

## Programme Completion Review

<b>Title:</b> Somali Advocates for Health and Nutrition (SAHAN)		
<b>Final Programme Spend £ (full life):</b> £7.73	<b>Review Date:</b>	March 2020
<b>Programme Code:</b> 204903-102	<b>Start Date:</b> July 2016	<b>End Date:</b> March 2021

### Summary of Programme Performance

Year	2016	2017	2018	2019	2020
<b>Programme Score</b>	A	B	B	A	A
<b>Residual Risk Exposure Rating</b>	Moderate	Moderate	Moderate	Major	Major

<b>DevTracker Link to Business Case (and any addendum):</b>	<a href="https://devtracker.fcdo.gov.uk/projects/GB-1-204903/documents">https://devtracker.fcdo.gov.uk/projects/GB-1-204903/documents</a>
<b>DevTracker Links to all logframes used during programme lifetime:</b>	<a href="https://devtracker.fcdo.gov.uk/projects/GB-1-204903/documents">https://devtracker.fcdo.gov.uk/projects/GB-1-204903/documents</a>

**ACRONYMS**

AAAQ	Availability, Accessibility, Acceptability and Quality framework
AAH	Action Against Hunger
AG	Accountable Grant
ANC	Antenatal Care
CHANGE	Community Health and Nutrition through Governance and Empowerment
CHW	Community Health Worker
DFID	The UK's Department for International Development
EPHS	Essential Package of Health Services
FCDO	Foreign, Commonwealth & Development Office
HCD	Human Centered Design
HCS	Health Consortium for the Somali People Programme
HPA	Health Poverty Action
INGO	International Non-Governmental Organization
JHNP	Joint Health and Nutrition Programme
MESH	Monitoring & Evaluation for the Somalia Humanitarian, Health & Resilience Programmes
MOH	Ministry of Health
PHU	Primary Health Unit
PSI	Population Services International
SAHAN	Somali Advocates for Health and Nutrition
SBA	Skilled Birth Attendance
SHINE	Somali Health and Nutrition Programme
UN	United Nations
UNFPA	The United Nations Population Fund
UNICEF	The United Nations Children's Fund
WRA	Women of Reproductive Age
MCH	Maternal and Child Health

## A. Summary and Overview (1-2 pages)

### Description of the programme and what it has achieved [1/2 page]

Somali Advocates for Health and Nutrition (SAHAN) is an FCDO funded project which was implemented by Population Services International (PSI) under the Demand Creation component of the Somali Health and Nutrition Programme (SHINE). The main goal of the SHINE programme was to positively impact the health of Somalis and lead to improved human economic development outcomes for Somalia.

### Somalia Health and Nutrition Programme (SHINE) programme structure

#### SHINE (2016-2021)

#### Service delivery and health system strengthening

<p><b>CHANGE</b> EPHS Service Delivery and district/regional health systems strengthening</p> <p><b>Locations:</b> Sahil, Somaliland Karkaar, Puntland Gedo, Jubaland</p>	<p><b>UNICEF</b> EPHS Service Delivery and district/regional health systems strengthening</p> <p><b>Locations:</b> Awdal, Toghdeer, Erigavo, Somaliland; Galgaduud &amp; Mudug, Galmadug and Banadir</p>	<p><b>SHINE SUPPLY</b> EPHS Service Delivery and district/regional health systems strengthening</p> <p><b>Locations:</b> Awdal &amp; Toghdeer, Somaliland; Galgaduud, Galmadug and Banadir</p> <p>Additional system strengthening work at the national level and in Federal Member States.</p>	<p><b>UNICEF Commodity Security Programme</b></p> <p><b>Locations:</b> SHINE Supply Sites</p> <p>UNICEF and UNFPA supply chain strengthening</p>
<p><b>SAHAN:</b> Design of demand creation and behaviour change interventions and piloting with service delivery partners across locations.</p>			
<p><b>MESH:</b> Cross cutting support to monitoring and evaluation and third-party monitoring</p>			

The Accountable Grant (AG) for the demand component, SAHAN, was issued to Population Services International (PSI) in July 2016 with an active period running through 31<sup>st</sup> March 2021.

SAHAN (initially known as '*Tusan Wade*') was the first large-scale, dedicated demand-creation for health programme in Somalia. Unlike typical development projects with pre-determined activities and interventions, this programme aimed to first gain a deeper understanding of the primary target audience and the influential human actors surrounding her.

The overarching programme approach used an evidence-based, participatory design to better understand the persistent barriers to uptake of health services and healthy seeking behavior, and develop and test innovations in demand creation that target the external factors in a person's life that influence individual behaviour.

The inception phase of the SAHAN programme covered the period July 2016-March 2017. The primary objective of the inception phase plan was to undertake formative research to inform the overall programme design and design of evidence-based interventions to increase demand for health services and preventive health behaviours. A comprehensive landscape review of existing evidence, policy and strategy as well as a mapping of demand creation interventions being implemented by other actors across the health sector in Somalia was undertaken. The findings complemented fieldwork research undertaken using human-centred design and social network analysis methodologies, which served to expand the understanding of the target audience's perceptions of health services, healthy behaviours and their influencers. All formative

research activities and analysis was conducted in with ministries of health (MOH's) full participation and collaboration to ensure full oversight and as a capacity building opportunity for health authorities<sup>1</sup>.

In summary, below are learnings from the inception phase activities:

a) From the Landscape Analysis<sup>2</sup>:

- There was limited evidence of the effectiveness of demand creation interventions in the Somali context and few peer-reviewed studies. What evidence that existed concentrated more on Somaliland or was generalized to all of Somalia. Very little evidence existed in the new administrations in Central South Somalia, particularly those where neither Joint Health and Nutrition Programme (JHNP) nor the Health Consortium for the Somali people programme (HCS) were implemented. Key policies developed from 2009-2014 were based on situational analyses of health in Somalia in which health services were provided in an ad hoc manner in the context of a fragmented health system. The focus at that time was on roll out of the newly finalized EPHS to provide quality health services through the public system with the expectation that health utilisation rates would increase accordingly.
- There were many organisations implementing demand creation activities targeting a range of population groups across Somalia, however this is concentrated on areas where JHNP and HCS were implemented, with minimal activities in the new administrative states.
- There had been very little coordination and oversight of demand creation activities to ensure quality, reduce duplication and address gaps. There were gaps in technical capacity in Social Behaviour Change among partners in general (no rigour); many demand creation activities were, in effect, social mobilisation with limited attention to underlying barriers to behaviour change. This extended to other social sectors beyond health as well as the media, where communications programmes and messages were aired, with limited analysis of their effectiveness.
- A lack of engagement by implementing partners in development of Behaviour Change Communication (BCC) policies and strategies had resulted in some strategies with limited implementation, and not being aligned to the needs of beneficiaries, particularly harder-to-reach groups.

b) From the Social Network Analysis (SNA)<sup>3</sup>:

Across all three geographies researched (Baidoa in South West, Burco in Somaliland, and Cadaado in Galmudug), women of reproductive age (WRA) tended to report the same actors as being influential. Actors who had universally strong influence on WRAs included: the husband, mother of the WRA, mother in law and neighbours. Those actors mentioned by two of three geographies as strongly influencing WRA included: hospital, MCH clinic, sheikh, women's community committee, friend and sister. While other actors/nodes were identified in some networks, these actors were consistently relevant for each of the social networks examined in this analysis. Channels of influence rarely operated separately. For example, findings suggested that male actors engaged influential females in order to influence WRAs. Ideally, the WRA would be hearing similar messaging from female community members, husbands, hospital and MCH staff and sheikhs. Mutual personal communication networks seemed to be particularly be influential amongst women, in that in each geography the sister, mother of WRA, mother-in-law of WRA, and female neighbours all had reciprocal connections with WRAs.

c) From Human Centered Design (HCD) research (Design research)<sup>4, 5, 6</sup>:

The methods used in the design research allowed PSI to combine analytical as well as creative processes to "discover" insights<sup>7</sup> into women's perceptions, knowledge, attitudes and behaviours regarding antenatal care (ANC), birth spacing and children's nutrition in different geographical locations in Somalia. These were developed for each of the themes explored and were grouped around design opportunities along the socio-ecological model<sup>8</sup>. The HCD research enabled the collection and analysis of preliminary insights. In providing these initial key insights, HCD aimed to use abductive

<sup>1</sup> SAHAN (Tusan Wade) Inception Phase Report

<sup>2</sup> Landscape Analysis Report

<sup>3</sup> SAHAN (Tusan Wade) Somalia Social Network Analysis Report

<sup>4</sup> HCD Inception Research - Part 1

<sup>5</sup> HCD Inception Research - Part 2

<sup>6</sup> HCD Inception Research - Part 3

<sup>7</sup> An "insight" can be one or all of these: a) The 'why' behind peoples' behaviors, b) Motivations and needs that people may not express but we infer, and c) Anything that makes you think "aha!"

<sup>8</sup> This model considers the complex interplay between individual, interpersonal, organizational, community, and policy factors.

reasoning to validate insights to design new prototypes<sup>9</sup>, to test and iterate in order to develop pilots which, if effective, would eventually be able to be scaled up.

With the completion of the inception phase, the broad foundation of evidence consolidated would be used to design interventions in the co-creation and design and iterate phase. The initial formative research and analysis conducted also helped to identify further areas and insights to explore during the design and iterate phase.

At the end of the inception phase in March 2017, an Inception phase report incorporating and implementation plan post inception was submitted to DFID (now FCDO). After back and forth and subsequent follow-on submissions inception & implementation plan reports covering DFID's (now FCDO) comments, DFID (now FCDO) provided guidance that more needed to be done specifically on: showing progress in HCD to the point of having initial prototypes; cocreation and agreement on implementation plan and geographical coverage; and implementation partnerships. This led to a 3-month action plan (September to November 2017)<sup>10</sup> being agreed upon, comprising the design and iterate phase of the project. During these three months, PSI led a series of stakeholder engagements to share the methodologies and results of inception phase research; validate programme approaches and concretise the way forward for the programme in terms of the ongoing research, the learning agenda and operationalisation of pilot interventions to address barriers to health-seeking behaviour. The action plan culminated with a Validation Workshop which brought together key stakeholders working on development issues in Somalia where dissemination and validation of research findings and programme approach was done and endorsement of the way forward for the programme in terms of the implementation and the learning agenda. Stakeholders included a range of voices from across Somalia including government representatives and civil society champions, implementing partners, UN and Somalia experts from health, behaviour change and related fields.

Following the validation workshop, DFID (now FCDO) and PSI agreed on a program approach which would guide SAHAN activities going forward. From January 2018 the focus was on operationization of the program approach and designing interventions as part of the design and iterate phase of the project.

#### Agreed upon Programme Approach<sup>11</sup>:

- The Socioecological Model would continue to provide the conceptual framework for the SAHAN programme. The Socioecological Model recognizes that women's health behaviours, including those related to demand for care and treatment, take place within a complex web of social and cultural influences. Nested within a system of sociocultural relationships - families, social networks, communities, nations – which are influenced by and have influence on them, women's decisions and behaviours depend not only on their own motivations, beliefs, attitudes and personal characteristics but also on the social and environmental contexts within which they live.
- Once insights gathered through prototype testing as part of HCD were better understood, interventions would be developed that respond more accurately to the actual underlying triggers and motivations of health behaviours. The vision for understanding behaviour was not intended to be an academic exercise, as unpacking all drivers of human behaviour is a complex and peripheral goal. The intent to better understand behavioural insights was to inform the development and adaptation of interventions; allowin the understanding of what was central to the intervention and what was peripheral in considering adaption for other geographies during scale up.
- The programme would continue prioritising the health areas featured in the Inception Phase (i.e. maternal nutrition, Antenatal care (ANC)/Skilled Birth Attendance (SBA), birth spacing), conducting design processes around various design challenges<sup>12</sup> that arise within each health area. New design challenges will be added to the design process as others are deemed complete.
- The programme would employ a phased approach in terms of geographic focus. This meant that prototypes would be tested in different locations that were more easily accessible and conducive to prototyping, and later tested in places that require a higher degree of logistical and risk considerations.

<sup>9</sup> Prototypes are low-cost estimations of what your solution will look like

<sup>10</sup> Concept Note for 3-month Action Plan Demand Creation\_Sept-Nov2017

<sup>11</sup> SAHAN Programme Approach\_2018

<sup>12</sup> Design challenges, based on technical input united with insights about user behaviours, barriers and motivations around health behaviours, are an active approach to tackling and prioritising these barriers and are framed as "how might we..." questions to focus the design journey

- Selection of implementing partners would take place in consultation with the relevant MOHs and the donor. The presence of health services and supplies would be critical to test those interventions related specifically to increasing utilisation of various services, for example prototypes to increase knowledge and use of birth spacing would not be deployed where there are no supplies or services available.
- The programme would undertake a two-track design process. The first track driven by inquiry and empathy: a classic human-centered design process. The second track being more agile, driven by testing: an incubation process. The use of a two-track would allow for both user-generated ideas and partner-generated ideas to be tested with equal consideration. Track 1 ensured design from a place of new insight and empathy with the user experience while Track 2 ensured capture of existing demand creation interventions that either needed a larger evidence base or needed refining for it to be replicable (scalable) across contexts.

ThinkPlace, a design firm with experience in engaging a range of stakeholders in the design of creative prototypes and pilot interventions across sectors was brought on board to lead in-country stakeholder validation and design workshops; co-facilitate the Validation Workshops, build national capacity in design methodologies (including SAHAN's own Innovation & Design Team), monitor roll-out of pilot interventions and lead the core design team.

After a lengthy period of insight generation, ideation<sup>13</sup> and prototyping, testing activities were accelerated towards the end of 2018 to move prototype intervention to the pilot stage. Emphasis was also given to partner engagement with the view of having long-term partnerships for testing and piloting prototypes. During the final quarterly review meeting of 2018, DFID (now FCDO) and PSI agreed on a partnership strategy prioritizing pilot locations where EPHS services were available and adequately funded, with priority given to SHINE health service locations and implementing partners. Steps were therefore taken to bring on board implementing partners under the Shine Supply and CHANGE consortia.

The 2018 Annual Review recommended for SAHAN to accelerate partnerships with SHINE service delivery partners for the piloting of designed prototype interventions and generate evidence. In late 2018 and early 2019, SAHAN brought on board SHINE service delivery partners to pilot designed interventions. The implementing partners included: Mercy- USA, covering Abudwak and Balanbale districts of Galmudug region; Action Against Hunger (AAH) covering Hodan, Abdiaziz and Waberi districts of Banaadir region; Health Poverty Action (HPA) covering Berbera and Sheikh districts of Sahil region; Trocaire covering Dollow, Luuq and Beled Hawa districts of Gedo region; and Population Services International (PSI) covering Boroma and Dilla districts of Awdal region, and Burco and Odweyne districts of Togdheer region.

In addition, DFID (now FCDO) in April 2019, commissioned the Monitoring & Evaluation for the Somalia Humanitarian, Health & Resilience Programmes (MESH) to conduct a rapid review of SAHAN. The review gave recommendations on how to accelerate piloting of interventions including prioritization of the prototypes to pilot. After the review, considerable progress was made by the project, with all 8 prioritised prototype interventions put on track and piloted with the aim of increasing utilisation of services. Their performance and impact was tracked and documented. Monitoring and evaluation data showed influence across key services including family planning, deliveries with skilled birth attendance, antenatal care and immunisation.

A follow up of the earlier rapid review in April 2020, also by MESH, found that through partnerships with SHINE service delivery partners, the programme had increased uptake across key services including family planning, deliveries with skilled birth attendance, antenatal care and immunization. Learnings from the programme were packaged for sharing the with key partners and to institutionalise the interventions over the longer-term.

## **Major lessons learned, evidence generated and recommendations [1/2 page]**

### Lessons:

<sup>13</sup> Ideation is an interactive process in which designers engage groups of target users to generate ideas around specific design challenges, building on insights to form coherent, actionable ideas for potential interventions that would deliver on those needs and desires of the user.

- Human centered design contributed to better understanding of barriers to health service access and design of interventions to address them. This iterative approach requires time and needs to be complemented with other behavior change paradigms but can yield benefits above simply continuing to repeat traditional approaches.
- The SAHAN programme took an ambitious new approach to working on demand creation in Somalia using human centred design to generate new interventions. The complexity and capacity required to make a success of this approach was underestimated.
- Structural issues in Somalia such as access to financial resources, distance and transport affect ability to access services and have not been addressed. However, within these constraints there are many ways to creatively support the Somali community to positively engage with needed health services.
- Involvement of men in service delivery is an often neglected but crucial element to supporting uptake of health and nutrition services by the most vulnerable.
- Work on the supply and demand side should be closely and intrinsically linked to determine the appropriate division of resources and optimal uptake of services.

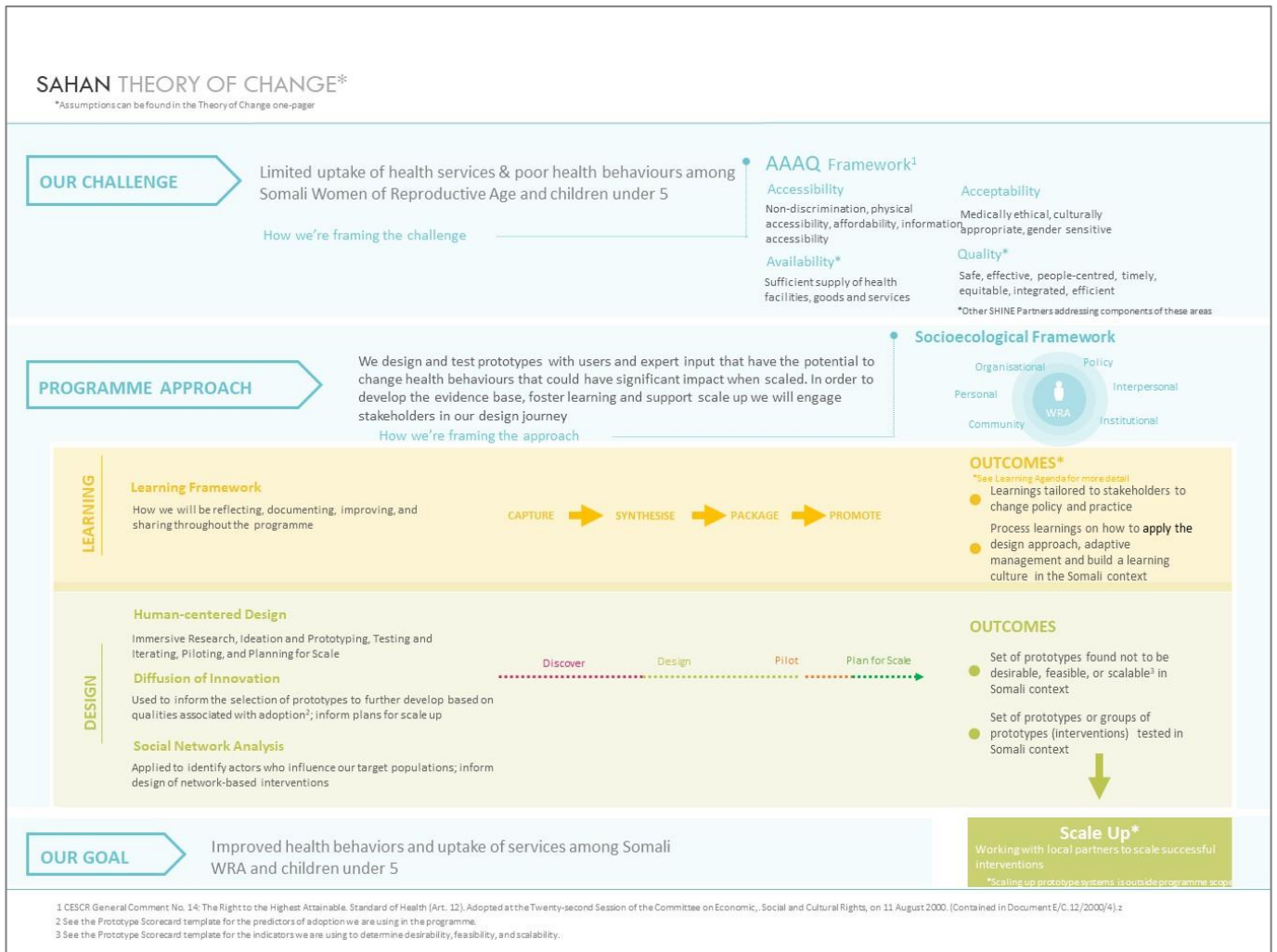
Recommendations:

- Lessons from SAHAN should be integrated into future health services implementation and demand creation work in Somalia. The approaches employed by the programme in developing and improving demand creation interventions proved to be effective in the Somali context and should be scaled and institutionalized within the health authorities. There were also interventions which were designed and tested and proved promising but could not be taken forward to pilot and scale due to time and financial constraints. An example being the Shelter prototype designed to increase facility based deliveries. These should also be explored further in future programming.
- It is vital that as demand creation activities are implemented, efforts and investments should continue to address issues on the supply side. These are issues such as shortage of commodities, availability and readiness of service providers, distances to health facilities. This is especially imperative in the Somali context where health services remain nascent and underfunded. If these are not addressed, there may be a reverse of gains made working with beneficiaries to adapt positive health seeking behaviour

**B: Theory of Change and Outcome Assessment (1-2 pages)**

	Starting point	Final result
<b>Budget</b>	£ 16 million	£ 7.73 million
<b>Timeframe</b>	July 2016 to March 2021	July 2016 to March 2021
<b>Outcomes</b>	Develop and support scale up of proven behaviour change interventions	See section C below

Summarise the programme’s [theory of change](#) and results framework, including any changes to outcome indicators. [1/2 – 1 page]



The Somali Advocates for Health and Nutrition (SAHAN) programme’s theory of change was intended to provide a high-level overview of the programme vision. It articulated the problem the programme was designed to address, the programme approach, programme outcomes and the ultimate goal. It was a visual aid to clarify how the different theoretical and practical frameworks the programme draws upon support the development of key outcomes.

**The Problem**

There is limited uptake of health services and poor health behaviours among Somali Women of Reproductive Age and children under five. These were categorized using the Availability, Accessibility, Acceptability and Quality (AAAQ) framework, a tool to identify potential barriers (service and demand) in accessing services under the domains availability, accessibility, acceptability and quality.



### Approach Used

SAHAN is the demand creation component of FCDO's Somali Health and Nutrition Programme (SHINE). Some of these AAAQ framework barriers would be addressed in partnership with the Supply component, which focuses on health systems strengthening for example overcoming distance through support to primary health units (PHUs) and community health workerd (CHWs). PSI used an adaptive, evidence-based, participatory approach to better understand barriers to uptake of health services and healthy behaviours, and develop and test innovations or existing best practices in demand creation targeting factors which influence individual behaviour. Using the socio-ecological framework these factors were understood to exist at and interplay between the individual, interpersonal, community, organizational and policy levels. Fundamentally the programme re-envisioned how "demand creation" was done, using cutting-edge methods. The human centered design approach was used to develop individual prototypes and, in some cases, group them into systems that when combined could change previously intractable behaviours. Prototypes would be developed through two tracks. Track One would engage partners with SAHAN-aligned funding and mandates. SAHAN would work with them to identify problems for the SAHAN user-centered design process to address. These prototypes could build off of existing concepts and best practices. These solutions would be created with scale-up implicit as SAHAN was designing to meet resourced partners' needs. As such it was anticipated that this track would yield "quick wins" that would help build broader support for the methods and prototypes developed via Track two. Track two prototypes would emerge guided by insights from technical experts and users. Users included women of reproductive age, caregivers of children under five, health care providers, private sector providers, pharmacy owners, community leaders, and others who influence the health behaviours of women. Social network analysis and diffusion of innovations would help better understand the influencers of Somali women and childrens' health behaviours and how best to accelerate adoption of promising prototype solutions. Learning was embedded throughout this programme. The programme would capture, synthesize, package and promote learnings tailored to different audiences. In parallel, programme activities would involve crafting opportunities to build a learning culture and contribute to the communities of practice in the Somali and global contexts.

### Outcomes: Vision of success

Over the life of the programme, a set of interventions would be developed, which, when scaled, would have the potential to improve health service uptake and promote healthy behaviors of Somali women and children under five. Evaluation and process learnings of use of innovative methods and adaptive management practices in a complex context would be documented and shared.

### Assumptions made

- Sufficient political stability and support to conduct programmatic activities
- With adequate support, implementing partners were able to implement a flexible and adaptive programme and development process
- Partner interest and available donor support for scaling prototype systems demonstrated over the course of the SAHAN programme
- Experts willing to engage in providing input and review of the prototypes developed
- Sufficient continuity of individuals involved (implementing partners, PSI staff, DFID (now FCDO) staff, MOH staff, UN and other INGO staff) to allow for programme advancement
- Programme success contingent on availability of health services and commodities

The theory of change was the guiding document for the SAHAN programme. The prototypes and the prototype systems developed would each fall under an area addressing an aspect of the AAAQ framework and a level of the socioecological framework

### **Overall assessment of programme outcomes, sustainability and VfM [1/2 – 1 page]**

#### **a) Programme Outcome:**

Please see C: Detailed Output Assessment

#### **b) Sustainability:**

##### ▪ Implementing Partners:

SAHAN implementing partners; PSI, HPA, AAH, Trocaire and Mercy-USA; are international organizations with footprints in Somalia and are set to still be working within Somalia well beyond

the SAHAN project. Most of organizations were involved from the discover (immersive research), design, iterate to the pilot stages of the project. They have participated, been trained and implemented the resultant interventions the SAHAN project processes. They have witnessed firsthand the impressive impact the interventions have had on health services utilization, being supply service delivery partners under the SHINE and implementers of demand creation. They contributed to the improvement areas where the interventions were weak or not working well. In short, SAHAN demand creation approaches and solutions have been adopted and to varying degrees institutionalised in these organizations. These partners have used learnings from the program to enrich proposals for new projects and to improve their existing demand creation activities. As an example, PSI will in April 2021, be kicking off implementation of the World Bank funded Female Health Worker program in Somalia. The approaches in this new project borrowed heavily from learnings from the Hooyo ku Hooyo intervention and the other SAHAN interventions.

- Private Sector Partnership:

The Shaafi IVR intervention – a mobile-based health consultation service providing tailored information on antenatal care, delivery, nutrition and birth spacing – was implemented on a 50/50 partnership with a private sector telecommunication partner, Telesom. Even after the end of the pilot period, Telesom has continued to run the expanded Shaafi intervention and will continue doing so for the foreseeable future through the corporate social responsibility (CSR) arm of the company.

- UNFPA:

The Values Clarification and Transformation (VCAT) – an intervention on family planning addressing issues around health workers personal values and attitudes to improve capacity to deliver confidential, non-judgmental birth spacing services – was adopted by UNFPA as a precursor to their standard technical training on family planning.

**c) VfM:**

In late 2020, FCDO commissioned MESH to review SAHAN programme on VfM. MESH assessed the financial aspects of the SAHAN programme with a focus on the 8 prototypes piloted by the programme. This covered the consolidated programme delivery period, 2019 – 2020, and considered the initial ‘testing’ of 47 prototypes and the final implementation of 8 final prototypes. It included any potential/realised value associated with how other partners (UNICEF, UNFPA, Save the Children, et. al.) have adopted SAHAN prototypes and approaches. The review built on an initial review from 2019 that assessed progress to date and provided a framework and recommendations for the newly consolidated programme and a follow-up review on progress, conducted in April – May 2020. The review was organised around FCDO’s value for money (VfM) ‘4Es’: economy, efficiency, cost effectiveness.

See VfM section of C: Detailed Output Assessment for summary findings from this review.

**C: Detailed Output Assessment** [aim for max. 1 page per output. Repeat for each output]

<b>Output Title:</b>		Develop and support scale up of proven behaviour change interventions					
<b>Output number per LF</b>	3	<b>Out put Score</b>	<b>2016</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>
			A	B	B	A	A
<b>Impact weighting (%)</b>			20%				
<b>Weighting revised since last AR?</b>			N				

<b>Output Indicator 3.1</b>		<b>SAHAN</b>
Number of interventions designed, tested and piloted	<b>EXP</b>	35 prototypes designed 24 prototypes tested 8 prototype interventions piloted/in pilot in the field 2 piloted interventions documented and packaged for scale
	<b>ACH</b>	47 prototypes designed <sup>14</sup> 29 prototypes tested <sup>15</sup> 8 prototypes piloted and packaging for scale <sup>16</sup>
<b>Output Indicator 3.2</b>		<b>SAHAN</b>
Number of evidence generation and synthesis products and processes used in prototype development	<b>ACHEXP</b>	20 quality evidence generation or synthesis products
	<b>ACHEXP</b>	More than 20 received <sup>17</sup>

**Briefly describe the output's activities and achievements during its lifetime, and provide supporting narrative for the score.** [1/2 page]

SAHAN used an adaptive approach, carrying out formative research to understand the barriers to uptake of health services and healthy behaviours by women and children under 5; and an iterative 'human-centred design' approach to designing, testing, piloting and gathering evidence for new approaches to increase access to and utilisation of reproductive, maternal and child health and nutrition services and promote healthy behaviour. The human centred design approach and behavioural science was used to understand people's behaviour through observation and immersive research; combining these with expert knowledge, and working closely with users themselves to design interventions or 'prototypes' and testing and iterating them before piloting at greater scale to measure impact.

Following a call for proposals in December 2015, this component was contracted, via an Accountable Grant to PSI in July 2016. The scoping of SHINE's 'demand creation' approach was the main task of the inception phase. Initial discussions took place through an Early Market Engagement exercise, which helped to set out the scope and meaning of 'demand creation' in the Somali context. During this exploratory inception phase, formative assessments were completed to help set out the scope and meaning of 'demand creation' in the Somali context. These were:

- A landscape review of existing evidence and mapping of demand creation interventions (literature review and key informant interviews)
- Social Network Analysis which looked at influencers of women of reproductive age's health decisions, key themes and potential pilot interventions.
- Ethnographic research on antenatal care, birth spacing and nutrition using a Human-centred Design (HCD) approach. This focused on understanding the motivations and behaviours of the target audiences by talking to them directly. Insights from the research were shared with experts for discussion and validation.

Due to challenges faced during the inception phase, an extension was granted to PSI from December 2016 to March 2017. A number of issues contributed to this, including the length of time it took to recruit a

<sup>14</sup> Updated Prototype Tracker\_March2019

<sup>15</sup> Updated Prototype Tracker\_March2019

<sup>16</sup> Prioritizing Prototype Tracker\_Micro Gantt\_June2019

<sup>17</sup> The comprise of documents annexed to this report and more submitted along with quarterly programme reports in the course of the programme

Behaviour Change and Communication Adviser and added difficulty in getting the right expertise to conduct the formative assessments in Somalia, particularly for the approaches used by the SAHAN project. Though a DFID (now FCDO) evaluation of the inception phase questioned the robustness and quality of some of the formative assessments, this was carried out successfully with recommendations for the post-inception presented to DFID (now FCDO) based on results accrued from this phase.

PSI's management of the programme improved with a lead project adviser joining in May 2017. At the end of the inception phase in March 2017, an Inception phase report incorporating and implementation plan post inception was submitted to DFID (now FCDO). After back and forth and subsequent follow-on submissions of inception & implementation plan reports covering DFID's (now FCDO) comments, DFID (now FCDO) provided guidance that more needed to be done specifically on: showing progress in HCD to the point of having initial prototypes; cocreation and agreement on implementation plan and geographical coverage; and implementation partnerships. A three month plan (Sep-Nov 2017) was therefore agreed upon to allow for technical expertise to quality-assure the formative assessments; socialise the programme amongst wider stakeholders working on similar programmes and to develop the full programme design. As part of this plan PSI collaborated with the consultancy Think Place<sup>18</sup> to pilot use of the human centred design (HCD) approach to design behaviour change interventions. Users (women of reproductive age, men, healthcare workers and government) discussed barriers to behaviour change (informed by the formative work) in the thematic areas of antenatal care (ANC), birth spacing and nutrition and worked with PSI and the design team to co-design interventions to tackle these. These were then tested in the community, health facilities and via social media. After further refining and testing they were presented to the Ministries of Health (MoHs) before being deployed, tested and re-iterated in additional locations in Somalia to further refine and contextualize them. This was completed with a validation workshop in November 2017 and a programme approach and theory of change agreed in January 2018.

Designing of interventions continued with field research and a series of successful consultation and design workshops generating ideas and following the co-design process with users mentioned above. These were subsequently turned into prototypes and captured on a tracker representing a pipeline of early stage interventions. Some examples of the prototypes designed at this time included:

- Shelters: prototype which sought to ensure women accessed facility delivery services while maintaining control of her home and her trusted support system. This was to be done by building simple shelters next to the delivery health facilities where women could temporarily move her home as she waits to deliver.
- Model Husband/Father: prototype exploring how to reframe the cultural perception of 'weakness' for the man who attends ANC and use this to drive attendance
- MCH Innovation Challenge: prototype engaging MCHs to develop and implement prototypes that would encourage healthy behaviours and drive use of health facilities
- National Birth Spacing Debate: prototype exploring how to use the International Conference on Family Planning (ICFP) to drive the National Birth Spacing Debate. Explore how to use multiple channels - digital, fireside chats to drive this debate.
- Small Millers Flour Fortification: prototype exploring opportunity to fortify flour through small scale millers and how to best market it and drive demand of fortified flour among both millers and the population
- Conditional Cash Transfer: prototype exploring a system that enables redemption in the private sector
- Super Sheikh: prototype envisioning a high-profile ("celebrity status") sheikh endorsing birth spacing (or other health messaging)
- Delivery positions: prototype exploring how to take advantage of identified reason for some women not delivering at health facilities because they don't like the delivery position of laying on bed but prefer other delivery position including on floor or while sitting.-'AHA' moment for us!
- Confidentiality Camp: Training for MCH staff on the topics of empathy, trust-building, privacy and confidentiality; to uphold the behavior change expected out of the training. Focused mostly on provider behavior change. This after it was noted that one of the barriers to family planning use was due to provider lack of confidentiality on clients family planning choices.

<sup>18</sup> <http://www.thinkplace.com.au/>

- C-Section rebrand: Concept was to develop a brand and messaging to counter the current Somali name for c-section i.e. directly translating to "slaughter"

To bring technical expertise into our process, SAHAN designed an Innovation Lab model<sup>19, 20, 21, 22</sup> where technical experts are gathered (based on health priority area) and invited to bring their knowledge to bear and help sense-check and design the most desirable, viable, and scalable solutions to health possible. Rather than passively contributing knowledge, they were active contributors to our design process by helping to improve prototypes, directing our immersive research priorities, and more. This was also replicated through quarterly sprint reviews meeting where in addition to the donor, stakeholders including government representatives and civil society champions, implementing partners, UN and Somalia experts from health, behaviour change and related fields were incorporated.

After a lengthy period of insight generation, ideation and prototyping, testing activities were accelerated towards the end of 2018 to move prototype intervention to the pilot stage. Emphasis was also given to partner engagement with the view of having long-term partnerships for testing and piloting prototypes. DFID (now FCDO) and PSI agreed on a partnership strategy prioritizing pilot locations where EPHS services were available and adequately funded, with priority given to SHINE health service locations and partners. Steps were therefore taken to bring on board implementing partners under the Shine Supply, UNICEF and CHANGE consortia. Nonetheless, in August 2018 a decision was made by DFID (now FCDO) to reduce the budget from £16 million to £ 8 million. This was at the back of what was seen as slow progress coupled with slow expenditure at the time, hence deeming the remaining budget to be too high for the remaining implementation period.

In April 2019 a decision was made to conduct a rapid review of the programme through MESH to assess the programme<sup>23</sup>. The assessment found that the combination of a long inception phase, personnel changes, and decision-making by DFID and others are cited as the primary reasons for delays. These occurred alongside a learning curve about HCD and possible results, shifting from one that focused on demand creation and behavioural change to learning and evidence. Confusion about what the programme was expected to achieve was a dominant factor that contributed to these and other delays. The inception phase set out a broad and ambitious approach that was not linked to a clear strategy and plan. This was followed by an overt insistence by SAHAN to treat the HCD process as sacrosanct. At some level, the results shifted to the process—to HCD—rather than practical results associated with specific prototypes. At the same time, it was not clear whether the process, HCD, was expected to generate long-term results in relation to increased demand across Somalia, as envisioned in the SHINE log frame, or if results were at the micro-level of each prototype were sufficient. This contributed to a focus on getting as many prototypes in development as possible without a clear link to possible results. It became about prototype generation rather than a more informed and strategic approach to see how HCD could produce interventions that could create demand or contribute to positive behaviours. Among other recommendations, the assessment recommended for PSI move quickly from design to piloting a prioritised list of interventions and gather evidence of their impact.

A follow up review in April 2020<sup>24</sup> found that the program had moved on this and SAHAN had piloted 8 interventions and gathered evidence on their impact across SHINE districts in Somaliland, Banadir, Jubaland and Galmadug. The interventions all addressed different barriers to service uptake and are designed to work in a system reinforcing each other. The need to prioritize the interventions to move forward led to a focus on communication-based interventions which was informed by evidence of their value in the Somali context. Some of the more complex interventions (e.g. food fortification, maternity shelters) were not progressed but evidence of their potential was captured and made available. It found that the programme had contributed significantly to uptake of essential health services with the following designed prototype interventions during pilot phase:

<sup>19</sup> Innovation Lab Nutrition Workshop Tracker\_Mar2018

<sup>20</sup> Innovation Lab Birth Spacing Workshop Tracker\_Mar2018

<sup>21</sup> Innovation Lab ANC Workshop Tracker\_Apr2018

<sup>22</sup> Innovation Lab ANC Workshop Tracker 2\_August2018

<sup>23</sup> Rapid Review of SAHAN\_MESH\_2019

<sup>24</sup> Follow-up on Rapid Review of SAHAN\_MESH\_2020

1. **Hoyo Ku Hoyo (Mother to Mother)<sup>25</sup>**: Experienced mothers educate young women in their homes through 1-1 or small group sessions. Focus on empathy, personalised support and building trust. Focus specifically on those not using services.  
*Results*: 284,433 home visits were conducted, and 143,646 beneficiaries were reached. 56% of those counselled required care for them or their children; 95% of those referred took up the service. Antenatal care and immunisation most utilised. A high proportion of visits were first-time contacts with health services.
2. **Birth Preparedness Class (BPC)<sup>26</sup>**: Classes at health facilities to educate pregnant women, familiarise them with the facility and reduce fear with the objective of increasing antenatal and delivery care uptake.  
*Results*: More than 50% increase in antenatal care attendance, 10% increase in facility delivery. The unpredictable timing of the latter means it is heavily affected by distance and availability of transport. There also remain issues with 24-hour maternity services. 64% of the evaluation study respondents reported that they completed the recommended 4 ANC visits. 74% of the study participants could recall the importance of ANC as discussed in the sessions. 78% of them could mention three benefits of facility delivery. 64% could mention at least three danger signs in pregnancy.
3. **Men's Club<sup>27</sup>**: Men are key decision makers but rarely discuss maternal and child health issues. The intervention introduces these topics through carefully designed activities in locations where men gather socially. For men requiring care for their families, referral cards are issued to track uptake of health services.  
*Results*: The majority of men attended more than one session. Between a quarter and half received referral cards and approximately 60% used them. 84% of evaluation study participants reported to have initiated discussions with their wives on health topics discussed during the men's club discussions.
4. **Poetry competition (Hiil Hooyo)<sup>28</sup>**: Competition conducted through social media leveraging on importance of poetry as a medium to communicate on health issues.  
*Results*: The competition's Facebook page had a following of more than 8,000 people and its posts having more than 3,000 engagements (reactions, comments, shares etc.). The page had also reached more than 45,000 unique Facebook users since its creation.
5. **1000 days campaign<sup>29</sup>**: TV, Radio, print and social media campaign aimed at rallying community support for women and children during 1000 days of pregnancy and early childhood. Content adjusted using behavioural insights and science on framing messages.  
*Results*: Over 5 million reached with content. The 1000 Days Campaign Facebook page had more than 2,000 followers.
6. **Shaafi Integrated Voice Response (IVR)<sup>30</sup>**: Mobile based health consultation service providing tailored information on antenatal care, delivery, nutrition and birth spacing.  
*Results*: During the 3-month pilot period, the number of calls increased from 15,551 in March 2020 to 108,263 and to 152,512 in May 2020 when the pilot concluded. Even after the pilot, with Telesom taking Shaafi forward by themselves, though lower than the high of May, the high number of calls remained high between 60,000 – 110,000 per month. Overall, since the start of the partnership in March to December 2020, the Shaafi IVR platform received more 1,029,635 calls from 102,845 unique callers, 32% of which was for birth spacing information
7. **Values Clarification and Transformation training on family planning**: Addressing issues around health workers personal values and attitudes to improve capacity to deliver confidential, non-judgmental birth spacing services.  
*Results*: Positive feedback from participants. UNFPA have adopted this curriculum as a pre-cursor to their standard technical training.
8. **Family planning method mix**: Work with private providers to offer a mixture of family planning (FP) commodities addressing issues with availability and confidentiality in the public sector and preference for private providers.  
*Results*: PSI continue to avail the family planning (FP) commodities in the private sector, working to develop a self-sustaining model with gradual reduction of the commodity subsidy.

<sup>25</sup> Hooyo ku Hooyo (HkH) Pilot Evaluation Study Report\_December2020

<sup>26</sup> Birth Preparedness Class (BPC) Pilot Evaluation Study Report\_December 2020

<sup>27</sup> Men's Club Pilot Evaluation Study Report\_February2021

<sup>28</sup> Hiil Hooyo Poetry Competition Pilot Evaluation Report\_December2020

<sup>29</sup> 1000 Days Campaign Pilot Evaluation Study Report\_January2021

<sup>30</sup> Shaafi IVR Pilot Evaluation Report\_January2021

In 2020, FCDO official development assistance (ODA) prioritisation process meant the SAHAN programme wrapped up slightly early i.e. December 2020. Demand will not be a separate component in the SHINE extension as the objective to design and pilot new interventions had been completed; its findings will be integrated into other elements of SHINE and the wider sector. The focus is on ensuring the wealth of lessons and learnings from the programme are captured and shared; and exploring opportunities to scale and sustain the interventions over the longer-term with, amongst others, World Bank, GAVI and Global Fund.

**Assess the VfM of this output based on performance over the past year, and over the lifetime of the programme [1-2 paragraphs]**

SAHAN aimed to find new and more effective ways to increase demand and the interventions piloted have successfully increased service utilization. In some cases, uptake has increased by 50% specific interventions and health services. A focus on equity and the hardest to reach also improved the uptake of services amongst the most marginal; and different interventions specifically targeted males and females to address gender equality in access to information and decision making. The need for supply and demand to work closely has also been clearly demonstrated. In some cases, demand was so successfully increased it has risked overwhelming supply side capacity. As the programme wrapped up a more holistic evaluation of value for money was MESH. This will look both at individual prototypes and the cost of implementation to impact on utilization; and take a more holistic view of the value of the iterative design approach and efforts to embed and sustain the interventions over the longer term.

In late 2020, FCDO commissioned MESH to conduct the VfM review. MESH assessed the financial aspects of the SAHAN programme with a focus on the 8 prototypes piloted by the programme. This covered the consolidated programme delivery period, 2019 – 2020, and considered the initial ‘testing’ of 47 prototypes and the final implementation of 8 final prototypes. It included any potential/realised value associated with how other partners (UNICEF, UNFPA, Save the Children, et. al.) have adopted SAHAN prototypes and approaches. The review built on an initial review from 2019 that assessed progress to date and provided a framework and recommendations for the newly consolidated programme and a follow-up review on progress, conducted in April – May 2020. The review was organised around FCDO’s value for money (VfM) ‘4Es’: economy, efficiency, cost effectiveness.

Below are summary findings from the MESH VfM review of SAHAN<sup>31</sup>:-

- Economy:

*How did the programme ensure effective economic approaches to cost centres and other direct costs?*

There was a significant acceleration in prototype development in the last two years of the programme, with a 15% – 23% increase quarter in quarter out. This was by design as there was increased pressure for prototype development from January 2019. While there was an increase in personnel management for the same period, this was around 10%, quarter in quarter out, over this same period. This implies a productivity gap of between 5% and 13% in all periods outside of Q1 2019 and Q1 2020.

- Efficiency:

*What were the primary efficiency drivers and how did these affect delivery timelines?*

The promise of demand creation from innovative prototypes depended on the actual implementation of different prototypes in socio-cultural/healthcare settings so that the effects could be measured and the most promising could be replicated and brought to scale. This implies that the only relevant efficiency driver was the rapid development of many prototypes (speed and volume) so that those with the most potential impact could be brought forward. Instead, SAHAN spent considerable time developing a process that went beyond common best practices for HCD.

*Comparatively, how did the speed of designing and testing prototypes compare with HCD approaches in other contexts? Could SAHAN prototype development been done more quickly?*

<sup>31</sup> SAHAN VfM Review\_MESH\_FCDO\_February2021

This process included both additional steps and was longer than comparable processes. The Design Journey included 13 steps. This is much more elaborate than the process set forth by IDEO, the originator of the HCD process, in their HCD Field Guide. This describes three steps: inspiration, ideation, and implementation. While these correspond roughly to different stages in the design Journey, IDEO puts emphasis on iteration—user testing. Their approach stresses that the inspiration and ideation phases should occur very quickly so that the iteration with prototypes that show promise can commence. This is reinforced by a UNICEF field guide for HCD in healthcare that the entire process should focus on experimentation and that the process should be conducted in a manner of weeks, not months or years, as in the case of SAHAN. There are other examples that stress the ‘fail quickly’ paradigm. The Design for Health initiative ([www.designforhealth.org](http://www.designforhealth.org)), funded by the Bill & Melinda Gates Foundation and US AID, includes rapid testing and iterations. Similar principles guide USAID’s Center for Accelerating Innovation and Impact (CII) that uses HCD for global health initiatives ([www.engagehcd.com](http://www.engagehcd.com)). No matter the approach and the stress put on engaging ‘users,’ which SAHAN did, best practices all call for rapid prototype development and testing. This was not done in SAHAN which tended toward laborious and long processes that did not get to any reasonable number of prototypes until the final year of the programme.

- Cost Effectiveness

*What were the direct and indirect costs associated with prototype development? (cost effectiveness)*

While difficult to substantiate without standards and comparatives, 54% for indirect costs (overhead) is substantial. It indicates how much this type of programme costs, at very least. This is compounded by the fact that 64% of direct costs (and 20.54% of the whole budget) were consumed by a single prototype (Hooyo ku Hooyo). Healthcare investments in fragile states tend to be small part of overall ODA even when fragile states account for one-third of global maternal deaths, 50% of children dying before 5 years of age, and one-third of the global population who suffer from malnutrition. This implies that this level of investment, especially with the limited scope and results of prototypes like Hooyo ku hooyo, may be better placed on direct service delivery.

*How effective was the programme in increasing demand or changing behaviours in relation to relevant health services?*

While the progress for some of these is promising, there has not been sufficient time or reach to determine actual demand creation or longer-term behavioural change.

*How effective was the programme in establishing HCD/SEM and other innovative approaches for demand creation as proven approaches for Somalia? Has ‘proof of concept’ been achieved? (effectiveness and value)*

SAHAN was effective at introducing the concept of human-focused design approaches and processes. This led to the adoption of approaches and prototypes by various actors. However, the lack of broader results and the fact that the majority of the work was collapsed into a 12 – 18 month period implies that any sustained change is certainly beyond the scope of the programme and may be fleeting in the longer-term. Unfortunately, HCD and SEM suffer from being viewed as the ‘latest trends’ or buzzwords that have little practical value. These perceptions may actually be amplified by SAHAN’s experience. This would be a loss as there is considerable value in user-centred design processes that can use rapid prototype development to identify considered for widespread behavioural change.

- Equity

*How did the programme develop prototypes that addressed issues faced by the most vulnerable populations in Somalia?*

SAHAN was, by design, focused on the healthcare needs of women and mothers, an usually the most vulnerable. There is some evidence that these groups benefitted from the different prototypes and on activities that focused on community leaders and men. At the same time, the design process did not include representative samples of vulnerable groups, including female headed households, IDPs, people from marginalised clans, or others. It is not clear whether a concerted effort to include these and other vulnerable groups would have solicited different insights or results



### **Highlights From Follow-up to Rapid Review done by MESH in 2020<sup>32</sup>:**

- **Relevance:** *Exploring and identifying innovative ways to increase demand and promote positive behaviours is relevant to the needs of women and mothers in Somalia.*

The relevance of finding innovative ways to create demand remains relevant. PSI SAHAN has created a body of knowledge and practice that can instruct further efforts to do this. Given that most of its prototypes focus on communication and messaging, SAHAN's approach goes beyond the individual and toward the social dynamics that affect widespread behaviours. This may be particularly relevant in Somalia.

- **Effectiveness:** *SAHAN established a multi-variated strategy from the outset that shifted in approach and ambition with each iteration.*

The review was critical of SAHAN for shifting its strategy and outcomes as tangible results remained elusive. As the review states: SAHAN did not "formulate a detailed strategy or plan that could guide the rest of the programme. Instead, it articulated different plans, different strategies, as tangible, on-the-ground results became more and more elusive. And, it continuously promoted HCD as of paramount importance. By March 2019, nearly two-years after a very long inception phase (1 ½ years), only one prototype was being implemented." After the review, SAHAN revised its strategy around 12, and then 8 prototypes, adapted its indicators and milestones to reflect progress across these prototypes, and focused its partnership strategy on actors that could adopt prototypes. This shift in strategy ensured that these prototypes were fully tested and brought to field in time.

- **Effectiveness:** *The development of prototypes has been slow and results of these have yet to be proven.*

SAHAN has been effective in accelerating prototype development since the June 2019 review. Some momentum for this existed before. The review prompted greater focus on a few prototypes (12, reduced from 24 that were in development at the time of the review.) This was further consolidated to 8 prototypes by combining media-based prototypes (Model Father and Super Sheikh) into a '1,000 days' campaign while extending the Hooya kuHooya, Birth Preparedness Class and Men's Club. Not only did SAHAN focus on 8 prototypes but it has, in subsequent reports, shown the effectiveness of these prototypes through number of people reached and other data that support results.

- **Effectiveness:** *SAHAN has sought various levels of partnership although these remain under-developed to date.*

SAHAN has focused on partnerships since the review that enable the adoption and scaling up of prototypes. This includes partnerships with Mercy USA, Action contre Faim (ACF), Health Poverty Action (HPA), Trocaire, and other parts of PSI. These have been based on the adoption of SAHAN tested prototypes (mostly), rolling them out in regions across Somalia. While a focus on partnerships that enable the further testing of the efficacy of prototypes and their roll- to more communities is positive, there has been less focus on other partners like the Ministry of Health or larger UN organisations who have the potential to make links between these and policies that could drive change nationally. While this review recognises the challenges of working with government, this is an opportunity that could have been pursued more vigorously.

### **Lessons learned through this output, and recommendations for future programming [1-2 paragraphs]**

#### Lessons:

- Client focused human centered design contributed to better understanding of barriers to health service access and design of interventions to address them. This iterative approach requires time and needs to be complemented with other behavior change paradigms but can yield benefits above simply continuing to repeat traditional approaches.
- The SAHAN programme took an ambitious new approach to working on demand creation in Somalia using human centred design to generate new interventions. The complexity and capacity required to make a success of this approach was underestimated.
- Structural issues in Somalia such as access to financial resources, distance and transport affect ability to access services and have not been addressed. However, within these constraints there are many ways to creatively support the Somali community to positively engage with needed health services.

<sup>32</sup> Follow-up on Rapid Review of SAHAN\_MESH\_2020

- Involvement of men in service delivery is an often neglected but crucial element to supporting uptake of health and nutrition services by the most vulnerable.
- Work on the supply and demand side should be closely and intrinsically linked to determine the appropriate division of resources and optimal uptake of services.

Recommendations:

- Lessons from SAHAN should be integrated into future health services implementation and demand creation work in Somalia. The approaches employed by the programme in developing and improving demand creation interventions proved to be effective in the Somali context and should be scaled and institutionalized within the health authorities. There were also interventions which were designed and tested and proved promising but could not be taken forward to pilot and scale due to time and financial constraints. An example being the Shelter prototype designed to increase facility based deliveries. These should also be explored further in future programming.
- It is vital that as demand creation activities are implemented, efforts and investments should continue to address issues on the supply side. These are issues such as shortage of commodities, availability and readiness of service providers, distances to health facilities. This is especially imperative in the Somali context where health services remain nascent and underfunded. If these are not addressed, there may be a reverse of gains made working with beneficiaries to adapt positive health seeking behaviour

**D: Risk** [½ - 2 pages]

**Overview of programme risk during the past year and over the life of the programme, drawing on FCDO's Risk Management Policy and Risk Appetite Statement and wider risk guidance.** [1/2 page]

**Overview of programme risk**

The SAHAN programme maintained its own project specific Risk Register to ensure that the risks are regularly monitored and managed. Some of the key risks monitored and corresponding mitigation actions included: -

Risk	Mitigating Actions
Out break of Pandemic Corona Virus ( COVID19)	<ul style="list-style-type: none"> <li>▪ Dedicated COVID-19 cross-functional taskforce, reporting to the Country Representative and selected from the operations and program team was established.</li> <li>▪ Weekly update meetings with IPs, SHINE Partners and DFID to analyze the impact of COVID-19, particularly on program implementation</li> <li>▪ Engagement with MoH, Partners-INGOs and UNCT/Humanitarian Country Team (HCT) to identify appropriate coordination mechanism including health cluster /sector and key technical/operational partners at country level;</li> <li>▪ Training of Staff, and frontline HWs on COVID19 Risk Communication and Community Engagement</li> <li>▪ Procurement of PPEs for the frontline employees and health workers</li> </ul>
Security risks that might affect the program delivery or performance	<ul style="list-style-type: none"> <li>▪ Safety and Security Procedures, plans and SoPs put in place</li> <li>▪ Quarterly security meetings conducted by PSI senior management team</li> <li>▪ Security briefing for visiting teams</li> <li>▪ PSI-SOM is member of network of security contacts (INSO, UNDSS)</li> <li>▪ Full-time security focal point in place</li> <li>▪ Use of armed protection used during field travels (mainly to insecure areas)</li> <li>▪ Continued Monitoring and analysis of the operating environment</li> <li>▪ Increasing the staff awareness through briefings,updates and trainings: Hostile Environment Awareness Training (HEAT) and personal security and safety courses</li> </ul>
Personnel safety risks: <ul style="list-style-type: none"> <li>▪ Road Traffic injuries are among the leading causes of death and life-long disability in Somalia and Somaliland .</li> <li>▪ Death and injuries of PSI-SOM staff and its partners staff</li> <li>▪ Property loss and damage e.g. vehicles</li> </ul>	<ul style="list-style-type: none"> <li>▪ Reinforcing travel safety and security SoPs</li> <li>▪ Use of programme vehicles instead of third party hires whenever possible</li> <li>▪ Emphasis on safety belt wearing</li> <li>▪ Orientating drivers on dangerous times and places not drive</li> <li>▪ Ensuring vehicles are well-maintained and equipped with safety equipment's</li> </ul>
Fiduciary - Fraud and theft	<ul style="list-style-type: none"> <li>▪ Strictly follow of procedures of procurements and payments.</li> <li>▪ Keep asset registers upto date and conduct regular checks.</li> <li>▪ Training of staff against fraud and safegurads; staff signing code of conducts.</li> </ul>
Fiduciary – Exchange Rate risk	<ul style="list-style-type: none"> <li>▪ Transct with Donor Currency as much as possible.</li> <li>▪ Re-alignment of budgets to ensure resources are allocated towards achieving the program activities.</li> <li>▪ Ensuring timely reporting of achievements and progress.</li> </ul>

Exploitation of beneficiaries by staff and other community members	<ul style="list-style-type: none"> <li>▪ Training of staff on safeguarding.</li> <li>▪ Sensitizing of beneficiaries on how to report abuses.</li> <li>▪ Feedback complaints mechanism will be put in place.</li> </ul>
Adverse media attention and /or heightened concerns of local community and local authorities associated with the sensitivity of family planning products and services in certain locations:	<ul style="list-style-type: none"> <li>▪ Involving, co-designing and co-creating with the MOHs, beneficiaries, thought leaders, Ministry of Religious Affairs (MoRA) for programming</li> <li>▪ Clear communication on Family planning and its benefits to the community</li> <li>▪ Working closely with other partners such as UNFPA to have common messaging on Family planning/child spacing</li> <li>▪ Focusing on the health benefits of birth spacing to mothers, children and families,</li> <li>▪ Developing culturally BCC and advocacy messages – to dispel myths and misconceptions about the view of birth spacing</li> <li>▪ Mainstreaming use of voluntary birth-spacing in place of family planning</li> </ul>

This risk register fed into the overall SHINE Risk Matrix. The risks in the programme were reviewed quarterly to ensure it remained current and management of risks

- **2016:** The overall residual risk rating for the SHINE programme was moderate.
- **2017:** The overall residual risk rating for the SHINE programme was moderate. The iterative and adaptable nature of the demand creation programme required a careful review and management risk.
- **2018:** The overall residual risk rating for the SHINE programme was moderate
- **2019:** The overall residual risk rating for the SHINE programme was increased to major. This was in recognition of the ongoing challenges of Somalia as an operating environment due to the weak government, high insecurity and recurrent risks of climatic shocks.
- **2020:** The overall residual risk rating for the SHINE programme was major. Covid-19 represented a significant additional risk this year, rated as severe due to its potential to disrupt service delivery.

#### **Fiduciary/Financial Risks:**

For SAHAN, managed by PSI, fraud and corruption are mitigated through standard financial, accounting and auditing procedures. A due diligence was conducted by DFID (now FCDO) on PSI in April 2016 to check financial management, expenditure control systems and strengthen the internal audit capacity. PSI was rated as having strong governance systems in place both at Head Quarters (HQ) and at the Somalia country level, though was requested to broaden the scope of the corporate risk matrix beyond security risk. PSI was also rated as having good internal control and financial systems in place with sound policies in place; past audit reports were unqualified and revealed a healthy and smooth cash flow. A follow on Due diligence assessment (DDA) was done in 2019. The enhanced DDAs confirmed that PSI has fiduciary safeguards in place as per their rules and procedures to enable the thorough management of downstream partners, with stringent expenditure reporting processes which provide information of funds utilised and any balances held. To date audit statements have received from PSI have given no indication that funds have been spent inappropriately.

- 2016: Flagged as possible and its impact major.
- 2017: Flagged as possible and its impact major
- 2018: Flagged as possible and its impact major.
- 2019: Due diligence assessment (DDA) conducted for PSI.
- 2020: Safeguarding concerns within the SHINE programme monitored through quarterly reporting and discussions. DFID (now FCDO) encouraged partners to report suspected or verified issues through the Reporting Concerns platform.

#### **Annual Statement of Progress (Financial Aid programmes only – delete if n/a) [1 page]**

<b>Current level of fiduciary risk and direction of travel since last ASP</b>	Minor/Moderate/Major/Severe Improving/Stable/Worsening
<b>Specific assessment of corruption risk and direction of travel since last ASP</b>	Minor /Moderate/Major/Severe Improving/Stable/Worsening

## E: Programme Management: Commercial and Financial Performance, Monitoring and Evaluation [1 - 1 ½ pages]

**Summarise the performance of partners and FCDO, notably on commercial and financial issues, and including VfM measures of economy and efficiency.** [1 page]

The delivery of SAHAN was assessed through progress against milestones in the logframe and regularly assessed through monthly/quarterly progress meetings.

The SAHAN programme had an extended inception period, and has subsequently been slow to move into partnerships to test interventions in the field. This has affected its ability to utilise the full budget leading to a decision to reduce it to £8m (September 2018). The programme underwent a rapid review in April 2019 (facilitated by MESH) to help prioritise and focus implementation. A follow up review in April 2020 found that the program had moved on this and SAHAN had piloted 8 interventions and gathered evidence on their impact across SHINE districts in Somaliland, Banadir, Jubaland and Galmadug.

Due to the need to adapt to new ways of working necessitated by the Covid-19 pandemic, the SHINE partner quarterly review meetings from March 2020 could not continue physically. However, sustained engagement during the review period has continued via bi-monthly online catchups. Initially designed to provide updates on the onset of C19 these have since been used for wider programmatic discussion, including on engagements with FMOH/ MoHD at a strategic level; and reprogramming.

The FCDO official development assistance (ODA) prioritisation process meant the SAHAN programme wrapped up slightly early i.e. December 2020 after reprogramming. This led to a balance of £270K to be reallocated to CHANGE programme to allow the stretch of service delivery to March 2021.

### **Programme-level approach to monitoring and evaluation** [1/2 page]

A proportional approach to M&E was agreed for SAHAN in order to provide robust evidence of impact without unnecessary complexity and cost. For each prototype an M&E plan is developed. An approach of consolidating and documenting this evidence was done.

Date of last narrative financial report	17 <sup>th</sup> February 2021	Date of last audited annual statement	29 <sup>th</sup> September 2020 (financial year April 2019 – March 2020)
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