1. Acronyms

CDC  Community Demand Creation  
DFID  Department for International Development  
DQA  Data Quality Assurance  
FCI  Female Community Influencer  
HPA  Health Poverty Action  
HCC  Health Communication Coordinator  
HCD  Human Centred Design  
HCO  Health Communication Officer  
MO  Monitoring Officer  
M&E  Monitoring and Evaluation  
MoH  Ministry of Health  
NGO  Non-Governmental Organization  
PSI  Population Services International  
RHO  Regional Health Officer  
RMNCH  Reproductive, Maternal, Neonatal and Child Health  
SAHAN  Somali Advocates for Health and Nutrition (programme)  
SHINE  Somali Health and Nutrition (programme)  
TOT  Training of Trainers  
WRA  Woman of Reproductive Age

2. Introduction

2.1. Purpose of this plan

This monitoring plan has been prepared by under the SAHAN programme, to provide a guideline on the indicators, process, tools to be used in monitoring the Hooyo ku Hooyo prototype intervention that has been designed under the SAHAN project. The intervention Prototype is will be piloted through various partners. The guide is to be used by these implementing partners to successfully monitor and measure the outcomes of the intervention and contribute provide evidence for scale up.

2.2. Project summary

The SAHAN project is the demand component of the Somali Health and Nutrition (SHINE) programme. It is dedicated to improving healthy behaviours and encouraging uptake of health services among women of reproductive age (WRAs). This programme is committed to expanding the base of evidence and learning around demand creation in the Somali context. To achieve this, SAHAN is using design as a core method for the programme. Design allows us to learn early, learn often, and learn quickly. It is the people closest to the challenge who have the motivation, the expertise and the insight to radically improve it.

Through Human Centred Design (HCD), SAHAN carries out an elaborate immersive research through a process of discovery and uses insights for the research finding to co-design user centred solutions to address the challenges. The low fidelity solutions are then tested with the user, the learnings then inform a redesign of the intervention, which is then packaged for pilot and/or implementation. The Hoyoo ku Hoyoo intervention is at the Pilot stage and this Monitoring plan serves to provide guidance for its monitoring.
3. Logical Framework

<table>
<thead>
<tr>
<th>Project Summary</th>
<th>Indicator</th>
<th>Means of Verification</th>
<th>Target</th>
<th>Assumptions/Risk</th>
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</thead>
<tbody>
<tr>
<td><strong>Goal</strong></td>
<td>Improved health of Somalis</td>
<td>U5MR, NMR, MMR</td>
<td>Beyond prototype pilot scope. Would require large population survey</td>
<td>NA</td>
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<tr>
<td><strong>Specific Objective</strong></td>
<td>Increased Utilization of Quality Maternal and Child Health services</td>
<td>% Increase in OPD consultations</td>
<td>Health Facility Records</td>
<td>BL: TBD, Target: 5% increase from BL</td>
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<tr>
<td><strong>Outcomes</strong></td>
<td>1. Increased Informed demand for RMNCH services</td>
<td>% increase in new users of ANC services, % increase in Immunization services</td>
<td>Health Facility records</td>
<td>BL: TBD, Target: 5% increase from BL</td>
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<td></td>
<td>2. Improved practice of healthy behaviours among Women of Reproductive Age</td>
<td>% of targeted women reporting at least 2 key healthy behavioural changes three months following intervention</td>
<td>CDC beneficiary feedback survey</td>
<td>BL: TBD, Target: 50% after 9months</td>
</tr>
<tr>
<td><strong>Outputs</strong></td>
<td>1.1 Increased Effective referral for RMNCH services</td>
<td># of effective referrals made for RMHCH services by FCI (Total, vs effective)</td>
<td>Referral cards, FCI registers, HF Records</td>
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<tr>
<td></td>
<td>1.2 House Hold Visits to promote healthy RMNCH services conducted</td>
<td># of HH visits conducted, # WRA reached via HH visits</td>
<td>FCI Registers, Beneficiary Data base and Data Summary</td>
<td></td>
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<td></td>
<td>2.1 Knowledge of RMNCH behaviours</td>
<td>% of targeted women reporting key messages of RMNCH topics discussed during HH visits three months after intervention</td>
<td>beneficiary feedback form.</td>
<td>BL: TBD, Target 50% after 9months</td>
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<td></td>
<td>2.2 Quality of RMNCH messages delivered by FCIs</td>
<td>% of FCIs delivering message according to protocol</td>
<td>Supervision reports</td>
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<tr>
<td>Activities</td>
<td>Activity Description</td>
<td>Indicator</td>
<td>Tool</td>
<td>Responsible</td>
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<tr>
<td>Identification and Screening of FCIs</td>
<td>Screen twice number of required FCIs (i.e. X * 2)</td>
<td>Screening Tool</td>
<td>MCH team leads with support of HCOs</td>
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<tr>
<td>FCIs Selected</td>
<td>Select 130% of X</td>
<td></td>
<td>HCO</td>
<td></td>
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<tr>
<td>Train FCIs on RMNCH Themes</td>
<td>Train 130% of X</td>
<td></td>
<td>HCC, HCO and MOH</td>
<td></td>
</tr>
<tr>
<td>House hold visits</td>
<td>52 visits per FCI pair per Month</td>
<td>House hold visit register</td>
<td>FCI</td>
<td></td>
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<tr>
<td>Monthly Supportive Supervision</td>
<td>Y number of sessions Supervised</td>
<td>FCI Coaching form</td>
<td>HCO</td>
<td></td>
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<tr>
<td>Monthly Support Supervision</td>
<td>Number of HCOs supervised</td>
<td>HCO Coaching form</td>
<td>HCC</td>
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<tr>
<td>Quarterly Activity Monitoring</td>
<td>Number of monitoring visits</td>
<td>RHO/MOH Checklist</td>
<td>RHO/MOH</td>
<td></td>
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<tr>
<td>Quarterly Activity Monitoring</td>
<td>Number of monitoring visits</td>
<td>Monitoring checklist, Beneficiary feedback form, Referral backcheck</td>
<td>MOs</td>
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<tr>
<td>Conduct Monthly Review Meetings with FCIs</td>
<td>1 per cluster of 30 influencers max.</td>
<td>Meeting Report</td>
<td>HCO</td>
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4. Data Flow

- Donor Receives Overall Program report
- Program Manager Receives Overall Program report
- Health Communications Coordinator
- Monitoring Officer (MO): Analyses Findings from Support Supervision sessions with WRA
- Health Communication Officer (HCO): receives report from FCI and MCH team leads and MCH Lead
- Monitoring officer support supervision through follow ups to the WRA
- FCI fills house hold register. Gives referral card to WRA
- WRA visits MCH Facility with referral card
- WRA provides data through home visits

RHO & MOH
5. Data Management

5.1. Storage
All hard copies of the data will be in a locked cabinet. All hard copies will be transformed to excel and SPSS formats. The hard copy of the data will be destroyed immediately after data entry and analysis. Data will be saved on different computers of Monitoring team for back up. All computers containing data/information of the monitoring will have passwords and only authorized monitoring members will have access to it.

5.2. Privacy
The information gathered such as names and medical records in the referral cards will be kept confidential. Data will be analysed on aggregate level, identifiable information like names, phone number etc will not be included in the analysis. During the data analysis and entry, password protected computers/files will be used. Hardcopy documents with names and identifying information will be kept in a locked cabinet, only monitoring staff will have access to it. At the end of the data entry hard copies documents with identifying information will be destroyed.

5.3. Data Quality
To ensure integrity of data, monitoring staff will carry out routine internal data quality assessments (DQA) and data verification exercises using the Routine DQA tool. DQAs will be conducted quarterly and reported activity-level data for each indicator will be compared to facility-level source documents to ensure validity and compliance with data quality standards. Additionally, the Ministries of Health and sub-grantees will conduct data quality checks as part of the joint supportive supervision. These DQA visits will be used as opportunities to further build the capacities of health facilities to regularly monitor the quality of data and take immediate corrective action.

6. Roles & Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibilities</th>
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<tbody>
<tr>
<td>RHO and MOH</td>
<td>They are responsible for the overall program results as the main stakeholder. 2 RHO officers and 2 MOH officers provide a quarterly joint supportive supervision activity using a checklist. Their oversight spans the entire continuum of care from home visit to service provided. The 3-day activity conducted by these officials alongside HCO or management staff.</td>
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<tr>
<td>MCH Lead (MOH)</td>
<td>• The MCH team leads are responsible for the identification of the FCI based on set guidelines.</td>
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<td>• They are responsible for placing the referral card into the referral box for successful referrals</td>
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<td></td>
<td>• They conduct a once monthly field supervision exercise of the FCI/HCO which is documented in a simple Monthly supervision report template and act as a link between the facility and community data.</td>
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<td>• They review that MCH register to audit and report on successful utilization of services</td>
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<tr>
<td>Health communication officer (HCO)</td>
<td>• The HCO supports the MCH Lead in the recruitment of the FCI using the harmonized recruitment and selection tool.</td>
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<td>• The HCO trains the long-listed candidates after which a shortlist is made based on observed participation and interaction, communication skills and pre/post-test performance.</td>
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<td></td>
<td>• HCO reviews the household register filled by the FCI for correctness, completeness and accuracy.</td>
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<td>• Reviews referral cards issued by the FCI from the facility</td>
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</table>
• Offers support supervision mentorship and coaching to the FCI through the coaching and supervision form

Health communication coordinator

• A Health Communications’ Coordinator is accountable for the for the delivery of set targets and performance of the team.
• S/He shall provide oversight to the activities of the HCO, collate HCO reports, monitor performance and well as mentor the officers

CDC Beneficiary Follow up:

• CDC beneficiary Follow up interview will be conducted for mothers who participated in a session at least three months before time of evaluation to check their level of knowledge gained on maternal and child health as well as look at their practice towards promoted health behaviour like health service utilization during pregnancy.
• The list of all mothers who participated in sessions will be obtained from FCI register book and a representative sample size will be randomly selected using lottery method. The total sample size will be proportionately allocated using probability proportion to size (PPS).
• Women will be interviewed using questionnaire about the health topic discussed during the session. Respondents will be drawn from the randomly predetermined list, women who are familiar with the local community called survey guiders will be recruited to help interviewers identify those mothers on the list. Respondents will be approached individually at home to administer the interview.
• Each completed interview will be checked for completeness and accuracy and back checks will conducted to ensure the quality of data. Data will be analysed, reported and shared with the program team.

CDC supervision:

• Physical session observation will be conducted. Program team may conduct CDC supervision, but this will be undertaken by monitoring team to provide a more independent observation from program team.
• All FCIs lists will be used. The list of the CDC agents also contains the total number of sessions since each FCI conducts at least four sessions per day. The list will be randomized and the sorted to select the top 5 FCIs and bottom 5 FCIs depending the number of FCI agents on duty.
• Data will be responsible for attending the sessions and filling out the supervision checklist or taking notes and filling the checklist after the session is complete. They will observe whether the FCIs follows the strategy, targets to the right women, building rapport, addressing barriers etc.

Monitoring team

Referral card back checks:
Referral cards used by mothers will be obtained from Health communication team. A sample of referral cards will be a randomly selected, the contact details on the cards will be used to call the selected mothers to confirm that visited the stated MCH and the services received to compare those services on the cards

Referral cards data entry and analysis:
Existing referral cards will be used. All hardcopy referral cards will be collected from health communication team. Monitoring team will develop a database in MS Excel or SPSS, data on the cards will be entered to the database and will be analysed to make summaries for the program team to use in their future decisions such as supervision and program improvement.

Data quality assurance (DQA):
M&E team will conduct DQA on all the intervention data like the registers, referral cards, registers of MCH who coordinates the operation of the FCIs in the field. Data will be checked using different indicators like its completeness, timeliness, integrity, consistency and accuracy
### Assessing outcome or the effect of HkH:

- This is to see the effect of the intervention on client flow to the MCH located where FCIs are working.
- Data of utilization of different health services provided in the MCH will be collected, attention will be given to ANC, Immunization, adult OPD and under 5 OPD services. Two to three months before HkH started and two to three months during intervention implementation will be selected, data on the above-mentioned services will be compared.
- NB: This is just to get an idea of possible effect (indicator) of the intervention on the client flow but is not absolutely say that the intervention itself attributed to the client flow increase. For this there will be need for more robust methodology which can differentiate the net effect of the program by control other factors. This will be done by a third party Evaluating agency.

### Conducting baseline and end line assessment:

- Baseline assessment of the status of the target population will conducted to see level of the different indicators of the program.
- Before the program starts, two community sites will be selected, one will be the target population for the intervention while the other will serve as a control, the same tool will be used on both communities to determine the status. The two communities should be as much as possible similar apart from the pilot intervention.
- An end line assessment will be conducted at the end of the pilot. Again, both communities will be assessed using same tool. Indicators like health service utilization will be compared between the intervention and control communities, all other factors will be contributed to see the net attribution of intervention.

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### 7. List of Appendixes

- FCI Recruitment Tool
- FCI Agreement (MoU)
- Training Attendance Sheet
- Pre and Post Test
- House Hold Register
- Referral Card
- Supervisor Work Planner
- Supervision Checklist
- Referral Backcheck
- Referral Data Base
- Beneficiary Follow-up Form