Somalia: Cash Transfers via Mobile Money for Maternal Child Health Services

LOCATION	Puntland (Badhan Somaliland, Yubbe)
MODALITY & SRHR OUTCOME	Unconditional cash transfers (UCTs) for maternal and child health (MCH) services and transport
TIMELINE	September – December 2020
TARGET POPULATION	Pregnant women in the last trimester of pregnancy
TRANSFER AMOUNT	Three monthly transfers
	Puntland – 80 USD per month
	Somaliland – 100 USD per month
MONITORING	Three 3 monthly post-distribution monitoring (PDM); pre/post knowledge, attitudes, and practices (KAP) survey; pre-post focus group discussions (FGD)
DELIVERY MECHANISMS	Mobile money
REACH	70 women

Background

This study is part of a larger multi-country study by CARE entitled "Cash and Voucher Assistance for Sexual Reproductive Health and Rights Outcomes: Learnings from Colombia, Ecuador, Lebanon and Somalia."

CARE Somalia has used Cash and Voucher Assistance (CVA) in its programs for over ten years. This includes CVA for food security and livelihoods, nutrition, WASH, and education, as well as multipurpose cash transfers. Since 2018, with support from Office of Foreign Disaster Assistance (OFDA) (now the Bureau for Humanitarian Assistance (BHA)), CARE Somalia has been implementing a food security and Livelihoods, health, nutrition, protection and WASH program. With BHA support, CARE currently supports 19 MCH facilities across Somaliland and Puntland that target children and pregnant and lactating women (PLW).

Program Design

Drawing on its vast experience with CVA in other sectors and with support from the Sall Family Foundation, the CARE Somalia team developed a pilot project with the objectives of improving pregnant women's access to at least three Antenatal care (ANC) visits and to delivery by skilled birth attendants. Target participants were pregnant women in their third trimester. Transfers were intended to cover costs related to safe deliveries and participants received three monthly cash transfers using mobile money through Telesom in Somaliland and Golis in Puntland.

IDENTIFYING NEEDS

The 2020 Somalia Demographic Survey underscored the high maternal mortality rate in the country (692 out of 100,000 live births) and pinpointed the biggest barriers to accessing MCH as: lack of money (65%), distance to health facility (62%), and lack of permission (42%).[1] The survey also found that 79% of births take place at home, 31% of women had received ANC from a skilled health provider prior to their last birth, and 89% of women did not obtain postnatal care within two days of giving birth.[2]

Transportation costs to hospital (roundtrip) and the MCH
Laboratory test in the last trimester
Ultrasounds (2)
Caesarean section delivery and basic emergency obstetric care (EmOC)
Blood transfusion
Allowance for fresh meat, poultry, fish, and vegetables

TABLE 1: MENU OF OPTIONS FOR UTILIZING CVA FOR PREGNANT WOMEN

CARE staff at MCH facilities noticed a drop in the number of pregnant women doing ANC visits the further along they got in their pregnancy. To investigate further, CARE Somalia conducted a baseline MCH survey and Focus Group Discussion (FGD) on health knowledge, attitudes, and practices.[3] The findings revealed that 48% of women preferred giving birth at home due for a number of reasons.[4] In addition, spousal support influenced decision-making; in Yubbe, over 60% of women said their husbands made birth decisions.[5] CARE Somalia designed a pilot project to address some of the financial barriers and support some of the MCH needs with CVA.

Transfer Values and Mechanisms

To ensure that the pilot was market aware, CARE Somalia utilized the **Minimum Economic Recovery Standards** (MERS) benchmarking tool. This provided guidance on what good market programming looks like and what to consider when developing the concept note. With this guidance, a targeted rapid market assessment was conducted in the two locations to determine the cost of ANC services and related costs for safe delivery. From the targeted market assessment, the

1 Government of Somalia and UNFPA. (2020). **The Somali Health and Demographic Survey**.

2 Ibid.

3 CARE Somalia. (2020). Baseline Survey for SRHR-Cash Voucher Assistance.

4 High costs at hospitals, lack of transport, distance to facility, concerns with privacy at the facility, lack of information, concerns with cleanliness and hygiene at the facility, perceived better care from Traditional Birth Attendants (TBAs)

5 Ibid.

transfer values were set at 100 USD and 80 USD for Yubbe and Badhan, respectively. These values were estimated to be the cost of the services not offered at the MCHs that were critical to safe pregnancy and delivery.

Although ANC, postnatal care (PNC), and normal delivery at MCH centers are free, the CVA aimed to cover transportation costs to the MCH centers and to referral hospitals as well as other comprehensive SRH services that are key for safe pregnancy, such as laboratory tests in the last trimester (e.g. syphilis screening, testing for anemia, etc.), ultrasounds, and blood transfusion in case of caesarean section. In addition, the transfer was intended to cover nutritious food, like fresh meat, poultry, fish, and vegetables available in the local market, particularly given the high rates of malnourished pregnant women in Somalia. In addition to the cash transfers, CARE also worked with two referral hospitals to cover costs for ten complicated pregnancies with a cap of 350 USD per participant.

The project adopted CARE Somalia's CVA Standard Operation Procedures (SOPs) guidelines developed the COVID-19 pandemic to ensure the safety and wellbeing of CARE staff, partners and beneficiaries. Adjustments were made for participant selection criteria, transfer value selection, and monitoring.

CARE Somalia selected two health facilities for the intervention, one in Yubbe, Erigavo District, Somaliland and one in Badhan, Badhan District, Puntland. These locations were selected based on the following criteria: highly trafficked CARE-supported MCH facilities, facility proximity to the catchment populations, and ongoing engagement with communities through nutrition programming. Furthermore, there was an interest in comparing peri urban (Badhan) to rural (Yubbe) facilities. The selected facilities also had referral mechanisms for Gender-Based Violence (GBV) survivors to access Clinical Management of Rape (CMR) and other relevant GBV services at hospitals with CARE-supported nurses and protection centers, case managers, and psychosocial counselors with longstanding relationships to the communities. Moreover, CARE has memorandums of understanding (MOUs) with both governments and strong relationships with the communities, including community health committees.

TARGETING PARTICIPANTS

Based on the available budget and the project objectives, 70 pregnant women were targeted (35 per location). Participants were identified using the ANC registers in consultation with healthcare staff and community leaders utilizing predefined selection criteria. As part of the project launch, CARE staff met with community health committees to orient them to the project goals, including offers of services.

Selection criteria focused on women who were:

- In last trimester of pregnancy;
- Considered malnourished;
- From a household where the head of household was unemployed/not working;
- Experiencing high risk pregnancies (geriatric/adolescent pregnancy, previous scarring, pre-eclampsia, diabetes, multiple births);
- Engaged in negative coping mechanisms such as selling firewood/charcoal (either the recipient or members of her household);
- Without any income or asset ownership;
- Recently the recipients of assistance from other sources.

Potential participants did not need to meet all of the selection criteria; women needed only to be pregnant and, preferably, in their last trimester. The other criteria were used for a scoring system; the higher the scores (indicating a greater fit with selection criteria) the higher the chances these women had to be selected as participants.

PROJECT ACTIVITIES

After selecting participants, CARE met with them as a group at each location. CARE had the mobile phone numbers of the women in the registers and the fact that mobile money is used a lot in these project locations made it easier to make the cash transfer. CARE received approval from each participant to receive cash transfers at their phone numbers in order to ensure safety, privacy, and ownership of the phones. The women attended the MCH twice a month where experiences and challenges were shared with other expectant mothers and staff. As part of ongoing programming, CARE-supported MCH centers continued to offer ANC services along with weekly education sessions. Topics for the awareness sessions included nutritious food, exclusive and complementary breastfeeding, the importance of delivery by skilled birth attendants, healthy timing and spacing of pregnancy, Family Planning (FP), and the involvement of husbands in ANC visits and during and after births. In addition to the ongoing engagement by project staff and participants through the MCH visits, an existing hotline for feedback on the project was shared with participants as a feedback mechanism.

The pilot also piggy-backed on the support CARE gives to the ANC mothers through the BHA funding where two midwives are paid incentives to be on-call overnight. This allowed for 24-hour care as typically, MCH facilities are only open during the day.

Outcomes

The first PDM included 70 respondents in-person at the facility or at home for those who had recently delivered. Sixty-nine participants responded to the second PDM and the endline KAP survey. Four FGDs were also conducted with women and adolescent girls. All findings were documented in the endline report.[6]

The monitoring results showed considerable positive changes from baseline to endline in MCH and SRHR attitudes and practices (See Table 4). There was a 48-percentage point increase in facility-based skilled birth attendance and a 38-percentage point increase in the perceived importance of visiting a facility before a birth. Awareness of methods to postpone pregnancy increased by 29-percentage points.

Joint decisions on FP in the household increased between baseline and endline KAP surveys. Men were directly included in the health information sessions, but some attended the with the women at their ANC visits and delivery. Men were, however, engaged during FGDs to inform program design (Figure 1).

KAP respondents (male and female) reported that participants were satisfied with the health system. The men interviewed in the FGD were a mix of project participants' husbands and other community members. They reported a higher willingness to visit a facility for ANC services, a considerable change from baseline.

TABLE 2: ATTITUDINAL AND BEHAVIORAL CHANGES FROM BASELINE TO ENDLINE

	Baseline	Endline
Preference for delivering at a facility	52%	100%
Perceived importance of visiting a facility prior to giving birth	61%	99%
Visits by pregnant women to health facility three or more times before giving birth (previous pregnancy at baseline; recent pregnancy at endline)	76%	82%
Awareness of methods to postpone pregnancy	43%	72%

6 CARE Somalia. (2020). Endline Survey for SRH-Cash Voucher Assistance.

DELIVERIES

Ninety-four percent of participants delivered during the project period. Of those who delivered, 85% delivered at a facility – either the MCH facility or a referral hospital. Ten women who gave birth at night and/or were not able to reach the facility were able to call for in-person skilled birth attendance supported by midwives stationed at the MCH center. These outcomes are encouraging given that at baseline 54% of women in Badhan and 41% in Yubbe reported preferring home delivery.

In both Badhan and Yubbe, compelling stories of women who had never delivered at a facility were reported. One woman who had previously lost six babies during the last trimester and had previously delivered stillborn, was able to safely deliver her first live baby at a referral hospital in Somaliland.

CARE staff reported that the pilot strengthened the referral system and greatly increased women's confidence in contacting midwives and accessing health facilities. In addition, staff reported that the transfer relieved the heavy financial burden on families that had been exacerbated during the outbreak of COVID-19. Staff also reported that women attending the education sessions spoke of sharing information with other women who were not participants.

Facilitating Factors

There were a number of factors that supported such a rapid and effective pilot. The program was integrated into existing nutrition programs run through the facilities

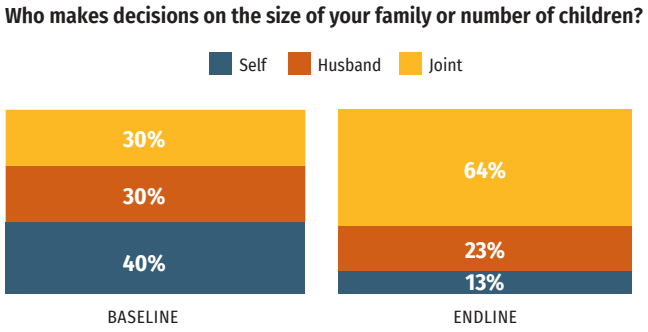

FIGURE 1: DECISION-MAKING RELATED TO FAMILY SIZE

so the trust that had been established with communities and relationships that had been built with women, their husbands, families, and communities. In addition, it was helpful that a very clear need and gap in services and access had been established providing a clear target in terms of financial and transportation hurdles to accessing MCH. This was made even more important after the onset of COVID-19 when families were under even more financial constraints.

In addition, the modality and distribution of monthly mobile money transfers was well established within CARE's programs and infrastructure, but also as a form of receiving money among communities since mobile money transfers are common in Somaliland and Puntland. The delivery mechanism is widely used and accessible for participants to receive and spend the transfers at no cost to themselves.

The pilot also leveraged existing MOUs and relationships with the Ministry of Health, referral hospitals, MCH staff, and community health committees. In addition, it worked with existing contracts for transport and the phone service. In

TABLE 3: LOCATION AND DELIVERY BY SKILLED BIRTH ATTENDANT DURING PROJECT PERIOD (DATA AS OF JANUARY 4, 2021)

	Total Delivered	Basic and/or Comprehensive EmOC at Referral Hospital	Normal Delivery at MCH center	Birth at Home (Supported by Midwives/Skilled Birth Attendants Stationed at MCH Centers 24/7)	Births at Home with TBAs
Badhan, Puntland	32	8	18	6	0
Yubbe, Somaliland	34	4	26	4	0

the facility, the pilot expanded existing health education sessions to include SRHR, worked with facility staff to expand monitoring tools, and worked with midwives to widen their scope of work to be on call at night for deliveries.

Awareness sessions also created space for greater one-on-one engagement between project participants and health providers to build up trust between them, for providers to remind participants about upcoming appointments, and for ongoing feedback on the CVA and any other needs.

Challenges

Challenges were related to the limited amount of time allocated for the design and implementation of the pilot. The PDMs ideally would be conducted one month after the distribution; however, delays in start-up shortened the time between PDMS, resulting in survey fatigue among recipients. In addition, the pilot was conducted in two different government systems, requiring the same approval process in each location and in locations where mobility can be constrained by security concerns. Only 70 women could be enrolled due to funding limitations, despite the high need in the communities. Lastly, particularly in Puntland, the COVID-19 outbreak and related restrictions added difficulties for staff and participants related to mobility and ability to reach facilities or communities.

Lessons Learned

CVA for SRH should be combined with complementary services to address complex issues. The pilot revealed that CVA for SRH when complemented by ongoing community-level engagement and awareness raising is not only feasible but also extremely effective in improving positive health-seeking behaviors for SRH. In just three months, the pilot project in Somalia not only demonstrated increased uptake of the key project objectives (to ensure access to at least three ANC visits and skilled birth attendance), but also highlighted key attitudinal changes related to greater preference for facility-based delivery and the perceived importance of facility-based deliveries.

Despite being unrestricted, the cash transfers motivated the project participants to seek services at the MCH and reduced barriers to access like transport in seeking services, contributing to increased uptake in ANC services and delivery by skilled birth attendants. Ongoing engagement through educational sessions and strong monitoring through the PDM process had several benefits. This process revealed the perceived financial barrier of cost of services like ANC while the educational sessions provided a platform to dispel this misinformation and raise awareness of the availability of free services at the MCH center. Furthermore, ongoing engagement facilitated trust building between participants and health providers, as demonstrated by pregnant women contacting midwives to assist even with home-based deliveries. Qualitative feedback also indicated that the unrestricted nature of the cash transfer supported women in birth preparedness and planning and in purchasing nutritious foods. Overall, this pilot indicates the potential for positive changes related to decision-making and that perceptions of SRHR can be achieved from an integrated program. These findings will need to be supported with further programming and integration of CVA within SRHR programming to sustain the attitudinal and behavioral changes.

Engaging stakeholders and community groups is key. Engagement of other household-level decision makers – including husbands and mothers-in-law – would be helpful given their role in delivery-related decisions. In addition, TBAs should be engaged to support through awareness raising on SRHR topics, addressing perceived and real financial barriers, and providing referrals. Staff also spoke of expanding the targeting to be more inclusive of women who had not yet accessed the MCH facility, including those who are seasonally mobile, who have disabilities, who lack permission to seek facility care, or who have negative perceptions of facility births and SRHR. It is also helpful to work through existing community platforms (like mother-to-mother support groups, female health workers, and other existing programming) for awareness raising on SRHR topics as well as on availability and location of free services. Finally, staff expressed that, although protection was considered in program design, it was not formally assessed, and protection staff should be engaged more to ensure considerations at every stage of the program.

Increasing demand requires simultaneous attention to supply availability and quality. The pilot also highlighted the concern that increasing demand requires simultaneous increases in service provision – through training and/or recruitment of staff and increasing supplies and equipment. Staff voiced concerns that facilities need to ensure they can welcome a growing number of women for deliveries.

Moreover, midwives who were on-call 24/7 for women who went into labor at night relied heavily on their ability to have network connectivity. There were ongoing concerns about the lack of full range of needed services including services for emergency obstetric and newborn care, essential drugs during delivery, FP services (including long-action reversible contraceptives), HIV testing and counselling services and ultrasounds at the MCH.

There are opportunities for growth and expansion of CVA for SRHR programming. Staff also reported a desire to expand the program to cover transport costs for seeking CMR and to complement CVA for SRHR programming with psychosocial support. This desire was based on community's, and especially women's, needs. Additionally, the modality could be considered for FP and postpartum family planning (PPFP) opportunities and health considerations should be expanded for issues like high blood pressure.

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