all these different approaches and identify which is the best way to approach capacity building especially with Somaliland being a highly patriarchal and egalitarian society- in such settings a top-down organizational approach is highly recommended that could later be integrated with a bottom-up approach.

For Data Demand Information Use and Quality Improvement

Our Somaliland stakeholder's feedback meeting revealed that the quality of the data, including those used to track Neonatal and maternal deaths in the Health Management Information Systems is suboptimal and may hinder efforts to strengthen service delivery. CBH should deliberately include an intervention to increase the completeness and accuracy of the public health data routinely recorded in the HMIs. Providing a simple, practical approach to improving the quality of public health information, both at the partner institutions and at the MoH level will ensure accurate information remains vital for health-care planning and for evaluating progress towards specific health targets. Noteworthy, studies have shown a connection between improved data quality and better health service delivery.

For Scaling up

Diffusion Approach: CBH should adopt a diffusion approach in developing its cadre of health care workers. This approach ensures there's a cascaded mentorship approach and plan. A detailed diffusion approach should be considered to ensure there are steps towards a cascaded learning process supported by long-term commitment, teamwork, and fidelity to scientific principles and core values of knowledge transfer.

e-learning: Progress in the use of digital platforms has made it possible to foresee the emergence of a learning health system that enables both the seamless and efficient delivery of best care practices and the real-time generation and application of new knowledge. Somaliland has had an upsurge of Facebook users and uptake in the use of digital platform. With rapid advances in approaches to e- learning, NNM should embrace the use of digital media to explore strategies for accelerating learning among pre-service and in-service institutions.

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Appendix 1:

Stakeholders Feedback Meeting in Somaliland: October 16th 2014 at Ministry of Health Offices:

In attendance:

Name	Institution	Email
Dr Ali Ali	MoH	calixaad@gmail.com
Magnar Naustvik	NNM	Horn.cordinator@nlm.no
Ugaso Juma Gulard	MoH	Ugaso562hotmail.com
Abdillahi Abdi	MoH	Abdillahi_69@hotmail.com
Amina Ahmed Mohamed	MoH	nnm.amina@gmail.com
Kiruja Jason	KPA	gkiruja@yahoo.com
Dr Madi Ali	MoH	malidiyare@gmail.com
Robert Wahome	NNM	nnmeastafrica@gmail.com
Dr Mohamed Mosa	NNM	drmohamed2009@live.co.uk
Dr Gerald Oyugi	Consultant	goyugi@gmail.com
Grace Kiiru	Consultant	wanjikukiiru@yahoo.com
Wandia Ikua	Consultant	w.ikua@yahoo.com
Dr. Peter Memiah	Consultant	pmemiah@gmail.com

Appendix 2:

List of Persons Interviewed

Name	IDI	FGD	Institution / Designation
Fadumo Kahin	X		Hargesia Group Hospital
Dr. Derie Ereg	X		University of Hargesia
Roda Ali	X		Edna Adan University Hospital
Dr. Khadar Axmed	X		Neonatal Unit- HGH
Fadouma Hassan	X		Neonatal Unit- HGH
Rahma	X		Neonatal Unit- HGH
Ms Asia Ahmed	X		WHO Somali Land
Dr Absdirashid Hashi Abdi	X		SMA
Fouzia Ismail	X		Somali Land Nursing and Midwifery Association
Jonah Kiruja	X		Kenya Pediatrics Association
Lula Hussein	X		National Health Profession Commission
Essa Juma	X		Ministry of Health
Dr. Mafuud	X		Internship Program Cordinator
Nurse Neonatal training		X	Nurses and Midwives
Helping Babies Breath		X	Nurses and Midwives
Internship Students		X	5th Year Medical Students
Shugri Bintu Abdulah	X		Clinical Coordination Office
Program Manager	X		THET
Prof Odd Morkve	X		University of Bergen
Dr Mohamed Mosa	X		NNM
Dr Espen Heen	X		Norwegian Lutheran Mission
Rune Mjolhus	X		Norwegian Lutheran Mission
Magnar Naustvik	X		Norwegian Lutheran Mission
Karen Marie Lundeby	X		Pediatrician

Appendix 3:

Focus Discussion guide- trainees

- Gender?
- Age
- Year of Experience in Specialty Area?
- Number of years at present institution?

1. Which NNM CBH training program did you attend? / Or complete?
2. How long was the training program you attended?
3. Did you feel the time allocated was adequate? If yes, why? If No, why not?
4. Was the program relevant to your profession? If yes, why? If no, why not?
5. How did you benefit from the training? Was there any change in your professional skills? If yes how can you tell? If no, why not?
6. How has the training helped you in executing your duties and responsibilities as a health care worker? If yes, how?
7. Did you feel adequately supported by your institution to fully implement the new skills you acquired or learnt from the CBH program? If yes, how? If no, what were the challenges you experienced?
8. What are some of the teaching methods that were used to facilitate learning?
    - Did you like the training approach used?
    - How did the approach facilitate your learning?
    - What did you like?
    - What didn't you like?

   (Topic knowledge of trainer, attitude of trainer, training method used, relevance of the topic to your profession)
9. Have you been through any other capacity building program similar to the NNM CBH one? If yes, which one? How does it differ or how similar is it to CBH?
10. What did you like about CBH as a project? What dint you like?
11. What are some of the challenges you experienced during the training period?
12. What could NNM CBH have done differently as a project?
13. Any other comment?

Appendix 4

Key Informant interview- Hospital administrators/University and teaching institution leaders

Section A

- Gender?
- Age
- Year of Experience in Specialty Area?
- Number of years at present institution?

Section B: program knowledge and understanding

1. What is your understanding of the objectives of NNM-CBH project in Somaliland? How about in your institution?
2. How long has the program been running in your institution?
3. What are the activities that NNM has carried out in your institution?

Section C: Program implementation strategy

4. What strategy does NNM use in implementation of these activities in regard to CBH? Has the strategy worked? If yes why? If not why?
5. Which cadre of health students have benefitted from the program so far? And how many? Do you think the competencies of the students who have benefitted from NNM have improved? How can you tell?
6. In your view do you feel that the CBH project strategy of working with different cadres of health workers is efficient? If yes, why? If no why not?

Section D: Program's contribution and sustainability

7. Of what benefit (if any) has the project been to your institution?
8. Has the implementation of CBH program and program staff had any positive contribution in:
    - training of health care workers,
    - system building at partner institutions,
    - Health research
    - Neonatal care of sick in Somaliland?
    - Any other aspect of healthcare in Somaliland? If yes, kindly explain.
9. Has NNM CBH program and program staff had any negative contribution in the above dimensions or others? If yes kindly explain.
10. Which specific unit in your institution has greatly benefitted from the CBH program? How? Are there other units you feel CBH should have focused on and did not? If yes, which ones?

11. Do you think the CBH implementation strategy is sustainable? If yes, why and how? If not, why not? What can be done to make it sustainable?

Section E: Overall views of the program

12. What has been your experience working with NNM staff? Who in particular have you worked with? Do you think they are qualified to perform their tasks?
13. What were some of the challenges you experienced while working with NNM project staff?
14. What worked well? What were some of the Best practices you observed that can be replicated? Were there any lessons learnt?
15. If NNM CBH project pulls out will there be any challenges that will be experienced? If yes, please specify.
16. If NNM CBH is to be rolled out in another phase how would you wish it was implemented?
17. Do you think NNM has received negative attention? If yes, how had that affected your partnership with her?
18. What are some of the recommendations that you wish NNM need to know about?

Appendix 5

Key Informant interview Guide- MOHL officials

Section A: Biographical data

- Gender?
- Age
- Year of Experience in Specialty Area?
- Number of years at present institution?

Section b: Program Knowledge and understanding

1. What are the main challenges that ail the health care system is Somaliland?
2. How has the ministry tried to address these challenges?
3. How many partners are you aware of that are currently running CBH capacity building projects in Somaliland? Of these partners which one do you think has the best implementation strategy? Why?
4. Specifically what are some of the activities NNM CBH project has been carrying out in Somaliland? What is NNM known for?

Section c: Program implementation strategy

5. What strategy has NNM CBH project to carry out their activities in Somaliland?
    - Did the strategy achieve the set objectives as in the MOU between NNM and MOH?
    - What could have been done differently?
    - Is it similar to other capacity building projects in the area? If not, how different is it?
6. What has been your experience working with NNMs staff?
    - Coordination of activities?
    - Collaborations between you and NNM? ,
    - What are some of the Challenges you experienced working with NNM staff?
    - What are some of the achievements that NNM CBH contributed to?

Section d: Programs contribution and sustainability

7. Do you think the NNM-CBH program has been beneficial to medical students in the institutions it has activities in? And to MOH? And to the partner institutions?

    Specifically has the CBH project had any positive contribution to:
    - Training of clinical health care workers? Kindly explain.
    - How about building of systems?
    - Health research in Somaliland
    - Neonatal care of the sick? Kindly explain.

ii) Did NMM have any negative contribution to the above (areas no.7)? If yes, kindly explain.

Section e: Overall views of the programs

8. What have been NNMs strengths and weaknesses as an organization/partner? Is there need for NNMs activities in Somaliland? Explain

9. The program recently came to an end? What are the probable reasons? What happened? Do you think NNM received negative attention? If yes, how has this affected its partners and partnerships?

10. What do you think NNM could have been done differently? What are your recommendations?

Appendix 6

Key Informant interview- partners/Collaborators

- Gender?
- Age
- Year of Experience in Specialty Area?
- Number of years at present institution?

1. What kind of program (CBH related) do you run in Somali? What are the objectives of your program?
2. What kind of activities do you implement/ and in which parts of Somalia? How long has your program been running?
3. What is your implementation strategy so as to meet your objectives? Targets? Partners? Institutions
4. What has been your experience in implementing your program? Government support and collaborations? Host institutions? Challenges?
5. What are the strengths of your organization? Threats, weaknesses,
6. What has worked best for you in your day to day running of the program? Best practices? Lessons learnt?
7. What have been some of the challenges you have experienced? How did you address them?
8. Have you heard of NNM CBH project? What do you know about it? (if negative attention is mentioned, probe more)
9. Do you think it was successful? What worked? What could they have done differently?