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What is it?
SAHAN is the first ever, large-scale demand creation programme in the Somali context. It is dedicated to improving healthy behaviours and encouraging uptake of health services among women of reproductive age. This programme is committed to expanding the base of evidence and learning around demand creation in the Somali context. SAHAN is led by PSI and supported by a group of partners.

SAHAN is a different kind of programme - we believe in taking risks and using design as a core method for the programme. Design allows us to learn early, learn often, and learn quickly. We believe that it is the people closest to the challenge who have the motivation, the expertise and the insight to radically improve it. For that reason, we know that organisations like yours who have an established presence in the Somali context understand first-hand where the greatest opportunities for innovation lie. SAHAN is currently focused on three primary health areas at right:
Understanding the value of Hooyo Ku Hooyo CDC Model

The notion of mothers supporting mothers to improve health and nutrition is intuitively appealing.

Mother-to-mother (M2M) Community Demand Creation (CDC) models that apply interpersonal communication are not new in Somalia/Somaliland. They have been implemented by a number of health and nutrition NGOs, including PSI and Save the Children.

Recent evidence from Nepal demonstrates that M2M CDC models can be successful in referring women to health services, but their scope can also be easily expanded to include efforts such as participatory health education and collective problem-solving.¹

Understanding the value of Hooyo Ku Hooyo CDC Model

While evidence does exist for support group and/or Interpersonal Communication models for maternal health in other settings, there is not a robust evidence base demonstrating their effectiveness in the Somali context.2

Some of the notable deficiencies of support groups in other settings include: they are often highly dependent upon the organizing entity (i.e. NGO), they often utilise Intrapersonal Communication training materials/techniques which are prescriptive and not adaptive, and they are often not adequately absorbed within local health or community structures.

While the Nepal evidence demonstrates that the group can be effective in serving multiple purposes, it is also worth noting that discussing a broad range of health topics with mothers can make it more difficult for a mother to neatly prioritise her health decisions and ultimately uptake specific services.3 In behavioral economics, this is referred to as choice overload and it often biases people into inaction.4

To address these weaknesses of existing Community Demand Creations, PSI, through the SAHAN project, has redesigned and improved their own existing Community Demand Creation, rapidly tested it, and are now referring to this revised model as Hooyo Ku Hooyo. In this Pilot Manual, we will introduce this revised model, highlighting the specific improvements made upon existing Community Demand Creations and providing details on how this model might be implemented.

The Journey to Hooyo Ku Hooyo

Like many of their partner organisations, PSI has been managing Intrapersonal Communication programming for many years, in a number of countries.\(^5\)

Most recently, PSI has utilised a community-based strategy to increase demand for and access to reproductive, nutrition, child and maternal health services as delivered by the essential package of health services (EPHS) in Somaliland for the USAID-funded Support for International Family Planning and Health Organizations (SIFPO) programme.

Within the context of that programme, PSI was able to interrogate and revise aspects of their existing strategy. Important shifts made during that programme include shifting away from large group-focused interactions and more towards more individualized interactions (including small group discussions, wherever needed based on household size).

A shift from Sessions conducted by mainly Health Workers recruited from different locations to Community based influencers and experiences mothers.

Another important shift was away from sessions held in public venues and more towards home-based visits, ensuring a more comfortable and tailored experience for the mother. As part of this programme, PSI was able to increase referrals more than twofold.

\(^5\) Refer to PSI’s IPC Evaluation.
The Journey
to Hooyo Ku Hooyo

An evaluation of PSI’s CDC program found that women who participated in the CDC sessions were significantly more likely to receive care from a certified health professional.

Although the previous intervention was highly successful, the lessons learnt as well as a deeper understanding of the Somali conservative cultural and religious context helped PSI iterate the approach to a more effective and efficient model. Some of such lessons included dropouts - since 3 days were required for the module per group, high costs – since refreshments and venue were required with nurses/midwives delivering the sessions.

Also, the inability of women to discuss personal issues within the group was reported. The new model called Hooyo Ku Hooyo, now prioritizes non-users of health services, and involves sessions being conducted by experienced mothers from the same community in form of home visits. They were trained on communication techniques as well on knowledge of health areas. These women are responsible for educating other women of reproductive age (WRA) and caregivers of children under 5 years through one-on-one and small group sessions in the comfort of their homes, while also dispelling myths and misconceptions and encouraging use of modern healthcare products and services in the public and private sector.
The Journey to Hooyo Ku Hooyo

To improve the model even further, PSI has recently conducted a Discovery Day within the context of the DFID-funded Somali Advocates for Health and Nutrition (SAHAN) programme.

A Discovery Day is a full-day workshop where the SAHAN team is able to learn from existing demand creation interventions by deconstructing and analysing its component parts - i.e. what’s working, what’s not, and where the key areas for improvement are.

The intervention is then ‘incubated’ using SAHAN’s resources, where the SAHAN Innovation Team tests the new elements of the intervention and tracks what works/doesn’t work. These learnings then inform a redesign of the intervention, which is thus packaged for pilot and/or implementation.
The Journey to Hooyo Ku Hooyo

In this case, the SAHAN Innovation Team conducted rapid testing to deduce whether specific improvements to the M2M Community Demand Creation would increase performance of the agents (encouraging adoption of new healthy behaviours and increasing the number of effective referrals).

In the pages to follow, we will introduce the Hooyo Ku Hooyo itself, its component parts, and how it all works. We will also introduce the ways in which this model differs from and improves upon existing Community Demand Creations (i.e. standard practice).

Following that portion of the document, in Appendix, we have included a number of tools that can be used to operationalize the intervention in whatever context in which you work.

We also present a “How to Pilot” Facilitation Guide which is intended to be an extremely practical how-to guide for conducting a pilot as part of an ongoing design-led approach to innovation (although you do not need to be designers in order to conduct this pilot).
Creating demand for health services requires understanding what is considered desirable to a specific population. Moreover, it also requires us to understand what’s most viable and relevant within a specific healthcare setting. Similarly, when piloting an intervention for demand creation, it is important to understand which aspects of the intervention are core to its effectiveness and which aspects of the intervention are adaptable based on the context.

In the pages to follow, we have structured the intervention according to what’s considered core (must be replicated exactly as intended, to achieve the desired effect) and what’s peripheral (can be adapted to suit the local resource context and cultural context).

In the following pages, we have presented the core components of this intervention in the description and have presented the peripheral aspects of the intervention as ‘recommendations’. We encourage implementing partners to tailor these aspects of the intervention to suit their specific context.
In addition to considering Hooyo Ku Hooyo as comprised of core and peripheral components, we will also present the components according to a three-part framework conventional to any CDC programming. Each component part should serve either an Implementation purpose, an Organisational purpose, or a Quality Assurance Purpose.

**Implementation Systems** refers to activities related to the actual execution of the HkH model. **Organisational Systems** refers to activities related to governance and communication structures, incentives and motivation, accountabilities, etc. **Quality Assurance Systems** refers to the activities related to measurement and supervision. Quality Assurance is pivotal to the success of this CDC model and as such its activities are cross—cutting.
Hooyo Ku Hooyo
Core Intervention

On the following pages, we present each Core component of the intervention. In addition to describing each component, we will also provide a breakdown of the elements which comprise each component of the intervention.

We will highlight which elements have been rapidly tested and improved within the context of SAHAN. Lastly, we will provide - wherever possible - a recommendation about how to best operationalise each component, based on PSI’s experiences implementing this model.

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Implementation Organisational Quality Assurance
# Hooyo Ku Hooyo

## Core Intervention Principles

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<th><strong>COMMUNITY OWNERSHIP</strong></th>
<th><strong>COMMUNITY SUPPORT</strong></th>
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<td>The Female Community Influencers are fully accountable to the communities in which they operate, and their services/responsibilities are community driven. Therefore, FCIs are ideally members of the community. They are mothers just as they are speaking to mothers.</td>
<td>While performing their roles and responsibilities, the FCIs shall be supported by their own communities and local health facilities and local political structures. This calls for respect by the community for their experience, expertise, knowledge, education, position of responsibility, moral standing and character.</td>
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<tr>
<th><strong>EQUITY &amp; ACCESS</strong></th>
<th><strong>VOLUNTEERISM</strong></th>
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<td>FCI services are meant to benefit all members of the community. As such, they should be non-discriminative and unbiased.</td>
<td>FCIs should appreciate the culture of selfless community service as this will ensure sustainability of interventions with or without funding.</td>
</tr>
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</table>
Description

For each home visit, the flow of the session is consistent despite if it is a 1:1 session or a 2:1 session. FCIs work in teams of 2 (or individually) to conduct health education sessions within the community. Each team is required to reach a minimum of at least 4 women of reproductive age (WRA) per day, six times per week, with or without their spouses. The number of interactions is dependent on the duration of the interaction which varies according to the condition of the WRA and barriers that have to be addressed.

Once a session is successfully conducted and a need is identified, the FCIs refers the WRA or caregiver to the nearest health facility using a referral card.

Continuous improvement is a core part of the delivery strategy, ensuring that FCIs’ performance is tracked regularly and upheld according to the training.

Instructions

One of the challenges with any CDC model is teaching and demonstrating what genuine, strong rapport-building looks like. For recommended rapport-building techniques and different types of listening, please refer to the Training Materials included in Appendix.

The general ‘flow’ of a home visit is presented visually on the following page.

In addition to these instructions, we would encourage implementing partners to consider audiovisual tools to enhance the comprehension of the FCIs’ message. This would also help standardize the timing for each session, adding efficiency.
CONDUCTING A HOME VISIT

**OPENING**
- Greeting & securing consent
- Building rapport & trust
- Understanding the mother’s priority needs

**IDENTIFY BARRIERS**
- Clarify key barrier(s)
- Empathise

**ADDRESS BARRIERS**
- Provide the appropriate response
- Address

**CLOSE**
- Focus on a soft close with the mother, meaning asking permission to issue a referral card (if applicable) and making an appointment to follow up with her

More details on active listening and open-ended questioning style are provided to FCIs during the training. These training materials and others are included in Appendix.
On-Job Mentorship and Coaching
The key health messages are tailored to address the specific needs of the priority target audience, and outline a clear call to action for the desired program health behaviors.

FCIs orally deliver health messages during a session using a job aid. While all mothers receive key points of the program Health areas, priority is given to messages that will help change an uncovered barrier or influence uptake of a required healthy behaviour. For the recommended structure and content for the job aid, please refer to the one in Appendix.

Messages should be structured and tailored to the needs/status of the mother being counseled. For example: Session 1 includes first contact with pregnant mothers, session 2 for second contact with breastfeeding mothers.

Consider developing and delivering messages according to specific user segments: new users, new mother, dissatisfied users, satisfied users, interested non-users AND/OR stage of change trial, interest, adoption.
Description

**Activity Types:** Home based visits including one on one and small groups (2-5 mothers).

**Settings:** Refers to household location only, as these are home-based visits.

Instructions

Measure effectiveness of teams of two versus 1 to 1 model.

Based on field work, ideal pairs include an older mother and a younger women with different responsibilities.

For a visual representation of the user interaction points, please refer to process map on the following page.
The HkH Model includes a number of different interaction points, to ensure that the messages shared during home visits are reinforced across various settings. These interaction points also help redefine the woman as she transitions from a first-time user to a repeat user and ultimately an advocate for health services.
Description

FCIs should plan for interactions with married women alongside their husbands where possible or the WRA alone if single or if husband is not available. The timing of the interaction must be convenient for the WRA, to ensure she is relaxed and able to speak freely, listen and comprehend. On average, sessions last for 30 minutes during which no more than 1 thematic area should be discussed. The open-ended questions should be properly applied to identify user priority needs to ensure for an effective interaction.

Qualification for client followed up: All WRA must be followed up until all thematic modules have been completed. All interested clients given referral cards should be followed up to confirm if they received service and to determine whether they were satisfied with service provided.

How to conduct follow up visit:
- FCIs take note of all clients who received a referral card in the previous month but did not come to the facility.
- FCI team then makes a follow-up visit to prospective clients to find out why they failed to come to the facility, and addresses any barriers raised.
- Lastly, the FCIs plan second visit with this client to ensure all issues have been addressed.

The total number of contacts by FCIs includes follow-up visits. FCIs conduct a maximum of 2 visits per client on a weekly/monthly basis.

Instructions

Follow-up is an incredibly important part of ensuring that the HkH model is a system of adoption rather than a linear model for adoption. That is, mothers are experiencing different life stages concurrent to experiencing different stages of adoption (e.g. initial curiosity, first trial). This HkH model has addressed the importance of this. To see a visual representation of the detailed follow-up plan, please refer to our table on the following page.
Because the average mother may fall into a different stage of change (see below, which evokes the diffusion of innovation theory model), it is important to tailor the follow-up interaction with each mother based on this.

<table>
<thead>
<tr>
<th>USER SEGMENT</th>
<th>STAGE OF ADOPTION</th>
<th>GOAL STAGE OF ADOPTION</th>
<th>FREQUENCY OF FOLLOW-UP</th>
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<tr>
<td>First-Time User</td>
<td>Trial</td>
<td>Adoption</td>
<td>Once a week for two weeks</td>
</tr>
<tr>
<td>New Mothers</td>
<td>Interest</td>
<td>Trial</td>
<td>Once a week for two weeks</td>
</tr>
<tr>
<td>Dissatisfied User</td>
<td>Interest</td>
<td>Trial</td>
<td>Once a week for two weeks</td>
</tr>
<tr>
<td>Satisfied User</td>
<td>Adoption</td>
<td>Advocacy</td>
<td>Once a week for two weeks</td>
</tr>
<tr>
<td>Interested Non-User</td>
<td>Interest</td>
<td>Trial</td>
<td>Once a week for two weeks</td>
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The MCH team leaders are responsible for the identification and recommendation of the FCIs from the pool of MOH trained Female Health Workers and Community Health Volunteers based on set guidelines. These candidates are then screened by health communications officers using the MOH-PSI harmonized tool.

The FCI selection guidelines and screening tools are attached in Appendix. The long listed candidates are then trained after which a shortlist is made based:

1- Pre/post test performance
2- Communication skills
3- Observed participation and interaction

For further guidance on what makes a highly effective FCI, please find a persona on the following page.

Recruitment from cadres of nurses and midwives should be included.

Consider including traditional birthing attendants in recruitment, given their status in the community.

Encourage partners to explore the effectiveness of male influencers in targeting men.
SELECTION CRITERIA

- Respected mother from assigned catchment area
- 25-45 years of age
- Be literate
- Previous experience in community mobilization for health
- Acknowledges the importance of confidentiality
- Good communications skills/able to express themselves
- Positive attitude towards modern health seeking behaviors for ANC, facility delivery PMC, FP and child health
- Married or divorced preferred, must be married if speaking about Family Planning topics
- Willingness to work with full 6 month commitment
RECRUITMENT STRATEGY

PROFILE FOR A HIGHLY EFFECTIVE FCI IN HKH

HER STRENGTHS ARE:
• A good listener
• Can easily build rapport with most women and build confidence that encourages openness in their discussions.
• Good communication Skills
• Has a good reputation in the community.
• Is respected and influential
• Knowledgeable about maternal and child health.
• Exceptional ability to empathize due to her experiences and understanding of the cultural and religious context.

HER BACKGROUND IS IN:
• Community Volunteer for immunization and measles campaigns
• Some of them are Traditional Birth Attendants who now encourage Facility Delivery.
• She is a Mother of more than 1 Child.

SHE LOVES WHEN SHE CAN HELP A CLIENT:
• In critical condition and sees the improvement after a few days.
• Change her perception concerning nature and cost of modern health services and that client voluntarily goes for services without need for follow up
• Adopt a new healthy habit like accepting to use MBS rather than just breast feeding or registering herself or her child at the MCH.
• Referred for a service is satisfied with the service received

SHE IS MOTIVATED BY: Self satisfaction when they save lives/improve lives; The wellbeing of all women in her community; Knowledge and skills she gains from exposure trainings by Govt various NGOs, paves the way for future opportunities; The respect, popularity and influence she earns from the community; Financial incentive..

SHE’S GOT AN ATTITUDE THAT’S: Non judgmental, kind, helpful, and friendly.

SHE’S PASSIONATE ABOUT: Being able to influence a fellow mother to adopt a new behaviour; sharing her life experiences to other women can learn form her mistakes and successes.
Description

All agents receive a multi-day training prior to the start of work. The trainings are guided by a curriculum developed in conjunction with the Ministry of Health, to ensure compliance. Health Communication Officers and other personnel who will perform the role of FCI Supervisor are provided training on supportive supervision and giving situation-behavior-impact (SBI) feedback.

Training Objectives: To provide Behavior Change Communication (BCC) skills to the FCIs on how to create demand and increase access of health services both maternal and child health.

By the end of the training, participants will have a clear understanding of the following:

• Communication and community demand creation strategy
• Roles and responsibilities of an FCI
• Maternal and child health situational analysis in Somalia
• Communication skills and group dynamics
• Definition of safe pregnancy and benefits of facility delivery
• How to drive awareness of harmful traditional practices related to pregnancy and delivery
• Benefits of specific health behaviors/services to be adopted

Instructions

Training could also include psycho-social approaches for dealing with mothers who have experienced traumatic health experiences (e.g. lost babies during HF delivery).
In addition to the content included in the Training Manual (see Appendix), we encourage highly experiential (role play and/or immersive) training activities. This tends to increase the amount of content retained for the influencers, and allows them to ask questions spontaneously rather than in a structured, lecture-style setting.

The training manual methods aim to stimulate active participation and ensure understanding of the highlighted learning objectives.

These methods include:

- Flip chart
- Group discussions
- Role play
- Brainstorming sessions
- Demonstrations
- Documentation Practical sessions
- Pre/Post Test
**Description**

The HkH programme uses a performance-based facilitation scheme to motivate FCIs. The figures below reflect market value for the Somaliland/Hargeisa (urban) context but can be adapted to suit a partner’s specific context as desired.

On a monthly basis, each FCI team is expected to reach and educate a minimum of 100 clients through home visits (4x a day). Of the 100 contacted, a minimum of 30 clients per team should be converted to an effective referral at the health facility in order to earn $80 per month. FCIs submit monthly reports, from which supervisors calculate performance.

Each FCI receives $10 airtime allowances in order to organize community-based sessions and follow-up with patients. All participants (FCIs and supervisors) in the monthly review meetings receive $10 for transport and snack allowance.

Attaching FCIs payments to number of effective referrals to the health facility would serve as a measure of effectiveness of both the intervention and the behavior change strategy, although this is again many agency best practices (and often, donor requirements). We instruct implementing organisations to encourage FCIs to target 100 mothers per month. If FCIs reach above 90 mothers, they receive full pay and if they reach below 70, then they are penalized by not receiving pay. This helps to eliminate mediocrity and encourage FCIs to reach core targets of the programme.

Non-performing FCIs will be dropped from the program after two consecutive months of poor performance or inactivity.

**Instructions**

Like many community-based health worker roles, FCIs are often motivated by the desire to gain social recognition, a sense of social responsibility and self-efficacy. Non-monetary incentives, such as awards or recognition for outstanding performance, are another effective approach for motivating FCIs and should be considered both as an addition to the performance-based payment scheme and/or as an alternative incentive scheme.
Each cluster of FCIs receive supportive supervision and mentorship from a health communications officer at least once a month. Each supervisor has a maximum of 30 FCIs. Supervisors provide support to FCIs using the supportive/coaching forms and give SBI feedback based on observations/interactions. Supervisor priorities are given to weaker or non performing teams. Non-performing FCIs are replaced after a maximum of 2 month of dormancy or poor performance.

Monthly review meetings are held for FCIs in convenient community venues, with the aim of providing an avenue for sharing experience, challenges and best practices. Led by supervisors it also allows the HCO to collect reports and provide feedback to the team.

Because any CDC model hinges on communication styles, rapport-building, and other difficult-to-quality-assure and difficult-to-scale techniques, it is important to have clear reporting lines, accountabilities, and roles/responsibilities in place. These will help de-risk misalignment and quality control issues overall.

For more information about the accountability structure we recommend for this intervention, see the following page.
RECOMMENDED ACCOUNTABILITY STRUCTURE

MINISTRY OF HEALTH

REGIONAL HEALTH OFFICER

HEALTH AND COMMUNICATIONS COORDINATOR

HEALTH COMMUNICATION OFFICER

MCH

PRIVATE PARTNER FACILITIES

FCIs WORKING IN PAIRS

MCH

PRIVATE PARTNER FACILITIES

FCIs WORKING IN PAIRS
The objective of the referral card system is to track effective referrals through the health care system.

**STEP 01:** FCIs successfully delivers the health messages to mothers during a home visit and she is ready to go for services.

**STEP 02:** FCIs enters her information in the register and assigns her a referral card based on the desired service. The information collected on the referral cards at this stage includes: date, patient name and contact details, reason for referral, health facility referred to and FCI team ID.

**STEP 03:** The mother then takes the referral card to the health facility where she is registered, cards are collected by the health provider who then fills in the remaining details, which include: name of the service provider (nurse or midwife) and contact details, service provided, signature, date and if patient was referred from another health facility, and the name of the health facility referred.

**STEP 04:** On a monthly basis, the FCI supervisor visits the health facilities to collect the cards and cross check the health facility level information with the client information entered in the FCI registration books.
Description

Like any intervention for demand creation, we recommend liaising directly with your M&E Officer to ensure that the right monitoring tools and processes are set up to track the performance of the FCIs.

A data collection tool has been developed for HkH to enable the FCIs to capture their activities and track their performance. Information on the client’s biometrics, topics discussed and, if referred, reasons for referral are also collected. A referral card is also be issued to such clients. The referral card has been developed to complement existing MCH HMIS tools in order to ease client follow-up and facilitate synergy with government structures. It will enable the M&E team to link the services provided to the client and to the source of information and referral. Data is collated and analyzed monthly, information on the total contacts made, total referrals, effective referrals, and the services provided/received can be tracked. This system makes it possible to track CDC performance and productivity monthly.

For evaluation, monthly reports are routinely subjected to process evaluation (i.e. CDC monthly reports, referral cards, supervisor monthly reports). The supervisor will evaluate performance by team and by activity; the quantity and the quality of work done, technical accuracy, communication skills, communication effectiveness and adherence to strategy. The supervisor with the support of the research team is able to use data to make decisions such as frequency of supportive supervision, areas of strength and weakness, improvement trends over the probation period, etc.

Outcome and impact evaluations are conducted by the PSI research team at designated intervals depending on project requirements and at the end of the intervention.

Instructions

Conversion rates (effective referrals) are the most important part of any CDC model, only insofar as they promote real behaviour change. It’s important that we recognise where this model can be tailored to the local context such that it increased conversion. We encourage partners to explore interventions for improving mother attendance at MCH, looking at interventions that target time, poverty and family obligation-related barriers. Moreover, because FCIs are often in pairs, there is an opportunity for reflection and continuous learning within the influencer teams. We recommend formalising this when implementing.
Register data is collected during monthly review meetings, referral cards are directly picked up from locked referral boxes by the supervisors.

Quarterly data dissemination to MOH and Donor with recommendation of possible iterations.

Referral cards are cross checked against register details and MCH service register. Back checks and phone calls are made to randomly selected beneficiaries for verification.

Data is analysed by M&E department and report is used for feedback to influencer teams and MCH for areas of improvement.
Recruitment Criteria
Vocabulary (Shared Language)
FCI Training Materials
Reporting Structures
M&E Tools for Demand Creation (data collection/workflow)
Supervision (structure; tools for supervision)
Payment Structures
FCI Tools (the ones the influencers use)
Mentorship Program for non-performing FCIs
Referral Cards
Quality Assurance indicators