Foreign, Commonwealth & Development Office

MESH

SHINE: PSI SAHAN

Value for Money Review:

Creating Demand through Innovative Approaches?

15 February 2021

Disclaimer

The views presented in this report are those of the authors and do not necessarily represent the view of UK Aid.

Figure 1: Map of Somalia.

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Abbreviations & Acronyms

ANC	Antenatal care
CBOs	Community Based Organisations
DAC	Development Co-operation Directorate (OECD)
DHIS2	Demographic & Health Surveys, District Health Information System II
DHIS	District Health Information Software
EPHS	Essential Package of Health Services
EQs	Evaluation Questions
FCDO	Foreign, Commonwealth & Development Office
HCD	Human Centred Design
IFRC	International Federation of Red Cross and Red Crescent Societies
INGO	International Non-Governmental Organisation
IOM	International Organisation for Migration
IYCF	Infant and Young Child Feeding
M&E	Monitoring & Evaluation
MAM	Moderate Acute Malnutrition
MESH	FCDO M&E for the Somalia Humanitarian Programme Project
MoH	Ministry of Health
MIYCN	Maternal, Infant and Young Child Nutrition
NGO	Non-Governmental Organisation
NRC	Norwegian Refugee Council
OECD	Organisation for Economic Co-operation and Development
PSI	Population Services International
PSS	Psycho-social Support
QA	Quality Assurance
SAHAN	Somalia Advocates for Health and Nutrition
SAM	Severe Acute Malnutrition
SBC	Social and Behavioural Change
SHARP	Somalia Humanitarian and Resilience Programme
SHINE	Somali Health and Nutrition Programme
SGBV	Sexual Gender Based Violence
SRH	Sexual and Reproductive Health
ToC	Theory of Change
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	The United Nations Children's Fund
VCAT	Values Clarification and Attitude Transformation
VfM	Value for Money

Creating Demand through Innovative Approaches?

1. Overview

Population Services International (PSI) implemented the Demand Creation for Health Services (Somalia Advocates for Health and Nutrition, or 'SAHAN') component of FCDO's Somalia Health and Nutrition (SHINE) programme (2016 - 2021). SAHAN sought to increase access to and utilisation of reproductive, nutrition, child, and maternal health services and to promote positive behavioural changes in relation to women's health services. SAHAN included Human Centred Design (HCD) to better understand and address barriers to women's health services. PSI SAHAN set out three goals:

1. At the **individual level** – improved treatment seeking and healthy behaviours among women of reproductive age and caregivers of children under-five.
2. At the **interpersonal level** - increased support for women to use the Essential Package of Health Services (EPHS) from influencers, such as male partners, mothers-in-law and religious leaders.
3. At the **community level** - improved favourable environment for sexual and reproductive health (SRH) and rights and maternal, infant and young child nutrition (MYCN) in the community."[1]

Each of these goals focus on increased demand for EPHS, SRH, MYCN. SAHAN also identified issues related to antenatal care (ANC), birth spacing, and preventative nutrition. These included insights from women that highlighted the constraints they face, from psychological and social issues to the conditions and location of the health facilities. This resulted in a "Landscape Review" that mapped these issues and possible demand creation interventions.[2] This provided a foundation for developing a series of interventions, called "prototypes," to address these constraints and issues. This could include simple tools, like the 'iron camel' used to increase nutrient in cooking, to campaigns to shift attitudes and behaviours of men in the community. The theory was that a combination of design principles and an iterative and 'user' focused process would result in innovations that could have a significant and sustained impact on behaviours and attitudes and thus lead to increased demand.

FCDO divested in the PSI SAHAN programme in June 2020 given COVID-19 restrictions and priorities. PSI SAHAN is currently documenting lessons, including a longitudinal evaluation and other activities that will establish a foundation for future decision making. Central to this will be understanding not simply the outcomes and potential impact of these programmes but whether these represent **good value for money—could the same have been achieved with fewer financial or other resources or more quickly through other means?** This includes what may constitute good value, especially in a fast moving and adaptive programme.[3]

To assess this, this MESH REVIEW **assessed the financial aspects of the PSI SAHAN programme with a focus on the 8 protypes piloted by the programme**. (See Annex 8.3.) This covers the consolidated programme delivery period, 2019 – 2020, and considers the initial 'testing' of 47 prototypes and the final implementation of 8 final protypes. This includes any potential/realised value associated with how other partners (UNICEF, UNFPA, Save the Children, et. al.) have adopted SAHAN prototypes and approaches.

This review builds on an initial review from June 2019 that assessed progress to date and provided a framework and recommendations for the newly consolidated programme[4] and a follow-up review on progress, conducted

Value for Money 4Es

- Economy: Are we (or our agents) buying inputs of the appropriate quality at the right price?
- Efficiency: How well are we (or our agents) converting inputs into outputs? ('Spending well'.)
- Effectiveness: How well are the outputs from an intervention achieving the intended effect? ('Spending wisely'.)
- Equity: How fairly are the benefits distributed? To what extent will we reach marginalised groups? ('Spending fairly'.)

[1] "Tusan Wade (SHINE Demand Creation Programme): Inception Phase Report, June 2016 – March 2017." PSI; 12 June 2017. Page 4.

[2] "A landscape review of existing evidence and mapping of demand creation interventions in Somalia/Somaliland" Tusan Wade Demand Creation Programme; March 2017.

[3] This follows recent research that call for VfM to focus on the complexity associated with programme delivery and how VfM can be used as tool for adaptive programming in complex operating contexts. Please see: Ed Laws and Craig Valters; "Value for money and adaptive programming: Approaches, measures and management." ODI, March 2021. Available here.

[4] Dorian LaGuardia & Catriona Byrne; "Rapid Review of Demand Creation Programme." FCDO; 6 June 2019.

in April – May 2020. This review is organised around FCDO's value for money (VfM) '4Es': economy, efficiency, cost effectiveness, and equity. This includes specific questions agreed upon with FCDO. (See Annex 8.2.)

2. Economy

2.1. How did the programme ensure effective economic approaches to cost centres and other direct costs?[5]

The primary costs for the programme include the following:

- Prototype development—discover (staff) (33.87% of total costs)
- Prototype development—design (2.27%)
- Programme personnel (36.85% of total costs)
    - Programme personnel—Local salaries for programme (13.75%)
    - Programme personnel—Direct salaries for international staff (7.07%)
    - Programme personnel—DC Staff (2.23%)
    - Programme personnel—Expat Staff expenses (3.94%)
    - Programme personnel—Local staff fringes (4.37%)
- Programme management—programme related travel; minus programme meetings, as included below (7.82%)
- Contract services—janitorial/other (2.65%)

In total, these constitute 83.46% of all costs. All other budget lines are less than 2%.

As this shows, the primary cost centres for this programme relate to staff, either through direct costs (prototype development) or indirect costs (programme management). Together, these constitute £5,215,243 of a total of £7,375,102.

Primary direct costs (prototype development, design and discovery) accelerated over the last two years of the programme. Figure 2 shows that most costs accelerated after September 2018.

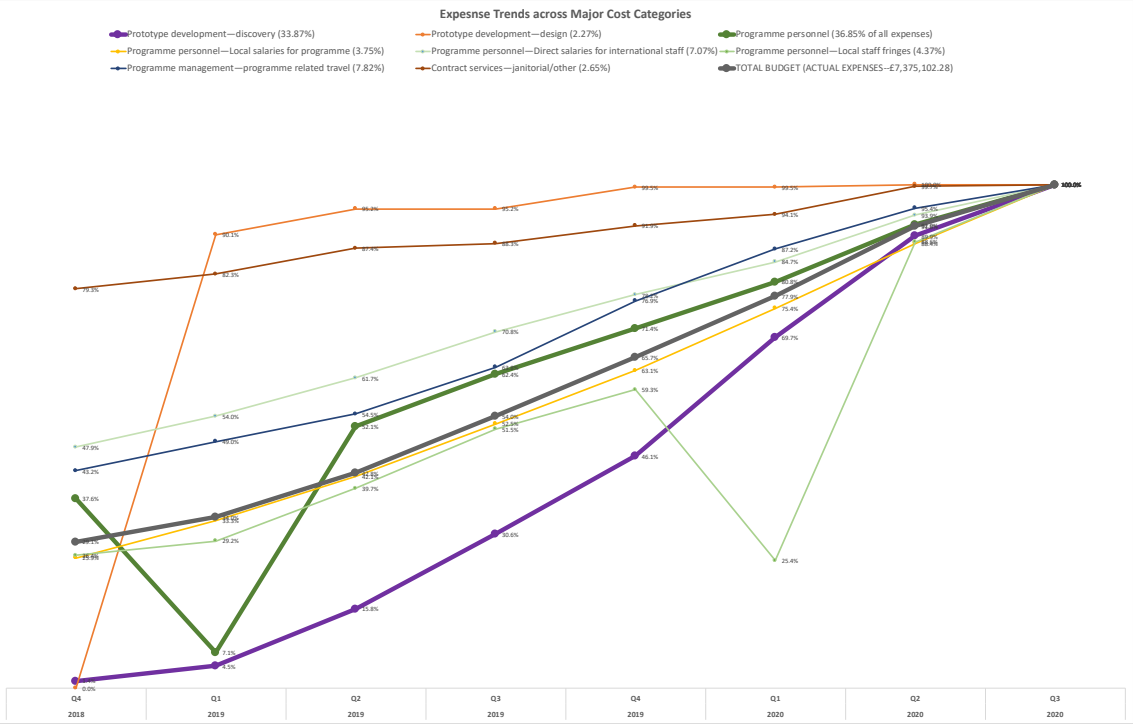

Figure 2: Primary cost centres and cost rates, Q4 2018 – Q3 2020. Source: PSI SAHAN financial statements.

There was a leap in costs associated with the design process for prototype development between Q4 2018 and Q1 2019, after which this spending remained relatively flat at over 90% of total expenses related to this category thereafter.

[5] Other direct and indirect costs are addressed in Section 4.1.

Prototype development, the second largest cost centre, accelerated the most during the period, from only 1.4% of total budget spent in Q4 2018 to a 15 – 23% increase per quarter across 2019. In fact, approximately 85% of prototype development expenses were incurred over 12 months between Q1 2019 and Q1 2020.

After a drop from 37.6% of total expenditures for personnel management from Q4 2018 to Q1 2019, this expenditure increased at about 10% per quarter thereafter.

Programme related travel followed a similar trajectory with a bump in spending between Q4 2019 and Q1 2020. As a comparison to these, janitorial services--a fixed cost and one of the largest cost centres—increased consistently over the period at around 1 -3% per quarter.

Overall, PSI SAHAN maintained standards associated with supplier contracting and overall purchasing for the programme. PSI provided financial statement quarterly and annual reports that detailed these procurement standards. This has been verified in FCDO SHINE quarterly and annual reviews.

Conclusion: 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.

3. *Efficiency*

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

Efficiency, as noted in Section 2.1, was constrained by the time it took to move into prototype development (discovery). This was collapsed into the last year of the programme and after remedial reviews and other programme adjustments that stressed the need to have tested prototypes in the field.

From SAHAN's perspective, the time prior to the accelerated protype development in 2019 was important for knowledge creation and prototype design that enabled them to narrow the number of protypes in development to those with the most promise. As noted in previous reviews, this goes against HCD practices that call for rapid development and deployment so that one can assess which protypes have the most promise and which can be brought to scale quickly ('fail fast').

Behavioural change programmes like SAHAN require a very large number of 'tests,' done very quickly, and with adequate measures in place to see which have the greatest effect given diverse and complex social drivers and behaviours. The process is human based in that it expects to derive insight from how people react, respond, and change because of the intervention. Thus, one needs to spark as many potential reactions as possible as quickly as possible (speed and volume) so that those with the most potential can be spotted early and then be brought to fruition. Efficiency is this based on how quickly one can develop/test/implement a large number of prototypes.

Doing this requires considerable sociological and even psychological insight. It entails describing the issue (behaviours that restrict the demand for healthcare services) and then reframing the issues from different points of view rather than starting with a specific solution already in mind. It is explorative and the process is often represented by complexity (squiggly lines[6]) rather than a strictly linear process. The theory is that a looser process focused on actual reactions can be more fruitful for innovation. Given this openness to ambiguity and apparent messiness, the approach is grounded in a disciplined flow that should lead to increasing convergence on the best ideas. The risk is that, if not disciplined, it can lead to repeated iterations that can consume energy and resources. This is why many HCD actors urge the 'fail fast' approach.

This may not have been possible in the context of Somalia. The ways in which actors are brought together, from international to ministerial to healthcare actors, is not always easy—logistically, socially, politically, and thus productively. SAHAN spent considerable time bringing different cohorts together and while indications are that these interactions were positive, the process was also very slow. As noted in Section 4.2, this did lead to greater acceptance for such approaches and yet this does not seem to be enough to justify the time and cost it took to put 8 protypes in the field.

[6] The 'squiggly line' as a representation of process is common in HCD. For a review, see: Sanders, E. B. N. , & Stappers, P. J. "Co-creation and the new landscapes of design." *CoDesign* , *4* (1), 5–18, 2008. Available here.

As in previous reviews, the process also seemed to take precedent over the initial research that indicated specific areas and issues that affected behaviours and demand. These were seemingly abandoned in favour of a focus on 'discovery,' or user generated ideas that could lead to prototypes. While there is no strict guidance for this, there are indications that it is important to have a clear notion of the issues and that these are then used to spring toward potential solutions. It is not clear how or if this was done.

Conclusion: The promise of demand creation from innovative prototypes depended on the actual implementation of different protypes 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 protypes (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.

3.2. 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?

Soon after the inception phase, SAHAN began designing 'prototypes'. Central to this were 7-day workshops that sought to establish the 'fidelity' of potential prototypes, e.g. their resonance and probability for success amongst a mix of women with children, without children, healthcare providers, and government entities. These were organised around ANC, birth spacing, and nutrition, and included idea generation, conceptual work, and the development and testing of potential prototypes.

The first 'Design Sprint' determined 9 prototypes, with four nutrition-based prototypes (*Somali cookbook*, nutrition on the go, cooking competition, and the lucky camel), 2 ANC prototypes (birthing preparedness class; healthy child bracelet) and 3 birth spacing prototypes (waiting room testimonials, refer-a-neighbour, and male role model). By March 2019 only one prototype, the 'mother-to-mother' pilot that seeks to create a network of mothers who espouse the benefits of different health care issues, was being implemented.

There was an exceptionally long inception period and an inordinate amount of resources consumed by learning and positioning the HCD approach with partners and other actors, like health Ministries. The primary output from the inception phase was the process ('Design Journey') by which HCD and other approaches would be incorporated into prototype development.

Conclusion: This process included both additional steps and was longer than comparable processes. As in **Error! Reference source not found.**, 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.[7] 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 protypes 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 of years, as in the case of SAHAN.[8] There are other examples that stress the 'fail quickly' paradigm. The Design for Health initiative (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

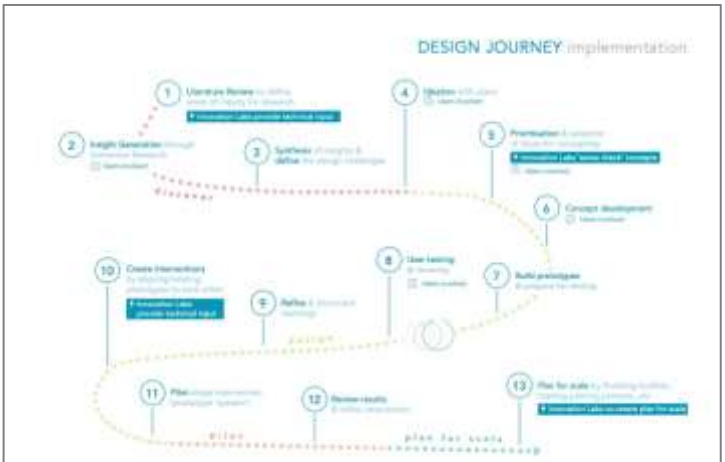

Figure 3: 'Design journey' developed by SAHAN

[7] "The Field Guide to Human Centered Design." IDEO, 2015. Available here.

[8] Grant Tudor & Benjamin Hickler; "Demand for Health Services Field Guide: A Human-Centred Approach." UNICEF, 2016. Page 15. Available here.

HCD for global health initiatives (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.

4. Cost Effectiveness

4.1. What were the direct and indirect costs associated with protype development? (cost effectiveness)

Direct costs are summarised by the following:

Direct Costs (prototype development)	Total Expense Sep-20	Category %	Total Budget %
Design	167,421	7.1%	2.27%
Programme Related Training - Partner engagement	78,198	3.3%	1.06%
1. Hooyo ku Hooyo (HkH)	1,514,489	64.1%	20.54%
2. Birth Preparedness Class (BPC)	271,680	11.5%	3.68%
3. Men's Club	153,934	6.5%	2.09%
4. Hiil Hoyoo Poetry Competition	22,345	0.9%	0.30%
5. '1000 days' Campaign	14,422	0.6%	0.20%
6. Interactive Voice Response (IVR) – Shaafi	8,404	0.4%	0.11%
7. Family Planning (FP) Method mix	-	0.0%	0.00%
8. Values Clarification and Attitude Transformation (VCAT)/Communit	130,132	5.5%	1.76%
TOTAL Direct Costs (Prototypes):	2,361,025	87%	32.0%
Direct Costs (knowledge development)	**Total Expense Sep-20**	**Category %**	**Total Budget %**
External Partner Engagement meetings (A2)	915	0.25%	0.01%
Learning, communications, M&E (A3)	222,931	61.85%	3.02%
Pilot (M&E) Evaluation Partner	85,328	23.67%	1.16%
Other direct costs related to protoype development:	51,256	14.22%	0.69%
M&E for pilot prototypes	31,562	8.76%	0.43%
Creative Work	14,694	4.08%	0.20%
Packaging	4,573	1.27%	0.06%
Prototype Start up kits (testing, iterating & Piloting)	335	0.09%	0.00%
Shipping and Handling	92	0.03%	0.00%
TOTAL Direct Costs (KD):	360,429	13%	4.9%

These direct costs show a disparity in the amount of expenses associated with the Hooyo ku Hooyo (hkH) prototype. It constitutes 64% of all direct costs and 21% of the overall budget. The next most expensive prototype is the Birth Preparedness Class (BPC) at 11.5% of direct costs and 3.9% of the overall budget.

The costs associated with knowledge development, especially during the accelerated prototype development phase, were minimal (4.9% of total budget; 13% of direct costs).

Indirect costs are summarised by the following:

Indirect Costs	Total Expense Sep-20	Category %	Total Budget %
A4. PROGRAMME MANAGEMENT (travel costs and programme meetings)	616,695	15.5%	8.36%
B. PROGRAMME PERSONNEL	2,717,635	68.2%	36.85%
C. CONSULTANCY SUPPORT RELATED (COMPLIANCE, SECURITY, OFFICE SUPPORT)	314,857	7.9%	4.27%
D. PROGRAMME EQUIPMENT/FURNITURE	48,742	1.2%	0.66%
E. PROMOTION AND ADVERTISING	4,342	0.1%	0.06%
F. COMMUNICATION AND EDUCATION	76,910	1.9%	1.04%
G. OTHER INDIRECT COSTS (Office and administrative)	204,020	5.1%	2.77%
TOTAL Indirect Costs :	3,983,203	86%	54.0%
Indirect Costs (Management Fees)	**Total Expense Sep-20**	**Category %**	**Total Budget %**
F. Non-Project-Attributable Costs (Management Fee)	670,432	9.1%	9.09%
F. Non-Project-Attributable Costs (Procurement) / Indirect Costs	13	0.0%	0.00%
TOTAL Indirect Costs :	670,446	14%	9.1%

The largest cost centre is programme personnel (68% of indirect costs and 37% of the budget overall). Programme management, which includes travel costs and programme related meetings, constitutes 8.36% of total budget and 15.5% of indirect costs.

Conclusion: 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.[9] 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.

Recommendation: Any future demand creation programme that focuses on changing behaviours and attitudes should have a much more nimble and iterative design. This should include a limited management structure that focuses on the generation of potential interventions quickly that is then followed by a different structure that is designed to bring these interventions to fruition, e.g. to test them adequately in the field and to have practical plans in place for replicating them/bringing them to scale.

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

There have not been enough evaluations or other research into how the different prototypes may have increased demand. However, in some cases, uptake has increased by 15-20% and more detailed analysis is going on to directly attribute this to specific interventions.

Other highlights include:

- Hooyo ku Hooyo (HkH): In Gedo, 16,053 home visits were conducted and of these 3,217 of them visited a health facility, with conversion rates between 83 and 99%. OPD (826) and immunisation (749) make up most of the referrals. In Banadir, 849 home visits were conducted; 530 women and children were referred for health services.
- Birth Preparedness Class (BPC): A total of 546 pregnant women participated: 220 in their first or second trimesters and 326 pregnant women in their 3rd trimester. These classes gave women the opportunity to share their fears and experiences while having time to clarify pregnancy and delivery issues and questions.
- Values Clarification and Attitude Transformation (VCAT): Two VCAT Training for Trainers (TOTs) for VCAT champions were conducted as VCAT trainers by Maries Stopes Master trainers. The first was in Hargeisa where 23 VCAT champions were trained including: 9 from the MoHD, 4 from UNFPA, 4 from Somaliland Nurses and Midwifery Association (SLNMA), 1 from University of Hargeisa (UoH) and 5 from PSI. The second was in Mogadishu for 17 VCAT Champions: 5 from Puntland MOH; 6 from Somalia & Puntland Midwifery Associations; 5 from FSG MoH; and 1 from UNFPA. This led to a revised curriculum that has been reviewed by the Federal, Somaliland, and Puntland MoHs. It also underwent peer review within PSI. The final curriculum will be rolled-out in the next quarter. UNFPA has adopted the VCAT concept as a compulsory 2 day precursor to the Family Planning Trainings being conducted across Somaliland and Somalia.
- Family Planning Method Mix: Procurement processes for 76,800 cycles of Combined Oral Contraceptives (COC) and 8,400 Vials of DMPA injections are underway. Packaging modifications have been concluded for both products to make the unit cost to the consumer as low as possible. These are the projected volumes of stock the private sector requires to support family planning services through pharmacies and private clinics across Somaliland for 24 months. Subsidies for these will be gradually removed to recover product costs and to ensure that the stock can be replenished after an initial 2-year period.
- The Hill Hoyoo Poetry Competition & 1,000 Days Campaign are both media campaigns and so their efficacy in demand creation remains unclear.
- The Men's Club and Interactive Voice Response (IVR) Shaafi prototypes did not have enough detail to judge uptake and possible behavioural changes.

Conclusion: 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.

[9] Emanuele Capobianco & Veni Naidu; "A Review of Health Sector Aid Financing to Somalia." The World Bank, 2008. Page 10. Available here.

4.3. 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)

The concept for PSI SAHAN was compelling. It meant to use proven techniques to change behaviours and attitudes towards healthcare. It was innovative in that it used a systems based approach that recognises that there are complex variables that influence behaviours and that the 'user experience' is key for understanding social drivers and the variables that influence health-related behaviours.

The problem was one of execution. Both systems based and HCD approaches depend on rapid and numerous iterations so that the most promising prototypes can be identified quickly. This has been explained in previous programme reviews. Speed and volume are also important from a value for money perspective. The costs, as demonstrated above, are driven by staff and meetings—exploring different interventions with an array of users and stakeholders. Such forums can devolve into discussion of context and needs, challenges and limitations. This can thwart any chance for speed and volume, meaning that they may not be used as a catalyst for identifying/testing/piloting interventions that can create positive demand for health services and/or change behaviours.

SAHAN achieved success in introducing user-centred processes and innovative approaches as useful for demand creation activities in Somalia. UNFPA has adopted VCAT as a compulsory 2 day precursor to the Family Planning Trainings and adopted VCAT Champions as family planning facilitators. PSI is using Hooyo ku Hooyo to improve the effectiveness of a long-term USAID funded community healthcare programme. The World Bank and Gavi have also shown interest in Hooyo ku Hooyo. Perspective Media is including health messaging in their Radio drama series, Sahaka Nolosha. Telesom have committed to continue with the IVR Intervention platform their own resources. Telesom received interest from WHO on using the platform for Covid-19 messaging. Trocaire and Action Against Hunger, SAHAN partners, have shown interest in continuing with the approach. The Health Ministries have shown similar interest and Somaliland has committed to sustaining proven activities through front line workers by supporting them directly and mandating partners to adopt proven prototypes.

However, the types of problems women and mothers face in relation to healthcare in Somalia are dauting. Design approaches, like those of SAHAN, can only affect the edges of the broad systemic issues that affect healthcare in Somalia. HCD and other design approaches seek commercial products, like new cars or new phones. It is reactive to trends, rather than a creator or catalyst for new trends.[10]

Conclusion: 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.

5. Equity

5.1. How did the programme develop protypes that addressed issues faced by the most vulnerable populations in Somalia?

The health issues identified, especially given the issues identified in the Landscape Review,[11] were those faced by vulnerable populations, especially mothers. Different interventions specifically target males and females to address gender equality in access to information and decision making.

At the same time, the process then shifted to include diverse stakeholders in design workshops and other activities that were not composed of other vulnerable groups. For instance, there was no concerted effort to include women who were the heads of their households, a mix of rural and urban participants, IDPs,

[10] This failure is detailed in a first person account in Wired. See; Panthea Lee; "Why Design for Development is Failing on Its Promise." Wired, May 2015. Available here.

[11] "A landscape review of existing evidence and mapping of demand creation interventions in Somalia/Somaliland" Tusan Wade Demand Creation Programme; March 2017.

marginalised clans, or others. While some of these were included, it was not a prominent aspect of the design.

Conclusion: 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.

6. Value

6.1. *What is the realised and continuing value of a programme like this? How many of the prototypes are being scaled-up/replicated by other actors? Is there unrealised potential for scaling-up and/or replicating prototypes in other areas? (value)*

The PSI SAHAN programmes expected to create value in three areas: ability to increase demand through changed behaviours; a number of prototypes that could be brought to scale/replicated across Somalia (and possibly other contexts); knowledge and wider acceptance of human centred design and other innovative approaches to healthcare demand creation. All three of these rest on the assumption that changed behaviours lead to better health outcomes/increased demand of clinical healthcare services, especially for mothers, and that international actors can develop approaches that create sustained and widespread behavioural change.

In relation to knowledge, SAHAN cites 52 products: innovation labs reports (4); discovery day reports (7); MOH, HPA, MERCY, ACF, BRCiS, Somali Justice league, Perspective media. Insight generation activity reports (4); Prototype Testing reports (29); piloting evaluation reports (2); and intervention packages (2). Most of these are related to prototype development and thus have limited value beyond their development. The landscape review, developed during the inception phase, provided a solid piece of research into the issues that affect demand for different healthcare services and the constraints faced by women and mothers.

Attitudes and behaviours toward the care of mothers and children are fraught in nearly all contexts because of the essential value humans place on mothers and children. This is the case in Somalia were strong patriarchal systems, extreme poverty, lack of education, and other societal features work against gender equality and women's empowerment. Changing behaviours that have prevented women from making positive choices about their lives, their healthcare, and their children is exceptionally challenging in such a context and most likely a very long enterprise that will go along with other development. The notion that any lasting behavioural change could be achieved in a few years by limited interventions is far-fetched. Indeed, this is probably why SAHAN's prototype development veered toward these basic societal drivers, like mother to mother support networks, positive messages amongst men's groups, and other communications efforts. The problem is that these cannot exist in isolation. There need to be broader societal changes that go hand in hand with such societal change.

More directly, these types of innovations cannot occur in isolation. They have to reflect societal trends as well as broader investments in healthcare services. In fact, there needs to be a more direct focus on services. For instance, a 2019 *Lancet* article that develops a model for investment in primary healthcare in 67 low and middle income countries.[12] The first level of investment includes basic preventative and outpatient care(measure 1), followed by general inpatient care and health systems (measure 2), and finally by cross-sectoral investments related to WASH, indoor air pollution, and food safety. This model shows that investments in actual service delivery dwarf any in behavioural change/demand creation activities.

In the case of Somalia, the needs remain at preventative and outpatient care and this entails ensuring that basic service delivery is in place. It is assumed that once this is achieved, demand will follow not only because of increased level of care but also because of broader societal trends beyond the influence any foreign investment.

[12] Karin Stenberg, Odd Hanssen, Melanie Bertman, Callum Brindlye, Andreia Meshreky, Shannon Barkley, et. al. "Guideposts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study." *The Lancet*; Volume 7, Issue 11, E1510, November 01, 2019.

Conclusion: There is not enough evidence to assess the actualised value of this programme beyond the knowledge created and the various prototypes that are continuing under the tutelage of other partners. As noted in Section 4.2, four of the eight protypes are being scaled-up/replicated by other actors and so the value of these is growing. However, without a 'unicorn' prototype, one that, because of the user insights and iterations, struck upon an activity or tool that had dramatic and replicable impact in terms of demand creation, any returns dissipate quickly.

6.2. How else should one consider the return on investment associated with this type of programme?

From a VfM perspective, the SAHAN investment strategy was similar to that deployed by venture capital funds that invest in dozens of enterprises with the expectation that one may become a 'unicorn' with 50 – 100 times the return on investment, thus overcoming losses that may have occurred in other ventures. Venture capital funds typically invest relatively small amounts in multiple early stage ventures, thus spreading their risk across as many different ideas as possible.

This investment strategy poses some constraints in development and humanitarian contexts.

First, investments where a majority of ventures are assumed to fail may seem wasteful when there are so many dire and immediate needs. This is overcome if the investments, in total, yield significant returns despite the failure of a number of components. This is, of course, a risk and thus necessitates not only good ideas but many, many ideas thus expecting that one may achieve expected traction, momentum, and results. In the case of SAHAN, the pipeline for prototypes was not broad enough and, because it did not follow the issues identified in the Landscape Review, may not have focused on the best ideas either.

Second, the very appetite for failure is anathema in development and humanitarian action. This is based on the limited resources and immense needs, as noted above, but also from the fact that investments are being made with public monies. One may be hard pressed to defend an investment strategy that expects a certain level of failure and loss. Again, this can be overcome if one investment proves to make a major and long-lasting impact. With SAHAN, this promise was part of the theory and various actors, as noted in this review, are using HCD and other innovative approaches to achieve such lasting impact. Thus far, such 'unicorn' level changes have not materialised, but they may. In Somalia, however, the socio-cultural and economic constraints that women and mothers face are massive, as described in this and other reviews, and so the notion that there could be a single protype that would cut through these issues and create significant change and demand is probably misguided.

7. Lessons

Given that this review is part of the PCR for the SAHAN programme, we have not included recommendations but instead focus on lessons for any similar future endeavours.

7.1. Are the lessons and knowledge created by PSI SAHAN useful to other demand creation programmes? What can be done to maximise the value of this knowledge?

The operating context rules and, in Somalia, changing behaviours and attituded to women's healthcare is a long term endeavour. A quick win, as promised through SAHAN, may prove elusive. SAHAN's focus on demand creation was rooted in complex socio-cultural and psychological drivers that affect how and if women consider public health facilities for pre- and post-natal care, amongst other healthcare services. These lay beyond the capacity and, possibly the moral purview, of international actors.

Innovative and impact oriented approaches are to be lauded, rather than opposed. Yet, given the use of public monies and the other risks associated with investments in innovation, a small and graduated investment approach is warranted. This implies a relatively small investment in the first phase (maybe 6 months) to generate ideas and activities and then subsequent rounds of investment in those that show the most promise. This mimics the way private sector investments in new venture work, following a trajectory from 'angel' investors to venture capitalists, to broader market/securities-backed level investments.

Don't become enamoured of the theory; focus on proven strategies for results. Innovative, creative, and compelling ideas, like HCD, can become the ends in themselves rather than the means to expected results. This can lead to continued investments in activities that do not contribute to expected results. Any such endeavours need to be based in very practical and stringent plans of action that include frequent milestones and, as based on these, a reconfiguration of resources, activities, and possibly intermediate results. This raises the potential of a significant level of transaction costs and so a graduated investment strategy may be considered, as described above. In fact, while HCD in healthcare may seem innovative and certainly the notion of design coupled with user participation is compelling, there are models for this type of process and investment.

Pull the plug earlier. While FCDO was diligent in introducing remedial and corrective actions, the investment in the end was over £7 million and the results remain unclear. SAHAN experienced a range of internal challenges, from shifts in personnel to a shift toward 'knowledge creation' as the primary result. This signalled that the actual team was not up to the job—that they did not understand the nature of this type of investment and could not muster a process to develop multiple protypes quickly. They faltered and while FCDO did come in and half the budget and get them to focus on getting protypes into the field, in the end, this was too little too late. While this is much easier to assess in retrospect, it does highlight the need to be decisive in stopping a programme that is bound to fail in expected results.

There is an appetite for innovative approaches amongst government officials and healthcare workers. The enthusiasm for innovative approaches is surely due to the level of need and the hope for something that could have a rapid and dramatic impact on expected health outcomes. While any quick wins or 'unicorns' should not be promised, the spirit for innovative approaches should be nurtured and fostered going forward.

Demand creation is probably better achieved by focusing on the quality of services. While there is a case to be made for innovative approaches to demand creation, the needs in Somalia are enormous and this, in the end, should prompt a focus on basic service delivery. Indeed, there is growing evidence that when the services are effective, people may return. Certainly, the reverse is also the case. If women and mothers are more prone to avail of relevant healthcare services but find their local facility as ill-equipped to meet their needs, they may give up on this for a long while. From an investment perspective, this is a significant loss.

8. ANNEXES

8.1. Approach & methodology

This approach was based on desk review of available documentation, especially financial information.

These were assessed according to FCDO standards for VfM. This included an assessment of the return on investment (ROI), value, and knowledge/operational insights associated with the programme. This included standard metrics and approaches for assessing value in complex operating environments.

Limitations

There were no material limitations or risks.

Team

The review was conducted by Mr. Dorian LaGuardia, MESH Team Leader. He led on a previous Review of the PSI SAHAN programme and is the VfM lead for MESH.

8.2. Review Questions/Indicators

As this is a review, it is expected to focus on the issues that will be most relevant to FCDO and PSI SAHAN in assessing the overall VfM of the programme. Given this, the primary question is:

Does the PSI SAHAN programme represent good value for money in terms of its costs and its realised, continuing, and potential results?

To answer this, the following questions will guide this review:

- How did the programme ensure effective economic approaches to cost centres and other direct costs? (economy)
- What were the primary efficiency drivers and how did these affect delivery timelines? (efficiency)
- 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? (efficiency)
- How effective was the programme in increasing demand/changing behaviours for relevant health services? (effectiveness)
- How effective was the programme in establishing HCD/SEM and other innovative approaches for demand creation as proven approaches for Somalia? (effectiveness)
- How did the programme develop protypes that addressed issues faced by the most vulnerable populations in Somalia? (equity)
- What were the direct and indirect costs associated with protype development? (effectiveness)
- What is the realised and continuing value of a programme like this? How many of the prototypes are being scaled-up/replicated by other actors? Is there unrealised potential for scaling-up and/or replicating prototypes in other areas? (value)
- Has 'proof of concept' been achieved for innovative approaches like HCD and SEM? (value)
- Are the lessons and knowledge created by PSI SAHAN useful to other demand creation programmes? What can be done to maximise the value of this knowledge? (value)
- How else should one consider the return on investment associated with this type of programme?

8.3. Final SAHAN Prototypes

After a review of the programme in May – June 2019, PSI SAHAN focused on fast tracking prioritised prototypes to pilot. This led to piloting 8 prototypes by the programme's end.

1. **Hooyo ku Hooyo (HkH):** A community-based intervention with female community champions (experienced women within communities) educating and influencing Somali women of reproductive age and caregivers of children under 5 through one-on-one and/or small group sessions in the comfort of their homes. Implemented in all regions i.e. Awdal, Sahil, Togdher, Karkar, Galmaduud, Banadir and Gedo. This pilot supports home visits by respected women in the community to discuss maternal health topics including antenatal care, facility delivery, postnatal care and birth spacing and child health topics including diarrhoea, pneumonia, and immunization.
2. **Birth Preparedness Class (BPC):** This is a facility-based intervention designed to increase the uptake of ANC visits and to scale up the number of mothers delivering at the health facility by mitigating delivery related fears and providing a cosy, friendly service at the health facility. It is integrated with fun activities like henna application. Implemented in Awdal, Togdher, Karkar, Galmaduud and Gedo regions.
3. **Men's Club:** This focuses on improving men's understanding and knowledge about the needs of women during and after pregnancy as well as the importance of child health care of those under 5 years of age. Implemented in Awdal, Karkar and Gedo regions. Male Champions initiate maternal health discussions where groups of men gather, e.g., tea shops, livestock market, construction sites, bus parks, and *Tabliqs* (Muslim Outreach societies). Men's Clubs expect to: improve awareness and knowledge among men on health issues; initiate couples' conversation on health matters at the household level; empower men with health information to make better health decisions with their wives; and enable men to prepare themselves financially for pregnancy, childbirth and emergency situations that may arise during this period.
4. **Hill Hoyoo Poetry Competition:** This is a media intervention designed to maximise the Poetry Culture of the Somali people as a medium for delivering key health messages and calls to action. It harnesses knowledge, skills and content from the community through a competitive process to draw and capture attention of the general public on maternal and child health issues. As a media camping, it covers all regions.
5. **1000 Days Campaign:** This is a media campaign designed to create a social movement that rallies the community towards supporting the mother during a period that she is described as most vulnerable and in need of emotional and psychosocial support (conception to 24 months postpartum). As a media camping, it covers all regions.
6. **Interactive Voice Respnse (IVR) Shaafi:** An interactive voice response mobile telecommunication-based health consultation service that provides an opportunity for an interactive question and answer session by users from the comfort and privacy of their home. This was implemented in partnership with Telesom through a 50/50 cost-share corporate social responsibility agreement.
7. **Values Clarification and Attitude Transformation (VCAT):** A standardized process of uncovering and addressing values and attitudes that act as barriers to the provision of quality services by healthcare providers. Healthcare Institutions are comprised of individuals with their own sets of values (some genuinely dependent on culture and religion, and many of which are erroneously associated with myth and misconceptions), it becomes pertinent to uncover those values and provide them with skills that will enable them to execute their duties without bias.
8. **Family Planning Method Mix:** Expanding the method mix is critical both for ensuring individual choice and equitable access, and for achieving the ambitious commitments made at the 2012 London Summit on Family Planning. Thanks to FCDO, seed funding was secured for this intervention which will be applied as a revolving fund that will guarantee the continuous availability of FP commodities in the Somaliland private sector in the short to medium term. The procured COCs and DMPA injections contraceptives will ensure a sustenance of the distribution channel and brand equity that has been built over the years. This approach will not only safeguard a continuous increase in the private sector CYP contribution, it will also enable an increased method mix in the private sector, as well as continued empowerment of the Somali women with their product of choice from their preferred source, closest to their homes.

By the end of the programme, the following prototypes had been piloted:

A. **Model Father:** During the Men's Club, some fathers expressed willingness to give testimonies and to be projected as role-models for desired behaviour related to supporting their spouses in health practices. Procurement of a media agency to produce content, including testimonies, is ongoing.

B. **Super Sheikh:** The intervention will include media talks and debates and reinforced by "Super Sheikhs" during the Friday Jumaat prayers. The Ministry of Religious Affairs (MoRA) recommended that the involvement of sheikhs was important to facilitate approval of the messages/content. Procurement of a media agency to produce content, including testimonies, is ongoing.

C. **Orphaned Foods:** Further research is planned to determine the need and extent of this prototype, including the identification the Somali traditional foods, before the introduction of rice and pasta. FAO may provide support. This intervention will be media based with a view of making the identified foods 'fun' to consume.

D. **IYCF:** PSI will engage a nutritionist with some BCC background to work with SAHAN and the nutrition partners to update the tools and improve IYCF messaging. Nutrition partners will implement ongoing IYCF activities with the improved version and evaluate shifts attributable to the improvements.

8.4. Bibliography

Cited sources:

- "A landscape review of existing evidence and mapping of demand creation interventions in Somalia/Somaliland" Tusan Wade Demand Creation Programme; March 2017.
- "The Field Guide to Human Centered Design." IDEO, 2015. Available here.
- "Tusan Wade (SHINE Demand Creation Programme): Inception Phase Report, June 2016 – March 2017." PSI; 12 June 2017.
- Capobianco, Emanuele & Veni Naidu; "A Review of Health Sector Aid Financing to Somalia." The World Bank, 2008. Page 10. Available here.
- Lee, Panthea; "Why Design for Development is Failing on Its Promise." Wired, May 2015. Available here.
- LaGuardia, Dorian & Catriona Byrne; "Rapid Review of Demand Creation Programme." FCDO; 6 June 2019.
- Laws, Ed & Craig Valters; "Value for money and adaptive programming: Approaches, measures and management." ODI, March 2021. Available here.
- Sanders, E. B. N. , & Stappers, P. J. "Co-creation and the new landscapes of design." *CoDesign* , *4* (1), 5–18, 2008. Available here.
- Stenberg, Karin; Odd Hanssen, Melanie Bertman, Callum Brindlye, Andreia Meshreky, Shannon Barkley, et. al. "Guideposts for investment in primary health care and projected resource needs in 67 low-income and middle-income countries: a modelling study." *The Lancet*; Volume 7, Issue 11, E1510, November 01, 2019.
- Tudor, Grant & Benjamin Hickler; "Demand for Health Services Field Guide: A Human-Centred Approach." UNICEF, 2016. Page 15. Available here.
- Van de Maele, Xu K, Soucat A, Fleisher L, Aranguren M & Wang H; "Measuring primary healthcare expenditure in low-income and lower middle-income countries." *BMJ Glob Health;* 2019.

Other sources:

- Bazzano, A. N. , Martin, J. , Hicks, E. , Faughnan, M. , & Murphy, L. "Human-centred design in global health: A scoping review of applications and contexts." *PLoS ONE* , *12* (11), 2017. Available here.
- Bratteteig, T. , & Wagner, I. *Disentangling participation: Power and decision-making in participatory design* . New York, NY : Springe; 2014. Available here.
- Brown, T. , & Wyatt, J. Design thinking for social innovation. *Stanford Social Innovation Review* , *8* (1); 2010. Available here.
- Friedman, B. Value-sensitive design. *Interactions* , *3* (6), 16–23; 1996. Available here.
- Gupta, R. , Patel, R. , Murty, N. , Panicker, R. , & Chen, J. "Developing sustainable global health technologies: Insight from an initiative to address neonatal hypothermia." *Journal of Public Health Policy* , *36* (1), 24–40; 2015. Available here.
- Kim, J. Y. , Farmer, P. , & Porter, M. E. (2013). Redefining global health-care delivery. *The Lancet* , *382* (9897), 1060–1069. doi:10.1016/S0140-6736(13)61047-8 Available here.
- Marmot, M. Social determinants of health inequalities. *The Lancet* , *365* (9464), 1099–1104; 2005. Available here.
- Peters, D. H. , Tran, N. T. , & Adam, T. *Implementation research in health: A practical guide* . Geneva : World Health Organization; 2013.
- Rowe, P. G. *Design Thinking* . Cambridge, MA : MIT press; 1987.
- Simonsen, J. , & Robertson, T. *The Routledge international handbook of participatory design* . London : Routledge; 2012.
- United States Agency for International Development (USAID); *Driving demand for chlorhexidine: A human centered design toolkit for the development of demand generation materials*. USAID Center for Accelerating Innovation and Impact; 2016. Available here.