COMPENDIUM

TO IMPLEMENT

COMMUNITY BASED FEMALE HEALTH WORKERS' PROGRAMME

The *'Marwo Caafimaad'* Programme

SEPTEMBER 2014

Together with Somali Health Authorities

UNFPA World Health Organization unicef

World Health Organization, Somalia,
UNICEF Somalia and UNFPA Somalia
together with
Ministry of Health, Central South Somalia
Ministry of Health, Puntland; and
Ministry of Health, Somaliland

The '*Marwo Caafimaad*' Programme:
Compendium to implement Community-based Female Health Workers' Programme

Version 1: January 2011
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Prepared by:
Raza Zaidi, Consultant, WHO (2011)
Humayun Rizwan, PHC Medical Officer, WHO

Reviewed by:
Mohamed Mahmoud Ali and Samar Elfaky
Assai Ardakani (WHO-EMRO)
Dr Khalif Bile Mohamud

..VISION..

Better Health of
Somali Women, Girls and Children,

through providing high quality
Integrated Health Services at

the Doorsteps of Communities by

Community based Female Health Workers
'Marwo Caafimaad'
–
Bridging the gap between
Health Services and Communities

....MAP....


DJIBOUTI
Djibouti
Āsayita
Dikhil
Saylac
GULF OF ADEN
Boosaaso
(Bender Cassim)
Bandar Murcaayo
Caluula
Breeda
Butyaalo
Qandala
Bargaal
Laasqoray
Xiis
Maydh
Karin
Ceerigaabo (Erigavo)
Hurdiyo
Xaafuun
BARI
SANAAG
Iskushubani
AWDAL
Baki
Bullaxaar
Berbera
WOQOOYI
GALBEED
Boorama
Togwajaale
Hargeysa
Burco
(Burao)
Garadag
Qardho
Dudo
Bandarbeyla
Diré Dawa
Nazrēt
Hārer
Jijiga
Oodweyne
Kirdh
TOGDHEER
Xudun
Taxeex
SOOL
Buuhoodle
Laascaanood
Garoowe
NUGAAL
Gori Rit
Eyl
Degeh Bur
ETHIOPIA
Megalo
Werdêr
K'ebri Dahar
Berdaale
Xamure
Beyra
Seemade
Gaalkacyo (Galcaio)
Garacad
MUDUG
Ímí
Godē
Shīlabo
War Galoh
Baxdo
Mirsaale
Hilalaya
Mereer-Gur
Dhuusamarreeb
(Dusa Marreb)
Hargele
Hobyo
GALGUDUUD
Fērfēr
Ceel Huur
Beledweyne
Ceel Buur
Xarardheere
BAKOOL
HIRAAN
Derri
Dolo Bay
Xuddur
(Oddur)
Buulobarde
Ceeldheere
INDIAN OCEAN
Tayeeglow
Luuq
KENYA
Garbahaarrey
Baydhabo
(Baidoa)
SHABELLE
DHEXE
GEDO
Mahadday
Weym
Cadale
El Beru Hagia
Buurhakaba
Wanlaweyn
Jawhar (Giohar)
BAY
Diinsoor
Baardheere
Balcad
Afgooye
Muqdisho (Mogadishu)
BANADIR
Wajir
Qoryooley
JUBA
DHEXE
SHABELLE
HOOSE
Marka (Merca)
Haaway
Baraawe
Bu'aale
Afmadow
Jilib
Bilis Qooqaani
Jamaame
JUBA
HOOSE
Kismaayo (Chisimayu)
Buur Gaabo
Garsen
Lamu
SOMALIA
The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the United Nations.
SOMALIA
National capital
Regional capital
Town, village
Airport
International boundary
Regional boundary
Main road
Track
Railroad
0 50 100 150 200 km
0 50 100 mi
Map No. 3690 Rev. 7 UNITED NATIONS
January 2007
Department of Peacekeeping Operations
Cartographic Section

FORWARD

We are very pleased to present the 'Compendium to Implement the Somali *Marwo Caafimaad* Programme'. This compendium provides a clarity of vision and direction for the implementation of the Programme. The focus is on launching and scaling up the programme while ensuring quality of services delivered and that these services are reaching at the doorstep of Somali women, girls and children in rural and urban slums.

In the health sector of developing world, community based health worker is recognized as one of the cost effective intervention to address barriers in access to primary health care, improving continuum of integrated care, delivering results and bridging the gap between health care delivery system and the communities. In addition, a well-designed community based health workers' approach within primary health system is considered as an effective strategy for moving towards the Universal Health Coverage (UHC) and achieving the Millennium Development Goals (MDGs).

The Alma Ata Declaration (1978) identified community based health workers as one of the cornerstones for provision of comprehensive primary health care at the grass root level. The movement which started from 'bare foot doctors' in China, witnessed a major development during the 1980s and 90s, when many developing countries trained large numbers of community health workers and those workers contributed significantly in improving health outcomes and are still providing care in the remote and disadvantaged parts of their country. Some examples include Aanganwadi workers in India, Lady Health Workers in Pakistan, Behvars in Iran, Raeda in Egypt, Community Health Agents in Ethiopia, Kader in Indonesia, Barangay Health Workers in Philippines, Activists in Mozambique and Brigadista in Nicaragua, etc. Somali 'Marwo Caafimaad' is an addition to the list.

The three Somali health authorities decided in 2013 to scale up this programme in the targeted regions of Joint Health and Nutrition Programme (JHNP) considering that the *Marwo Caafimaad* programme is an excellent example of nation-building and state-building as people start to see and experience the '**state coming to their village and providing needed services**'. This programme is consistent on the emphasis to meet agreed principles of the 'Somali Compact'.

This compendium was developed in 2011 in consultation with stakeholders through GAVI support and updated in 2014 considering the lessons learnt through implementation of phase-I of the programme, under which 200 *Marwo Caafimaad* were trained in Somaliland, Puntland and Central South Somalia. This updated version of the compendium provides implementation clarity for the scaling up of the intervention under the JHNP and other development initiatives.

The compendium focuses on developments that need to occur both with service delivery and with the organization of the Programme in order to ensure that its contribution to health outcomes is increased and that the benefits are seen more significantly in rural and urban poor areas. The success of the *Marwo Caafimaad* programme has been dependent on the support of all stakeholders and on the energy and commitment of Somali leadership.

The Ministries of Health in Somaliland, Puntland and Central South Somalia are committed to the policy of devolution of powers - bringing decision making closer to the communities and facilitating

their involvement in the process of health development - and integrating the different services so that primary health care is delivered coherently and with the best use of staff, material and resources. The level of delegation of decision-making in the programme will be greater than any other intervention in the Somali health sector. Moreover the intervention is in line with the commitments of National authorities in moving towards Universal Health Coverage endorsed during 60th session of the Regional Committee (EM/RC60/R.2).

We would like to acknowledge the support from the highest policy levels that this Programme has been able to get in a short period of time. We are thankful to GAVI and JHNP donors especially Governments of United Kingdom (DFID), Sweden (SIDA), Australia (AusAID) and United States (USAID) who have provided generous funds for strengthening of Somali health systems at levels never before achieved. The decision of scaling up the Programme is an excellent example of the level of support from the donor community in Somalia.

We particularly acknowledge the leadership role of the United Nations Resident Coordinator and support & guidance provided by the three UN agencies i.e. World Health Organization (WHO), United Nations Children Fund (UNICEF) and United Nations Population Fund (UNFPA) in the design and implementation of the Programme.

We would also like to express our gratitude to the Ministers of Health from Somaliland, Puntland and Central South Somalia for their support, without which we would not have been able to reach this milestone.

We are confident that the Programme will be broaden and more and more partners would join hands in achieving our common goal of improving health status of Somali women and children, ensuring peace and ending poverty.

September 2014

Mohamed Abdi Farah
Acting Director General Health
Ministry of Health, FG of Somalia

Ousman Warsame
Director General Health
Ministry of Health, Somaliland

Abdirizak Hersi Hassan
Director General Health
Ministry of Health, Puntland

ACRONYMS

ARI	Acute Respiratory Tract Infection
BCC	Behaviour Change Communication
CHD	Child Health Days
CHW	Community Health Worker
MW	Midwife
DMO	District Medical Officer
EPHS	Essential Package of Health Services
EPI	Expanded Programme of Immunization
FGM/C	Female Genital Mutilation/ Cutting
FHW	Community based Female Health Worker / '*Marwo Caafimaad*'
FHS	FHWs' Supervisor
GAVI	Global Alliance for Vaccine and Immunization
HAB	Health Advisory Board
HC	Health Centre
HFA	Health Facility Assessment
HMIS	Health Management Information System
HP	Health Post
HR	Human Resource
HSAT	Health System Analysis Team
HSC	Health Sector Committee
HSS	Health System Strengthening
HSSP	Health Sector Strategic Plan
IEC	Information, Education and Communication
INGO	International Non-Governmental Organizations
JHNP	Joint Health and Nutrition Programme
LFW	Logical Framework
MCH	Mother and Child Health
MDG	Millennium Development Goals
MICS	Multiple Indicators Cluster Survey
MIS	Management Information System
MMR	Maternal Mortality Ratio
MNCH	Maternal, Newborn and Child Health
MoH	Ministry of Health
MOU	Memorandum of Understanding
NGO	Non-Government Organization
OR	Operational Research
PHC	Primary Health Care
PHU	Primary Health Unit
PL	Puntland
RMO	Regional Medical Officer
RMNCH	Reproductive, Maternal, New-born and Child Health
RHMT	Regional Health Management Team
R/DMO	Regional or District Medical Officer
SDRF	Somali Development and Rehabilitation Facility (under the Somali New Deal)
SL	Somaliland
STI	Sexually Transmitted Infection
CSS	Central South Somalia
TB DOTs	Tuberculosis Directly Observed Treatment-short course

TB	Tuberculosis
TIC	Training Information Checklist
TT	Tetanus Toxoid
UC	Universal Coverage
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WMO	Women Medical Officer
ZHNCF	Zonal Health & Nutrition Coordination Forum

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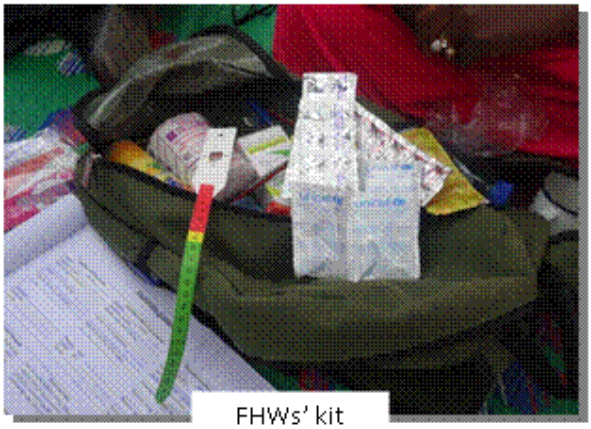
'Marwo Caafimaad'

Community based Female Health Worker (FHW)

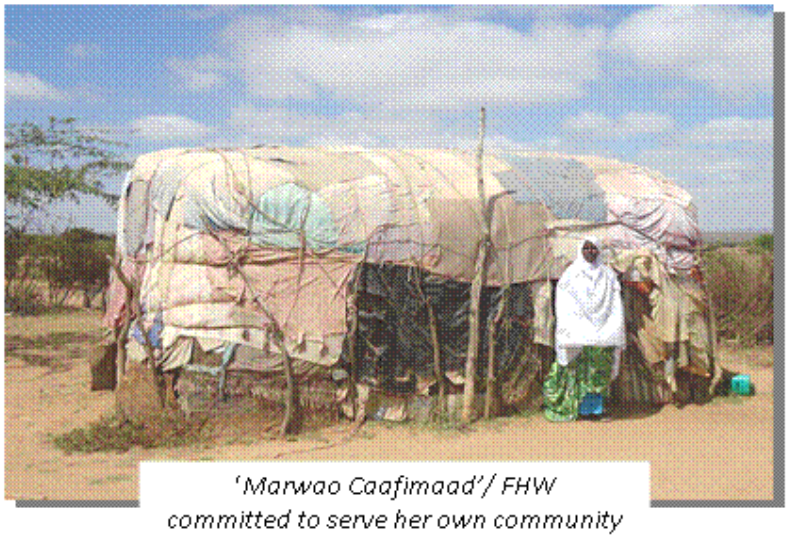
Training of FHWs

Batch of FHWs ready for deployment

Supervision of FHW



FHWs' kit



'Marwao Caafimaad'/ FHW committed to serve her own community

Introduction

The community based Female Health Workers (FHW – '*Marwo Caafimaad' in Somali language)* intervention was conceived during the development of a joint WHO-UNICEF proposal for Somali Health System Strengthening (HSS), which was submitted to the Global Alliance for Vaccine and Immunization (GAVI) in May 2009. In this regard; a proposal was developed to pilot test the community based FHWs' intervention in an attempt to strengthen the efforts to reduce the high levels of mortality and morbidity, especially among women and children, through: (i) development of an effective and efficient package of health services at community level which is available, equitable, accessible, acceptable, affordable , sustainable and of reasonable quality, especially in the rural areas and urban slums; and (ii) build capacity to deliver the basic primary health care services at community level based on their own needs and preferences.

The GAVI proposal consisting of the FHWs' intervention along with other recommended health system strengthening interventions was approved in May 2010 and confirmation of approval was communicated in September 2010. The Grant Agreement was signed after a delay of one year, on 29 September 2011 and the Programme officially started from 1 September 2011.

The vision of the '*Marwo Caafimaad*' Programme is "Better Health for Somali women, girls and children, through providing high quality integrated health services at the doorsteps of communities by community based Female Health Workers - Bridging the gap between Health System and Communities". Through GAVI-HSS Programme, the intervention was launched at a very small scale through training and deployment of 200 FHWs in selected areas of Somaliland, Puntland and Central South Somalia (SCS), to generate evidence on the appropriateness and effectiveness of the intervention. Considering the urgent need to make a progress in achieving the 'Universal Health Coverage' (UHC) and the 'Millennium Development Goals' (MDGs), the Somali health authorities decided to increase the number of '*Marwo Caafimaad*' to 8,000 or more, giving a priority to rural and urban slums.

The Compendium of the FHWs' intervention was initially developed in January 2011 in consultation with all stakeholders to explicate the strategic directions, address the critical issues and rules and the way forward in line with different sub-systems of the intervention. The compendium helped the stakeholders particularly health authorities, managers, supervisors and implementing partners to manage the programme with full understanding of critical issues, rules and procedures and how to have a positive impact on health outcomes. Considering the Somali context, lessons were learnt during the pilot phase, which need to be incorporated in the Compendium before further scaling up and expansion of the intervention.

In the meantime, a five year Joint Health and Nutrition Programme (JHNP) was launched in Somalia in 2012 - the only attempt to be clearly aligned with the Somali Health Sector Strategic Plans (HSSPs) as well as developing leadership and enhancing governmental ownership and strengthening health systems. The JHNP is an important early recovery / development response which seeks to empower the Health Authorities with the support of three implementing UN agencies (UNICEF, WHO and UNFPA). It is recognized as a platform to lead the way in development programming in Somalia due to its collaborative and inclusive governance structures as well as providing much needed financing to the health sector's own HSSPs.

The JHNP looks for potential opportunities to build positive relationships between the people and the state. The presence and work of locally based female health workers who are members of the community – serving, totally engaged and having relations with households - is an excellent example of nation-building and state-building as people start to see and experience the 'state coming to their village and providing

needed services'. Considering this it was agreed to scale up and expand the '*Marwo Caafimaad'* programme during 2014 in the JHNP targeted regions with successive phases in 2015 and 2016.

The '*Marwo Caafimaad'* Programme and the JHNP have been consistent on the emphasis to meet five generally agreed principles of the **Paris declaration** for effectively delivering aid i.e. ownership of partner countries; alignment with national development strategies; harmonisation of development partners in pursuit of national development goals; managing of results; and mutual accountability. Both the '*Marwo Caafimaad'* Programme and the JHNP are committed to necessary actions and reforms under the '**Somali New Deal**' to: transparency; risk sharing; use and strengthen country systems; strengthen capacities and timely and predictable aid.

This revised version of **the Compendium** (June 2014) uses the Somali health sector strategic plans and other strategies, as a platform and illustrates different sub-systems of the 'Marwo Caafimaad' Programme using local knowledge, global best practices, experiences and lessons learnt. The Compendium focuses on progress that is needed to be achieved in relation to health workforce, service delivery and the organization of the 'Marwo Caafimaad' Programme, ensuring positive impact on health outcomes especially in rural areas and urban slums – hence contributing to achieving progress towards the MDGs, Somali peace building and state building goals. The intervention is in line with the commitments of National authorities in moving towards Universal Health Coverage endorsed during 60th session of the Regional Committee (EM/RC60/R.2).

The structure of the compendium encompasses different sections. The first section provides an overview of the key issues that further shape the '*Marwo Caafimaad'* Programme and possible resolutions to address those issues. Section two outlines key targets and performance indicators for the '*Marwo Caafimaad*' Programme. Section three covers different sub-systems in relation to the needs of the '*Marwo Caafimaad*' Programme, detailed description and performance indicators that are needed to assess the sub-system operational performance. For more details and information on the '*Marwo Caafimaad'* Programme, annexures have been attached to cover the following topics:

- Essential Package of Health Services at community level;
- Supervision Schedule for Regional/ District Supervisors;
- Checklist for Regional/ District Supervisors;
- List of Drugs & Non-drug items for the '*Marwo Caafimaad*' Programme.

The compendium has been prepared primarily for Zonal Health Authorities, UN staff, Regional/ District Supervisors (Regional Medical Officer, District Medical Officer, UN's Regional and District staff….etc.) and partners involved in the FHWs' Programme at different phases and levels. In addition, staff working at MCH/HC level and any other health professional interested in the programme can be among the target audiences of this compendium to learn more about the '*Marwo Caafimaad'* Programme and approach.

PART I: Issues in the Context of Strategic Direction for the 'Marwo Caafimaad' Programme:

Primary Health Care (PHC) is defined by the Alma Ata Declaration as ''the first level of contact of individuals, the family, and community with the national health system'' and ''the first element of a continuing healthcare process''. The Alma Ata declaration identified Community Health Workers as one of the cornerstones of comprehensive primary health care. Development of delivery of care based on PHC approach has shifted toward the deployment of various types of community health workers as a cadre at the community level who deliver low-cost, life- saving and effective PHC services at the community and household level to protect and promote public health and link community members with the PHC facilities. Therefore; countries signatory to the declaration considered establishment of a community health workers' programme synonymous with the primary health care (PHC) approach.

A policy debate in the context of community health workers was whether those workers would be static providers or should provide outreach services at community settings and doorstep of households. Evidence suggests that community workers who have access to households through doorstep services contribute more positively to the health outcomes especially in relation to Reproductive, Maternal, Newborn and Child Health (RMNCH) , Nutrition services and control of communicable diseases. Experiences derived from different countries across the world have been shown that the services are more acceptable by the local communities if delivered by a local health worker, interventions are more sustained and continuity of care is more secure through this intervention.

As community based health worker has to respond to local societal and cultural norms and customs to ensure community acceptance and ownership so most of the countries have largely relied on females as community health workers. Although both men and women are employed at grass-roots level, globally, there is evidence that female workers are able to deliver care more effectively and acceptable than male workers at community level due to cultural issues. While this may be true of reproductive, maternal, newborn and child health (RMNCH) and nutrition related services, the role of male workers in provision of environmental health and control of epidemics (in the past), such as cholera, small-pox and plague, at the community level has been substantial across countries. Nonetheless, there has been even an explicit policy-shift in some countries to replace male health workers with female workers at community level.

In Somalia, the static community health workers (CHW) intervention started earlier by deploying mostly male workers at health posts (static facilities) and considered them as an important and integral part of health system workforce that aims to provide essential package of health services (EPHS) and improve coverage especially for rural and remote areas. The Somali Essential Package of Health Services foresees up-gradation of Health Posts to Primary Health Units (PHU). Therefore, community based female health worker concept emerged to introduce a cadre who could offer mainly RMNCH and nutrition services, at the doorstep of households.

The community based '*Marwo Caafimaad*' - Female Health Workers' Programme (along with continuation of community health workers posted at health posts) is expected to play an important role to operationalize the policy priorities of Somaliland, Puntland and Central South Somalia through providing services at the doorstep of the households that will effectively contribute to achieving health and poverty reduction objectives. In particular, the programme is expected to contribute to health equity and improving the health

of poor and disadvantaged communities and in particular vulnerable groups such as women, girls and children. This intervention is based on a Somali programmatic and health system reform with a concept of bridging the gap between available static health services and communities through linking the community members with the health system and providing people-centered integrated primary health care services through community based '*Marwo Caafimaad'* - Female Health Workers (FHW) at the doorsteps of households.

ISSUES:

For the utmost result producing by '*Marwo Caafimaad'* Programme; a number of key issues need to be addressed during initiation and scaling up of the programme. These include:

1: An integrated approach for the '*Marwo Caafimaad'* Programme;
2: Clear roles and responsibilities in the '*Marwo Caafimaad'* Programme;
3: Scope of the '*Marwo Caafimaad*'s Services and her Capabilities;
4: Qualification and criteria of selection;
5: Initial and on job training;
6: Quality assurance of services;
7: Catchment areas (Target Population, Coverage and Expansion);
8: Strengthening accountability internally and to the Community;
9: Governance arrangements of the Programme;
10: The '*Marwo Caafimaad'* Programme in the context of Conflict, Disasters and other Crises;
11: Monitoring and supervision mechanisms of the programme

******

1: An Integrated Approach for the *'Marwo Caafimaad'* Programme

The FHWs - '*Marwo Caafimaad'* are expected to deliver promotive, preventive and limited curative primary health care services to their own communities at the doorstep and facilitate delivery of number of other priority development and humanitarian health interventions. Each community health worker covers on average 600-1000 people.

This programme is not expected to operate as a stand-alone vertical or humanitarian programme but it has to be an integral part of the regional/ district health system. It relies on the full involvement of Zonal Health Authorities, the Regional/ District Health Offices, functional health facilities, implementing partners, private sector and the successful operation of other health programmes.

For better performance, the '*Marwo Caafimaad'* Programme need the support of regional /district health system, MCH/ Health centers, other health programmes and must have the opportunity to refer cases in need to higher levels of health care services. For example, the health care providers in the nearest MCH/ HC will support on job training of '*Marwo Caafimaad'*. Improved management and availability of equipment, supplies and medicines in health facilities will improve the efficiency of the referral mechanisms of the

'*Marwo Caafimaad'* and will ensure the availability of the supplies and the management of medicines and supplies of the programme.

On the other hand; a vertical approach will lead to duplication of efforts and loss of resources along with limited chances of achieving results.

The '*Marwo Caafimaad'* Programme *contributes to the overall Health Systems strengthening at regional/ district level and below. Therefore, it is important to take into account the overall expected achievements and outcomes in relation to the Health Systems Strengthening, which are:*

- *Improving utilization of available services at MCH/ Health Centers by linking the community members with the health centers;*
- *Addressing health problems and priority health needs of the community in their catchment area and ensure access of the population to promotive, preventive, and limited curative services accordingly;*
- *Expanding the coverage of Reproductive, Maternal, Newborn and Child health (RMNCH) and Nutrition services in urban slums and rural areas; and contributing to access of the community to health care services such as control of diarrhea diseases, management of respiratory infections immunization, Malaria and Tuberculosis control and Nutrition, ….etc.;*
- *Ensuring accessibility of women, girls, children, underserved and the poor, especially in urban slums and rural areas to the available health care services;*
- *Promoting community participation through raising awareness, changing attitudes and behaviour, organization and mobilization of local scared resources; and*
- *Generating evidence to ascertain the effectiveness of health system strengthening interventions that can create evidence -based planning and decision making.*

Resolutions:

1. Establish linkages with other primary health care programmes and services to ensure coordination of policy and support to service provision.
2. '*Marwo Caafimaad'* will work as a multipurpose health worker to provide primary health/ RMNCH and nutrition services in the defined catchment area of her own community.
3. The '*Marwo Caafimaad'* Programme will start in the catchment area of those health facilities, which are appropriately functional and capable of providing support to '*Marwo Caafimaad' and receive referred cases*.
4. Develop an integrated and coordinated monitoring and supervision mechanisms that link the 'Marwo Caafimaad' with the nearest health facilities with role assignment among the health staff in relation to continuous training and supervision. Health Authorities, the Regional/ District Medical Officers, implementing partners and others will be involved in the programme activities with clear roles and responsibilities.
5. Establish a reporting mechanism and pathway for receiving regular reports and community based information system from 'Marwo Caafimaad'. Integrate information related to the programme into a single Health Management Information System (HMIS), at a later stage.
6. Utilize existing system for logistics support for medicines and supplies to the facilities for '*Marwo* Caafimaad' Programme.

7. FHWs' supervisors (FHS) should be considered as staff of MCH/HC, with mainly field supervisory responsibilities.

2. Roles and Responsibilities of the *'Marwo Caafimaad'*

The '*Marwo* Caafimaad' are valuable workforce that aims to improve service delivery to their local communities so they may facilitate improving health status and quality of life of the communities. The '*Marwo Caafimaad'* Programme will not operate as a stand-alone programme. It will rely on the involvement of Zonal Health Authorities, the Regional/ District Medical Officers, functional health facilities, implementing partners, private sector (for referrals) and the successful operation of other health programmes.

Figure 1: Expected contribution of '*Marwo Caafimaad'* to other Somali Health Programmes

PHC Programmes/ Interventions	Expected Roles of *'Marwo Caafimaad'*
EPI	**Mobilization, community organization and vaccination**
Reproductive, Maternal, Newborn and Child Health	**Antenatal care; screening of pregnant women for early detection of risks; improved access to skilled birth attendant; tetanus toxoid immunization; postnatal care; care of newborn; prevention and limited management of childhood illness; adolescent health; birth spacing; information, education and communication (IEC); and referral of patients and clients**
Nutrition	**Nutrition counseling; screening of children, adolescent girls and women for malnutrition; micronutrient supplementation; and referral**
TB, Malaria, HIV, other common ailments, Mental Health, and Environmental Health	**Health education and promotion; promotion of safe drinking water and hygiene; treatment of common ailments; first aid; support DOTs; diagnosis of high risk groups and initial treatment of malaria; and referral of suspected cases**
Others	**Community organization; promoting volunteerism, health promoting school health initiatives; raising community awareness; emergency preparedness and response and participation in humanitarian activities**

The '*Marwo Caafimaad'* Programme needs to collaborate with other health sector interventions/ programmes to ensure that policy priorities are reflected in the service delivery of the '*Marwo Caafimaad'*. However, there will be a need to strengthen the policy and analysis functions at the Zonal level, efficiency of the regional/ district health offices and performance of health facilities.

Where the policies of different PHC interventions overlap, there needs to be consistency of procedures and performance standards. Implementation of interventions that includes using '*Marwo Caafimaad*' services must be in accordance with procedures and performance standards. An example is that '*Marwo Caafimaad*' would be expected to provide services only in her catchment area (core principle) and her working outside of her catchment areas for some other intervention, which is against the rules, should be discouraged.

Development and functioning of the '*Marwo Caafimaad*' Programme relies on the capabilities of the regional and district health managers. The management, recruitment and supervision of the '*Marwo Caafimaad*' programme at the Regional/District level will be provided by the Regional/ District managers; whereas oversight, selection and continuing training will be done by the health facilities – initially MCH/HC. Dedicated regional staff (preferably female) for the '*Marwo Caafimaad*' Programme will be required for effective planning, implementation and monitoring.

Enhancing community participation, as planned by the '*Marwo Caafimaad*' Programme, will also raise the quality, appropriateness and acceptability of services through feedback to '*Marwo Caafimaad*' on their performance and in providing opportunities for engaging in health improvement initiatives. Role of '*Marwo Caafimaad*' working closely with other community workers (CHW, MW, TBA, etc.) is significant for the success of programme. High performing '*Marwo Caafimaad*' are more likely to have active Health Committees and Women' Groups.

Resolutions:

1. The Regional/ District health managers/ supervisors will work closely to ensure coordination of policy and support to integrated service delivery.
2. Advocate for health systems improvement at all levels will support service delivery by '*Marwo Caafimaad*'.
3. Focus on performance improvement of *'Marwo Caafimaad'* in order to maximize their contribution to the targeted policy priorities.
4. Strengthen community participation through the *'Marwo Caafimaad'* role in Women's Health Groups and through community involvement in *'Marwo Caafimaad'* selection.
5. Strengthen linkages among all community level health workers – FHW, CHW, traditional birth attendants and midwives
6. Strengthen capacity of Zonal health authorities on policy analysis and development functions.

3. Scope of *'Marwo Caafimaad'* Services and Capabilities

The '*Marwo Caafimaad*' will provide primary, preventive, promotive and some curative care services to the community in her catchment area and will cover both development and humanitarian aspects through:

- Developing and organizing women groups and local health committee through arranging meetings to ensure their engagement in delivery of primary health care services with special focus on immunization, maternal and child health, nutrition and related community development activities.
- Increasing community awareness on issues related to health, hygiene, nutrition, sanitation and RMNCH emphasizing their benefits towards improved quality of life.
- Liaising between the formal health system and catchment community and ensuring coordinated support and networking between public health system, NGOs and private sector.

- Acting as a community- based information centre through registering all households in her catchment area, and maintaining up to date information about children, women and other high risk and vulnerable groups including vital registration (death and birth). '*Marwo Caafimaad'* will visit on average 5-7 household per day, working six days a week. She will motivate and counsel clients for adoption and continuation of healthy practices. To promote healthy behaviours and increased utilization of services, she will keep in close liaison with influential women in her area such as lady teachers, traditional birth attendants and clients with good experiences with health care services. A kit composed of essential medicines and equipment for home visit provided to each FHW that facilitates service provision at the doorsteps of the households.
- Providing medicines and supplies to patients/ clients in the community and informing them of proper use and possible side effects. She will also refer clients needing higher level of care to the nearest appropriate health facility.
- Coordinating with local traditional birth attendants, midwives or other skilled birth attendants and local health facilities for efficient antenatal, natal and postnatal and birth spacing services.
- Undertaking nutritional interventions such as prevention and treatment of anaemia, screening, assessing risk factors causing under-nutrition and nutritional counselling. The '*Marwo Caafimaad'* will be able to treat iron deficiency anaemia among women especially pregnant and lactating mothers as well as young children. She will promote nutritional education with emphasis on breast feeding and weaning practices, maternal nutrition and micronutrient deficiency.
- Coordinating with EPI outreach team for immunization of mothers against tetanus and children against vaccine preventable diseases. The '*Marwo Caafimaad'* trained in giving vaccines themselves will ensure timely vaccinations with support from the local health facility staff. The '*Marwo Caafimaad*' will also participate in various campaigns for immunization against EPI target diseases e.g. polio, measles, diphtheria, pertussis, tetanus, hepatitis B, haemophilius influenze type b, etc. The '*Marwo Caafimaad'* will be involved in the surveillance activities.
- Preventing and treating common ailments e.g. malaria, diarrheal diseases, acute respiratory infections, intestinal parasites, primary eye care, scabies, injuries and other common diseases using essential drugs. The '*Marwo Caafimaad'* will refer cases to the nearest appropriate MCH/ health centres or hospitals as per the given guidelines. For this purpose a kit of certain inexpensive basic drugs will be provided to each '*Marwo Caafimaad*'. They will also be involved in DOTs, malaria control and promotion of mental health.
- Disseminating health education messages and materials on individual and community hygiene and sanitation, harmful practices like Female Genital Mutilation / Cutting (FGM/C) as well as information regarding preventive measure against spread of sexually transmitted infections including HIV & AIDS.
- Submitting a monthly progress report to in charge of the MCH/health centre containing information regarding all activities carried out by her including home visits, number of patients & clients and stock position of medicines and supplies.

For details, also refer to the Essential Package of Health Services (EPHS) defined for '*Marwo Caafimaad'* Programme (Annex A).

'Marwo Caafimaad' capabilities

- The '*Marwo Caafimaad'* is expected to have a minimum of 8 years of education and be capable of learning the basic knowledge in their training curriculum. However, it may be a difficult to find interested applicants with 8 years of education from hard to reach and socio-economically poorest areas. In such cases, it is important that the interested candidate must be (6 in special cases) able to read, write and do basic calculations. Global evidence suggests that community workers acquire a

reasonable level of knowledge through their basic training and refresher trainings, if they have minimum 8 years of schooling or more. Improvements are also attributable to experience and training.

- The '*Marwo Caafimaad*' should serve on average 600-1000 people in her community. She is expected to visit 5-7 households per day and to work 6 days a week. She should also be available in her community to provide after-hours services in the case of emergencies. She will work around 4-5 hours a day and nearly eighty percent of her work time will be spent in household visits. Apart from household visits the major activity of the '*Marwo Caafimaad*' will be working on special immunisation activities.
- Any new proposed services for '*Marwo Caafimaad*' need to be assessed for their impact on her time and how well they integrate into the current model of service delivery, which is primarily through household visits. The demands on '*Marwo Caafimaad*' time and services are likely to increase in future. It is therefore necessary to avoid overburdening the FHWs. The involvement of '*Marwo Caafimaad*' in new areas will require the approval of a **Review Committee** (including Health Authorities, WHO and HSAT) after having completed a detailed study or analysis of the benefits for the community and the health system. Demands on '*Marwo Caafimaad*' time need to be defined in terms of safety, capabilities, workloads and remuneration, cost effectiveness of interventions and the ability of the health system to support supervision and introducing new services along with assuring quality that are in line with the standards.

Resolutions:

1. The '*Marwo Caafimaad*' will provide services to her community and will be given a stipend in recognition of this contribution. The priorities of the '*Marwo Caafimaad*' services will be immunization, reproductive, maternal, new-born and child health services, control and treatment of common ailments, nutrition, health education and promotion.
2. Preferably, there will be no compromise on the basic education criteria of minimum 8 years of schooling (up to 6 years of schooling in special cases and linked to the condition of written test). Policy makers may review the criteria with strong justification and evidence or through a feasible alternate strategy.
3. All new services will continue to be approved by the Review Committee (consisting of Health Authorities, WHO and HSAT) after a detailed analysis. The Review Committee will publish a set of clear guidelines for the priorities for future development of services.
4. The programme will allow '*Marwo Caafimaad*' to deliver routine immunisation services under supervision and to support skilled birth attendants after completing training with special focus on improving skills.
5. Special immunization days will be a high priority activity. However, '*Marwo Caafimaad*' will work in her catchment area and registered population only.

4. Quality of Services

Evidence from other developing countries suggests that dedicated and knowledgeable female community health workers have an impact on personal Hygiene (hand washing practices), sanitation improvement, prevention and treatment of diarrhea, pneumonia management, full immunization of children at the appropriate age, pregnant women receiving tetanus toxoid injections and taking iron tablets, safe delivery practices, birth spacing and neo-natal checkups. On the other hand, poor performing workers may be a very significant drain on resources and are unlikely to deliver services that change health outcomes.

To ensure quality of services, the strategy should be regular monitoring, continuous training, supportive supervision, providing regular feedback to identify the poor performers. Meanwhile; 'Marwo *Caafimaad'* that will be noticed to have limited motivation or unable to deliver necessary services, she will be replaced.

The selection criteria for '*Marwo Caafimaad'* should be maintained to ensure the potential for improvements in service quality. Once recruited the '*Marwo Caafimaad'* should be trained, supervised and provided with required supplies and essential medicines and vaccines.

Dedicated and hardworking health workers can produce results in spite of the weak health system, however; effective health system must provide incentives for all staff to do a better job, and maximize their capacity to spend their time on priorities and not be distracted or impeded by unnecessary administrative concerns. Management and supervision capability at the regional/ district level needs to be developed and supported. Good FHWs' supervisors (FHSs) are also expected to make a difference in improving the performance of '*Marwo Caafimaad'*. Managers and supervisors need to have free mobility in order to provide supportive supervision.

The training system has to ensure that all '*Marwo Caafimaad'* and their supervisors have needed knowledge and skills to provide high quality primary care services. The training system will facilitate integration and collaboration between the health facility and the '*Marwo Caafimaad'* Programme by using health facility staff as trainers for their continuing training and refresher training. There will be a need for supervision and quality control of the training system.

The '*Marwo Caafimaad'* and FHSs will be given a stipend to support provision of services at community level ensuring full and on time payment.

The '*Marwo Caafimaad'* Programme needs annual procurement and distribution of drug, non-drug and prints to convey them to their corresponding communities avoiding any delay.

Resolutions

1. The most cost-effective way to improve impact of the '*Marwo Caafimaad'* Programme is by increasing productivity and quality of services by '*Marwo Caafimaad'*.
2. Processes and rules for dealing with poor performance should be strictly followed.
3. Management, supervision and systems to support high quality of services are important requisite for the success of intervention.

5. Target Population Coverage and expansion

Under the GAVI-HSS Programme, the coverage of the FHWs' intervention was at a small scale. However, the success of the programme and the availability of more resources lead to expanding the programme that will significantly increase the population coverage. Expansion of '*Marwo Caafimaad'* coverage is likely to improve health outcomes, particularly if the expansion is targeting the poorer areas. The 'Marwo Caafimaad' programme is expected to improve the cost-effectiveness of health care systems by reaching large numbers of underserved people with high-impact basic services at low cost adding to that the social benefits (including community mobilization), which often constitute the strength of such programmes.

Two hundred FHWs in phase-I (pilot) have covered more than 140,000 people in the three zones. However, to cover the targeted population which will be up to 75% of the total population, the programme will need to deploy more than 8,000 '*Marwo Caafimaad*' in the three zones, through a phased approach. The 75% coverage will cover most of the rural population. To be efficient, the coverage of the intervention in urban areas is not needed, where there is a good coverage and access to health services. However, provision of services through '*Marwo Caafimaad*' in urban slums areas should be considered as a priority.

In the early phases of the '*Marwo Caafimaad*' Programme, there is a need to closely monitor the attrition and drop-out rate of '*Marwo Caafimaad*' and FHSs and to identify the reasons for attrition and to consider this as a lesson learnt that must be sorted out as this can have serious implication on the coverage targets.

Another important consideration before expanding the programme is the recurrent cost. Funds are required for stipend payment and incurring non-salary expenditures, once '*Marwo Caafimaad*' are deployed in their community after completion of training. A predictable financing for the programme is an important consideration, before expansion at a large scale to avoid irregular payment that can be one of the main causes of their attrition.

The poor are the people who have the fewest options available to them, and for whom the consequences of illness are perhaps the greatest in terms of disability, death and lost income. As the programme is likely to expand, it will cover some of the poorer areas but it will also increase the workload on services in the health facilities. The areas that will remain uncovered by the intervention may even be more disadvantaged.

Expanding services to a larger share of the rural population, might lead to severe constraint in terms of the availability and the quality of the health services at health facilities. Recruitment of '*Marwo Caafimaad*' and their supervisors may be more difficult, as fewer candidates are likely to reach the selection criteria. Similarly, training and support will be difficult in areas with non-functioning MCH/HCs. Remote areas will imply higher transport costs. These limitations might hamper the effectiveness of the intervention. The capacity of the regional/ district medical officers to recruit further FHWs while maintaining the selection criteria would be a key to success of the intervention.

The regions should prepare their own plans based on the areas where '*Marwo Caafimaad*' are required and need to be covered. The intervention areas should then be further prioritized by them indicating which areas and facilities will be enrolled in different expansion phases. Those plans should then be consolidated at the zonal level to provide a comprehensive image of the areas and availability of health facilities.

Resolutions

1. Provide guidelines and develop plans before any expansion of the programme into disadvantaged and underserved areas.
2. Any expansion of the programme should preferably take place in those facilities which are already involved in programme activities and have gap at community level, although this may lead to exclusion of some facilities whose catchment area is underserved but these can be taken up in subsequent phases.
3. Introduce measures to ensure the quality of services is maintained in areas where MCH/HC are non-functional and where '*Marwo Caafimaad*' can be available meeting selection criteria.
4. Review the functioning of the intervention in urban slums, to ensure that resuming expansion will have maximum health impact.
5. Ensure allocation of required funds to implement and expand the programme.

6. Strengthening Accountability internally and at Community level

The '*Marwo Caafimaad'* programme needs to be accountable for the appropriate use of funds and resources ensuring quality and efficacy of the services that will be provided to the community.

It is important to ensure that the core services provided by the '*Marwo Caafimaad'* are agreed by the community. It has to be noticed also that there may be a high demand on '*Marwo Caafimaad'* time from a range of health and non-health interests/ programmes. These may have risks of reducing health/ reproductive health impacts and of reducing accountability.

Internal accountability needs strengthening at the Zonal, Regional, District and Health facility levels, along with an oversight role from the development partners. Delegation of functions within the intervention requires that the various implementing bodies can be accountable for their performance.

The information system should be designed and operationalized in the early stages of the programme. However, time management should be considered to distribute *Marwo Caafimaad'* time between administrative and technical work and providing data for the information system. HMIS should ensure that it captures critical information and evidences required for decision making and risk management.

External evaluation and audits should be used on regular basis to improve management quality and to increase internal accountability. Results from the evaluations should be disseminated at all levels of the intervention and among all partners and stakeholders.

Community accountability means that the programme should continue to strengthen community organization and mobilization for health through establishing and empowering the Village/Area Health Committee and Women's Health Groups. Each '*Marwo Caafimaad'* should be involved with the committee along with her supervisor and other community workers – CHW, TBA and MW. The intervention will provide opportunity for households to give feedback on their level of satisfaction on the '*Marwo Caafimaad'* and provided services, through conducting regular visits to households by the supervisor and independent evaluators. Households will also be surveyed by the third party evaluation to get insights.

The community should be actively involved in the recruitment of the '*Marwo Caafimaad'*, with a community member on the selection panel.

Resolutions

1. The intervention should develop and improve the MIS integrated with HMIS and conduct assessment to increase transparency and accountability for performance.
2. Annual progress report of the '*Marwo Caafimaad'* Programme will include a specific comparative report against key performance indicators.
3. Village/Area Health committees and Women Groups will be formed and empowered with involvement of all community workers – FHW, CHW, TBA and MW.

7. Governance arrangements of the Programme

The Somali Health Authorities and the International Community agreed to a Somali Health Sector Committee Reforms in June 2010. For the programme the same governance mechanism was used for strategic decision

making and implementation of the programme. Currently, more changes are expected in the Somali Health Sector Coordination mechanism with more empowerment at the zonal level. The programme needs to ensure the governance arrangements and functions at each level of government in accordance with the policy priorities.

The '*Marwo Caafimaad*' Programme is an integral part of the health system and funds are provided to WHO and UNICEF through separate Grant Agreements. Additional funding for phase–II and successive phases will come from JHNP and other development initiatives. Strategic decisions will be made by the Health Advisory Board (HAB) and Health Sector Coordination Committee (HSC), Zonal Health & Nutrition Coordination Forum (ZHNCF) and Regional Health Management Team (RHMT). JHNP governance mechanism will also review the programme performance on a regular basis.

Most of the activities under the '*Marwo Caafimaad*' Programme are at the regional/district level or below, that means that the intervention is designed under a devolved setup. However, one key issue to be considered is that most of the MCH/Health centers are under the managerial control of NGOs which are accountable to different development partners. While the aim is to improve the management of the selected MCH/HCs, the governance arrangements should include implementing partners in addition to regional and district medical officers who must be involved decision making process with strong backup support of WHO, UNICEF and UNFPA.

Resolutions

1. The '*Marwo Caafimaad*' Programme as an integral part of the GAVI-HSS and JHNP will follow the governance arrangements of Somali Health Sector Coordination (being revised currently).
2. The '*Marwo Caafimaad*' Programme will delegate operational decisions to the maximum extent possible to regional, district and health facility level with strong accountability mechanisms.
3. The implementing partners will be involved in the decision making process to ensure their ownership to the Programme. Contractual clauses will be amended to include the scope of work related to the '*Marwo Caafimaad*' Programme.

8. The *'Marwo Caafimaad'* Programme in the context of Conflicts, Disasters and emergencies

Conflicts, disasters and emergencies in Somalia have had profound effects on the health care system in all areas, and resulted in extremely grim situation of Maternal and Child Health. The impact of weak governance has resulted in creating a public situation without adequate access to social services and the collapse of public institutions for health and welfare.

There has been mass movement of people especially from Central South Somalia, and the situation has further worsened by a series of natural disasters. Major disasters included several droughts (in Sool/Sanag and in Bay/ Bakool), regular floods (in the Shabelle and Juba regions), and the 2004 tsunami (in Puntland). Failure of the autumn rains caused millions of people to be in dire need, while internally displaced people who need assistance and protection. In 2008, the most severe drought in two decades affected approximately 3.3 million Somalis, triggering a major humanitarian response. Somalia was hit by the worst drought during 2010-11.

Somalia is at a crossroads where decades of one of the world's most complex and protracted conflicts have shaped a fragmented country in stark contrasts. For example, South Central Somalia has experienced years of fighting and lawlessness; while Puntland (PL) has achieved a fragile semblance of peace, stability and is mostly willing to join the emerging federal system and Somaliland (SL) is advancing towards development and is seeking autonomy. Both SL and PL have their own Constitutions, regulatory frameworks, Presidents, Parliaments and Executive and functioning central and local levels of government. Whereas South Central Somalia is still experiencing large areas of active conflicts and emergencies with the control of the Federal Government of Somalia (FGS) being limited geographically as well as by capacity constraints.

All the above natural events and conflicts generated mass movement of people leading to major blows to the local economy and increased demands of the affected population.

Therefore, conflict, disasters and other crises in Somalia have led to a weak and fragmented health system with extremely poor health indicators. According to the latest estimates of the UN interagency group, 69,000 Somali children (2010) and 3,800 mothers (in 2013) are dying because of the poor health status and weak health system. UNICEF's 2006 and 2011 multiple indicator cluster survey revealed very slow or no improvement in the maternal, neonatal and child health, and conversely very low levels of vaccination coverage.

The '*Marwo Caafimaad*' Programme is a development initiative not only to strengthen the health system but to bring a positive change in the health outcomes by bridging the gaps and building evidence about best practices in such an environment. The role of '*Marwo Caafimaad*' should not be limited to developmental activities but should also cover humanitarian aspects where needed.

Resolutions

1. No Zone should be ignored while implementing the '*Marwo Caafimaad*' Programme as this will assure health equity across the country and provide an opportunity for experience exchange and lesson learnt from different environments, which will guide health authorities in future planning.
2. While selecting implementation sites, selection of appropriate and well-functioning health facilities (or likely to made fully functional) should be considered to ensure accessibility, efficiency and feasible for supervision activities.
3. The '*Marwo Caafimaad*' Programme should be adoptable to the changing circumstances and situations in case of any humanitarian crises. For example, if there is internal migration due to drought; it is likely that '*Marwo Caafimaad*' should map their own community (especially vulnerable groups such as women, children, girls, etc.) to help the migration process and be prepared to migrate along with her community. In such cases, she should continue to provide needed services to her community and should have linkages with the regional/district health authorities to get supplies and regular guidance.

PART II: Aims and Targets for the *'Marwo Caafimaad'* Programme

1. The 'Marwo Caafimaad' Programme implementation phases as follow :

Phase	Target	Time frame	Programme
Phase - I	200 FHWs	2012-15	GAVI-HSS
Phase- II a	400 '*Marwo Caafimaad*	2014-16	JHNP
Phase- II b	400 '*Marwo Caafimaad*'	2015-16	JHNP
Phase- II c	400 '*Marwo Caafimaad*'	2016-16	JHNP

2. Funding opportunities will be explored from the Somali Development and Rehabilitation Facility (SDRF) under the Somali Compact and other support from development and humanitarian partners.
3. Start offering community based health services into the implementation sites of the three zones soon after completion of training.
4. Increase its health impact in the selected rural and urban slum communities by end 2016 through:
    - Improving immunization coverage in children;
    - Improving coverage of Tetanus Toxoid;
    - Decreasing infant and child mortality and morbidity due to common causes (Diarrhea, Pneumonia) through early diagnosis, management and referral;
    - Improving antenatal care, skilled birth attendance, post natal care, birth spacing and identification and referral of complicated cases to appropriate health facilities;
    - Promoting breastfeeding and Increasing the number of children who are exclusively breastfed;
    - Screening of acutely under-nourished children and referral to health facilities for treatment;
    - Improving hygiene and sanitation in the served areas through increasing awareness and advocating for safe drinking water and sanitation.

By end 2016, the 'Marwo Caafimaad' Programme will contribute to:

1. Increasing the utilization of targeted MCH/ Health Centres
2. Increasing the number of births attended by skilled birth attendants
3. Increasing prevalence of birth spacing
4. Improving health outcomes in selected rural and urban slum communities by:
    - Increasing access to RMNCH and nutrition services;
    - Increasing immunization coverage in children;
    - Increasing TT immunization coverage among pregnant women;
    - Increasing antenatal care;
    - Reducing anaemia.

    Thus contributing to
    - Reducing the infant mortality rate;
    - Reducing the maternal mortality rate.

Key Performance Indicators for the 'Marwo Caafimaad' Programme:

- % of '*Marwo Caafimaad*' trained and deployed in their communities
- % '*Marwo Caafimaad*' fulfil the Programme selection criteria
- % of deployed '*Marwo Caafimaad*' carrying out at least 5-7 visits per day
- % of deployed '*Marwo Caafimaad*' with regular supply of essentials kit items (no stock out of ORS, antibiotic, iron/folic acid tablet, paracetamol and anti-helmintic in the previous month)
- % of '*Marwo Caafimaad*' at least supervised by her supervisor in the previous month

Overall Performance Indicators of the Programme and Means of Verification

The following indicators will be highlighted in '*Marwo Caafimaad*' Programme for monitoring purposes. These will provide an overview of the progress. Where possible these will be measured on a biannual basis and a report provided to stakeholders.

Table 1: Performance Indicators and Means of Verification:

	Level	Performance Indicator	Timing	Means of verification
A.1	Health Impact	All FHWs, will have an average Performance Score of 70%	End 2016	3rd party evaluation
A.2	Health Impact	All FHWs will score more than 70% on the supervisor checklist	Ongoing	Monitoring by Regional/ District Health Office
A.3	Health Impact	90 % of FHWs and their supervisors score over 75% in the Knowledge Test.	End 2016	3rd party evaluation
B.1	Outputs	By 2016 there will be 900 FHWs deployed (With exploring possibilities to increase the number of FHWs to 2000 by end 2016)	End 2016	HMIS/ Monitoring reports
B.2	Outputs	All registered households are regularly visited by the FHW at least once a month / on average 5-7 households are visited per day	Ongoing; End 2016	Monitoring by supervisors and measured by 3rd party evaluation
C.1	Inputs/Process	All FHWs and their supervisors meet the selection criteria	Ongoing; End 2016	R/DMO monthly reports and 3rd party evaluation
C.2	Input/Process	Five key drug items have not been out of stock for more than two months for 90 % of	Ongoing;	R/DMO monthly reports and 3rd

	Level	Performance Indicator	Timing	Means of verification
		the FHWs.	End 2016	party evaluation
C.3	Input/Process	Presentation of the annual report showing performance against targets	Annually, end of year from 2012	Annual Performance Report
C.4	Input/Process	Annual plan submitted by Regional Medical Officer to Zonal MoH/ WHO/ UNICEF by due date	Annually	Report to HSC
C.5	Input/Process	The community report that >90% of FHWs visit their registered households	Ongoing	Monitoring by supervisor and measured by 3rd party evaluation
C.6	Input/Process	All FHWs were supervised by their supervisors in last month	Ongoing	Monitoring by R/DMO and measured by 3rd party evaluation

Assumptions

In setting these goals, targets and key performance indicators, the following assumptions have been made:

- The 'Marwo Caafimaad' Programme continues to be regarded as a priority and an integral part of the health sector
- The level and flow of funds remains consistent with the coverage and performance targets of the Intervention
- The intervention is not affected by the security, lawlessness and humanitarian crises
- Political situation in the three zones improves
- Gradual improvement in literacy and education levels
- Improved coordination among stakeholders

PART III: Operational Framework of the *'Marwo Caafimaad'* Programme

Introduction

To achieve the key targets and outcome, the '*Marwo Caafimaad'* Programme will need to be delivered in a higher level of performance with more knowledgeable '*Marwo Caafimaad'* and effective supervision. The management should facilitate the programme coverage to more disadvantaged areas with improving quality of services and ensuring timely availability of logistics and supplies.

The Zonal leadership will have to embark on strengthening the overall health sector; managerial capacity and internal controls and systems development and ensuring availability of sufficient funding. Management and implementation capacity at the regional/ district level will have to be strengthened as well as the accountability for the delivery of intervention as previously explained in this compendium.

The intervention will be implemented in different phases:

Phase I, (1 January 2011- 31 December 2015), where the FHWs' Intervention will undergo a design process and early implementation with a focus on:

1. Covering selected communities in the catchment areas of designated 40 MCH/HC of the three zones through 200 FHWs;
2. Building a system for productivity and quality of service delivery of FHWs;
3. Strengthening accountability, governance and management;
4. Strengthening health system and integrating the FHWs' intervention;
5. Generating evidence on the effectiveness of the FHWs' intervention;

Phase II, (from Jun 2014 - Dec 2016), where the '*Marwo Caafimaad'* Programme will:

6. Recruit of an additional 1200 '*Marwo Caafimaad'* in underserved and poorer areas;
7. Testing innovative approaches;
8. Improve scope of services in line with emerging needs, priorities and clinical efficacy.

Phase III, (from Jan 2017 - Dec 2020), the '*Marwo Caafimaad'* Programme (depending upon availability of resources and strategic priority of the health authorities) will:

9. Review strategic priorities (based on the evaluation results);
10. Further expand the intervention to cover >50% of the total population (targeted population) by increasing the number of '*Marwo Caafimaad'* to 6,000;
11. Further improve scope of services in line with evidence;
12. Generate more evidence on the effectiveness of the intervention.

The principal sources for the verification of the Intervention's performance both for achievement and contribution to health outcomes and impact will be the Multiple Indicator Cluster Survey (MICS) and 3rd party evaluations. Key performance indicators for outputs and inputs will be measured by external evaluations and regularly monitored from information collected by the health management information system and supervisory mechanism.

Availability of predictable funding would be a key factor for the implementation and expansion of the intervention. The main cost would be the stipend of '*Marwo Caafimaad'*, followed by cost of medicines & supplies and cost for supervision and training activities. Rough estimated recurrent unit cost of the intervention is expected to be $8000 per '*Marwo Caafimaad'* per year during training phase. However after first year of training, the unit cost is $5500 per '*Marwo Caafimaad'* per year OR $6.8 per beneficiary per year. Unit cost may go down with political stability, improved security situation and overall strengthening of the health system in the three zones. In the initial phase, reducing the cost per FHW is not an option as costs can only be reduced by withholding supplies, supervision and management, which is not recommended to ensure the efficiency and quality of the provided services . If more funding is not available, the health authorities should concentrate on the strategic option of increasing productivity rather than expansion as an alternative.

This section will explain different components of the system, rules and procedures required to implement the '*Marwo Caafimaad'* Programme effectively, efficiently and thus delivering results. System components related to the following areas will be explained in following sections:

1. Governance and Administrative Structures
2. Selection and Recruitment
3. Training
4. Deployment and Scope of Work
5. Supervision
6. Monitoring / HMIS
7. Logistics
8. Financial system
9. Evaluation

1. Governance and Administrative Structures

Purpose is to use the existing agreed structures for strategic direction, decision making process, implementation of activities, coordination and developing consensus of '*Marwo Caafimaad*' Programme. The '*Marwo Caafimaad*' Programme is an integral part of the Somali Health Sector rather than a vertical and separate governance and management system.

The Health Advisory Board (HAB), Health Sector Coordination Committee (HSC) and Zonal Health & Nutrition Coordination Forum (ZHNCF) with active participation of health authorities, international organizations and civil society will provide the policies, strategic priorities and guidance necessary for the health sector development and to implement the intervention.

WHO and UNICEF would be responsible for the implementation of activities and meeting the commitments as outlined in the separate grant agreements signed by the two organizations with the GAVI secretariat. WHO, UNICEF and UNFPA have also signed an MOU to define roles and responsibilities of the UN organizations in the context of six building blocks of health system and will play their role accordingly.

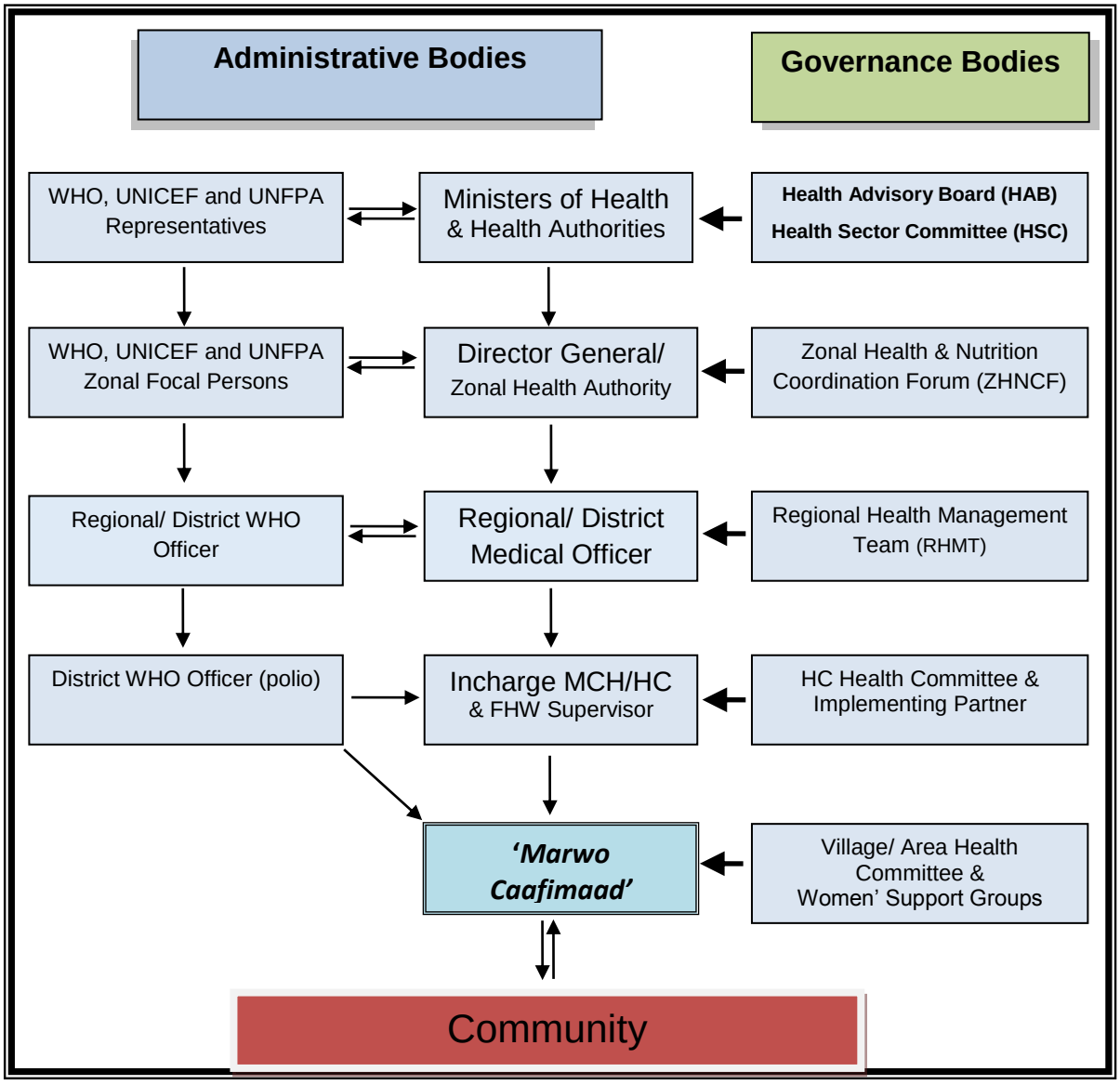
To ensure adequate performance by the '*Marwo Caafimaad*' Programme, effective management, regular monitoring and close supportive supervision is required. The Zonal Health Authorities will be responsible for the management and implementation of activities in the respective zones with support of Zonal WHO, UNICEF and UNFPA offices. Zonal health authorities with the support of WHO, UNICEF and UNFPA will organize quarterly/ annual joint review missions to observe progress on ground about health sector activities including '*Marwo Caafimaad*' Programme. Development partners and International Organizations will be invited to join the review. The Zonal Health & Nutrition Coordination Forums (ZHNCF) will ensure information sharing and coordination platform for the health sector stakeholders. The Forum will also facilitate setting standards, norms and procedures for planning, implementation, monitoring and evaluation as well as the delivery of quality health care services.

The regional and district medical officers will be directly responsible for effective implementation, supervision and monitoring of the activities in the region/district with support from WHO, UNICEF and UNFPA. Monthly supervisory visits will be organized to review progress of different health sector interventions at the health facility and community level using an integrated friendly used checklist. The regional/ district health management team (once formed) will be responsible for regional/district level planning, supervision and monitoring of the activities with support of WHO regional/ district staff. The option of recruiting a Regional Coordinator of '*Marwo Caafimaad*' Programme with support staff will be explored during the expansion phase – II to strengthen management and supervision function at the regional and district level.

A training center in each intervention region will be identified and upgraded for training of '*Marwo Caafimaad*' and their supervisors. Accommodation facilities for the students will be ensured along with availability of well trained and skillful master trainers. MCH/Health Centres in the catchment area will be responsible for selection, continuing training and supervision of '*Marwo Caafimaad*' in the catchment area with the technical support of WHO staff. FHW Supervisor will be based in one of the MCH/HC but would be responsible mainly for field supervisory activities. A health committee with involvement of community and staff of health posts will regularly review implementation of activities.

The '*Marwo Caafimaad*' will be responsible for provision of primary, preventive, promotive and some curative care services to her community in a catchment area of 600-1000 population (consisting of approximately 90-140 households). She will facilitate formation of health committee and women support group to discuss local needs, health sector issues and participate in implementing health sector activities in the community. The following figure explains the governance and administrative structures for the implementation of FHWs' Intervention.

Figure 2: Governance and Administrative Structure for the *'Marwo Caafimaad'* Programme



Performance Indicators

1. Biannual meetings of HAB and Quarterly meetings of HSC (Minutes of the meetings)
2. Quarterly review meetings between Zonal health authorities and Regional health authorities and quarterly meetings of ZHNCF (Minutes of the meetings)
3. Annual and quarterly joint review (Review report)
4. Management of the '*Marwo Caafimaad*' Programme (Annual Progress Report)
5. Number of zonal, regional/ district medical officers/ managers trained on planning, management, supervision and monitoring (Training record)
6. % of intervention regions having annual plan of action (Plans of action)

2. Selection and Recruitment

Purpose is to deploy '*Marwo Caafimaad*' and FHW Supervisors (FHSs) - based on the allocated posts - who meet the selection criteria, and who, after completing the training, will be capable of successfully conduct their role and responsibilities.

WHO Zonal Office and Zonal Health Authorities and will announce the recruitment of '*Marwo Caafimaad*' by allocating number of positions against targeted MCH/HCs. Ensuring availability of required numbers of trainers and regional training center/ facilities in the region, the Regional Medical Officer (RMO), in consultation with WHO staff, will announce the selection of '*Marwo Caafimaad*' and FHSs in the region, along will closing date for submitting the applications and Interview date. They will allocate number of '*Marwo Caafimaad*' to each MCH/HC (and FHS to selected MCH/HC) and will direct the staff of the health facility to communicate with the community leaders to ask interested applicants (meeting the criteria) to apply for the position. The interested candidates should submit the following, by closing date, to the MCH/HC:

- A formal application for the job, addressed to the Regional Medical Officer;
- Evidence of education;
- Evidence of relevant experience; and
- Evidence of the residence/ Identity.

MCH/HC will receive applications till the closing date and will prepare a list of all applicants and will share the same with the office of RMO. The interview panel – that must include community representatives- will conduct test/ interviews on the announced date. No Travel allowance/Daily allowance will be paid to the applicants for the interview.

The chairperson of the interview panel will send the recommended list of candidates and waiting list along with all documentary evidence to the RMO for record. Regional Medical Officer with active participation of WHO's staff will conduct verification exercise and the successful candidates will be sent offer letters to join the training classes on specified dates. The final list along with database of the candidates will be shared with the Zonal Health Authorities and WHO's Zonal office. The starting date for the training will be the joining date of '*Marwo Caafimaad*' and FHS.

Selection Criteria for '*Marwo Caafimaad*'**:** The first major task under the '*Marwo Caafimaad*' Programme would be the selection in the catchment area of selected MCH/HC. The following criteria will be followed for selection of '*Marwo Caafimaad*':

Criteria for selection of '*Marwo Caafimaad*':

i. Female, preferably married
ii. Resident of the community to serve
iii. Education: 8 (6 in difficult situation) grade pass or more
iv. Age: 20-45 years at the time of selection (Minimum age may be 18 years in case she is married)
v. Preference:
    - Endorsed and respected by the community
    - Health sector work experience, (e.g. experience of working as health worker/volunteer, experience in Child Health Days, National Immunization Days, Measles campaign …etc.)

vi. Test (reading, writing and numerical) / documented evidence that she can write in Somali language and do simple calculations

There is a risk that a literate woman may not be available in some communities. However, all possible efforts will be made not to relax the selection criteria. '*Marwo Caafimaad*' will be responsible to serve her own community where she is a permanent resident and will serve a population of 600-1000, consisting of approximately 90-140 households. After completing the basic training, she will register all households and will visit 5-7 households every day. Her own house will be labeled as a 'Health House' but she will not be a static health care provider.

Criteria for dismissal of '*Marwo Caafimaad*':

- Violation of the selection criteria
- Continuous poor performance assessed through supervisory checklist

Selection process of '*Marwo Caafimaad*': The selection committee will consist of:

- Incharge of MCH/HC or trainer
- Local Community Leader
- Representative from implementing partner
- WHO staff (Chairperson)

WHO's Regional/District staff and the Regional Medical Officer will issue the offer letter after re-verification of the selection criteria and will also be responsible for keeping selection record, maintaining and updating the list of '*Marwo Caafimaad*' and sharing the information with Zonal health authorities.

It is expected that day to day issues will emerge on the selection and termination of '*Marwo Caafimaad*' and their supervisors. ZHNCF in consultation with the WHO will resolve such issues about selection, recruitment and termination of '*Marwo Caafimaad*' and FHS as per agreed criteria.

Selection Criteria for FHW Supervisors (FHSs): The following criteria will be followed for selection of FHSs:

Criteria for selection of FHWs' supervisor:

ii. Female, preferably married
iii. Resident of the district to serve
iv. Education: Minimum 12 class pass or above
v. Age: 22-45 years at the time of selection
vi. Preference:
    - Endorsed and respected by the district community
    - Health sector work experience (nurse, midwife)
vii. Test (including mathematics) / evidence that she can read, write and do simple calculation.

One FHW-supervisor will be responsible to supervise 10-15 '*Marwo Caafimaad*' in a district/ region where she is a permanent resident. She will be responsible for visiting each '*Marwo Caafimaad*' twice a month using a supervisory checklist and will be based in one of the MCH/HC in the same district/ region.

Selection of FHWs' Supervisor: One FHWs' supervisor would be responsible for the supervision of 10-15 FHWs and will visit all FHWs minimum two times in a month. She will carry out supervision activities by using a checklist to assess the performance of '*Marwo Caafimaad*'. In case there is few number of '*Marwo*

Caafimaad' in a region, ZHNCF may consider using MCH/HC skilled health care providers to have additional responsibility as FHW supervisor. Such issues should be resolved after allocation of '*Marwo Caafimaad'* to the districts/ regions.

The selection committee of FHW's supervisor will consist of:

- WHO staff
- District Community Representative
- Representative from implementing partner
- Regional Medical Officer (Chairperson)

WHO's Regional Officer and the Regional Medical Officer will issue the offer letter after re-verification of the selection criteria and will also be responsible for keeping selection record, maintaining and updating the list of FHSs.

Performance Indicators

1. By mid-2014, 200 '*Marwo Caafimaad'* deployed under Phase-I (Database, copy of offer letters, HMIS)
2. All '*Marwo Caafimaad'* and FHSs meet the selection criteria (Selection record)
3. Average ratio is about 10 to 15 '*Marwo Caafimaad'* per FHS (Database of '*Marwo Caafimaad'* and FHSs, HMIS)
4. Average catchment population of '*Marwo Caafimaad'* is in between 600-1000 population (HMIS)

3. Training

Purpose is to ensure that '*Marwo Caafimaad*' and FHSs are trained on basic necessary skills and gained knowledge to provide a high quality service in their own community. Training will also allow for the implementation of new advances in primary health care, where appropriate, through '*Marwo Caafimaad*'.

Training is also required to induct and familiarize '*Marwo Caafimaad*' and FHSs with the values, objectives and needed knowledge for their new role. Training will also facilitate developing the linkages between the health staff and the '*Marwo Caafimaad*' by using health staff as trainers.

There are two different approaches to impart training in a cascade manner:

A: Training Centre Approach (preferred option in the Somali context)**:** A trickle down approach consisting of two tiers of trainers is adopted. **Level-1** training is training of Zonal Master Trainers and there will at least 4 master trainers for each zone. At **Level-2**, these master trainers will impart training to the trainers at the regional level, which will finally impart training to '*Marwo Caafimaad*' at **Level-3,** in designated training centres with residential facilities. The same approach is used for trainings of FHS.

B: Health Facility Training Approach: The same trickle down approach consisting of two tiers of trainers is adopted. **Level-1** training is of Zonal Master Trainers and there will be at least 4 master trainers for each zone. At **Level-2**, these master trainers will impart training to the staff of MCH/HC at regional level, which finally impart training to '*Marwo Caafimaad*' at **Level-3,** in their own MCH/HC. The same approach is used for training of FHS but the final training will be in a district or regional hospital.

Criteria for the Zonal master trainers (minimum 4) will be:

- Senior health provider/ staff with good clinical knowledge and experience in public health and primary health care (Two of them should be female);
- Previous experience of imparting didactic and practical training; and
- Committed and willing to spare time for training of regional staff/ health facility staff in future.

Zonal master trainers will train at least 3-5 regional trainers (at least 2-4 should be female health care providers) OR three staff members (Nurse, Midwife and Auxiliary midwife) from each MCH/HC as trainers of '*Marwo Caafimaad*'. For training of FHS, doctor of the district/ referral hospital can also act the trainer of FHS.

Training of '*Marwo Caafimaad*': The content of training curriculum determine the duration and nature of training of '*Marwo Caafimaad*'. However, following approach for the training of '*Marwo Caafimaad*' is adopted:

- Initial phase of 3 months intensive class room training with exposure of clinical training in a training center attached with a health facility;
- Second phase of 9 months field (3 weeks) cum class room (1 week) training;
- Third phase of continuing education – on going 1 day per month augmented by different refresher courses (of maximum 15 days/ year);
- FHWs' supervisor also helps '*Marwo Caafimaad*' through identification of capacity issues and on the job training/ recommending refresher training.

'*Marwo Caafimaad'* are trained at their respective regional training centre or MCH/HC nearest to their residence. A batch of 5-12 '*Marwo Caafimaad'* is trained by 3 trainers in one batch. Before start of training, availability of training aid, curriculum and residential facilities are ensured. The RMO and WHO staff discuss and agree to merge training in a single or more regional training centre considering accessibility issues and availability of training facilities.

Training of FHWs' Supervisors: Again, the content of training curriculum determine the duration and nature of training of FHS. However, following approaches for the training of FHS are adopted:

- Initial phase of 3 months (13 weeks including 8 weeks for '*Marwo Caafimaad*'s trainers manual and 5 weeks for FHS's manual) intensive class room training with exposure of clinical training and supervision skills;
- Second phase of 9 months training - field (3 weeks/ month) cum class room (1 week/ month) training;
- Third phase of refresher training courses (of maximum 15 days/ year);
- Regional supervisor/ coordinator also help FHWs' supervisors through identification of capacity issues and on the job training/ recommending refresher training.

FHSs will be trained at the nearest possible district or regional hospital preferably in the same region. In Phase – I, all FHSs are trained at maximum 2 places in one zone by a group of 3 trainers. Before start of training, availability of training aid, curriculum and residential facilities are ensured.

All trainings are monitored regularly by regional/ district medical officers and WHO's officers using specific training information checklist (TIC). Refresher training are given priority over training for activities outside the scope of the core services, to ensure her clinical safety in the field. The policy of '*Marwo Caafimaad'* only attending approved training programmes will be enforced.

WHO will pay training allowance to trainers and participants for each training, as per policy. The '*Marwo Caafimaad'* and FHS will receive the full amount of stipend as the training allowance during one year training period.

Performance Indicators

1. 90% of '*Marwo Caafimaad'* and FHSs score over 75% in the Knowledge Test (3rd Party evaluation)
2. All '*Marwo Caafimaad'* and FHSs have completed full one year training (Training record; 3rd Party evaluation)
3. Recommended number of trained trainers available to train all '*Marwo Caafimaad'* and FHSs (TIC)
4. Teaching aid, curriculum and residential facilities available in all trainings (TIC)
5. Training allowance is paid to all trainers and trainees on time (Record)

4. Deployment and Scope of Work

Purpose is to ensure that '*Marwo Caafimaad*' are providing services only in their own catchment areas, after completion of the 3 months basic training and in line with their scope of work as defined in Part 1 (and Annex – I) of the compendium and are provided with a stipend in recognition of this contribution.

The '*Marwo Caafimaad*' should serve on average 600-1000 people in her community. She is expected to be after- work hours available to the community to provide aid and guidance in the case of emergencies and work around 4-5 hours a day, visiting 5-7 households to provide services 6 days a week. Nearly eighty percent of her work time will be spent in household visits. The core priorities of the '*Marwo Caafimaad*' services are immunization, reproductive, maternal, new-born and child health, nutrition, management of common ailments and provision of first aid, etc.

The demands on '*Marwo Caafimaad*' from other developmental and social sectors are likely to increase in future. It is therefore necessary to guard against overburdening the FHWs. The process for the involvement of FHWs in new areas is to gain the approval of the governance mechanism (consisting of Health Authorities, WHO and HSAT) after having completed a detailed study or analysis of the benefits for the community and the health system. Demands on FHWs time need to be defined in terms of safety, FHW capabilities, workloads and remuneration, cost effectiveness of interventions and the ability of the health system to support new services to high quality standards. The Review Committee will publish a set of clear guidelines for the priorities for future development of services through FHWs.

Linkages with other workers at the community level: Linkages will be developed for close working relationships among '*Marwo Caafimaad*', TBA/ MW and CHW/Health Post. All will:

- work together in organizing meetings of Health Committee and Women Support Groups;
- attend one day continuing education session at MCH/HC, every month after completion of basic training of '*Marwo Caafimaad*';
- strengthen referral linkages with each other and with the health facilities/ hospitals on need basis;
- jointly test approaches like community transport fund for the referral of emergency cases; etc.

Regional Coordinator will visit all health workers at the community level to encourage development of linkages.

Performance Indicators

1. Average catchment population for '*Marwo Caafimaad*' is in between 600-1000 (Supervisory reports and 3rd Party evaluation).
2. All '*Marwo Caafimaad*' and FHSs have received their stipend on time (Supervisory reports; 3rd Party evaluation)
3. All registered households are regularly visited by the '*Marwo Caafimaad*' at least once a month / on average 5-7 households are visited per day (Supervisory reports; 3rd Party evaluation)
4. All '*Marwo Caafimaad*' supervised by their supervisors in last month (Supervisory reports; 3rd Party evaluation)
5. No FHS has more than 15 '*Marwo Caafimaad*' to supervise and travel cost paid for last month (Supervisory reports; 3rd Party evaluation)
6. The Review Committee is functional and has published a set of clear guidelines for the priorities for future development of services through '*Marwo Caafimaad*' (Minutes and guidelines)

5. Supervision

Purpose is to provide information that can be used to trigger action aimed at improving performance of '*Marwo Caafimaad'* or resulting in termination.

The supervision of personnel is one of the key success elements of the programme and it serves many critical purposes. It ensures that staff performs their duties effectively, through support, guidance, on-job-training, and assistance in identifying and solving problems. It is a means

- to motivate and boost the morale of staff;
- to provide continuing education and advice;
- to enhance field worker's credibility in the eyes of community members;
- to assess quality and quantity of staff efforts;
- to gather other information which can be fed back to programme staff and community members; and
- the adoption of appropriate objectives surmounting the difficulties encountered.

Supervision is one of the functions of both management and leadership, and is defined as "*the overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work"*. Supervision thus is the interface between management techniques and the qualities of leadership which all primary health workers in positions of responsibilities should in theory possess and in practice display at all levels of the health system. Supervision presupposes that there is a programme/ intervention whose objectives and development have already been determined. It is one of the management activities and it has its place alongside monitoring and evaluation.

Many programmes successfully initiated failed later due to lack of effective supervision. In the '*Marwo Caafimaad'* Programme, due attention is being given to ensure supervision at every level. The supervisory support both from the health facility staff and the community is of considerable importance in order to ensure the adequate performance of '*Marwo Caafimaad'*. To ensure close and supportive supervision, regular field visits of health managers at all levels are expected to be carried out. In addition, cadre of regular supervisor - FHW's Supervisors (FHS) - is being introduced specifically for supervision of '*Marwo Caafimaad'*.

Supervisory activities comprise a wide range of exchanges, between the supervisor and the other people involved: these may be logical, rational exchanges aimed at solving problems, exchanges involving values and aimed at strengthening or modifying behaviour, or even exchanges within an emotional setting, such as the resolution of conflicts. The profile of the supervisor will therefore have to be defined on two different levels:

*on the level of personality
*on the level of professional/ technical skills

The **personality profile of a supervisor** is explained in terms of psychological, affective and moral qualities or values that are necessary in order to be able to acquire the varied skills and carry out the tasks. The salient features of the personality that the supervisor ought to have are:

- While planning, there must be an ***ability to identify*** with the objectives of health care and ***personal commitment*** to them, with a *sense of fairness*, *social justice* and a sense of *personal responsibility* towards the user's communities.

- In interpreting the data, the supervisor must be able to take ***past experience*** into account, must have the ability to imagine different scenarios, and must also display a self-critical attitude. ***Imagination*** and a ***critical attitude*** must be balanced in the supervisor.
- At the implementation stage, ***open-mindedness, helpfulness*** and the ***ability to listen*** are required. An effort must be made to encourage the staff to express their ideas and feelings.
- During the dialogues, ***try to be a good listener***. The supervisor should be able to establish a rapport that goes beyond the discussion and the topic discussed; a capacity for *empathy* is needed. At the same time there needs to be some degree of discipline in the dialogue, the essence of which is the ability to keep his/her ***emotions under control***.
- While interpreting the facts in the dialogue, the basic features of good supervisor are intellectual ***honesty*** and ***integrity***. However these characteristics must not be accompanied by rigidity. ***Flexibility*** is needed.
- Leadership i.e. "**art of influencing**" can be exerted at different level: you can convince people intellectually, you can motivate them by gaining their confidence, and you can lead by example.

In '*Marwo Caafimaad*' Programme, two types of supervisory activities are conceived:

A: **Supervision activities at health facility (MCH/HC) and community level by Regional/ District Supervisors:** Regional and District Supervisors include Regional Medical Officer, Regional Coordinator, District Medical Officer, WHO's Regional / District Officer, etc. To carry out supervision activities in a systematic way, the Programme has reviewed different checklists currently being used for supervision activities at the facility and community level or for different programmatic interventions. The Programme has developed integrated supervisory checklist, which also include supervision activities in the context of '*Marwo Caafimaad*' Programme. As a guide, to assess performance of the '*Marwo Caafimaad*' Programme, a checklist for Regional/District Supervisors is given at Annex C.

B: **Supervision activities of FHS to assess performance of '*Marwo Caafimaad*':** FHS uses a checklist to assess performance of each '*Marwo Caafimaad*' on monthly basis using a supervisory checklist. The data for the checklist will be drawn from record of '*Marwo Caafimaad*', asking questions to assess knowledge, observation to assess skills and getting feedback from households on the performance of '*Marwo Caafimaad*'. The information collected, is used to measure performance of '*Marwo Caafimaad*' and identification of strengths and weaknesses, which are used to provide feedback to '*Marwo Caafimaad*' or for on-job training. Details of this checklist and supportive supervisory system are explained in the curriculum of FHS.

There are three main **styles of supervision**: i) autocratic, ii) anarchic and iii) democratic. Most people prefer to work under a democratic supervisor. However, a mix of supervisory styles must be followed based on the kind of work to be done (job factors) and the kind of people to be supervised (personal factors).

Supportive supervision is a system of management whereby supervisors at all levels in an institution focus on the needs of the staff they oversee. The most important part of the supportive supervisor's role is to ***enable*** staff – to manage the quality- improvement process, to meet the needs of their clients, and to implement institutional goals. This approach emphasizes mentoring, joint problem solving and two-way communication between the supervisor and those being supervised. Supportive supervisor realizes that staff cannot provide quality services unless their needs are met.

Supervision activities are comprised of three stages: i) preparatory stage; ii) implementation stage; and iii) follow-up stage.

Stage One: Preparatory stage:

A) In depth study of Documents: The following documents are useful for careful preparation

- Map of the District; Plan of Action of the District; Monthly report of FHW's supervisor; HMIS monthly report; Minutes of the last monthly meeting; Official correspondence/ letters; Previous monthly reports of the supervisor:

B) Identify Priority Areas for Supervision

C) Preparation of a Monthly Supervision Schedule (Annex B)

Stage Two: Activities Involved in Supervision as such:

A) Establishment of contacts with health teams, individuals and community representatives through dialogue, observation, record checking and analysis. This will be followed by discussion, suggestions and conclusions, and concerted efforts to decide upon remedies for shortcomings which have been identified.

B) Review of the objectives, targets and norms:

C) Observation of workers as they carry-out their tasks:

The supervisor will arrange to observe - without intervening - the performance of all tasks involved in activities under priority supervision, with particular regard to skills, attitude (towards users, colleagues), organization of resources and utilization of resources (time, supplies). The supervisor and the worker will then discuss the points that have been noted by the supervisor and will refer to the training manuals.

D) Identification of gaps and any follow-up and support needs:

- Ask the worker to suggest changes to help improve performance of the tasks.
- Ask the worker to suggest specific ways in which necessary learning can be accomplished and note down any suggestions.
- Take note of any needs for logistics support, supplies or other factors relevant to the proper performance of the tasks.

E) Consultation with Community Representatives:

- The supervisor will ensure that the health committee and women support group are familiar with and understand the objectives and targets of the program and that community supports these objectives.
- The supervisor will find out that the committee/ group is aware of the norms of the services.
- The supervisor will endeavor the level of "consumer" satisfaction by discussing with other members of the community.
- The supervisor should try to find out the behavior of the health worker.
- The supervisor should try to find out her relation with TBAs, MW, CHW and other community workers.
- Always take notes of the specific suggestions by the members of the community concerning ways of improving the community perception about the program.
- In case the community has not yet set up a village committee to coordinate health activities, contact with the leading local figures with a view to setting up such a committee.

F) Report/ Feedback to Health Team:

After completing field tour, the supervisor will attend a general meeting with team of health facility to summarize findings and any differences in interpretation and lead the discussion towards resolution by consensus. Summarize the comments and carefully explain the observations. Start with positive aspect and lead to points where knowledge, attitude and skills need to be improved. Outline the salient points of the contacts with the community. While providing feedback to the health team, boost their motivation and help to improve their performance.

Stage Three: Follow-up Supervision:

After passing through all steps of stages one and two, the supervisor has given place to diagnosis and the remedial action needed is now fairly evident. Follow-up must be systematic. It will focus on workers individually and corrective action will be addressed to the needs of each in turn. The entire "regional/district health team" will discuss, determine and carry out the follow-up activities; leadership will pass from the supervisor to one or more members of the staff selected to assume this responsibility. Now the regional/ district health team will jointly discuss and decide on how to address the issues.

Role of Regional/ District Health authorities in supervision activities: The Regional/ District medical officer (supervisors), Regional Coordinator and WHO staff are responsible for joint supervision activities with implementing partners. WHO/ UNICEF will facilitate the process. It is expected to carry out supervision activities, using checklists, at least 5 days a month. All health facilities covered under the Programme and their communities should be visited at least once in a year by the Regional/District supervisory team in a year. All visit reports should be submitted to the Zonal authorities and WHO/ UNICEF for information, action and feedback.

Zonal health authorities with WHO, UNICEF and UNFPA staff will organize joint quarterly supervisory visits to review progress and learn lessons from the programme in the intervention regions.

Performance Indicators

1. '*Marwo Caafimaad'* will have an average Performance Score of 70 % and no '*Marwo Caafimaad'* will score below 60 % (3rd Party evaluation)
2. All '*Marwo Caafimaad'* score above 70% on the supervisory checklist (Supervisory reports)
3. All '*Marwo Caafimaad'* have a FHS and no FHS have more than 15 '*Marwo Caafimaad'* (Record and 3rd Party evaluation)
4. All '*Marwo Caafimaad'* will have received a monthly visit from their FHS who will have used checklist and visited households with and without '*Marwo Caafimaad'* (Record and 3rd Party evaluation)
5. All health facilities and their communities are visited every month by health authorities using checklist (Reports and 3rd Party evaluation)
6. All FHS have access to transport through Travel Allowance (Supervisory reports and 3rd Party evaluation)

6. Monitoring / HMIS

Purpose is to build evidence and provide efficient information about the programme and it's results to fulfil the needs of various management/ decision making levels of the health system.

Monitoring is defined as "the systematic examination of a Programme's coverage and delivery". Assessing coverage consists of estimating the extent to which the Programme is reaching its intended target population; whereas estimating delivery consists of measuring the degree of congruence between the plan for providing services and the ways they actually are provided. In addition, the monitoring of a Programme includes collecting information about resource expenditures, information that is essential for estimating whether the benefits of a Programme justify its cost. Monitoring also may include assessing whether activities comply with legal and regulatory requirements—for example, whether affirmative action requirements have been met in the recruitment of staff.

An information system is a group of service indicators that reveals the status of the programme. The main principles of information system are data collection, analysis and dissemination of that information for action. Formal information usually reaches health managers in the form of routine statistical and management reports. These reports, which are generally standardized in format and produced on a regular basis, constitute the most visible part what is called the **Health Management Information System (HMIS)**. HMIS is designed to collect important information about demographic details, morbidity & mortality details, socioeconomic status, community, inputs and services provided by the health system.

WHO has developed community based reporting and recording forms in close consultation with health authorities, UNICEF and other partners. At a later stage, UNICEF may want to review the HMIS tools and consider the option of integration of '*Marwo Caafimaad*'-MIS into HMIS, with involvement of Zonal authorities and WHO.

It is, however, important to understand the needs of the '*Marwo Caafimaad*' Programme in the context of integrated HMIS. HMIS instruments required for the '*Marwo Caafimaad*' Programme can be classified into three categories:

- Recording Instruments
- Patient / Client Record Cards
- Reporting Instruments

1. Recording Instrument:

The following recording instruments are required at the level of '*Marwo Caafimaad*':

1. Map of Catchment Area (To be prepared by '*Marwo Caafimaad*')
2. Community chart – to be displayed in the health house having monthly community demographic details, vital events (birth & deaths), water and sanitation and summary of community health events.
3. Family Register – to be used to register the catchment population with basic details about household, members of the households and high-risk members (women, children etc) needing attention.
4. Treatment Register – to record preventive and curative services offered on daily basis
5. Tool to record monthly plan and implementation, activities of health committee and women support group, lists of targeted population (women and children) and monitoring their status (e.g. EPI, ANC, delivery and birth spacing details etc)

The recording instruments for FHWs' Supervisor are the following.

1. FHS's Monthly Visit/ Work Plan
2. Supervisory Checklist and Feedback Sheet
3. Checklist for Training at Health Facility

2. Patient / Client Record Cards

The Patient / Client Record Cards are

1. Antenatal and Child Health Counseling/ follow up Card
2. Referral Slips
3. EPI Card

3. Reporting Instruments

Different Reporting Instruments will be

1. '*Marwo Caafimaad'* Monthly Report
2. FHS Monthly Report
3. Monthly activities of '*Marwo Caafimaad'* & FHS will be summarized in health facility HMIS report
4. District and Regional HMIS reports will include summary information of '*Marwo Caafimaad'* Programme.

Report Transmission and Data Processing: All reports are to be transmitted through regular line management channels: from '*Marwo Caafimaad'* to MCH/HC, then to district, then to Regional and Zonal Office. Timetables for transmission will be as following:

FHW
- Prepares on daily basis and submits to MCH/HC in the 1st week of every month.

MCH/HC
- All '*Marwo Caafimaad*' monthly reports arrive at MCH/HC, where FHS aggregates these to be included in the Health facility monthly HMIS report.

DISTRICT
- Aggregated HMIS reports of health facility arrives at the District at the latest before 2nd week of the same month

REGION
- Aggregated HMIS report of the district arrives at the Regional Health Office at the latest before 3rd week of same month

ZONE
- Aggregated report of region arrives at the Zonal office at the latest before 4th week of same month

It is expected that as part of the HMIS, a feedback system will be developed to share information back to the service providers.

Performance Indicators

1. All regional monthly HMIS reports submitted to Zonal health authorities on time (Record)
2. HMIS reports providing accurate data (Data validation operational research)
3. Minimum one performance feedback in a year is provided to regions (Feedback Report)
4. No '*Marwo Caafimaad*' or FHS has stock out of HMIS instruments (Supervisory report and 3rd Party evaluation)

7. Logistics

Purpose is to create an efficient supply system on a continuing basis in order to assure the regular delivery of essential drugs, vaccines and other supplies that are fit for purpose, to the '*Marwo Caafimaad*'.

A **logistics system**, in the broadest sense, encompasses all the activities that occur between manufacture of the products and the point at which products are dispensed to consumers/ patients/ clients. Many organizations state their logistics objective as "the six Rights", which are

"Getting the Right quantities of the Right goods to the Right places in the Right condition at the Right time for the Right cost"

Ideally, logistics system decisions should result in a level of service that meets outlet needs. The key logistics factors, which determine this level of quality of service, include:

- Availability of accurate and timely information on consumption and stock levels;
- Accurate forecasting of needs;
- Timely ordering and processing of supplies;
- Reliable delivery;
- Organized and efficient warehousing.

In the '*Marwo Caafimaad*' Programme, the services provided to clients/ patients must be consistent and of high quality. Because a stock-out can result in increase in diarrheal or ARI morbidity and mortality or unwanted pregnancy, a programme cannot afford to run out of medicines / supplies at any outlet and therefore must ensure that medicines / supplies are always available at all levels. Similarly, overstock situations may allow the quality of the product to be compromised and result in wasted resources. To be successful, the '*Marwo Caafimaad*' Programme needs a smooth flow of medicines, supplies and equipment with no overloads and no interruptions and Regional/ District level Supervisor and Implementing partners can ensure a well establish logistics system provided they are able to monitor logistics system effectively. UN will support health authorities to procure and ensure uninterrupted supplies for the service provision in selected MCH/HC, all FHS and all '*Marwo Caafimaad*'.

The **drugs and non-drugs items list** is at annexure which will be reviewed by the health authorities, WHO, UNICEF and UNFPA on a regular basis, to ensure that they are appropriate for both the '*Marwo Caafimaad*' and for purchasing.

The Programme will ensure implementation of the annual forecasting and replenishment system for drugs, non-drugs items, printed material and other supplies (e.g Health House board). All procurements will be through UN to ensure quality control. UN will use its own storage and distribution channels to ensure that medicines and supplies are available for the Programme without any interruption.

Performance Indicators

1. No medicine or printed material has been out of stock for more than two months for 90 % of the '*Marwo Caafimaad*' (3rd Party evaluation).
2. There is no expired stock being held in stores or in the kit of '*Marwo Caafimaad*' (Supervisory reports)
3. Basic equipment and administrative/ printed materials replaced as per standards (Supervisory reports and 3rd Party evaluation)

8. Financial System

Purpose is to provide stipends, allowances to staff and to reimburse appropriate expenditures transparently and on time and as per agreed policy/ approval for the budget.

WHO's Zonal focal person for the Programme will prepare and demand **quarterly** budgetary estimates for the Zonal Programme in consultation with health authorities. For the '*Marwo Caafimaad*' Programme, budgetary estimates will be prepared keeping in view the working strength of different cadres, e.g. '*Marwo Caafimaad*', FHSs, trainers, number of Zonal, regional and district managers involved in the activities, etc. UN Zonal office will demand budget from their head office for repair & maintenance, transportation of medicines, stationery items, and other miscellaneous items.

Monthly budget estimate is based on:

1. Salary/ Stipend for '*Marwo Caafimaad*': No. of FHWs **x** Stipend ($100/ month from 2014) [Note: Stipend during 1 year training will be considered as training allowance]
2. Salary/ Stipend for FHSs: No. of FHS **x** Stipend ($ 400/ month from 2014) [Note: Stipend during 1 year training will be considered as training allowance]
3. Top-up incentive for CHWs (HP) – In case of GAVI-HSS only: No. of CHWs **x** Incentive ($ 40/ month in 2012 with 8% increase from 2014) - [The maximum total salary/ incentive amount would be based on UNICEF rates] – In JHNP region, cost to be covered through EPHS
4. Top-up incentive for TBAS (HP) – In case of GAVI-HSS only: No. of TBAs **x** Incentive ($ 20/ month in 2012 with 8% annual increase from 2014) - [The maximum total salary/ incentive amount would be based on UNICEF rates]
5. Transport cost for FHSs for supervision activities or to attend training: To be reimbursed on actual basis maximum 15 days/ month. (Average is $15/ day and should not exceed $35/ day in exceptional cases, and will need WHO consent).
6. Training of '*Marwo Caafimaad*': 3 trainers **x** Training allowance ($100 per trainer per month) [This would be maximum for 1 year training duration and will not be paid afterword]
7. One time cost for procurement of items required for training of '*Marwo Caafimaad*' and for FHS training (white board, markers, papers, chairs etc – to be procured by WHO Zonal office)
8. Training of FHSs in Referral Hospital: 3 trainers **x** Training allowance ($100 per trainer per month) + Reimbursement of actual travel cost, in case a trainer coming from other district and with prior consent of WHO zonal office. [This would be maximum for 1 year training duration and will not be paid afterword]
9. 1 day budget for attending interviews (in case travelling from other district) and later on 1 day budget for verification activity per facility.
10. Other activities in the zone as communicated by WHO Somalia office.
11. Approximate monthly supervision cost (transport cost and per diam) for supervision activities of zonal, regional and district health officers as per WHO guidelines.
12. Approximate monthly salary/incentive/top-up cost for concerned zonal (3), each involved regional (1) and district (1) health authorities and maximum 5 staff of selected MCH/HC as per approved UNICEF Salary/ Incentive guidelines.
13. Operational Research budget as per approved proposals.
14. Other Misc. items of expenses with details.

UN agencies will procure and supply medicines, non-drug items, printed materials and other supplies as per their own plan, in addition to carrying out repair & maintenance, Behaviour change communication and Survey activities. WHO Somalia will pay salary and operational cost to the staff recruited at Zonal and regional level for the Programme. Preferably, this will be part of Zonal budget later on.

Availability of funds for the Programme will depend on availability of funds/ release of funds by GAVI secretariat/ JHNP donors. Actual expenditure should not be in excess of funds approved, released and it should be ensured that excess funds are not demanded. Every vouchers or summery of vouchers against which payment is to be made require to be numbered, as per WHO financial rules and regulations. Similarly this vouchers number should be recorded on the over leaf of check counter folio and cheque issued should also be recorded on vouchers.

Payroll of '*Marwo Caafimaad*' and FHS must be prepared every month. All the relevant information including Code No., Name, Father/ Husband name, Name of health facility, etc must include in the payroll. Similarly monthly bills of training allowance and travel allowance for FHS should also be prepared before payment.

Stipend of '*Marwo Caafimaad*' and FHSs will be considered as training allowance during first year of main training. Payment of stipend/ training allowance to newly recruited FHWs and FHSs should be made in one go after completion of first three months basic training (WHO may review this policy as per local needs).

WHO will reimburse transportation cost, lodging allowance and allowance for supervision to zonal, regional and district health authority on receipt of bill and supervisory report (filled through using supervisory checklist).

Ideally all substantial payments should be made through cross cheques or bank transfer. However, considering no formal banking system exists, WHO will transfer funds and make payments as per tested mechanisms used for polio activities. A review of fund flow mechanism is recommended.

Statement of Expenditure on 1st of following month must be sent to WHO Somalia office.

Performance Indicators

1. All '*Marwo Caafimaad*' and FHSs (other than those under three months basic training) have been paid full stipend in the last month (Supervisory reports and 3rd Party evaluation)
2. All training allowances and supervision allowances are paid on time and as specified (Finance Record)
3. No fraud issue is identified (Audit reports)

9. Evaluation

Purpose is to inform outcomes of the Programme to policy and decision makers and to hold them to account for choices and actions.

Evaluations are rigorous research studies which are designed to look specifically at whether development interventions have resulted in specific outcomes on the ground or not. The definition of evaluation agreed by the OECD Development Assistance Committee is: "The systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation, and results in relation to specified evaluation criteria."

UNICEF, WHO and UNFPA and Somali health authorities are committed to more and better evaluation of health development initiatives. The concept of rigorous evaluation was built in right from the development of the Programme. It is expected that different sub-systems in the '*Marwo Caafimaad*' Programme i.e. Monitoring/HMIS, Supportive Supervision, Evaluation, Audit and Operational Research will work together to deliver results for decision making, promote synergies, ensure a clear division of labour and avoid duplication.

The evaluation will ask questions about: what, why and how the results are achieved; how the programme is working; who benefits/ loses effects on health and poverty (including intended and unintended effects); whether policies and objectives are relevant to ultimate aims of improving health.

First major step will be to establish a baseline at the start of the Programme, followed by an independent evaluation in 2015-16. Two major activities in this context are:

i) **Health Facility Assessment (HFA)** – The assessment will be conducted in all types of health facilities annually to know the situation on ground, gaps in meeting the agreed essential package of health services. Baseline will not only set a benchmark at the start of the programme but will also help to plan effectively to deliver complete package through the selected MCH/HC. Another round of HFA will be conducted in 2015 and 2016, to evaluate what, why and how results have/ have not been achieved.

ii) **Household Survey** – To understand the health status at the start of the Programme in the catchment area of MCH/HC, a random sample of communities and household will be selected to measure baseline indicators which are to be achieved by the Programme. This exercise may lead to revision in the milestones and targets of the Programme. The evaluation to be conducted in 2015-16, will review progress made against the targets and compared to the baseline, in addition to assessing relevance, effectiveness, efficiency, coverage, coherence and coordination during the implementation of Programme. A special focus of the evaluation will be to assess outcome of the '*Marwo Caafimaad*' Programme in their communities.

The Operational Research component will also help to understand and find out solutions to the issues faced during implementation of the Programme.

Performance Indicators

1. HFA and Baseline household survey carried out jointly at the start of Programme.
2. An independent third party evaluation of the Programme conducted in 2015-16.

Annexure:

Annex A: EPHS for 'Marwo Caafimaad' (FHWs)

Annex B: Supervision Schedule for Regional/ District Supervisor

Annex C: Checklist for Regional/ District Supervisors

Annex D: List of Drugs & Non-drug items for the *'Marwo Caafimaad'* Programme

Annex A:

A: Essential Package of Health Services – *'Marwo Caafimaad'* Level

Key competencies of *'Marwo Caafimaad'* (FHWs)	**Suggested key topics for training** *(NB each micro module includes practical training, and is completed with practical and written tests of competencies)*
– Knowledge of key concepts: can define health & disease; understands ill health, vectors and disease; understands interplay between family, community & cultural beliefs & practices; understands the components of PHC; understands the levels of the health system; understands roles and functions of '*Marwo Caafimaad*'	Disease, health, communities, environment, PHC & the health system - core training
– Understands community organization and participation – Establish health committees and facilitate a community discussion – Master BCC techniques – Interpersonal skills gained and able to use IEC material – Able to conduct home visit for health promotion – Can prepare a promotion lesson plan	Community mobilization, behavioural change communication, interpersonal communication core training
– Understands how water and food become contaminated – Understands the transmission of water borne disease – Understands elements of environmental sanitation – Can distribute ORS sachets – Communicate key hygiene messages (CHAP & PHAST competent) – Can conduct home visit for hygiene & WATSAN promotion – Can treat child with ORS & zinc & advise parents – Can advise on safe handling/ preparation of food	Water & environmental sanitation – hygiene promotion, PHAST & CHAP training & water treatment
– Can advise on anaemia prevention – Can give iron/ folate tabs and micronutrients – Can advise on diarrhoea prevention & management – Can treat child with ORS & zinc & advise parent – Can treat a child with cough & cold (ARI no pneumonia) – Can identify and treat pneumonia – Can identify and refer cases of severe pneumonia and very severe disease – Can take temperature and manage fever with advice and Paracetamol – Can identify & support sick child with measles with Vitamin A, advise on appropriate food and ORS and referral – Can advise parent on care of newborn – temperature management, cord care, exclusive breast feeding – Can conduct home visit of sick child to advise nutrition and hydration and referral to appropriate health facility	Management of key childhood illness (fever management, malaria, ARI, diarrhoea, anaemia & worms) and care of newborn
– Can identify and treat scabies and advice on prevention – Can identify and treat simple conjunctivitis and refer other eye diseases	Illnesses diagnosed and treated in the PHU – includes simple UTI, thrush, oral candidiasis, conjunctivitis, mild gastritis, mild allergy, simple skin diseases
– Can do a simple dressing – Can apply antiseptic	First aid and simple dressings; accident risk reduction

Key competencies of *'Marwo Caafimaad'* (FHWs)	**Suggested key topics for training** *(NB each micro module includes practical training, and is completed with practical and written tests of competencies)*
– Can identify severe injury/ burn and refer	
– Can identify suspicious cases of epidemic potential in community and advise family on rapid transfer to health centre – Can participate in public awareness campaign	Communicable disease surveillance & reporting
– Can promote need for immunization – Can register all children and women of reproductive age who needs immunization in her catchment area and update their record – Can organise immunization sessions in her community in collaboration with CHW and outreach teams from MCH centers – Can immunise children and mothers under supervision	Immunisation
– Can increase awareness and promote HIV transmission reduction with women in the community – Can promote preventive measures	Understanding HIV & HIV & STI prevention & TB awareness
– Can talk to person with mental illness and recommend referral – Can help reduce stigma against people with mental illness	Mental health and counseling skills
– Can advise on appropriate nutrition for pregnant women and on anaemia prevention – Can give iron/ folate tabs and micronutrients – Can give Vit A cap – Can promote birth spacing and advise appropriate contraception – Communicate key messages on STI prevention – Can conduct home visit of pregnant woman for health promotion and follow up on antenatal checkups – Can identify danger signs during pregnancy, delivery, postpartum and advice and refer – Collaborate with local TBAs and community midwives to ensure safe delivery practices – Can promote exclusive breast feeding – Can advice on care of the newborn and low birth weight babies – Can raise awareness about harmful effects of FGM	Maternal health, menstruation, birth spacing, reduction of gender based violence
– Can carry out MUAC screen (women and children) – Knows key nutrition promotion messages and how to convey them – Can give micronutrients and explain their importance – Can identify some signs of under-nutrition and understands the cause – Understands the link between nutrition, growth, development and health – Can visit under-nourished women, girl and child at home and promote good nutrition, including appropriate young child feeding & weaning – Can promote exclusive breast feeding	Nutrition promotion – maternal, newborn, infant, child and elderly; Screening and rehabilitation/ supplementary feeding/ Community based management of acute malnutrition; micronutrients
_ Can raise awareness about harmful substance abuse	Reduction of harmful substance abuse (tobacco, qat, alcohol)
– Register of births and deaths	Data collection, HMIS

Key competencies of *'Marwo Caafimaad'* (FHWs)	**Suggested key topics for training** *(NB each micro module includes practical training, and is completed with practical and written tests of competencies)*
– Keep immunization records of children and women in her community – Keep records of pregnant women – Submit a monthly report	
– Can advise clients to self-refer	Referral systems
– Manages her supply of medicines and non-drug items in bag and small stock at home	Essential drug management
– Knows composition of Community Health Committees and roles	Working with community health committees
– Promotes contribution to the PHU and community improvement programmes	Raising resources (human, financial and material) in the community for health, water and sanitation improvements, and building, upkeep & maintenance of PHU
– Can make simple map of her community	Community mapping
– Understands health system back up in case of disaster – Can communicate rapidly in case of disaster to relevant contacts	Disaster preparedness, mitigation and response
– Achieves above 60% average in oral and practical tests – receives qualifying certificate – understands limitations of role of 'Marwo Caafimaad' – understands code of conduct of 'Marwo Caafimaad'	Assessments – oral and written tests, practical procedures tests. Qualifying certificate Code of conduct

Annex B:

B: Supervision Schedule for Regional/ District Supervisors

Tour Schedule	Dr./Mr./Ms. _____ , Designation _____ , Schedule for the Month of _____ / Yr. _____.				
MONDAY					
TUESDAY					
WEDNESDAY					
THURSDAY					
FRIDAY					
SATURDAY					
SUNDAY					

Approved by: _____ Submitted by: _____

Annex C:

C: Draft Checklist for Regional/ District Supervisors

The draft checklist is intended to be a general guideline for supervision and the supervisor may not limit observations only to the questions in the checklist.

This checklist consists of three parts:

a) Work sheets
b) District Tour report
c) Feed back sheet

This checklist will be used only in those regions covered under the Programme and will be replaced by an Integrated Supervisory Checklist at a later stage.

WORK SHEET 1

Regional/ District Health Offices

(To be filled minimally once a month, unless otherwise specified)

Name of the user _____ Designation_____
Date of visit _____ District _____ Region_____ Zone_____

1) FUNCTIONING OF THE OFFICES OF REGIONAL AND DISTRICT MEDICAL OFFICERS

Section 1.1 **Planning / Establishment**

Indicator	Yes	No	Remarks (Briefly record relevant observations)
Annual Regional Plan of Action available for current year			
All positions of Regional/ District Medical Officers in the Region filled			
Management support available (Office, Furniture, Equipment, etc.)			

Section 1.2 **Meetings held by Regional Medical Officer (RMO) in previous month**

Type of Meeting (attended by)	Date of meeting	Specific issues discussed	Minutes available / Actions taken
Regional/District Health Management Team (R/DHMT)			
DMOs and Incharges of Health Facilities			
Other meetings			
With other offices			

2) HUMAN RESOURCES

Section 2.1 **Female Health Workers (FHWs) -** '*Marwo Caafimaad*'

Allocated	Recruited	Drop outs	Terminated	Presently working	Current Training status (Mention numbers)			Remarks
				(after 3 months Training)	Under 3 months	Under 9 months	Completed	

Section 2.2 **FHWs' Supervisors (FHS)**

Required	Recruited	Drop outs	Terminated	Presently working	Current Training Status (Training Phase)			Remarks
				(after 3 months Training)	Under 3 months	Under 9 months	Completed	

3) FINANCES

Item	Status	Remarks
Stipend of FHWs / FHSs paid till (Specify last month/Yr)		
Transport cost paid to FHSs/ Regional/District medical officers for the last month (Y/N)		

4) LOGISTICS

Section 4.1 Store

	Yes / No	Remarks
Space adequate		
Storage conditions proper		
Stock register / Issue-receipt vouchers / Bin card maintained		
Demand & Distribution system		
Medicines Available		
Printed Material Available		

5) SUPERVISION AND MONITORING

Section 5.1 **Supervisory visits for the Programme**

Undertaken by	No. of days in the field (during last month)	Tour reports available (Yes/No)	Remarks
Regional Medical Officer			
Regional Polio Officer			
District Medical Officer			
District Polio Officer			

Section 5.2 **Status of Monthly HMIS Reports**

Type	Number		Remarks (Comment on the quality of report after reviewing them)
	Expected	Submitted	
MCH/HC			
District Reports			
FHS			

DISCUSSION

Attended by: _____

Date: _____ _____

_____

Issues Discussed	Actions agreed for R/DMOs	Actions required at Zonal level
1.		
2.		
3.		
4.		
5.		

Critical Issues (to be followed during next visit)

1._____

_____

2._____

_____

3._____

_____

WORK SHEET 2

FHW's SUPERVISORS (FHSs)

(To be used for two FHSs only)

Name of user _____ Designation _____

District _____ Region _____ Zone_____

Name of FHS		
Based at MCH/HC		
Date of Visit		
	Status / Remarks	**Status / Remarks**
Advance tour plan available at MCH/HC and DMO office.		
Conducted 80% tours as per last month tour plan		
Continuing session attended in all concerned MCH/HC		
Each FHW visited (at least once every month)		
Uses Supervisory Checklist properly		
Monthly reports submitted regularly to • MCH/HC • DMO office		
Transport cost paid for last month		
Knowledge of FHS satisfactory • Supervision & Training • IPC and Community org. • Mother health • Child health • Nutrition • Common ailment +doses of medicines + First aid • HMIS (Y/N) (Use annex C-II)	• • • • • • • •	• • • • • • • •

Skills of FHS satisfactory • Supervision & Training • IPC and Community org. • Mother health • Child health • Nutrition • Common ailment+ doses of medicines + First aid • HMIS (Y/N) (Use annex C-II)	• • • • • • •	• • • • • • •

Discussion with FHS:

Name of the FHS	Issues discussed	Action agreed for FHS	Action required at MCH/DMO/ RMO/ ZHA
	1.		
	2.		
	3.		
	4.		
	5.		
	1.		
	2.		
	3.		
	4.		
	5.		

Critical Issues (to be followed during next visit)

1. _____
_____
2. _____
_____
3. _____

WORK SHEET 3

MCH/Health Centre

(For 2 facilities only)

Name of user _____ Designation _____

District _____ Region _____ Zone_____

Name of MCH/HC		
Date of visit:		
No. of FHWs attached:		
	Status / Remarks	**Status / Remarks**
1. **Training (including continuing education session)** a) Trained Trainers available(at least 2) b) Female trainer in the team. c) Classroom conditions satisfactory d) Training according to the guidelines e) Attendance register maintained f) Training Material Available		
2. **Record Keeping** a) FHWs monthly reports regular b) Facility reports regular c) Personal files of FHWs d) Feedback from DMO on reports		
3. **Logistics** a) Storage proper (Refer to checklist for store maintenance, C-III) b) Stock register / Issue-receipt vouchers/ bin card maintained c) Sufficient stock available, of medicines: d) Need for HMIS instruments e) Regular monthly replenishment to FHWs by MCH/HC f) Regular quarterly replenishment to MCH/HC by Unicef		
4. **Referrals** a) Records of FHW referrals maintained (Check record of Referral slips) b) Feedback to FHW on referrals.		
5. **Supervision** a) Trainers undertaking field visits b) Regular submission of monthly reports by FHS c) Date of FHS next visit known to staff d) MCH/HC visited by any Regional/ District Supervisor during last 3 months		

Discussion with Trainers:

Name of the MCH/HC	Discussion Attended by:	Issues discussed	Action agreed for MCH/HC	Action required at DMO/ RMO/ ZHA (If required)
		1.		
		2.		
		3.		
		4.		
		5.		
		1.		
		2.		
		3.		
		4.		
		5.		

Critical Issues (to be followed during next visit):

1._____
_____
2._____
_____
3._____
_____

WORK SHEET 4

Health House & 'Marwo Caafimaad' (FHW)

(For 2 FHWs only)

Name of user _____ Designation _____

District _____ Region _____ Zone_____

Name of FHW		
Date of visit		
	Status / Remarks	**Status / Remarks**
Fulfills Selection Criteria (If not, specify)		
Health House established as per given guidelines		
Satisfactory knowledge of FHW (Use annex C-I)		
Satisfactory skills of FHW (Use annex C-I)		
Stipend received for last month (If not, for how long)		
Supplies available (If not, for how long)		
Correct maintenance of HMIS instruments		
Last Monthly report submitted		
Referrals being entertained by MCH/HC (Check no. from record)		
List of vulnerable groups available and maintained correctly		
Advance plan of FHW prepared		
Health Committee constituted/ functional (Comment on contribution of HC)		
Women Group constituted/ functional (Comment on contribution of WG)		
List of children <3 years maintained		
Regular visits by the vaccinator		
Date of next visit of FHS known		
Visits by anyone else during last one year (Give name)		
% of infants (immunization started)		
% of children 12-23 month with immunization completed		
% of delivery cases visited by FHW during delivery or within 24 hours after delivery in last month.		

1. **Discussion with FHWs:**

Name of FHW	Issues discussed	Action for MCH/HC/FHS	Action for DMO/RMO/ZHA
	1.		
	2.		
	3.		
	4.		
	5.		
	1.		
	2.		
	3.		
	4.		
	5.		

Critical Issues (to be followed during next visit):

1._____
_____
2._____
_____
3._____
_____

WORK SHEET 5

COMMUNITY

Name of user _____ Designation: _____

Date _____ Name of FHW _____

Village/Area _____ MCH/HC_____ District_____ Region _____

A: HEALTH COMMITTEE /WOMEN GROUP (Information to be obtained from members)

Status	Yes/No	Remarks
Regular meetings held		(at least once a month / record date)
Meeting organized properly		(Agenda, Date, Venue and number of participants)
Discussed Health Problems		(Environmental sanitation, personal hygiene, MCH, communicable disease, others)
Attended by Health Personnel		(Trainers , Supervisor, record names)
Action taken/achievement		
Community participation in other programme activities		(Participation in national campaigns, Immunization, MCH etc./ record specific event)

B: COMMUNITY MEMBERS (Other than health committee)

Status	Yes/No	Remarks (Record Observations)
Knows FHW		(Can identify FHW)
FHW conducts regular visits		
Satisfied with her work		(If not, specify reasons)

Suggestions for improvement:

A: By Health Committee/Women Group members

1._____
2._____
3._____

B: By Community members

1._____
2._____
3._____

Tour Report

For one district only

INSTRUCTIONS:

1. The Tour report of the last month should be sent in the first week of the next month to Zonal health Authorities/WHO. However, in case immediate action is required, the intimation should be done on an urgent basis by telephone etc.
2. Supervising Officers should submit the original report to their headquarters and copies to be submitted to other offices.

Name of reporting officer: _____ Designation: _____

District _____ Region _____ Reporting month _____

Total Days in Office _____ Total Days in Field _____

Total MCH/HC visited _____ Total Health House visited _____Total FHS visited _____

Part A: FOLLOW UP OF THE PREVIOUS VISIT

(Should be filled from Section 3 of Part B of the previous visit's tour report)

Critical Issues identified (Not more than three)	Resolved (Y/N)	Reasons if not resolved	Suggestions for intervention (mention level applicable)
1.			
2.			
3.			

PART B: OBSERVATIONS OF THE CURRENT VISIT

Section 1: (a) Status of FHWs

Phase	Alloc-ated	Recrui-ited.	Drop outs	Termi-nated	Presently working	Training status			Remarks
					(after 3 M. Trg)	Under 3 months	Under 12 months	Complete d	

(b) Status of FHS

Required	Recruited	Drop outs	Terminated	Presently working	Training Status (Phase)				Remarks
				(after 2 M. Trg)	1	2	3	Completed	

Major strengths of the intervention found in the present visit:

1. _____
_____

2. _____
_____

Section 2: ***ISSUES IDENTIFIED***

Issues identified in the present visit (not more than seven)	Level applicable	Action taken by R/D Supervisor	Actions required at ZHA/WHO/UNICEF (If required)
1.			
2.			
3.			
4.			
5.			
6.			
7.			

SECTION 3: **Critical Issues to be followed on next visit** (Pick three most important from the issues identified in Section 2)

1. _____
_____
2. _____
_____
3. _____
_____

Dated: _____

Copy to:

_____
Signature

Monthly Tour Report

(To be submitted at ZHA and WHO)

Name of reporting officer: _____ Designation: _____

Province _____ Reporting month _____

Total Districts visited: _____ Name of Districts: _____

Total Days in Office _____/ _____ Total Days in Field _____/ _____

Total MCH/HC visited _____Total Health House visited _____Total FHS visited _____

Date	Tentative Tour Programme	Actual Tour Conducted	Reasons for any change
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			

Dated: _____

Copy to:

_____

Signature of reporting officer

(Approved / Not approved by ZHA) _____

Signature of ZHA

ANNEX C-I

GUIDELINES FOR ASSESSMENT OF KNOWLEDGE & SKILLS OF 'Marwo Caafimaad'

Instructions: This is a general guideline to assess the FHW's knowledge & skills. You may select a few or all of these questions; you may even devise questions on your own. Grade your assessment about satisfaction on knowledge & skills, with a "Yes" or "No", in the relevant columns of the Worksheet 4.

No.	Areas of Assessment	Explanation
1	Can she give correct advice to an expectant mother on nutrition?	• Take a balanced diet • Increase food intake • Iron supplements
2	Can she demonstrate the presence of danger signs during pregnancy?	• Bleeding P/V • Edema / sudden Weight gain • Loss of fetal movements etc.
3	Does she know when to refer a case of delivery to the health center?	• Prolonged labor • Severe blood loss • Prolapse of fetal part • Fits etc.
4	Does she know the conditions in which a newborn should be referred immediately to the health center?	• Delayed crying • Blue discoloration • Fits • Severely jaundiced • Congenital malformation etc.
5	Is she aware of the proper dosage of:- a. Chloroquine Tablet b. Cotrimoxazole/ Amoxyl Syrup. c. Antihelmintic d. Others	• Refer to FHW Manual
6	What is her advice on nutrition, to a mother with a child less than 4 months of age?	• Breast Feed with in 1/2 hr • Exclusive Breast Feeding • No Bottle feeding
7	How will she counsel a 25 year old woman with two children under five years regarding FP practices?	• Refer to FHW' Manual
8	Does she know the contra indications of:- • IUCD • Injectable • Pills	• History of ectopic pregnancy/pregnancy • Pelvic infection • Hyper tension/diabetes
9	Does she know the EPI schedule of an infant?	• Refer to FHW' Manual
10	Ideally, how many T.T vaccinations should a female have in her lifetime and during pregnancy?	• Five and two respectively
11	Can she correctly assess the dangers signs in a child with: • Diarrhea • ARI	*Diarrhea* • Severe Dehydration • Continuous vomiting • Drowsiness • Fits *ARI* • Difficult breathing • Chest in drawing • >60 Respiratory Rate in an infant • Drowsy / Comatose etc.
12	Can she correctly demonstrate how to: a. Use MUAC? b. Read the EPI card? c. Take temperature of a child?	• Ask her to perform these activities
13	Can she demonstrate the correct preparation of ORS?	• Ask her to prepare
14	Can she correctly demonstrate how to:- a. Count the Respiratory Rate in a child b. Look for signs of dehydration	• Ask her to perform

ANNEX C-II

GUIDELINES FOR ASSESSMENT OF KNOWLEDGE & SKILLS OF FHSs

Instructions: This is a general guideline to assess the FHS knowledge & skills. You may select a few or all of these questions; you may even devise questions on your own. Grade your assessment about satisfaction on knowledge & skill, with a "Yes" or "No", in the relevant columns of the Worksheet 2.

No.	Areas of Assessment	Explanation
1	What will she do if the assessment score of FHW is:- • < 60% • 60 - 70% • 80% & above	• If < 60%, retraining at MCH/HC • If 60 - 70%, needs improvement & on the job training by supervisor • If > 80%, appreciate the good work
2	How will she assess the quality of training at MCH/HC?	Training is : • Regular • According to schedule • Participatory
3.	What will be her action in a woman who is in labor for past 8 hrs?	• Take her immediately to a well equipped obstetric facility • On the way, monitor mother & fetus
4.	What kind of contraception will she advise to : • A lactating mother • A mother with 2 children • A mother with 8 children • A woman with lump in the breast	• Refer to FHS' manual
5.	What is the most important aspect of supervision of FP activities of FHWs in a community?	• Regular follow up of clients by FHWs
6.	Ask her to demonstrate Antenatal checkup on a pregnant mother	• Observe
7.	How will she manage a patient in shock?	• Refer to FHS' manual
8.	Is she aware of the correct dosage of medicines in FHWs kit?	• Ask about any 2 or 3 medicines
9.	Supposing there has been an epidemic, e.g. of Malaria in her community? How will she manage / supervise FHWs in such cases?	• Refer to FHS's Manual
10.	Does she assist the FHW in completion of her monthly report?	Observe whether she is • Supportive • Communicative • Enjoys confidence
11.	Standard of her communication skills in convincing a reluctant mother to adopt FP?	• Observe
12.	Suppose there is a 4-month pregnant woman with Hemoglobin of 7 gm/dl. On which aspects would she monitor the FHWs in this case?	FHW ensures: • Dietary intake of Iron • Iron and FA supplements • Follow up Hb checkup

ANNEX C-III

CHECKLIST FOR STORE MAINTENANCE (if required)

1. Separate space for storage of contraceptives / general medicine available?
2. Present space adequate?
3. Store is clean?
4. Floor is cemented and walls whitewashed?
5. Roof does not leak and plaster is intact?
6. Adequate ventilation and light present?
7. Direct sunlight does not enter the store?
8. Fire fighting equipment available?
9. Door / Windows secure?
10. Storerooms disinfected and sprayed every third month against insects, rodents and birds?
11. Cartoons stacked four (4) inches of the floor (using wooden planks) and approximately two (2) feet away from any wall?
12. Are stacks more than eight (8) feet high?
13. Each consignment stacked separately? (to facilitate counting and access to hind stack)
14. Is first-expiry-first out (FEFO) method followed?
15. Medicines and drugs are not stored with insecticides, chemicals and office equipment?
16. Are marking, labels. Manufacturing or expiry dates visible?
17. Has each stack a bin card?
18. Entries are proper in the bin card?

Feedback Sheet for Regional/District Supervisors

(To be retained by R/D Supervisor for next month visit)

Region: _____ District: _____ **Month: _____/ _____**

	Present status of issues identified in previous visit (resolved / unresolved)	Major issues identified in present visit (not exceeding 3)	Actions taken during the field visit by the supervisor	Actions for follow up by
1.				**FHS:** **DMO/ DPO:** **RMO/ RPO:** **ZHA/ WHO:**
2.				**FHS:** **DMO/ DPO:** **RMO/ RPO:** **ZHA/ WHO:**
3.				**FHS:** **DMO/ DPO:** **RMO/ RPO:** **ZHA/ WHO:**
4.				**FHS:** **DMO/ DPO:** **RMO/ RPO:** **ZHA/ WHO:**

Annex D:

D: List of Drugs and Non-drug Items for the *'Marwo Caafimaad'*

Table 2: List of Medicines for FHW's Kit:

Medicine items in the FHW kit to be replenished on monthly basis

S.#	Name of Items	Proposed Quantity/FHW/Month	Remarks
1.	Tab. Paracetamol 500mg	200 tab/month	For management of fever/pain in adults
2.	Syp, Paracetamol 120mg/ml	10 bottles/month	For management of malaria/ pneumonia/ fever in children
3.	Tab. Mebendazole OR Albendazole-	150 tablets /round	May be supplied on 06 months interval only to be used during Child Health Days, as over dosage has multiple side effects as well as cost implication.
4.	ORS Sachets along with Zn.tablets (02-ORS Sachets along with Packing of 10 Zn. Tab.)	10 Packs/month	This package for diarrheal treatment is already available in markets of Somalia so using the same will ease the acceptability at community level.
5.	Dispersible Amoxicillin Tab. -250 mg. (Blister of 12 tablets.)	10 packs/month	For treatment of Pneumonia and bacterial infections
6.	Iron-Folic Acid Tablets (Blisters of 10 tab.)	100 blisters/ month.	Can be used only for pregnant females or adolescent girls. Though the compliance is poor but it is the most essential requirement during pregnancy and has no side effects on fetus. Option for Multi-micronutrients preparations has certain considerations of possible adverse effect during pregnancy.
7.	Cotton bandage 4"x 3m	01 dozen/month	For first aid
8.	Benzyl Benzoate Lotion (Bottle of 250 ml.)	10 lotions/month	For Scabies
9.	Tetracycline Eye Ointment	10 ointments/month	For eye infections
10.	Cotton Roll	01 roll/month	For first aid
11.	Tab. ACT 50 mg+ Fansidar 25mg/500 mg	100 tablets/month	For treatment of malaria
12.	Antiseptic Lotion	01 bottle/month	For first aid
13.	Tab Multi-micronutrients (Blisters of 10 Tab)	50 blisters/month	For CBAs (non pregnant) like adolescent girls, lactating and married women.

Table 3: List of Non-drug items for FHW:

S.#	List of Non Drug Items	Proposed Quantity/FHW/Month	Remarks
1.	Sticking Plaster	01 roll/month	
2.	FHW's Kit Bag	01 for 3 years	
3.	Scissors	01 pair for 2 years	
4.	Clinical Thermometer	02 (Replace as and when required)	
5.	MUAC Tape	20 tapes/ 3 years	
6.	Pencil Torch with Cells	01 for 01 year. 02 Cells /month	

1.	Charts, communication material and HMIS tools for FHWs	01 set per year	
2.	Training Manual and Job Aids	01 set	
3.	Health House Board	01 for 4 years	