

salhan



MEN'S CLUB INTERVENTION

September 2019



A photograph of four men sitting around a table, engaged in a discussion. The man in the center is wearing glasses and a patterned shirt. The man to his right is wearing a white and blue striped polo shirt. The man on the far right is wearing a light blue shirt. They are all looking towards the center of the table. The background shows a wall with a colorful pattern and a chain-link fence.

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Acronyms

ANC	Antenatal Clinic
BPC	Birth Preparedness Class
CBO	Community Based Organization
CHV	Community Health Volunteer
CPR	Contraceptive Prevalence Rate
DFID	Department for International Development
FBO	Faith-Based Organization
FCC	Female community Champions
IEC	Information, Education and Communication
IPC	Inter-personal Communication
MCH	Maternal and Child Health (Clinic)
MCPR	Modern Method Use
MOH	Ministry of Health
MOHD	The Ministry of Health Development
PSI	Population Services International
SAHAN	Somali Advocates for Health and Nutrition
SBCC	Social Behavior Change Communication
SGC	Small Group Communication
SHINE	Somali Health and Nutrition programme
TBA	Traditional Birth Attendant
TOT	Trainer of Trainers
SOM	Somalia and Somaliland

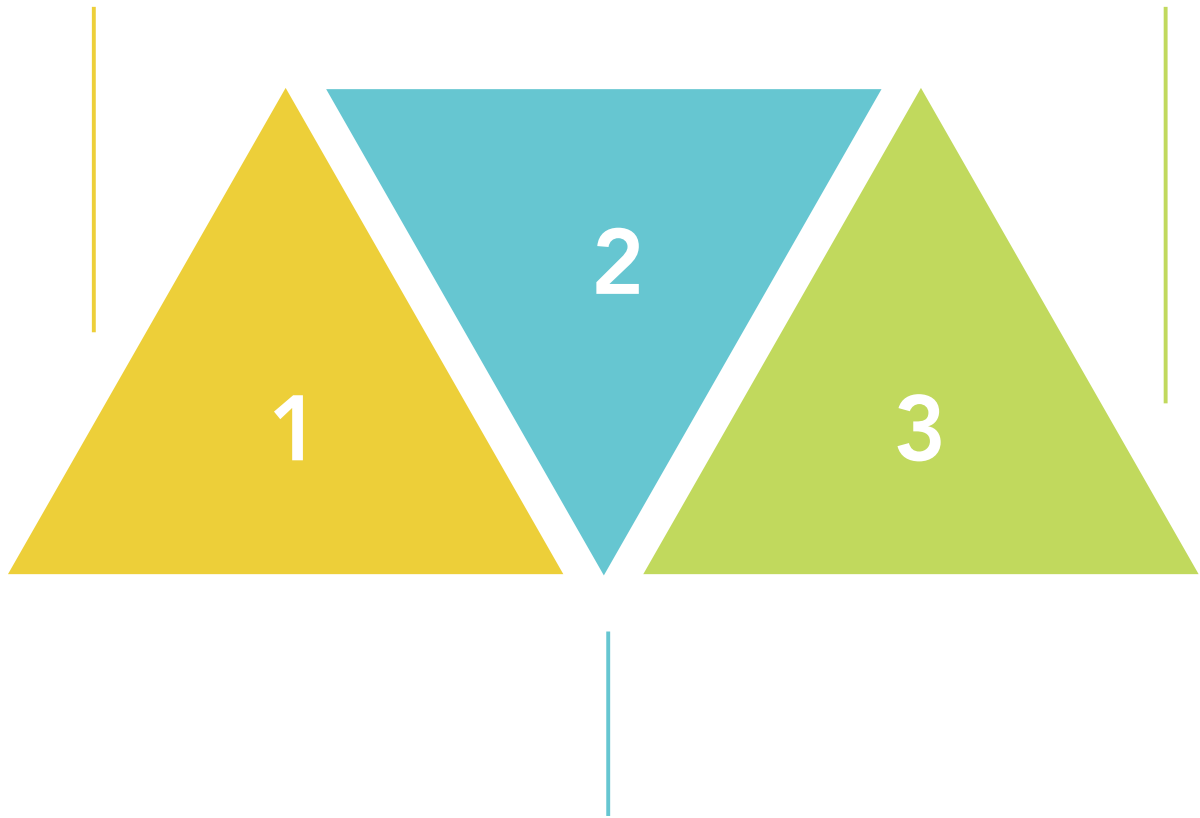
01

INTRODUCTION

The Somalia and Somaliland MoH and PSI are implementing the Demand Creation for Health Services component of DFID's Somali Health and Nutrition Programme (SHINE) programme dubbed SAHAN (Somali Advocates for Health and Nutrition). SAHAN is the first ever, large-scale dedicated demand creation programme being implemented in the Somali context.

Antenatal Care

Nutrition



Birth Spacing

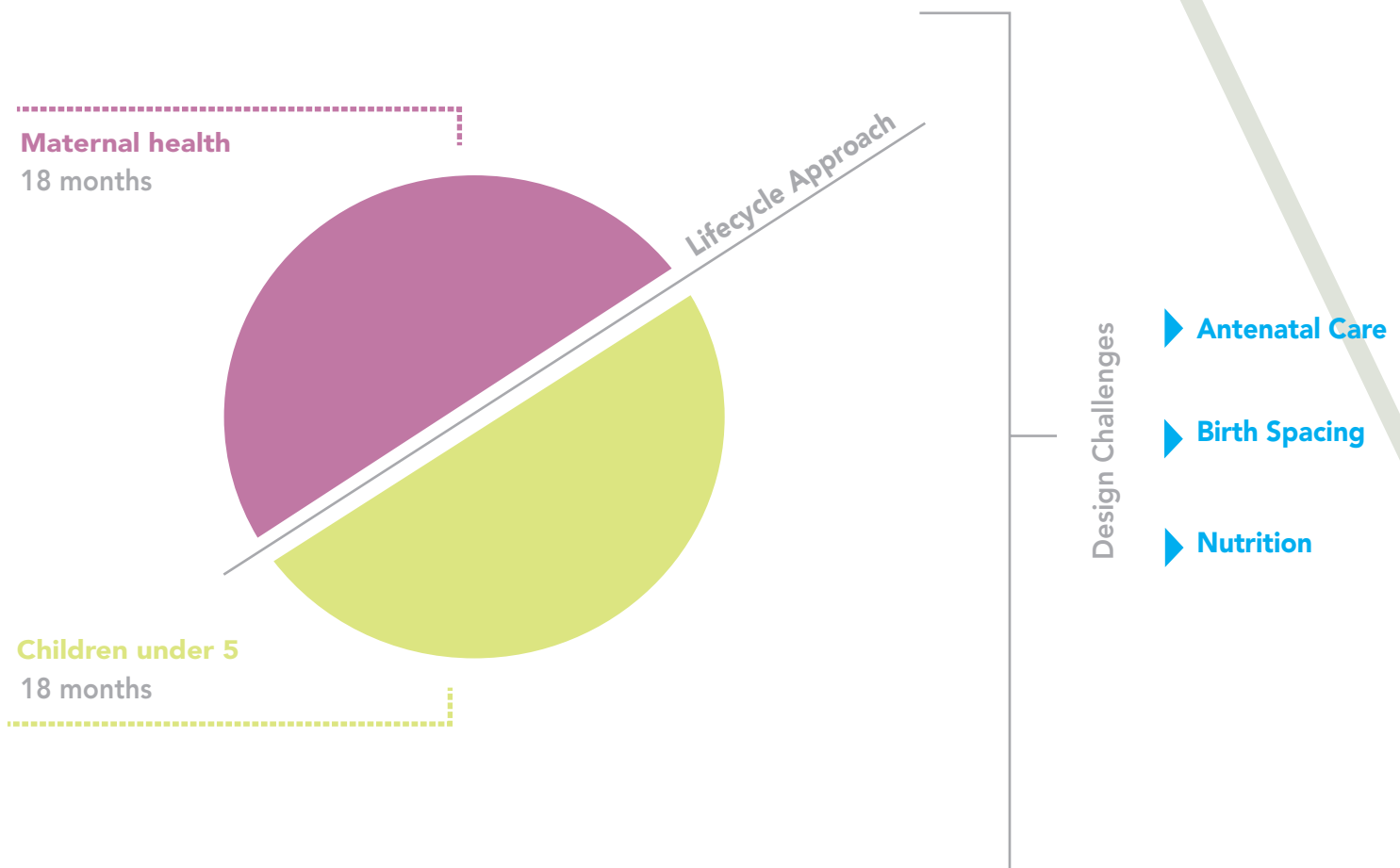
Under this programme, the MoH and PSI aim to increase access to and utilisation of reproductive, nutrition, child, and maternal health services and to promote healthy behaviour change. We are using an adaptive, evidence-based, participatory design to better understand the persistent barriers to uptake of health services and health-seeking behaviour and develop and test innovations in demand creation that target the external factors which influence individual behaviour to improve the health of Somali women and children.

SAHAN’s strong learning agenda is to influence the global community of practice (CoP)’s development of reproductive, maternal and child health and social and behaviour change programmes and policies in contexts like Somalia and Somaliland. SAHAN also wants to influence the use of innovative methods like human-centred design (HCD) and social network analysis (SNA) for promoting behaviour change in addition to adaptive learning and management in the Somali context.

SAHAN Program Approach

This program approach involves several rounds of immersive research, which is followed by ideation, design and co-creations activities to produce prototypes. The prototypes designed are then tested and iterated until the user finds them suitable. They are also tested for scalability, desirability and feasibility, the results of which determines if and how they will be piloted. The piloting activities are carried out at a modest population scale, just large enough to provide evidence that will inform country wide scalability, and also influence the international community of practice on key learnings and best practices.

The end products from SAHAN will be used by multiple stakeholders working within the Somali context and beyond, hence proper capture, packaging and documentation of all the processes within SAHAN is of vital importance.



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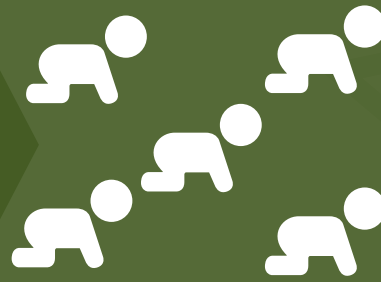
BACKGROUND

Somalia has some of the highest infant, child, and maternal mortality rates in the world. In 2015, the maternal mortality rate was 732 per 100,000 live births and the under-five mortality rate was 137 per 1,000 live births. One in 18 women die in pregnancy or childbirth in Somalia. Contributing to this is indicators are the lack of access to skilled delivery, closely-spaced births and adolescent marriages. Low government investment in health services, poor infrastructure and several socioecological factors also contribute to low access and utilisation of maternal health services. Family planning which could reduce maternal and new-born mortality is highly unpopular in Somalia. Misconceptions associated with contraceptive use, religious and cultural barriers have been repeatedly identified among reasons that prevent both women and men from accessing reproductive health information and services.

Somalia has some of the highest infant, child, and maternal mortality rates in the world.

**20
15** Maternal mortality was **732 / 100,000** live births

&



under-five mortality was **137 / 1,000** live births.

1  in **12** women die in pregnancy or at childbirth in Somalia.

Furthermore, **CPR remains at**

15% while **mCPR** only increased from **4.3%** in **2012** to **5.1%** in **2016**

The causes of maternal mortality in this context include low literacy levels, poor coverage and limited access to quality health care products and services, poor nutrition, poverty and a range of myths and misconceptions about modern health care, health facilities and the health care providers.

Problem Statement

The Somali society is highly patriarchal such that positions of authority are considered an exclusive entitlement of men even at the level of the family unit. Women's roles are typically in most cases confined to domestic and informal labour, while decision making, including those related to reproductive health issues is left solely to the head of the family, who is the man. Due to this longstanding tradition, young girls are taught that submission to her husband is paramount to the success of her marriage

SAHAN research findings show that a Somali woman trusts her husband's wisdom and leadership; she also expects that her husband is well informed and acts for the good of the family. Even though husbands have low knowledge about health matters and harbour myths about modern birth spacing methods, the husband remains the key determinant for family health outcomes, because he is the decision maker. Husbands have been reported to make the decisions with regards to whom, where and when their wives or children are allowed to seek medical attention.

Fear of jeopardizing the relationship between a woman and her husband limits her ability to take decisions even when it affects her health in the most critical circumstances. Her ultimate submission to her husband takes superior priority; hence, she waits for his decision sometimes at the expense of her life or that of a child. It was also uncovered that most husbands do not have a plan in place for pregnancy, childbirth or any emergency situations and lack adequate knowledge, to make favourable decisions for the benefit of their families.



“even if mother visit the MCH for ANC or Nutrition they rarely discuss with their husbands as they do not want to burden him because he is a daily cash worker who is out there to earn for his family.”
Said one of the participants and echoed by a majority of the groups.



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THE CONCEPT OF MALE INVOLVEMENT

The WHO recommends that involvement of men during pregnancy, childbirth and after birth is imperative in supporting improved self-care for women, improving home care practices for women and new-borns and improving use of skilled care during pregnancy, childbirth and postnatal period for women and new-borns.

Several studies back up these recommendations:

Finding	Source
<p>"there were many benefits of male involvement in maternal and child issues because it serves as an avenue for giving them information so that they would understand more about the risks that women have to go through in their reproductive life cycle, especially during pregnancy, delivery and post-natal period".</p>	<p>A qualitative study of policymaker and practitioner perspectives in the pacific involving five countries; Cook Island, Papua New Guinea, Fiji, Vanuatu and Solomon Island (Davis. J et al 2016)</p>
<p>"lack of awareness of male partners of the dangerous complications that may happen during pregnancy as key factors preventing their involvement".</p>	<p>Asefa, Fekede & Geleto, Ayele & Dessie, Yadeta. (2014). Studies on Male involvement in maternal health issues in a Harari public health institution in eastern Ethiopia</p>
<p>"more male education programs should be carried out by government and non-governmental organizations to address lack of awareness and negative attitude associated with male involvement in ANC care".</p>	<p>Perception, attitude and involvement of men in maternal health care in a Nigerian community. Olugbenga-bello, Adenike & Asekun-Olarinmoye, Esther & Adewole, Adefisoye & Adeomi, Adeleye & SO, and. (2013)</p>

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MEN'S CLUB DESIGN CONSIDERATIONS

The Men's club is an intervention that seeks to increase Men's knowledge on maternal and child health matters and shift men's attitudes, beliefs and perceptions on their role in maternal child health decision and practices. It is designed around a place where men regularly congregate for social activities. Somali men spend time together almost every day from 3- 8pm at Khat chewing places and tea shops. In these social settings, men tend to discuss current economic and political affairs but not much is discussed regarding maternal and child health issues. The Men's club employs the following design considerations:

Key Design Considerations



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THE JOURNEY OF THE MEN'S CLUB

To increase male involvement in maternal and child health matters, PSI through the SAHAN programme sought to get a better understanding of the current practices with regards to nutrition, birth spacing and maternal health and how men can be empowered with accurate, reliable health information within the cultural and religious context and act upon this. This prototype came into being after successive design sprints with different men groups in Hargeisa, Borama and Sahil on the design challenge:



How might we empower the husband with accurate, reliable health information to initiate maternal health discussions with their wives and make informed choices regarding the health wellbeing of his family.

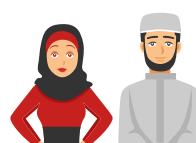
The Co-design Workshop

SAHAN team further articulated the ideas generated during co-design workshops with those groups and built the Men's club as one prototype with an overall design objective of involving men in the process of making better health decisions with their wives focusing on key maternal and child health issues such as ANC, Maternal Nutrition and Birth spacing.

The Specific Objectives were 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



Enable men to prepare themselves financially for pregnancy, childbirth and emergency situations that may arise during this period.

To achieve this, SAHAN engaged 46 fathers through two separate co-creation activities conducted in Hargeisa and Borama. These "fathers" were recruited based on "Ahmed" – the Male persona with the basic characteristics of having young children or are expecting at least their first child, with middle-low income levels and either exposed or not- exposed to family planning information and available options.

The co-creation activities sought to find out from the users (Men) on how best fathers and men in general can participate in ensuring good health of their families especially maternal child health and nutrition. They identified the lack of awareness and knowledge on the part of the fathers as the key challenge hindering their participation and a consistent lack of communication between couples especially on health issues.

The Initial Prototype:

SAHAN team further articulated these outcomes from the co-creation workshops into the initial 3 intervention concept prototypes:



Men's Club

Designed as a health education intervention, focused on awareness creation, to improve 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.



Model Father

envisaged as a media campaign, through which messaging on fatherhood and maternal health is disseminated via testimonies of positive deviants on mass and social media channels, in order to enhance the communities understanding of the importance of a father's participation in family health care.



Couple Counselling

An initiative to facilitate maternal and child health discussions between husband and wife. The idea was to have a:



Father led (role model)

A healthy maternal health discussion at the household between husband and wife initiated by the husband, for a private, sustainable family led initiative.



Group couple counselling

Bring together a number of couples (preferably 5 per session) to be engaged through a trained communication agent, religious leader or provider.



This prototype came into being after successive design sprints with different men groups in Hargeisa, Borama and Sahil. It is an iteration of a previous PSI male IPC intervention that involved the male IPC agents mobilizing men to attend an FP/RH course during which refreshments were provided.

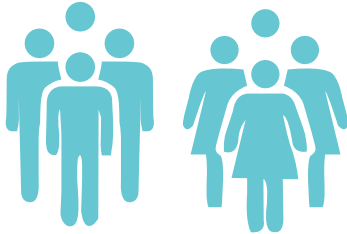
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PROTOTYPE DEVELOPMENT, TESTING AND ITERATIONS

The above intervention concepts were developed further, factoring the ongoing system of prototypes, lessons from previous interventions in Somalia/ Somaliland and other countries and through partners engagements and feedback to enhance their fidelity and prepare tangible interventions for testing.

Several modifications were made as follows:

The Iterated Prototype



Improved Men's Club

The new iteration placed the man at the centre building his capacity and confidence to initiate couple discussions with their wives at the household level, in the hope that these discussions will motivate their wives to freely seek services at the health facility. The old couple counselling model was not preferred as it was considered costly and unsustainable.



Model Father

Considerations were made, to identify husbands who were confidently performing the desired behaviours, promoted at men's club sessions, in order to profile them as role models who could share their personal testimonies, with their peers through mainstream media channels such as Radio and TV, as well as social media.

Testing of the Men's Club intervention

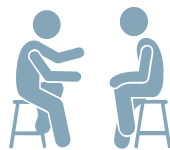
The Men's club intervention testing focused on the below features which essentially formed the key winning elements of the intervention:



Target Audience and Source of information



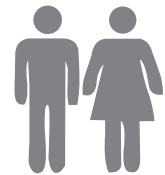
Setting and format



Delivery:



Facilitation materials



Desired output and outcomes

- | | | | | |
|---|--|---|--|--|
| <ul style="list-style-type: none"> • Can we find our archetype socialising with his peers in the afternoon/ evening hours? • Is the group a good source of information for him? | <ul style="list-style-type: none"> • Do settings like teashops, construction sites, markets, bus stations, khat chewing shops Exist? • Would they be an appropriate venue and setting to address serious issues like health? | <ul style="list-style-type: none"> • Are there natural leaders among these groups of peers? • Will they and the group be willing to have their natural set up "affected" by the health discussions. • Will the natural leader be able to deliver the sessions? | <ul style="list-style-type: none"> • Test for the understanding, appropriateness and relevance of facilitation materials. • Test for the use of the material in an open session. | <ul style="list-style-type: none"> • Test the men's desire to stick through the sessions and listen to health messages. • The willingness and intention to initiate discussions with their wife's. |
|---|--|---|--|--|

Testing activities took place in Hargeisa, Boroma, Dilla and Sahil. PSI identified and recruited men from the homogenous groups with potential to be an authority in health matters, oriented them on some health messaging with a view of making them the health champions in the groups. Their role was to engage his peers for a period of 2-3 weeks to share maternal and child health messages that will help the fathers in his group understand what the mother goes through during pregnancy and child raising. The discussions would cover a range of topics starting with the most important issue to men as providers i.e. finance, then weave this into health, family communication and collective decision making.

Model Father testing sessions Topic

Week/Session	Session 1	Session 2	Session 3
WEEK 1	Introduction and session agenda <ul style="list-style-type: none"> • Family health issues • Family Finances • Saving money • Preparing for new baby • Antenatal Care • Family communication • Q&A 	<ul style="list-style-type: none"> • Safe delivery • After Pregnancy • Exclusive Breastfeeding • Nutrition after child-birth • Immunization • Family communication • Q&A 	<ul style="list-style-type: none"> • Benefits of birth spacing to the child and mother • Risks of lack of birth spacing to child and mother • Family communication • Q&A

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TESTING RESULTS

There were three Rounds of testing occasioned by the geographic coverage and the need to iterate testing elements based on lessons from the previous round. The First and second rounds of testing took place in Hargeisa and Dila to test the validity of the prototype in terms of content, delivery and pre-test of its materials, while the third round of testing which largely addressed the desirability of men to seat through the sessions uncompensated and the availability of the settings given the context (environmental and social-economic) took place in Sahil. The test evaluation took an in-session observations approach and follow-up questionnaires interviews to find out the impact it had on the participants. The testing took place between the 4th -28th of July 2019 where 6 facilitators and 29 participants together with the SAHAN team HPA and the Regional health teams.

Testing outputs:



Target Audience and Source of information



Setting and format



Delivery:



Facilitation materials



Desired output and outcomes

- Our target socialises with his peers in the afternoon/ evening.
- Their peer group is a good source of information.

- Settings like teashops, construction sites, markets, bus stations, khat chewing shops Exist.
- They can be utilised to address serious issues like health, but are prone to interruptions.

- There are natural leaders among these groups of peers and participants are willing to have their natural set up "affected" by the health discussions.
- The natural leaders are able to deliver the sessions, but a bit of skill building will be required.

- Acceptance and recall of the facilitation materials, was quite high.
- The open delivery approach was well received.

- Men didn't mind sitting through the sessions, and the Intention to initiate SRH discussions with wives was noted.

- Request to find a quiet place within the same vicinity for an engaging session.
- The cost of a cup of tea will be covered for each participant.

- Combine both seasoned facilitators and the natural leaders to co-facilitate the session in order to achieve the desired objective.

Recommendations

The following is a summary of the testing outputs:



The sessions were appreciated by the men as important in health, family structure and behaviour change.

Issues of family finances were discussed at length and budgeting for the mother and the new born baby was deemed as important.



Some participants however expressed reservations in sharing information because of social and cultural factors surrounding the topic of maternal health.

The venue of the sessions was suitable for majority of the urban dwellers; some men from the rural areas expressed the importance of extending such sessions to the rural areas where they are much needed because they lack of access to information.



The facilitator skills seemed to be directly proportional to the effectiveness of the session. The better the facilitation skills, the better the participation and therefore output of the sessions.

Materials were appreciated as culturally acceptable, and some participants felt that the booklets should involve more success stories of men who have taken up involvement in maternal and childbirth issues as opposed to those who have not and should be more visual as compared to the fine text.



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PROGRAM RECOMMENDATION

There was recommendation to gamify some of the sessions by including games infused with health messages.



Gamification entails applying game mechanics into something that is not a game to increase engagement, excitement and loyalty as a novel field in health, it is used for aim to engage users to change their behaviours to acquire and adhere to behaviour.



The team identified 3 key games as that Somali men play different games in their public gatherings mainly in afternoon and at night. These include but not limited to: Ludo, domino and different form of Shax (crafts). In an effort to incorporate the Ludo game developed a partner in Puntland we realized that the version played in Somaliland is digitized and is played on phones, plus the most popular game played with the backdrop of an audience is domino while Shax is played by the older generation 65year and above.





Recruitment of Facilitators

- Recruit Male champions from among the natural leaders at local meetup venues.
- Pair them up with seasoned facilitators.



Training

- Facilitators will be identified and taken through a 3-4 -days training on health areas and BCC facilitation skills. Sessions will be delivered in pairs



Format and Setting

- Sessions will be conducted with the target group at a quiet section in their natural setting.



Mapping

- Pairs will recruit 10 groups of 8-10 men.
- They will Visit each group and hold the 3 session within a week



Delivery

- Sessions will be delivered in an open ended discussion format with the facilitator following a basic guide



Follow up


- Follow-up discussions will be had with men that have wives between the age of (15 – 49) and children U5.



Targets

- 30 sessions for the pair reaching at least 300 men, every 3months.
- Beneficiaries receive and utilise referral cards
- Beneficiaries initiate conversations on SRH with their wives

Mens' Club Improvement based on findings:



The interventions proved to be Desirable, feasible and Scalable from the numerous tests done and the successful interest it generated during the test period. It was agreed that the recommendations being incorporated and the final intervention to be piloted at scale especially within the areas covered by the Hooyo ku Hooyo interventions to complement the FCIs sessions with WRAs.

CURRICULUM/DISCUSSION GUIDE

Week/Session	Session 1	Session 2	Session 3
WEEK 1	Introduction and session agenda <ul style="list-style-type: none"> Family health issues Family Finances Saving money Preparing for new baby Antenatal Care Family communication Q&A 	<ul style="list-style-type: none"> Safe delivery After Pregnancy Exclusive Breastfeeding Nutrition after childbirth Immunization Family communication Q&A 	<ul style="list-style-type: none"> Benefits of birth spacing to the child and mother Risks of lack of birth spacing to child and mother Family communication Q&A
WEEK 2	Referral Follow up and discussions with Husbands of WRA and care givers of Cu5		
WEEK 3	Referral Follow up and discussions with Husbands of WRA and care givers of Cu5		

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MONITORING AND EVALUATION

The Sahan Program developed tools and processes, to systematically collect and analyse information to track a programme's progress toward reaching its objectives and to guide management decisions. For evaluations, it is recommended that outcome and impact evaluations be conducted by an internal or independent research team at designated intervals depending on project requirements, in the middle, or at the end of the intervention

Project Log Frame

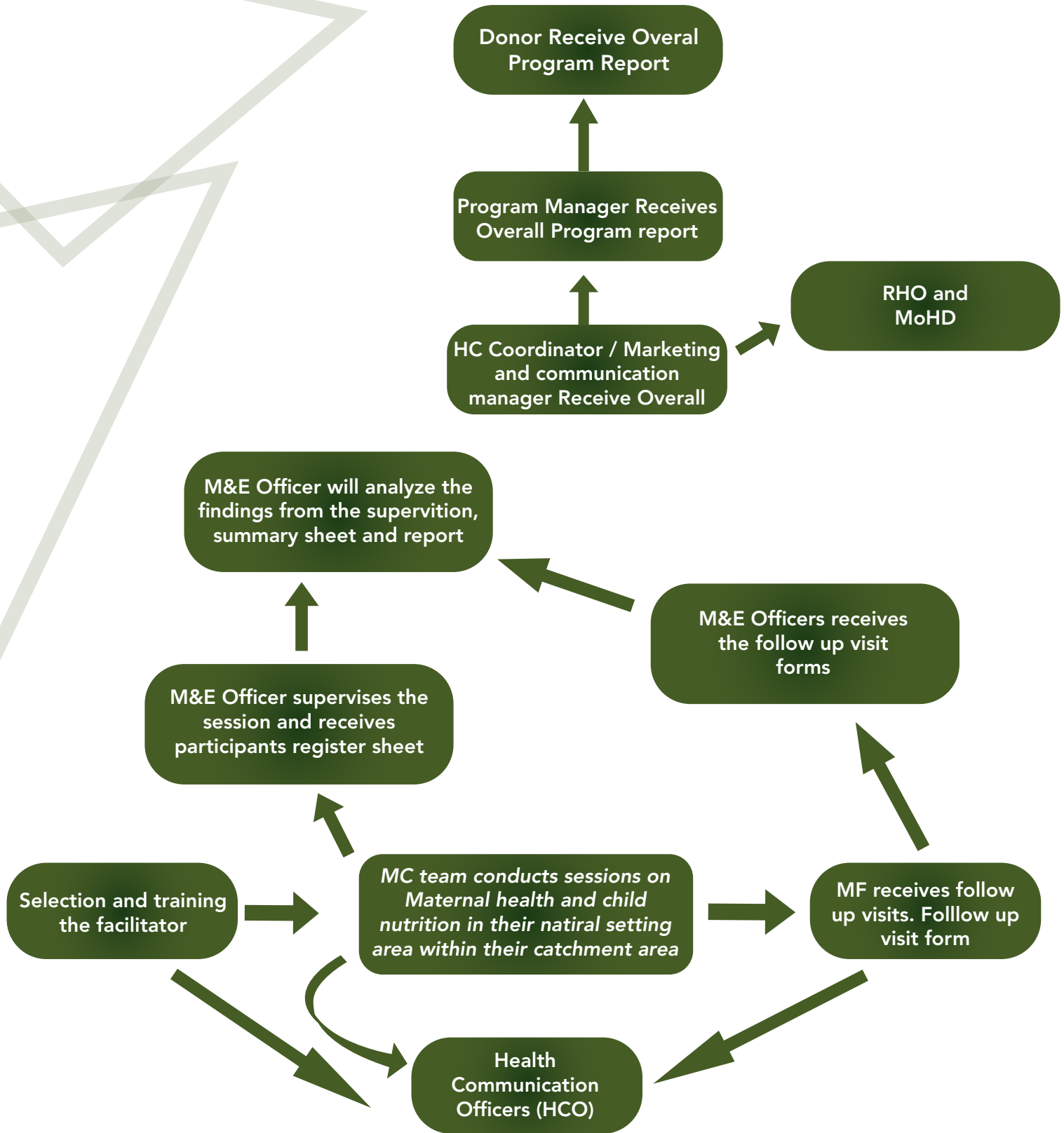
	Project Summary	Indicator	Means of Verification	Target	Assumptions/Risk
Goal	Improved health of Somalis	U5MR NMR MMR	Beyond prototype pilot scope. Would require large population survey	NA	Security allows MOHs will fully support the initiative Targeted Communities embrace the intervention and positively change behaviour
Specific Objective	Increased Utilization of Quality Maternal and Child Health services	% Increase in OPD consultations	Health Facility Records (Referred by MC team)	BL: TBD, Target: x% increase from BL	
Outcomes	1. Initiated couples' conversation on health matters at the household level.	# of men discussing with their wives on child and maternal health	MC team Follow up sheet	BL: TBD Target: x% after 6 months	
	2. Increased Effective referral for RMNCH services by MC session's participant	# of effective referrals made for RMNCH services by MC session participant (Total, vs effective)	Referral cards by MC team	BL: TBD Target: x% after 6 months	
	3. Men are prepared themselves financially for pregnancy, child birth and emergency situation during this period	% of participants preparing themselves financially for pregnancy, child birth and emergency situations during this period.	Follow Up Visit Sheet/ Summary Sheet	BL: TBD Target: x% after 6 months	
	4. Improved awareness and knowledge among men on health issues.	% of men referring their wives to the MCH/HF for RMNCH services after sessions	Health Facility records	BL: TBD Target: x% increase from BL	
Outputs	1.1 increased participation of beneficiaries in all the sessions	% of beneficiaries attending all the sessions	Men's Club Summary Sheet	BL: 0 Target: x%	
	2.1. Participants are discussing health issues with their family/wives	% of participants discussing child and maternal health with their wives/family	Participants Feedback Form	BL: TBD Target: x% after 6 months	

	3.1 Participants understand the importance of Maternal health and child nutrition	% that can recall key Danger signs in pregnancy % that can accurately recall key take out message for ANC, Nutrition, and birth spacing.	Participants Feedback Sheet	N/A	
	4.1 Quality of MNCH and finance messages delivered by MC team	% of MC team delivering message according to protocol	Supervision reports	N/A	
	4.2 MC team trained on CDC for RMNCH for	Number of MC trained on CDC for RMNCH themes	Training reports	N/A	
	Activity	Indicator	Tool	Responsible	
Activities	Identification and Screening of MC teams	Screen twice number of required MC (i.e. X * 2)	Screening Tool	MCH team leads with support of HCOs	
	MC Selected	Select 130% of X		HCO	
	Train MC team on RMNCH Themes and family finance	Train 130% of X		HCC, HCO and MoH	
	Conduct sessions for homogenous men that have wives between the age of 15-49 with U5 in their catchment area	12 sessions per Month	Session attendance register	MC team	
	Follow up sessions for beneficiaries	Z# of times per month	Beneficiaries Follow up Sheet	HCO/MoH	
	Monthly Supportive Supervision	Y number of sessions Supervised	MC team Coaching form	HCO	

Roles and Responsibilities

Role	Responsibilities
RHO and MOHD	They are responsible for the overall program results as the main stakeholder. RHO officers and MOH officers provide a quarterly joint supportive supervision activity using a checklist. Their oversight spans the entire continuum of care from home visit to service provided. The 3-day activity conducted by these officials alongside HCO or management staff
MCH Lead (MOHD)	<ul style="list-style-type: none"> The MCH team leads are responsible for the identification of the MC and record the effective referral cards used by model father's families/wives. Carry out support supervision and assist the MC in clarifying technical health issues as and when they arise.
Health communication officer (HCO) and social behaviour change officers (SBC)	<ul style="list-style-type: none"> The HCO/SBC officers are responsible for the recruitment of the male champions(-facilitators) using recruitment and selection tools and strategy and guided by the MOH Team lead The HCO/SBC train and educate the selected male champions The HCO/SBC prepare and provide all the support documents and tools to the male champions to be fully equipped. The HCO/SBC conduct support supervision and mentorship to the male champions through the sessions using supervision forms. The HCO/SBC conduct follow up visits to the model fathers after sessions through follow up visit forms The HCO/SBC collect and review the effective referral cards from the MCH.
HC Coordinator/ BCC manager Marketing and communication manager	<ul style="list-style-type: none"> A HC Coordinator/ BCC manager marketing communication manager is accountable for the for the delivery of set targets and performance of the men's club sessions S/He shall provide oversight to the activities of the HCO, collate HCO reports, monitor performance and well as mentor the officers
M&E team	<ul style="list-style-type: none"> The session participant's list will be obtained from the participant registers by M&E officer and will be checked using the phones number of the registered model fathers.M&E Officers will conduct session supervisions, to monitor and check that the session conducted as per the plan. M&E Officers will counter check the effective referral cards used by model father's families/wives from HCO/SBC officers. M&E officer will conduct DQA on Men's club participant register, follow up visit forms, effective referral cards from MCH, data will be checked using different indicators i-e completeness, timeliness, integrity, consistency and accuracy. M&E will analyse data and share summary monthly activity report <p>Conducting baseline and end line assessment:</p> <ul style="list-style-type: none"> To assess the outcome of the intervention, will see discussions between MF and their families/and client flow to the MCH, to know that M&E team will conduct baseline and end line assessments. Baseline assessment of the status of the target population will conducted to see level of the different indicators of the program. Before the program starts, two community sites will be selected, one will be the target population for the intervention while the other will serve as a control, the same tool will be used on both communities to determine the status. The two communities should be as much as possible similar apart from the pilot intervention. An end line assessment will be conducted at the end of the pilot. Again, both communities will be assessed using same tool. Indicators like ANC will be compared between the intervention and control communities, all other factors will be contributed to see the net attribution of intervention

DATA FLOW DIAGRAM



Annexes:

Monitoring Tool
The session discussion guide
The Men's club booklet take home IEC

saHlan



Healthy lives. Measurable results.

