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 Togdheer regions of Somaliland; Karkaar region of Puntland; Galgudud 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 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 of 2019.
- For qualitative part of the study, health facility teams, implementing partner programme teams and MoH representatives were interviewed as key informants.
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.

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.
STUDY LIMITATIONS AND CHALLENGES

» 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. Despite all of these efforts the study could not manage to reach the determined sample size.

» 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, because there were no activities in 2019. However, desk reviews and KIIs from these regions were included in this report.

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

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.

FACILITY DELIVERY

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 just 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.

PROGRAMME 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.

» 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.

» 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.
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:

1. Future continuation of this intervention was recommended with focus of villages and rural areas and not only in big cities.
2. Increasing the number of BPC session from two to four per week to reach many more pregnant women.
3. Strengthening health system, EPHS, supply-side, and infrastructure to complement the demand creation.
4. Hiring dedicated BPC facilitators was highly recommended
5. Many key informants recommended the inclusion of some material handouts to increase participants’ interest and hence increase their number.