Birth Preparedness Class (BPC) Pilot Evaluation Study Report

October 2020
In addition, key informants from health facility teams and MoH observed that BPC contributed highly to the completion of recommended 4 ANC visits for pregnant women.

One of the two main indicators in BPC intervention was to increase ANC4 by 4%. As shown in the bar graph below, an average of 64% of interviewed respondents reported to have completed ANC4.

Among those completed who reported to have completed 4 ANC visits, 77% said it was their first time (see table 5 below). The pilot was therefore able to incorporate women who were not previously connected health facilities.

In addition, key informants from health facility teams and MoH observed that BPC contributed highly to the completion of recommended 4 ANC visits for pregnant women.
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# Acronyms

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<td>AAH</td>
<td>Action Against Hunger</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>BPC</td>
<td>Birth Preparedness Class</td>
</tr>
<tr>
<td>DFID</td>
<td>Department for International Development</td>
</tr>
<tr>
<td>DG</td>
<td>Director General</td>
</tr>
<tr>
<td>DHIS 2</td>
<td>District Health Information Software 2</td>
</tr>
<tr>
<td>EPHS</td>
<td>Essential Package of Health Services</td>
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<tr>
<td>FCC</td>
<td>Female Community Champions</td>
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<tr>
<td>FCDO</td>
<td>Foreign, Commonwealth &amp; Development Office</td>
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<tr>
<td>HKH</td>
<td>Hooyo ku Hooyo</td>
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<tr>
<td>HPA</td>
<td>Health Poverty Action</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MIS</td>
<td>Management Information System</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MoHD</td>
<td>Ministry of Health Development</td>
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<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>SAHAN</td>
<td>Somali Advocates for Health and Nutrition</td>
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<tr>
<td>SHDS</td>
<td>Somali Health and Demographic Survey</td>
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<tr>
<td>SHINE</td>
<td>Somali Health and Nutrition Program</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nation Development Programme</td>
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<tr>
<td>UNFPA</td>
<td>United Nation Population Fund</td>
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<td>UNICEF</td>
<td>United Nations Children's Fund</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
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</table>
Acknowledgement

The evaluation study and development of this report involved various people whose support and dedication are highly acknowledged. Heart-felt gratitude goes to implementing partners (IPs) who implemented the Hooyo ku Hooyo intervention including PSI, Trocaire, Action against hunger (AAH), Health Poverty Action (HPA), and Mercy USA. Special thanks go to Europe Busharo and Khalif Aden from Trocaire for their great support in hosting and handling the data collection exercise in Gedo region. The study is also very grateful to New Access Consulting, a research agency in Somalia, for providing data collectors in all the regions and managing field work.

The support and information provided by the Somali ministries of health (MoHs) is also greatly appreciated. Special gratitude goes to Dr. Nur Ali Mohamud (Director of Policy and Planning Department, GGS MoH), Mr. Saed M Saleban (Director of Policy, Planning and Strategic Information, Somaliland MoHD), Idiris Hassan (Director General, Jubaland MoH), and Dr. Abdiweli Mohamed (Director General, Galmudug MoH).

Finally, special appreciation goes to the respondents of this evaluation including mothers, facility team leaders, female community champions among others who shared plenty of information that was extremely useful for this exercise. Without the incisive information they provided, this evaluation would not have been possible.
Executive Summary

Women in Somalia and Somaliland have a one in 22 lifetime risk of maternal death making the maternal mortality rates in Somalia and Somaliland amongst the highest in the world. Most of these deaths (94%) occurred in low-resource settings, and most could have been prevented (WHO, 2019). It is estimated that the maternal mortality ratio is 699 deaths per 100,000 live births in Somalia (SHDS 2020).

FCDO (formerly DFID) is implementing a health system strengthening programme under the name Somali Health and Nutrition (SHINE) from 2016 to 2021. This program has both a supply side strengthening and demand creation components. PSI is implementing the demand creation for health services, called SAHAN (Somali Advocates for Health and Nutrition) component which aims to increase utilization of reproductive, nutrition, child, and maternal health services and to promote healthy behaviour change.

The Birth Preparedness Class (BPC), one of the SAHAN interventions, was piloted in Awdal, and Togdher regions of Somaliland; Karkaar region of Puntland; Galguduud region of Galmudug; and Gedo region of Jubaland. It is a facility-based intervention which addresses lack of knowledge and aims to increase levels of awareness among pregnant women in the Somali community by providing free, fun, and informative sessions together with fellow supportive pregnant women. The intervention was designed to:

a) increase the uptake of ANC visits i.e. at least 4 visits if no complication occurs
b) to scale up the number of women delivering at the health facility by mitigating delivery-related fears and providing conducive, friendly service at the health facility.

The BPC sessions were integrated with fun activities like henna\(^1\) art application. The fun activities are meant to get the women at ease and to create a convenient learning environment. At the end of the sessions, women were given a familiarization tour of the delivery room.

After the pilot period of the intervention, an evaluation was conducted in three regions (Awdal, Togdheer, and Gedo) and is the subject of this report. The purpose of the evaluation was to assess the effect of the Birth Preparedness Class in increasing uptake of facility delivery and completing recommended ANC visits. It also intended to determine the knowledge retention of BPC participants. The evaluation was a cross-sectional descriptive study using both quantitative and qualitative data:

- For the quantitative part of the study, a sample of 600 women who were projected to have already given birth by the time the survey was conducted were randomly selected out of a total of 5,490 BPC beneficiaries in 2019.
- For qualitative part of the study, health facility teams, implementing partner programme teams and MoH representatives were interviewed as key informants.

Key Evaluation Findings

Antenatal Care (ANC)

- 77% of the study respondents reported that they were new users of ANC
- 64% of the study respondents reported that they completed the recommended 4 ANC visits

Facility delivery

\(^1\) Hinna is an inexpensive temporary body art causing pigmentation of the skin worn by Somali women on their hands, and feet, mainly during festival occasions
Among the study respondents (N=478), 449 representing 94% of the study participants, reported to have given birth at a health facility. The remaining 6% reported to have delivered at home.

65% of the 449 women who reported to have given birth at a health facility said it was their first time to deliver at a health facility.

Health knowledge retention
- 74% of the study participants could recall the importance of ANC as discussed in the sessions.
- 78% of them could mention three benefits of facility delivery.
- 64% could mention at least three danger signs in pregnancy.

Perception towards the pilot project
- 86% of the study participants thought that BPC was useful and like the intervention. They particularly like the elements of birth preparation, nutrition, danger signs of pregnancy, and pain management techniques.

Lessons Learnt
- Successful demand creation dependent on strengthened health systems and supply-side availability. Some women could not deliver in the health facility because they could not afford transportation, or the services sought was not available in the health facility.
- Maternal and child health awareness is very crucial. Most of the health facility teams, MoH representatives and other key informants emphasised the importance of raising health awareness among Somali women, giving reference to the positive change they have seen during the pilot project.
- Hiring dedicated BPC facilitators should be considered in future implementation. The intervention incorporated existing ANC providers as BPC facilitators for session which were to happen in the afternoon when health services are not provided. However, during implementation many facilities chose to conduct the sessions in the morning hours in response to pregnant women’s requests. It therefore became challenging for the ANC providers as they had to conduct the sessions and at the same time serve her ANC clients.

Challenges
- Poor physical access: Long distances to health facilities especially in IDP settlements and slums and the nomadic lifestyle of some of the participants was a key barrier to initial uptake of BPC, particularly for the second session.
- Some participants attending more than two sessions: The intervention design required for pregnant women to attend two BPC sessions – the 1st during first/second trimester, and the 2nd during the third trimester. However, it was noted during the evaluation study that some women attended more than 2 sessions. On being prompted, the health facility team members said that some pregnant women kept coming back for more sessions even though they had completed the 2 required sessions and they could not turn them away. This multiple attendance may make it difficult to specify the exact number of beneficiaries reached. BPC facilitators were advised not to re-register names of those who had completed sessions to mitigate against this.
- Most of the women who participated in the intervention were expecting some handouts (e.g. baby kits, food etc) like some interventions in the past had done. Also, among the key informants in qualitative study, giving handouts was a common recommendation.

Conclusion
The design and approach of the intervention was found to be good and addressing the objective as per the interviewed key informants. In addition, many of the beneficiaries liked the intervention and demonstrated some positive health behavioural change. Though the intervention was designed to increase ANC 4 completion and
facility delivery, key informants mentioned that it also addressed other challenges the health facilities had been facing including poor birth preparation by pregnant women and inability by the facilities to retain regular clients. Nonetheless, it is also important to note that there still exist some barriers to health service utilization including lack of transportation to health facilities and some women still trusting traditional birth attendants (TBAs) more than the health providers contributing to some women continuing to give birth at home.

**Recommendations**

The following recommendations were raised during the evaluation survey:

- Future continuation of this intervention was recommended with focus villages and rural areas and not only in big cities.
- Increasing the number of BPC session from two to four per week to reach many more pregnant women.
- Strengthening health system, EPHS, supply-side, and infrastructure to complement the demand creation.
- Hiring a dedicated BPC facilitator was highly recommended
- Many key informants recommended the inclusion of some material handouts so as to increase participant interests and increase their number.
# 1.0 Introduction

## 1.1 The Somalia/Somaliland Context

Maternal mortality is a substantial burden in developing countries. The World Health Organization (WHO) estimates that 500,000-600,000 women die from pregnancy and childbirth-related complications each year, with 99% of these deaths occurring in developing countries (SHDS, 2020). Somalia & Somaliland have one of the highest lifetime risks of maternal deaths in the world, 1 out of every 1,000 women die due to pregnancy related causes. Ratio estimated to be 692 deaths per 100,000 live births (Somalia, 2020). According to WHO, UNFPA, UNICEF & UN population division, the main causes behind maternal mortality is lack of education, lack of accessible health care on time, as well as poor nutrition, poverty and misconception about health facility and health care providers.

Childbirth is a normal physiological process for most women and a process that, like all other life events, is looked upon with a mixture of anticipation and happy expectation. Studies in developed countries have shown a positive impact on pregnancy and birth outcomes when the woman feels in control of the process of pregnancy and birth. Making a birth plan has been shown to facilitate this feeling of self-control and autonomy.

Historical evidence shows that no country has managed to bring its maternal mortality ratio below 100 per 100,000 live births without ensuring all women are attended by an appropriately skilled health professional during labour, birth and the periods immediately afterwards (WHO, et al, 2019). So, receiving care from a skilled provider (doctor, nurse) during childbirth has been identified as the single most important intervention in safe motherhood and reducing maternal mortality. Many of the complications that result in maternal deaths and many that contribute to perinatal deaths are unpredictable, and their onset can be both sudden and severe. Delay in responding to the onset of labour and such complications has been shown to be one of the major barriers to reducing mortality and morbidity surrounding childbirth (Ganchimeg T, Ota E, Morisaki N, et al, 2014).

However, approach to use skilled providers in developing countries remains low. According to the demographic and health surveys, only 51% of women in developing countries were assisted by a skilled provider at last birth, while it is even much lower in Somalia & Somaliland as only 32% of the childbirth is attended by a skilled person (SHDS, 2020).

Information on how to stay healthy during pregnancy and the need to obtain the services of a skilled birth attendant on recognizing signs of onset of labour, and on recognizing danger signs for pregnancy-related complications and what to do if they arise would significantly increase the capacities of women, their partners and their families to remain healthy, to take appropriate steps to ensure a safe birth and to seek timely skilled care in emergencies.

## 1.2 Project Summary

The Birth Preparedness Class (BPC) is an intervention designed to have 2 sessions conducted at the health facility once a week, and four times a month. The first session is for a cohort of pregnant women in their 1st and 2nd trimesters. The second session is intended for pregnant women in their 3rd trimester. In both sessions, the pregnant women gather with their peers to participate in the class and the fun activities like henna application. The sessions cover the following key topical issues as concerns expectant women:

- Advance birth preparedness: Planning and preparation for delivery (Session 1 & 2)
- Nutrition during pregnancy: What to eat to ensure that the mother and baby are healthy and food hygiene (Session 1)
- Breast Feeding: Benefits of breastfeeding, early initiation and exclusive breast feeding for up to six months and benefit of colostrum, how to help the baby to latch onto the breast properly and breastfeeding positions. (Session 1 and 2)
• When to seek medical attention: the importance of early health seeking in the event of concerns – Danger signs of pregnancy (Session 1 & 2)
• Labour: How to manage labour pain/pain alleviation techniques, breathing exercises and recognition of the tell-tale signs that baby is coming. (Session 2)
• Importance of PNC and birth spacing: A brief topic covering the importance of PNC and recommended timing of PNC visits, and the importance of family planning. (Session 2)

1.2.1 BPC Session facilitation methodology
The class facilitation is guided by the BPC training manual and job aids provided for each facilitator. Facilitation is mainly participatory and conducted in the Somali language as all the participants are Somali speakers. The session involves:
- Short lectures covering the above-mentioned topics
- Singing activities
- Video demonstration of breathing exercise
- Demonstration doll for breast feeding
- Visual materials like booklets and take a home material
- Henna application
- Tour to the delivery room for women in 3rd trimester

1.2.2 Intervention Objectives and Expected Outcome
The objective of the pilot project was to increase levels of health awareness among pregnant women by providing free, fun, and informative sessions together with fellow supportive pregnant women. It intended to increase the uptake of ANC visits i.e. at least 4 visits if no complication occurs, and to scale up the number of mothers delivering at the health facility by mitigating delivery related fears and providing a conducive, friendly service at the health facility. The project was expected to achieve three main outcomes:
1) Increase in the number of pregnant women who complete the recommended four ANC visits
2) Increase in the number of mothers who deliver at health facilities
3) Increase level of health awareness among pregnant women on the key health topics related to pregnancy

1.2.3 Pilot intervention Locations

<table>
<thead>
<tr>
<th>Region</th>
<th>Implementing Partner</th>
<th>Project Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awdal region, Somaliland</td>
<td>PSI</td>
<td>Sept 2019 to June 2020</td>
</tr>
<tr>
<td>Togdheer region, Somaliland</td>
<td>PSI</td>
<td>Sept 2019 to June 2020</td>
</tr>
<tr>
<td>Gedo region, Jubaland State</td>
<td>Trocaire</td>
<td>Sept 2019 to June 2020</td>
</tr>
<tr>
<td>Galgaduud region, Galmudug State</td>
<td>Mercy USA</td>
<td>April 2020 to June 2020</td>
</tr>
<tr>
<td>Karkaar Region, Puntland State</td>
<td>PSI</td>
<td>April 2020 to Sept 2020</td>
</tr>
</tbody>
</table>
1.2.4 Beneficiaries' Eligibility Criteria

All pregnant women, with bias to low income communities, both users and non-users of health services are eligible to attend BPC sessions. Women were counselled at the facility ANC rooms by an ANC provider or at their homes by a Female Community Champion (FCCs\(^2\)) to let them know about the sessions and encourage them to join.

1.3 Purpose, Objectives and Study Scope

1.3.1 Study Objectives

Objectives of this study is to determine the effect of the BPC pilot intervention on maternal health with a focus of ANC visits and facility delivery and to document successes and failures of the intervention.

1.3.2 Specific objectives

- To determine the effect of BPC on pregnant women’s utilization of ANC and facility delivery
- To test level of health awareness of the women who participated in BPC sessions focusing on maternal health topics (ANC, facility delivery, birth preparation, birth spacing, and nutrition during pregnancy)
- To identify factors motivating or demotivating women to give birth at health facility.
- To identify barriers preventing mothers to get connected to a health facility.
- To document lessons learnt, challenges and recommendations of BPC intervention.

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\(^2\) FCCs are female community champions who visit women in their homes, counsel or them, and encourage them to attend BPC session
2.0 Methodology

This survey was conducted in Awdal, Togdher, and Gedo, part of regions where BPC was piloted. Cross-sectional design was employed for this survey. The entire study, from design to report writing, was carried out from October 2020 to December 2020 in the above-mentioned regions. A sample of women who participated in BPC sessions were interviewed using a questionnaire developed based on the BPC curriculum. Before the tool was finalized, it was shared with the SAHAN program team for their review and inputs. The study also included a qualitative section where MoH representatives, health facility team members and implementing partner program staff were interviewed as key informants (KII). A desk review was also included to verify and analyse all available documents including monthly MIS reports, quarterly reports, DHIS2 data, BPC register books, and joint supervision reports with the ministries of health.

2.1 Sampling

All pregnant women who participated in the BPC intervention in 2019 and had given birth prior to at the time of the survey, were used as the sampling frame. The study selected a sample from those mothers who attended BPC session in 2019 as it is already passed their due date. No consideration was given to place of delivery during the sampling. A total sample of 600 women were randomly selected from a total of 5,490 women who attended the sessions in 2019. A total of 200 participants were selected from each region to give the total of 600 women. To ensure representativeness and equal chances for all the target BPC participants inclusion, simple random sampling technique was employed using the list of participants in the BPC register books as the sampling frame. Excel randomization was used to select the respondents. Due to unavoidable limitations as mentioned in the limitation section, the study managed to reach 478 respondents: 161 from Gedo, 172 from Awdal and 145 from Togdher region.

2.2 Data collection

2.2.1 Data collection tool

A structured questionnaire was used to collect data on the key behaviours such as attending ANC, giving birth at the health facility, birth spacing intention, associated knowledge on danger signs of pregnancy, importance of ANC, birth preparedness, and nutrition during pregnancy. The study participants were also asked general questions regarding the BPC sessions they attended. The questionnaire was based on the BPC curriculum and the project’s key indicators. Each interview was estimated to take an average of 30 minutes to complete. The tool was drafted in English and translated into Somali. Tablets were used to collect data. The qualitative questionnaire was used to interview the health facility team members, MoH representatives and implementing partner programme staff.

2.2.2 Training of Interviewers

A total of 12 enumerators were trained covering the following:

- Orientation to BPC and the objectives of the survey
- Data quality and how the survey would be conducted (sampling, logistics)
- Ethical considerations
- Mobile data collection particularly Survey CTO
- Practical practice the questionnaire.

2.2.3 Interview Procedure

Female Community Champions (FCCs) who are very familiar with the locations and residences of the BPC participants were employed to guide and help interviewers to identify the study respondents on the list. Enumerators were distributed to the sites where the selected women live. These women were approached

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3 SurveyCTO is a field-tested platform that allows you to collect data using mobile phones, tablets, or computers—even when you’re offline (https://www.surveycito.com/product)
individually and interviewed at home (face-to-face interview) in Togdheer and Awdal regions. In Gedo region the interviews were conducted via telephone. Records for refusals and incomplete interviews were kept – 13 respondents refused to be interviewed. Data collectors were required to interview ten women per day. The PSI M&E team were responsible for the checking the quality of the collected data, including random back-checks, and checking the completed questionnaires on the tablets.

2.2.4 Data Cleaning and Validation
The data cleaning and validation was part of the data collection because the team was using the mobile data collection app (Survey CTO) which enabled the M&E team to review data daily. Once the data collection was completed, the raw data was exported to Statistical Package for Social Sciences (SPSS) and Excel for analysis and report writing.

2.2.5 Ethical Considerations
Informed consent was obtained from each participant and the consent form read to all participants prior to the interview. Women were approached individually, given information regarding the purpose of the study, invited to participate, and reassured that opting out would not compromise the care they would receive. Only those who were willing to participate freely and voluntarily were interviewed. The right not to respond or refuse participation was respected. Personal privacy and cultural norms were respected as well.

2.3 Study limitations
- This evaluation depended on both primary and secondary data to a considerable extent. While triangulation was used to verify accuracy of data and related findings, there may be instances of discrepancies especially from the DHIS2.
- It was challenging to reach women for face-to-face interviews in Togdheer and Awdal regions. Some women were busy with their children and family matters whereas others were not available in their homes. Data collectors had to visit more than twice to get some of the women. Replacements were done for those women who could not be reached.
- Due to Covid-19 and security reasons, data collection in Gedo region was conducted through telephone interviews. It was challenging to reach women for the telephone interviews. Quite number of the calls did not go through as phones were either off or unreachable. The data collection team had to conduct more than 200 call attempts to get the expected daily respondents of 50. Despite all these efforts, the collectors were not able to reach the target selected sample in all the regions.
- The quantitative data collection was not conducted in Karkaar and Galgaduud regions. However, desk reviews and KII’s from these regions were included in this report.

2.4 Dissemination plan
The findings will be used by Somali health authorities (SHAs), FCDO, PSI, and other implementing partners to inform future and current implementation of similar demand creation interventions.
3.0 Key Findings and data analysis

3.1 Indicator Performance Tracking Table (IPTT)

The following Indicator Performance Tracking Table (IPTT) shows the main indicators as described in the BPC pilot intervention M&E logical framework. The achievement and baseline data are taken from illiterate women 2 and BPC Summary sheets. This is an aggregate of all the regions where BPC was piloted in the past 9 months. As seen in the table, the pilot met most of its set targets. ANC 4+ increased by 58%, while facility delivery by 10% in the project areas against target of 4% and 5% respectively.

Table 2. Overall IPTT

<table>
<thead>
<tr>
<th>Overall Objective</th>
<th>Improved health behaviours of Somali women of reproductive age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific objectives:</td>
<td>Indicators</td>
</tr>
<tr>
<td>1)</td>
<td>% change in ANC4+ utilization within pilot period</td>
</tr>
<tr>
<td>2)</td>
<td>% change in facility delivery utilization within pilot period</td>
</tr>
<tr>
<td>3)</td>
<td>Number of eligible pregnant women who attended BPC sessions</td>
</tr>
<tr>
<td>4)</td>
<td>Number of session participants who received follow ups</td>
</tr>
</tbody>
</table>

3.2 Demographic information

3.2.1 Regions

![Study participants per region](image)

In Awdal region 120 of the study participants were from Borama district whereas the remaining were from Dilla district. In Togdheer region, 109 participants were from Burao district and the remaining 36 were from Odweyne.

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4 Baseline is the addition of the first three quarters (9 months) before the intervention
district. In Gedo region, the 161 participants were from three districts: 44 from Luq, 72 from Doolow and 45 from Belethawa.

3.2.2 Age Segregation
The intervention targeted women of reproductive age group (18-49). The graph above shows that the right beneficiaries were reached. Most of the study participants were aged between 26 to 35.

![Age Segregation](image)

**Figure 2. Age segregation**

3.2.3 Employment status
92% of the study participants were not employed, whereas 5% were self-employed and only 3% were employed in privately-owned businesses.

![Employment Status](image)

**Figure 3. Employment Status**

3.2.4 Income level per month for the households
Majority of the participants in Awdal (72%) and Togdheer (55%) regions had monthly income of $100 to $200 while in participants in Gedo region, 52% had income less than $100 per month. The monthly income level is for an average household size of 5 persons per family.
3.2.5 Level of education

More than half of the study participants (57%) were illiterate, 35% could read and write, 15% were primary level, and only 8% had reached secondary and university level. Participants from Awdal and Togdheer were more educated as compared to participants from Gedo region.

Table 3. Level of education

<table>
<thead>
<tr>
<th></th>
<th>Awdal</th>
<th>Togdheer</th>
<th>Gedo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illiterate</td>
<td>54%</td>
<td>52%</td>
<td>65%</td>
<td>57%</td>
</tr>
<tr>
<td>Can read and write</td>
<td>16%</td>
<td>28%</td>
<td>17%</td>
<td>20%</td>
</tr>
<tr>
<td>Primary school</td>
<td>17%</td>
<td>10%</td>
<td>17%</td>
<td>15%</td>
</tr>
<tr>
<td>Secondary school</td>
<td>9%</td>
<td>6%</td>
<td>0%</td>
<td>5%</td>
</tr>
<tr>
<td>University and above</td>
<td>4%</td>
<td>3%</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

3.3 Achievement of expected outcomes – Output indicator 01: Number of pregnant women who participated in BPC sessions

19,332 pregnant women attended BPC session in all the five the regions of implementation. Out of these, 5,124 were referred by FCC and the rest come on their own to the health facilities and were then referred by ANC providers to the BPC sessions.

3.3.1 Time preference to attend BPC sessions

The sessions were designed to be held in the afternoon because the health facilities are busy in the morning attending to clients. On asking study participants what time they preferred for the classes, 74% in Awdal and 66% in Togdheer preferred the afternoon sessions. However, in Gedo, 88% of them preferred morning sessions.
3.4 Antenatal care (ANC) – Output Indicator 02: % change in health facility ANC 4+ visits

3.4.1 ANC visits (Source: MoH DHIS 2)

For comparison and to find out the contribution of the BPC program to ANC 4, the study included secondary analysis of DHIS 2 data, before and after the intervention. The graph below shows ANC4 trends nine months before and after the intervention (from January 2019 to June 2020). In all the regions except Awdal the trend shows some increments, particularly after the BPC intervention was started. In Awdal region, ANC 4 fluctuation was irregular in all the quarters. It is increasing in one month and decreasing in the second month.

ANC 4 dropped little on first quarter of 2020 in all the regions except Karkaar region. The decline of the service could be due to COVID-195 pandemic which began in Somalia at that time. On average, ANC4 increased 58%; from 7,168 (baseline) to 11,344 (achievement) during the intervention.

3.4.2 Completing ANC visits

\[\text{ANC 4 Trend}\]

---

5 Coronavirus disease 2019 (COVID-19) is defined as illness caused by a novel coronavirus now called severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2; formerly called 2019-nCoV), https://www.medscape.com/answers/what-is-covid-19
One of the two main indicators in BPC intervention was to increase ANC4 by 4%. As shown in the bar graph below, an average of 64% of interviewed respondents reported to have completed ANC4.

![Number of ANC Visits attended](image)

Figure 7. Number of ANC Visits attended

Among those completed who reported to have completed 4 ANC visits, 77% said it was their first time (see table 5 below). The pilot was therefore able to incorporate women who were not previously connected health facilities.

<table>
<thead>
<tr>
<th>Question:</th>
<th>The region</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awdal</td>
<td>Togdher</td>
</tr>
<tr>
<td>Was it your first time to go to an ANC when you went for BPC?</td>
<td>Yes</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>30%</td>
</tr>
</tbody>
</table>

Table 4, First time ANC visitors; New mothers connected to the health facility

In addition, key informants from health facility teams and MoH observed that BPC contributed highly to the completion of recommended 4 ANC visits for pregnant women.

“...I have seen some women who were taking part in the BPC session were consequently going for ANC in the following days; this evidence may tell us how quick the women were changing their health behaviours in seeking health services...”

Balanbale Health facility team leader

“... when PSI was going to kick off piloting the demand creation programme, I thought it was not relevant and will not make any difference to service utilization. But when I took part in MoHD-PSI jointly quarterly supervisions, I realized that it had increased primary healthcare service utilization and changed the behaviours of the clients... for instance, when I was taking part in Awdal jointly quarterly supervision, I came across a woman who had not previously been connected to the health facility. The woman said, “I used to feel headache when I was pregnant and thought it was just a mild headache and bought paracetamol from a nearby shop to relieve the pain. Then the FCC come to me and advised me to take part in the BPC session. During BPC session I learned that what I was suffering from was not a simple headache but a “pre-eclampsia” and got prescribed the right medications after going to the ANC”

---

6 Pre-eclampsia is a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys. ([https://www.webmd.com/baby/preeclampsia-eclampsia#:~:text=Pre-eclampsia%20is%20a%20complication%20characterized%20by%20high%20blood%20pressure%20and%20signs%20of%20damage%20to%20another%20organ%20system%2C%20most%20often%20the%20liver%20and%20kidneys](https://www.webmd.com/baby/preeclampsia-eclampsia#))
3.5 Facility Delivery – Output Indicator 03: % change in number of deliveries at the health facility

3.5.1 Facility delivery tracking (Source: MoH DHIS 2)

The graph below shows facility delivery trends from January 2019 to June 2020 in BPC project implementation areas. The data was extracted from DHIS 2.

![Facility Delivery Trends Graph]

Figure 8. Facility delivery trends from 2019 to 2020 (Source: DHIS2)

After analysing the trends, the following observations were noted:

- Facility delivery trend was irregular in Awdal and Togdheer regions; it was decreasing in one quarter and increasing in the next quarter whereas in Gedo and Karkaar region facility delivery was increasing, particularly after the BPC intervention was introduced.
- When COVID-19 pandemic reached Somalia in quarter 1 of 2020, facility delivery declined in all the regions except Karkaar and Gedo region.
- On average, facility delivery increased by 10% during the BPC intervention period.

4.0 BPC contribution to facility delivery
The graph above indicates the proportion of BPC participants among the total women who gave birth in the health facilities (a total 15,471) during BPC intervention period (September 2019 to June 2020). Of those women who delivered at the health facility, 49% in Gedo, 30% in Togdher, 12% in Awdal, 7% in Galgaduud and 4% in Karkaar had taken part in BPC sessions.

In the qualitative study, the key informants mentioned that the project connected the community to the health facilities, and more importantly maintaining clients to regularly visit the health facilities during pregnancy and after it.

“…besides increasing facility delivery, BPC intervention has solved another problem at our health facility. Before BPC, we had a problem with clients, women used come to the health facility, give birth, and never come back again. But as BPC intervention was going on we had the chance to make follow ups and retain our clients, so that they regularly come to the facility, started completing ANC visits, giving birth in the health facility, coming for vaccination and PNC after delivery…”

Burao Central MCH Team leader

“…we had a problem with facility delivery before BPC intervention, mothers were coming to the health facility with no new-born clothes. You can imagine when we even can’t get a small piece of cloth to cover the baby, we sometimes use to tear up our clothes; but later on when mothers were educated about the importance of advance birth preparation they come with all the materials needed during delivery”

Dr. Alag MCH Team leader

### 4.1.1 Place of delivery after attending BPC

Respondents were asked where they delivered their baby. A great majority reported to have delivered at a health facility. As seen in the graph above, 99% in Gedo, 97% in Awdal and 85% in Togdher reported to have delivered at a health facility. Cumulatively, for all the three regions, 94% of the study participants reported to have delivered at a health facility, with 65% of them reporting that it was their first time to deliver at a health facility. The respondents were also asked what motivated or influenced them to deliver at a health facility. 56% of them cited that both the BPC and Hooyo ku Hooyo (HkH) interventions influenced them; 28% cited that it was only BPC while 10% said it was only HkH intervention. The remaining 6% said they were influenced by either their husband or a friend.
6% of the study participants reported to have delivered at home. The study further investigated the reasons for them choosing to deliver at home after taking part in BPC. The reasons are as per table 5 below. A further probing to determine if the respondents experienced any complication while delivering at home. 86% mentioned that it was a “normal delivery” whereas the remaining 14% experienced some complications including prolonged labour and bleeding.

Table 5. Reasons for delivery at home

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Awdal</th>
<th>Togdheer</th>
<th>Gedo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facility was closed</td>
<td>0%</td>
<td>4%</td>
<td>19%</td>
<td>10%</td>
</tr>
<tr>
<td>Curfew at night</td>
<td>0%</td>
<td>7%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Health facility far away</td>
<td>50%</td>
<td>7%</td>
<td>19%</td>
<td>14%</td>
</tr>
<tr>
<td>No transportation</td>
<td>0%</td>
<td>32%</td>
<td>14%</td>
<td>24%</td>
</tr>
<tr>
<td>Cannot afford transportation</td>
<td>0%</td>
<td>29%</td>
<td>14%</td>
<td>22%</td>
</tr>
<tr>
<td>Healthcare providers are not welcoming</td>
<td>0%</td>
<td>0%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Trusted TBA</td>
<td>50%</td>
<td>21%</td>
<td>14%</td>
<td>20%</td>
</tr>
</tbody>
</table>

4.1.3 Preferred health facility type for delivery
Public hospital was the most preferred place of delivery for majority of study participants, with health centre being the second

Table 6. Preferred health facility for delivery

<table>
<thead>
<tr>
<th></th>
<th>Awdal</th>
<th>Togdheer</th>
<th>Gedo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Centre</td>
<td>45%</td>
<td>68%</td>
<td>5%</td>
<td>37%</td>
</tr>
<tr>
<td>Public Hospital</td>
<td>18%</td>
<td>20%</td>
<td>94%</td>
<td>45%</td>
</tr>
<tr>
<td>Private health facility (Clinic or hospital)</td>
<td>12%</td>
<td>6%</td>
<td>0%</td>
<td>6%</td>
</tr>
<tr>
<td>No preference- all the same</td>
<td>25%</td>
<td>6%</td>
<td>1%</td>
<td>11%</td>
</tr>
</tbody>
</table>

Study participants were also asked what they liked least about facility delivery. Though 73% mentioned that they like facility delivery, 27% of them mentioned long queues, and ‘unskilled’ midwives as least liked.

4.2 Perception towards the pilot project
Majority of the study participants showed a positive attitude towards the pilot project. Birth preparation, touring the delivery room and a breathing exercise being most popular elements.

![How would you rate BPC project?](image)

**Figure 11. Rating of BPC pilot project**

<table>
<thead>
<tr>
<th>What did you like most about BPC?</th>
</tr>
</thead>
<tbody>
<tr>
<td>OTHERS</td>
</tr>
<tr>
<td>BIRTH SPACING</td>
</tr>
<tr>
<td>DANGER SIGNS OF PREGNANCY</td>
</tr>
<tr>
<td>NUTRITION</td>
</tr>
<tr>
<td>BIRTH PREPARATION (FINANCIAL AND PLACE OF DELIVERY)</td>
</tr>
<tr>
<td>HINNA</td>
</tr>
<tr>
<td>PAIN MANAGEMENT TECHNIQUES</td>
</tr>
</tbody>
</table>

**Figure 12. What was liked most about BPC pilot project**

### 4.3 BPC Session duration satisfaction

The study participants were asked about their satisfaction with the session duration. The sessions were designed to last between 1 to 1 ½ hours. Majority of study participants from Awdal (95%) and Togdheer (90%) were satisfied with the duration while almost half of the mothers from Gedo (47%) said the duration was too long.

<table>
<thead>
<tr>
<th>Table 7. BPC duration satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Too long</td>
</tr>
<tr>
<td>Enough time</td>
</tr>
<tr>
<td>Too short</td>
</tr>
</tbody>
</table>
4.4 Feedback on the pilot BPC intervention

The key informants, who included health facility teams and MoH staff, had a positive attitude towards the pilot project and recommended that it be scaled up. Facility team leaders however noted that participation was quite high in the initial days of the project but a gradually declined as time progressed. They related this trend to the women were expecting some material handouts from the project. They therefore recommended for the project to consider including some food or non-food items such as mother and baby kits to be given to women in future programming.

“…… women were expecting some material distribution when they were called for BPC, and even the number of class participants decreased when they realized that this was not part of the sessions. If the programme is restarted, I would recommend including some handouts like pregnant women kits, delivery kits or baby care kits”

Health Facility Team Leader, Togdheer

“…during the programme implementations, the most asked question from the community was what material support the project was. They were never we quite satisfied with the answer that there was none. I would recommend including some incentives or some giveaways in similar demand creation programmes in the future. This will help us to increase the beneficiaries’ interest in our programmes. I would suggest giving some baby kits or water jerrycans to those mothers who gave birth at health facilities as a promotion of facility delivery

Health Communication Officer, Burco

4.5 Project Impact and Sustainability Assessment

4.5.1 ANC Visits

According to WHO\textsuperscript{7}, a minimum of 4 ANC visits are recommended for pregnant women. One of the main objectives of BPC increase the number of women completing the recommended visits. Participants were asked the number of recommended ANC visits during pregnancy. 61% of them said that pregnant women needed at least 4 ANC visits.

<table>
<thead>
<tr>
<th></th>
<th>Awdal</th>
<th>Togdheer</th>
<th>Gedo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 time</td>
<td>0%</td>
<td>3%</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>2 times</td>
<td>2%</td>
<td>3%</td>
<td>16%</td>
<td>7%</td>
</tr>
<tr>
<td>3 times</td>
<td>19%</td>
<td>23%</td>
<td>48%</td>
<td>30%</td>
</tr>
<tr>
<td>4 times</td>
<td>50%</td>
<td>34%</td>
<td>20%</td>
<td>35%</td>
</tr>
<tr>
<td>More than 4</td>
<td>30%</td>
<td>36%</td>
<td>14%</td>
<td>26%</td>
</tr>
</tbody>
</table>

4.5.2 Key danger signs of pregnancy

\textsuperscript{7} Opportunities for Africa’s Newborns (WHO, N.D) https://www.who.int/pmnch/media/publications/aonsectionIII_2.pdf
On average about 98% of the study participants mentioned at least one key danger sign of pregnancy majority able to mention at least four key danger signs of pregnancy.

Here is the story about key danger signs of pregnancy of a 30 years’ old Asma Ali Muse, a mother of 3 children, is one of the beneficiaries of the Birth Preparedness Class.

“It was exciting to interact with other women. I was expecting my third baby. The female community champions referred me to the health facility and encouraged me to attend the class. Even though I had given birth twice before, I had not known about danger signs during pregnancy. It was in this class that I learned that I should see a doctor immediately after I start experiencing bleeding and severe vomiting. These classes are very beneficial to women in my community. I will now rally my friends to attend the classes when they are pregnant to learn more on how to keep healthy and feed their babies well when they give birth”

Asma Ali Muse, 30-year-old BPC beneficiary

4.5.3 Benefits of facility delivery.

An aggregate of 97% of the study participants mentioned at least one benefit of facility delivery as discussed in the BPC. Sterile equipment (76%), quality drugs to prevent anaemia (80%), trained healthcare professionals (78%) are the main benefits of facility delivery mentioned by the study participants. A small percentage of the study participants, specifically 1% to 3%, could not recall facility delivery benefits.
4.5.4 Postnatal Care (PNC)
Women were tested on their knowledge on when they are expected to go back to the facility for health check-up as well as vaccination and/or family planning after delivery. 47% of the study participants mentioned that was required around the 6th week after delivery.

Table 9. Knowledge on PNC

<table>
<thead>
<tr>
<th></th>
<th>Awdal</th>
<th>Togdheer</th>
<th>Gedo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>On day 3</td>
<td>17%</td>
<td>3%</td>
<td>18%</td>
<td>13%</td>
</tr>
<tr>
<td>Between 1st and 2nd week</td>
<td>2%</td>
<td>17%</td>
<td>52%</td>
<td>23%</td>
</tr>
<tr>
<td>Around 6th week</td>
<td>74%</td>
<td>64%</td>
<td>2%</td>
<td>47%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>2%</td>
<td>8%</td>
<td>28%</td>
<td>13%</td>
</tr>
<tr>
<td>Others (specify)</td>
<td>5%</td>
<td>9%</td>
<td>0%</td>
<td>4%</td>
</tr>
</tbody>
</table>

4.5.5 Sustainability of Positive Health Seeking Behaviour
Some positive behavioural changes could be noticed from the respondents’ responses to the questions. For instance, their intention to be connected to the facility in the future, their interest to give birth in a health facility in the future pregnancies and their willingness to encourage other women to go to a health facility.

“I used to give birth at home with the help of a TBA and sometimes with nobody around for the delivery of all the previous eight children. There were times when I had heavy bleeding and even become unconscious. The health facility is just around 15 minutes’ walk from my home, but I have never been there. I thought the TBA is better than the health workers. One day, a team of two health workers came to me in my home while I was pregnant and advised me to attend a maternal health session (BPC) in the health facility. After attending the session, I learned the importance of facility delivery, danger signs of pregnancy and postnatal care; I am now connected to the health and plan to give birth at the health facility”

BPC Beneficiary in Burao

The FCCs reported, during follow up, that the beneficiary above gave birth to her 9th child at the health facility for the first time. The FCCs also stated that she is also willing to space future births.

5.0 Challenges and Lessons Learnt

5.1 Challenges
This section presents the key challenges encountered during implementation of the pilot project and outlines actions taken to address them.

- **BPC Session timing**: Sessions were designed to be conducted in the afternoon from 4:00 p.m. to 6:00 p.m. by the health facility ANC provider. As in line with the programme design, in Awdal and Togdheer regions, the ANC providers, who were already working in the health facility, did the BPC facilitation. However, there was a regular rain in the afternoon making it difficult to conduct the sessions. This led to some facilities rescheduling to conduct the sessions in the morning hours. This change in the timing brought about another challenge because the BPC facilitator has other duties serving ANC clients at health facility in the morning. In response to the challenge, one more facilitator was recruited to co-facilitate and/or conduct the session in the absence of the other.

- **Beneficiaries attending more than two BPC sessions**: The project was designed for every pregnant woman to attend 2 sessions, the first in her 1st and 2nd trimesters and the second in her 3rd trimester. However, the study revealed that some women attended more than two times. On being asked, the health facility team explained that some women came back again to attend more sessions, even though they have completed all the two sessions. They felt they could not turn them away as they were interested to learn more. This may make difficult to specify the exact number of beneficiaries reached. Therefore, during supervision, BPC facilitators were advised not re-register the names of those women who had completed the required sessions.

- **Poor physical access**: Long distances to health facilities especially in IDPs and slums was a key barrier to uptake of BPC and more so for the subsequent second session. This was particularly noticed for those with nomadic lifestyle and within IDPs.

- **Unsatisfactory services at health facilities**: Some women reported that the service they sought for at the health facilities were not available. The unavailability of the service sometimes due to shortage of commodities at the health facilities. This was exemplified in Awdal, where the demand component began before the supply due to some delay in supply kick-off. This was noted by the Director of Policy, Planning and Strategic Information for Somaliland MoHD.

  “...there were some delays in the different components of the overall SHINE program and the commodities that affected the availability of the services. This meant that we could not fully realise the impact of the SAHAN program as the demand creation component required all other SHINE components to be operational at the same time, this would be a lessons learnt for all of us – the MOHD, and the implementing partners – so that we can create better results in the future.”

  Director of Policy, Planning and Strategic Information, Somaliland MoHD

- **Women’s expectations from the programme**: It was reported that most of the women expected some material handouts when they attended BPC. On realizing that there are none, it led to reports of reduced enrolment in some areas.

- **Long queues**: Some health facility team leaders reported that the demand creation caused long queues at the health facilities and even though they sometimes worked overtime so as to serve everyone, some women, particularly those referred through BPC and HKH wanted to be favoured and prioritized.

### 5.2 Lessons learnt

The following lessons were learnt during implementations and from the study:

- **Successful Demand creation is dependent on strengthened health systems and supply-side availability**: Some women did not deliver at a health facility because they could not afford transportation to the facility and/or did not get the services at the health facility. In the context of Somalia/Somaliland where scale up of the EPHS faces both demand and supply sides barriers, it is critical that demand side efforts go hand in hand with addressing the supply-side challenges such as long distances to health facilities, shortage of commodities and capacity building for service providers. Moreover, at times the queue was too long that some women could not wait and simply went away.

- **Hiring dedicated BPC facilitators**: The intervention incorporated existing ANC providers as BPC facilitators for session which were to happen in the afternoon when health services are not provided. However, during implementation many facilities chose to conduct the sessions in the morning hours in response to pregnant
women’s requests. It therefore became challenging for the ANC providers as they had to conduct the sessions and at the same time serve her ANC clients.

- **The programme had secondary positive effects:** Though the intervention was designed to increase ANC 4 completion and facility delivery, key informants mentioned that it also addressed other challenges the health facilities had been facing including poor birth preparation by pregnant women and inability by the facilities to retain regular clients by making follow-ups.

- **Community ownership:** Most of the women referred to BPC by FCCs mentioned that they were happy with the programme because they feel that the FCCs, who are from their community were incorporated into the intervention. This made many of the women feel a sense of ownership for the intervention.

- **Revising and strengthening the project M&E system:** Designing a stronger M&E system which tracks, collects and analyses accurate and relevant indicators is very important. Although the intervention’s M&E plan was sufficient, the capturing of the unique number of women who have completed both sessions could have been better - women were registered in a new sheet for every session hence no sufficient tracking for the second session hence it was challenging to determine the actual number of the women who completed both sessions. One had to scan all the names from the register books and count one by one and then group records with the same unique identifier (name).
6.0 Conclusion and Recommendations

6.1 Conclusion
The design and approach of the intervention was found to be good and addressing the objective as per the interviewed key informants. In addition, many of the beneficiaries liked the intervention and demonstrated some positive health behavioural change. Although BPC contribution to antenatal care visits and facility delivery is a small proportion as compared to the health service utilization. However, the key informants mentioned that the project improved some other health facility challenges including poor birth preparation from mothers’ side and inability to retain regular clients.

Most of the pregnant women, health facility teams and MoH representatives were positive about the project and recommended for it to be implemented at large scale to cover a wider coverage, including rural areas and villages, where they believe the need is more even as compared to the big towns. Nonetheless, it is also important to note that there still exist some barriers to health service utilization including lack of transportation to health facilities and some women still trusting traditional birth attendants (TBAs) more than the health providers contributing to some women continuing to give birth at home.

The following key highlights can be drawn from the study:

- 77% of the study respondents reported that they were new users of ANC
- 64% of the study respondents reported that they completed the recommended 4 ANC visits
- Among the study respondents (N= 478), 449 representing 94% of the study participants, reported to have given birth at a health facility. The remaining 6% reported to have delivered at home.
- 65% of the 449 women who reported to have given birth at a health facility said it was their first time to deliver at a health facility.
- The project reached 19,332 pregnant women, which is 86% of the pilot target beneficiaries.
- The programme has increased 10% of facility delivery in implementation locations
- An aggregate of 97% of the study respondents mentioned at least one benefit of facility delivery as discussed in the Birth Preparedness Class.
- 86% of the study participants thought that BPC was useful and like the intervention. They particularly like the elements of birth preparation, nutrition, danger signs of pregnancy, and pain management techniques.
- BPC intervention improved mothers birth preparation and their connection to the health facilities.
- More than 57% of the study participants were illiterate, this shows the intervention reached out to illiterate women and changed their behaviour towards ANC visits and facility delivery.
- More intervention participants attended ANC4 which then led them to deliver at the health facility, good example was that more than 40% in Awdal and Togdher attend more than 4 ANC visits.

6.2 Recommendations
The following recommendations were provided by study participants including health facility team leaders, BPC facilitators, and key informants from the MoHs. Some recommendations were also provided based on the study findings.

- Future continuation of this intervention was recommended with focus villages and rural areas and not only in big cities.
- Hiring a dedicated BPC facilitator was highly recommended
- Increasing the number of BPC session from two to four per week to reach many more pregnant women.
- Many key informants recommended the inclusion of some material handouts to increase participant interests and increase their number.
- Strengthening health system, EPHS, supply-side, and infrastructure to complement the demand creation
- Need to address some of the barriers to service access including those related to transportation to the health facilities particularly for facility delivery.
**Bibliography**


7.0 Annexes

7.1 Detailed Summary of main indicators

<table>
<thead>
<tr>
<th>BPC Data in 2019-2020</th>
<th>BPC data 2019-2020</th>
<th>Consolidated</th>
<th>G. Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Awdal</td>
<td>Togdher</td>
<td>Karkaar</td>
</tr>
</tbody>
</table>

Service utilization

Total Number of pregnant women visited health facility during BPC implementation (ANC)  
20941 | 25105 | 4953 | 21421 | 2680 | 75,100

Promoting BPC class

Number of pregnant women who received BPC class counselling to attend the sessions  
4012 | 6861 | 2693 | 8916 | 728 | 23,210

Number of sessions conducted in these years (2019-2020)  
533 | 574 | 282 | 417 | 72 | 1,878

Target sessions in the years (2019-2020)  
640 | 560 | 312 | 306 | 72 | 1,890

Performance (% of target sessions completed)  
83% | 103% | 90% | 136% | 100% | 99%

Number of pregnant women who attended BPC class sessions  
5231 | 5658 | 2724 | 5064 | 655 | 19,332

Target participants  
7680 | 6720 | 3744 | 3456 | 864 | 22,464

Performance (% coverage of target participants)  
68% | 84% | 73% | 147% | 76% | 86%

Number of pregnant women who attended BPC class sessions from HKH  
1606 | 1703 | 528 | 1001 | 96 | 4,934

proportion of participants received from HkH intervention  
31% | 30% | 19% | 20% | 15% | 26%

Number of pregnant women who attended BPC class sessions who came by their own  
3615 | 4062 | 2196 | 4063 | 28 | 13,964

1st trimester  
567 | 970 | 715 | 808 | 133 | 3,193

2nd trimester  
2000 | 1902 | 654 | 1790 | 205 | 6,551

3rd trimester  
2675 | 2801 | 1355 | 2466 | 317 | 9,614

1st ANC visit  
2131 | 2567 | 969 | 1418 | 269 | 7,354

2nd ANC visit  
1478 | 1419 | 776 | 1576 | 217 | 5,466

3rd ANC visit  
1087 | 988 | 567 | 1125 | 107 | 3,874

4+ ANC visit  
536 | 684 | 412 | 897 | 62 | 2,591

Number of BPC attendants who planned to give birth at health facility  
5214 | 5610 | 2520 | 4902 | 639 | 18,885

Number of BPC attendants who planned to give birth at home  
17 | 43 | 40 | 137 | 16 | 253

Health facility delivery

Number of pregnant women who gave birth at the health facility  
5667 | 4344 | 1557 | 3517 | 282 | 15,367

Number of BPC class participants who gave birth at the health facility  
681 | 1285 | 142 | 1716 | 41 | 3,865

% of facility delivery from BPC class participants.  
12% | 30% | 9% | 49% | 15% | 25%

Follow Ups
<table>
<thead>
<tr>
<th>Participants received follow ups</th>
<th>884</th>
<th>1537</th>
<th>587</th>
<th>9964</th>
<th>623</th>
<th>13,595</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of participants received follow ups</td>
<td>17%</td>
<td>27%</td>
<td>22%</td>
<td>197%</td>
<td>95%</td>
<td>70%</td>
</tr>
</tbody>
</table>
### 7.2 Study questionnaires

#### 7.2.1 Quantitative questionnaire

<table>
<thead>
<tr>
<th>Questions</th>
<th>Options</th>
</tr>
</thead>
</table>
| 1. Region | 1. Awdal  
          | 2. Togdheer  
          | 3. Gedo  |
| 2. District | 1. Borama  
            | 2. Dilla  
            | 3. Burco  
            | 4. Odweyne  
            | 5. Luuq  
            | 6. Dolow  
            | 7. Beletxaawo  |
| 3. Site | (Name) |
| 4. Age | 1. Personal business  
         | 2. Government employee  
         | 3. private business employee  
         | 4. Not employed  
         | 5. Others  |
| 5. Employment Status | Write the income per month in USD |
| 6. Income level | 1. Illiterate  
                   | 2. Can read and write  
                   | 3. Primary school  
                   | 4. Secondary school  
                   | 5. College and above  |
| 7. Respondent level of Education | 1. Number of children Over 5  
                                         | 2. Number of children under 5  
                                         | 3. Number of pregnancies  
                                         | 4. Number of live births  
                                         | 5. Number of deliveries at home  
                                         | 6. Number of deliveries at health facility  
                                         | 7. Number of miscarriages  
                                         | 8. Number of stillbirths  
                                         | 9. Number of ANC visits during last pregnancy?  
                                          | 1. 0  
                                          | 2. 1  
                                          | 3. 2  
                                          | 4. 3  
                                          | 5. 4+  |

### Section 2: Obstetric characteristics

1. Number of children Over 5  
2. Number of children under 5  
3. Number of pregnancies  
4. Number of live births  
5. Number of deliveries at home  
6. Number of deliveries at health facility  
7. Number of miscarriages  
8. Number of stillbirths  
9. Number of ANC visits during last pregnancy?  
10. How did you first find out about BP?  

### Section 3: BPC Session

1. How did you first find out about BP?  
2. Health worker in the health facility
### Section 1: Experience of BPC Session

1. **How many times have you attended BPC session?**
   - a) 1 time
   - b) 2 times
   - c) 3+ times

2. **How did you find BPC sessions?**
   - 1. Useful
   - 2. Not bad
   - 3. Not useful

3. **At what time did you attend BPC session**
   - 1. Morning
   - 2. Afternoon
   - 3. Both
   - 4. Another time (mention)

4. **What is your best time to attend BPC session**
   - 1. Morning
   - 2. Afternoon
   - 3. Both morning and afternoon
   - 4. Another time (specify)

5. **How was the duration of the sessions?**
   - 1. Too long
   - 2. Enough time
   - 3. Too short

6. **What did you like most about BPC?**
   - 1. Pain management techniques
   - 2. Breathing exercise
   - 3. Hinna
   - 4. Birth preparation
   - 5. Nutrition
   - 6. Danger signs of pregnancy
   - 7. Birth spacing
   - 8. Facilitator
   - 9. Others

7. **What did you like least about BPC?**
   - 1. Pain management technique
   - 2. Breathing exercise
   - 3. Hinna
   - 4. Birth preparation
   - 5. Nutrition
   - 6. Danger signs
   - 7. Birth spacing
   - 8. Facilitator
   - 9. Others

### Section 2: Knowledge Test

1. **What are the most important things that you have learnt from the BPC?**
   - 1. Importance of ANC
   - 2. Nutrition during pregnancy
   - 3. In advance birth preparedness

### Section 3: Recommendations

1. **Would you like to participate BPC again in your future pregnancy?**
   - 1. Yes
   - 2. No
   - 3. Don’t know

10. **If no, why?**

11. **Have you recommended other mothers to participate in BPC?**
    - 1. Yes
    - 2. No

---

**Page** 35 | Page
| (Multiple responses are allowed) | 4. Danger signs of pregnancy  
5. Risks of delivering at home  
6. benefits of delivering in facility  
7. Any of the labour pain management techniques  
8. Importance of breast milk  
9. Importance of PNC  
10. Importance of birth spacing  
11. Others |
| 2. Why ANC visits are important? | 1. Early detection and treatment of problems  
2. Prevention of complications using safe, simple, and cost-effective interventions  
3. Preparation for birth  
4. Promotion of health  
5. Others—Specify |
| (Multiple responses are allowed) | 3. How many times are essential to visit health facility during pregnancy?  
1. 0  
2. 1  
3. 2  
4. 3  
5. 4+ |
| 4. How many meals per day are required for pregnant women? | 5. What are the drinks that pregnant women need to avoid that interfere absorption of iron?  
1. Tea  
2. Coffee  
3. Don't know  
4. Others |
| (Multiple responses are allowed) | 6. What are the things that expecting mothers need to prepare when giving birth?  
1. Save money for emergency situations  
2. Arrange transportation to the health facility  
3. Confirm place of delivery  
4. Assign someone to look after home and other children while away  
5. Prepare supplies and equipment  
6. Don’t know  
7. Others—specify |
| (Multiple responses are allowed) | 7. What are the key danger signs of pregnancy that mothers need to immediately go to the nearest health facility?  
1. A bloody, sticky discharge from the vagina.  
2. Painful uterine contractions increasing in duration, frequency, and intensity with the passage of time.  
3. Feeling the baby has dropped lower  
4. Sudden gush of fluid.  
5. Don’t know  
6. Others, specify |
| (Multiple responses are allowed) | 8. What are the benefits of facility delivery?  
1. Sterile equipment’s  
2. Drugs  
3. trained health care professionals  
4. Don’t know  
5. Others specify |
| (Multiple responses are allowed) | 9. Tell us the pain alleviation techniques learned in BPC sessions  
1. Breathing exercise  
2. Focus and distraction  
3. Eat |
4. Drink  
5. Movement and change position  
6. Touch and message  
7. Go to ANC  
8. Don’t know  
9. Others, specify

10. Tell us benefits of colostrum

1. The colostrum milk is thick, yellow, and nutritious for the baby's health and immunity.  
2. It helps to prevent postpartum haemorrhage  
3. Facilitate uterine contraction.  
4. Tend to be very awake and alert which is the ideal time to initiate breastfeeding.  
5. Don’t know  
6. Others

11. How long is recommended to exclusively breastfeed your baby?

1. 6 months  
2. Others  
3. Don’t know

12. How long is it recommended for the mothers to stay in the facility after delivery?

1. At least 24 hours  
2. Don’t know  
3. Others

13. After how long mothers are required to go back to the facility after giving birth?

1. On day 3  
2. Between 1st and 2nd week  
3. Around 6th week  
4. Don’t know  
5. Others

Section 5: ANC Visits

1. Was it your first time to go to an ANC when you went for BPC?

1. Yes  
2. No

2. Would you like to visit for ANC in the future?

1. Yes  
2. No

Section 6: Facility Delivery

1. After attending BPC, where did you deliver your baby?

1. Health facility  
2. Home

2. Was it your first time to deliver at a health facility? (If answered (1.) to Q1)

1. Yes  
2. No

3. Reasons for home deliveries (Ask this question if answered (2.) in Q1)

1. Facility closed  
2. Curfew at night  
3. Facility far away  
4. No transportation  
5. Cannot afford transport  
6. Health care providers are not welcoming us  
7. Trusted TBA  
8. Other reason (__________)

(Multiple responses are allowed)

4. Who assisted you in giving birth at home?

1. TBA  
2. Mother  
3. Others specify

5. How was your experience in giving birth at home?

1. Normal delivery  
2. Prolonged labor
| 6. What do you like about delivering at the health facility? | 3. Bleeding  
4. Others |
|---|---|
| (Multiple responses are allowed) | 1. Skilled midwives  
2. Clean equipment  
3. Drugs to prevent Anemia due to bleeding  
4. Don't like  
96. Others (specify) |
| 7. What do you like the least about delivering health facility? | 1. Unskilled midwives  
2. Unclean equipment  
3. No quality drugs to prevent Anemia due to bleeding  
4. Nothing  
96. Others (specify) |
| (Multiple responses are allowed) | 1. BPC session  
2. HKH  
3. Recommended by my Husband  
4. Recommended by friend  
5. Others |
| 8. What influenced you to decide to give birth at the health facility? | 1. Health center- MCH  
2. Public Hospital  
3. Private health facility (Clinic or hospital)  
4. Any health facility |
| (Multiple responses are allowed) | 1. Yes  
2. No  
3. Undecided |
| 9. Which type of health facility do you prefer giving birth at? | 1. Yes  
2. No |
| 10. Would you give birth at the health facility in the future? | 1. Recommended to others to give birth at the health facility? |
| 11. Would you recommend to others to give birth at the health facility? | |
| Section 7: Suggestion | |
| 1. What is your suggestion on BPC session |
7.2.2 Qualitative guide

Key informant interview guide

A. Facility team leaders
1. Tell us about yourself, your name, role, and how long you have worked in this health facility?
2. What do you know about BPC? Explain?
3. How do you gauge BPC? Has there been any change to ANC and delivery numbers during BPC implementation? How can you attribute these changes to BPC?
4. Do you think that BPC is improving mothers’ behaviour regarding facility delivery? Probe more
5. Do you think that there is a need to change the way that BPC’s sessions are designed? What needs to be changed?
6. Can your health facility continue having BPC with no external support? How?
7. What are the main challenges you have encountered during the BPC implementation? How did you solve it?
8. What are your recommendations in improvement of BPC?
9. What do you think will happen when BPC intervention stops? does it effect on ANC, facility delivery? How? How will you manage it with this intervention?
10. Would you like to continue BPC by your own?

B. BPC Facilitators
1. Tell us about yourself? Your name, role, and how long you have worked in this health facility?
2. Do you think that BPC is improving mothers’ behaviour regarding completing ANC visits? How did it affect? Probe more
3. Do you think that BPC is improving mothers' behaviours regarding facility delivery? Probe more?
4. Do you think that BPC is improving mothers’ knowledge on pregnancy and its associated behavioural changes? Probe more?
5. What do you think about BPC’s timing and session duration?
6. What do you think about BPC curriculum?
7. Do you think that mothers like BPC? What do you think can arouse their interest?
8. What are the main challenges you have encountered during the BPC implementation? How did you solve it?
9. What are your recommendations to the improvement of BPC?
10. are you willing to continue this voluntarily? How? Probe more

C. Program teams
1. What did the BPC program do well?
2. What did the BPC program not do well? Weaknesses?
3. What are the challenges you faced during the program? From. (Facilitator and team leaders, Community/traditionally, any other areas) How did you handle these challenges.
4. How could the program address the identified challenges?
5. What could the program even do better? Any recommendations?