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CVA CASE STUDY

Vouchers for Fresh Food and Uptake of Sexual and Reproductive Health Services for Pregnant Women: Cox's Bazaar, Bangladesh

SUMMARY OF FIELD LEARNING

UNFPA found that facility-based deliveries by women in refugee camps in Cox's Bazaar were low (35%), which is linked to increased maternal mortality. In addition, undernourishment among pregnant women in this community increased their risk of poor pregnancy outcomes such as obstructed labor and premature and low birth weight newborns. From September 2018 to August 2019, UNFPA provided vouchers to encourage antenatal care visits and facility-based deliveries. Participatory assessments and feedback mechanisms, financial risk mitigation such as the use of QR codes for voucher tracking, and ongoing outreach by community health workers contributed to the success of the voucher assistance as part of a broader humanitarian sexual and reproductive health and rights (SRHR) programme.

- Baseline: **35% facility-based deliveries**. Low facility-based deliveries (35%) in the Rohingya community and increased maternal mortality.
- **Food supplement vouchers** were introduced to increase the utilisation of SRHR services and to encourage pregnant women to deliver in the health facilities.
- Eligible women received a **BDT 1400 (US$16) voucher** conditional upon their completion of two antenatal care visits in the third trimester and delivery in a designated health facility. The voucher could be exchanged for fruits and vegetables in 19 local shops.
- A total of **12,005 pregnant women** received vouchers that they used to purchase nutritious food items for their household.
- Results: **47% increase in antenatal care** uptake in the third trimester and a **14% increase in facility-based delivery**, compared to the proportion of women using these services prior to the introduction of CVA in the programme. The relatively small increase in facility-based deliveries is thought to be due to the strong social norms among participant communities around delivering at home and highlights the need for a longer-term strategy to build trust in health facilities.
- **40% of women** used their vouchers to purchase fruit and vegetables, and other necessary items.

HUMANITARIAN CONTEXT IN COX'S BAZAAR

In August 2017, conflict between state and armed non-state actors forced hundreds of thousands of people from the Rohingya community to seek refuge in and around the city of Cox's Bazaar, Bangladesh. More than 700,000 people crossed the border from Myanmar, half of whom were women and girls. This influx in 2017 exacerbated a protracted refugee situation that had existed for decades. Supported by various donors, UNFPA Bangladesh has been successfully implementing sexual and reproductive health and rights (SRHR) programming with women in refugee camps and in host villages since the onset of the emergency.

According to a health sector report prior to the CVA intervention, only 35%[1] of deliveries by refugee women were conducted in health facilities in the refugee camps. Traditionally, Rohingya women prefer to deliver at home assisted by a family member and/or traditional birth attendant. According to UNFPA's field observations, there were a number of undernourished pregnant women in the community, with increased risk of poor pregnancy outcomes including obstructed labour and premature and low birthweight newborns.

UNFPA Bangladesh has been successfully implementing sexual and reproductive health and rights (SRHR) programming with Rohingya women in refugee camps and in host villages.

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1 ISCG Situation Report: Rohingya Refugee Crisis, Cox's Bazar, 29 November 2018 and Health Sector Bulletin No. 10: Rohingya Crisis in Cox's Bazar, Bangladesh, July 2019.

Voucher Pilot

UNFPA introduced a voucher for food supplements for pregnant women. The voucher was conditional in order to incentivize pregnant women to access local health facilities and ensure a diverse diet. The women had to attend antenatal care visits in their final trimester to receive the voucher. The use of cash vouchers allowed women to choose what to purchase from local shops, as opposed to receiving a food kit. This pilot used QR-coded vouchers that could be printed or presented on a smartphone.

UNFPA introduced a voucher for food supplements for pregnant women that was conditional on the women attending antenatal care visits.

The voucher assistance was part of a comprehensive sexual and reproductive health (SRH) programme that included outreach by community health workers, who provided information and guidance on nutrition, family planning and other topics to intended recipients. UNFPA and its partners noted that financial barriers did not constitute the main obstacle to facility-based delivery, as services were mostly free of direct charges. Rather, in refugee communities, women were unaccustomed to facility-based delivery and preferred home-based delivery. Although Bangladesh has a relatively high (50%) home-based delivery rate, there are ongoing efforts by the government to encourage facility-based deliveries. Based on evidence from development settings, UNFPA hypothesized that the intervention would serve as an introduction to facility-based deliveries, breaking down taboos and increasing women's familiarity with health facilities, encouraging future uptake beyond the duration of the CVA programme.

Community health workers provided information and guidance on nutrition, family planning, and other topics to voucher recipients.

Given home-based deliveries are traditional in Bangladesh, UNFPA hypothesized that the intervention would serve as an introduction to facility-based deliveries, encouraging future uptake beyond the duration of the CVA programme.

UNFPA coordinated with other actors in the SRH Working Group to enable access to a range of the approximately 20 health facilities, including non-UNFPA supported facilities, in the Cox's Bazaar area. UNFPA called for an invitation to see who wanted to be part of the voucher scheme.

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PROGRAMME DESIGN

Assessments

In order to identify risks and pinpoint relevant shops where women could make their preferred purchases, UNFPA's implementing partner conducted interviews with 382 pregnant women. During the interviews, women were asked about their detailed food needs and their safety and security concerns.

UNFPA conducted a rapid needs and market analysis using a free open-source field data collection toolkit on tablets and smartphones. Shops were selected based on proximity to women's homes to reduce travel time and related road security risks as well as the opportunity cost of women's participation. The team asked women what they would prefer to buy in terms of fresh food items. Staff then prioritised the top ten items and went to shops to check on supply and agree on prices for key items. It was found that women were eager to access fresh food such as vegetables, fruits, fishes and meats during their pregnancy, particularly in the displacement camps where their food rations only included dry foods. UNFPA's implementing partner then worked with the participating shops to ensure that particular items were consistently in stock during the duration of the programme.

Risk Analysis

UNFPA's implementing partners conducted interviews with 382 pregnant women and older girls across 19 health facilities in both refugee camps and host communities[2] concerning their safety and security concerns. These discussions led to the selection of shops in close proximity to the women's homes.

The table below summarizes identified risks. The risk of harassment and insecure feelings when travelling outside of their community were identified as the top concerns in both communities. When women travelled outside their communities, they preferred doing so as part of a group instead of individually.

The risk of harassment and insecure feelings when travelling outside of their community were recipients' top concerns about participating in the CVA intervention.

2 Respondents profile: 18% under the age of 19 and 82% age 19 and above. The minimum number of respondents required for the assessment was 269 women from 19 facilities selected for this program. This number fulfilled the requirement to have a 90% confidence interval with a 10% margin of error out of the total of 6,231 targeted beneficiaries.

Women's most significant safety and security concerns in refugee and host communities with respect to voucher assistance are highlighted below:

Most significant safety and security concerns	Women in refugee communities	Women in host communities	Percentage of responses
Harassment when traveling outside their community	23	49	26%
Violence in the home	15	15	8%
Sexual violence and abuse	13	21	11%
Unable to access services and resources	10	39	21%
No safe place in the community	9	42	22%
Trafficking	9	7	4%
Being asked to marry by their families	7	16	8%

UNFPA and its partners put in place mitigation measures for these risks, including: 1) Using a value voucher to provide women with choice in the selected shops; 2) Using a voucher requiring on-site verification at the point of expenditure to mitigate the risk of fraud; 3) Permitting recipients to designate a family member to use the voucher in case the female recipient felt unsafe to go there herself; and 4) Ensuring a selection of shops in each camp area to minimize the travelling time required for voucher use.

Eligibility Criteria and Targeting

UNFPA designed the pilot programme with a balanced target of 50% women living in refugee camps and 50% women living in host communities in order to prevent community tension. Pregnant women were identified by the community health workers in sites where UNFPA was already working with local health facilities.

The pilot programme targeted 50% women living in refugee camps and 50% women living in host communities.

Partnering with local Community Health Workers (CHWs) was essential to designing the CVA pilot in a participatory manner, and in ensuring that women understood and could ask questions about details such as the conditionality based on antenatal visits. CHWs acted as the bridge between women in the communities and the health facilities, approaching women directly rather than using large-scale announcements. They spoke to women about the benefits of contacting midwives

and doctors. Many of the refugee women in the programme had not previously had access to healthcare facilities in Myanmar and were unsure of their functions. The collaboration with the CHWs allowed for women to comfortably experience the process and become informed. For future implementation, UNFPA may consider small cash-based incentives to these CHWs to incentivize their outreach and engagement of women in the programme.

Partnering with community health workers was vital to the success of the CVA intervention.

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Modality and Delivery Mechanisms

Vouchers were provided in the monthly amount of BDT 1400 or approximately USD $16 to each woman who fulfilled the criteria. The vouchers included a QR code to safely store recipients' information on the voucher, which could then be retrieved easily at the redemption point in shops to compare with their physical ID. QR codes could be scanned using a mobile phone. At the time of this programme's implementation, local authorities in Cox's Bazaar had expressed concern that previous humanitarian cash assistance by a number of agencies had contributed to community tension due to lack of understanding of the targeting criteria, frustration over exclusion, and large-scale distributions. This was one of the reasons why UNFPA decided to use a voucher modality for the pilot programme, hoping to help gradually build back their trust for CVA. In addition, evidence from development settings showed the potential benefits of conditional vouchers for health-seeking behavior. However, vouchers could be "cashed out" at participating stores for up to 5% of

Monthly vouchers worth BDT 1400 (approximately USD $16) were provided to participating pregnant women using both mobile and printed paper QR codes.

their value to cover transportation cost from and to recipients' camps or villages. This provided more flexibility and choice than a traditional value voucher which could not be cashed out.

UNFPA wanted to ensure that women in both refugee camps and host communities would receive voucher assistance. An existing electronic voucher assistance system had been set up by another UN agency, but it could not guarantee widespread coverage in the refugee camps nor coverage within the host population. Thus, given the short timeframe of this humanitarian programme, UNFPA set up its own voucher system for camps and villages.

UNFPA's implementing partner delivered the vouchers to women at the health facilities in the camps as well as villages. Refugees in the camps were not permitted by the government to hold mobile phones. Printed QR-coded vouchers were thus prioritized over mobile vouchers. QR codes stored recipients' information on the voucher, which could then be retrieved at the shop to compare with their physical ID. The QR code allowed all recipient information to be collected in one quick scan using a mobile phone, and this could be done offline.

Due to time constraints and the other limitations mentioned above, it was faster to set up a temporary delivery mechanism directly through UNFPA's implementing partner. In the future, inter-agency collaboration will be prioritised, and if possible a single-payment platform service that allows "top-ups" from multiple agencies should be considered.

Contracts were drawn up with shops in Cox's Bazaar city for host communities, and with vendors in the camps for refugee communities. UNFPA pre-selected 19 local shops that would provide resources to women throughout the programme. Each shop was provided with a QR code reader and application for mobile phone data collection, which they were trained to use. Implementing partner staff were asked to be on-site during cash-out days in order to ensure the safety of recipients and to respond to any questions from shopkeepers using the system.

There were multiple factors to consider when selecting the shops that would be used for the programme. Most of the criteria revolved around payment logistics and location. Some of the criteria included:

- Location within a one-kilometer radius of health facilities where the woman was registered. This was based on the safety and/or security concerns of women interviewed during the Pre-Project Assessment.
- The shop needed to have a bank account or another type of transferable account.
- The shop had to agree to allow recipients to exchange their value voucher against shop items, as well as allow for the possible cash-out of maximum 5% of the total voucher value for coverage of transportation costs.

MONITORING AND LEARNING

UNFPA's implementing partner conducted daily exit interviews with a 10% sample of recipients over the course of the programme. The purpose of daily exit interviews was to monitor the availability and affordability of items in the shops. Overall, the findings demonstrated that recipients were satisfied with the items they could purchase. Highlights included:

- **100% of respondents** said that the quality of the products was good and the price was either "normal" or "cheap."
- **Over 99%** of recipients in both communities agreed that the food supplemental voucher encouraged them to use antenatal care and opt for facility-based delivery.
- **93% of women** stated that they felt safe receiving food supplement vouchers.
- **79% of women in refugee communities** and **83% of women in host communities** preferred receiving vouchers over cash because they could ensure that the funds were used for their personal needs.
- **Only 7%** answered that they felt jealousy from other community members or felt unsafe due to the long queuing, location of shops, attitudes of the shop owner, or being forced to sell the procured items by their family members.

Over 99% of surveyed recipients agreed that the food supplemental voucher encouraged them to use antenatal care and opt for facility-based delivery.

In the third quarter of the programme, UNFPA interviewed a sample of recipients using a questionnaire to monitor process indicators. The questionnaire was administered to 5% of recipients. Findings confirmed that the average age of the recipients was 20 to 35 years old. Questions also focused on the voucher reception and redemption process. Findings were overall positive and did not prompt the need for significant adjustments.

The Post-Distribution Monitoring (PDM) interviews served three main purposes:

1. To determine if the vouchers contributed to the intended results of increased antenatal care uptake and purchase of fresh food;
2. To evaluate the efficiency of the CVA programme; and
3. To understand the recipients' perceptions regarding the entire process related to CVA.

The PDM explored recipients' safety and satisfaction throughout the CVA process. Findings indicated that the vast majority of women felt safe throughout the duration of the programme. 100% of respondents reported that they did not face any problems receiving the cash distribution and did not face any harassment. Additionally, 99% of the recipients reported that they did not perceive jealousy from their community members for receiving CVA. 98% of recipients stated that they experienced no conflict at home because of the programme. Finally, 70% of recipients were aware of the complaint mechanism that they could use during the programme. Overall, the positive PDM findings demonstrate that participatory planning helped to mitigate potential risks for women at home and in the community.

100% of surveyed beneficiaries reported that they did not face any problems receiving the cash distribution and did not face any harassment.

Use of the Vouchers

Results indicated that participants in the programme put around 55% of the value of the voucher that they received towards food, and the rest of the value towards other basic needs items. Of the food that participants bought with the voucher, 93% of recipients purchased fruit, 84% purchased vegetables, and 83% purchased eggs. Other common food items were rice, pulses, fish, meat, and milk. Out of the 8% of recipients who chose to "cash out" the small portion of their voucher at the shop, 20% went towards savings, 19% towards health treatment, 6% towards other miscellaneous expenses and the rest towards transportation.

SRH Outcomes

- **47%** antenatal care (ANC) uptake in third trimester
- **14%** increase in facility-based delivery compared to the average prior to the introduction of CVA
- **40%** **of women used their voucher to purchase fruit and vegetables, while** others **prioritized other** food and basic needs items.

In addition to analyzing the use of CVA and the recipients' experience during the SRH programme, the PDM also analyzed where participants chose to give birth during the program. Of the women who responded, 47% were still pregnant at the time of the questionnaire and 53% had already given birth. Of the women who gave birth, 56% delivered in a static healthcare facility (as compared to 35% before the intervention) while 44% gave birth at home. This represented a 47% increase in the uptake of antenatal care and a 14% increase in facility-based deliveries relative to the baseline measures taken immediately prior to the CVA programme's implementation. The relatively small increase in facility-based deliveries is thought to be due to the strong social norms among participant communities around delivering at home, and requires a longer-term strategy to build trust in health facilities that cannot be accomplished during a short-term emergency intervention.

The relatively small increase in facility-based deliveries is thought to be due to the strong social norms among participant communities around delivering at home.

CHALLENGES AND LESSONS LEARNED

Participation of Women – Recipients and Staff

- More than 60 staff were involved in technical support, monitoring and consulting with recipients. They were posted to each health facility and to the shops where women or their family members purchased food. Due to local social and gender norms that discourage women's work outside the home, as well as the rapid project setup time frame, the majority of staff were men, meaning that potentially meaningful consultations with women participating in the programme may have been lost. With more time for planning, and with regards to future programming, efforts will be made to ensure that the majority of programme staff are women in order to facilitate more comfort and communication with recipients.
- Some recipients did not feel comfortable travelling to shops as they were located far away with poor road conditions. Thus, approximately 26% of refugee women and 16% of host community women asked their husband or a relative to spend their voucher on their behalf, which raises questions about joint decision-making and whether women were able to fully decide on which items to purchase with their vouchers. In future CVA programmes this area of concern will be further assessed and explored during the response analysis phase and through qualitative post-distribution monitoring. In future consultations with women and girls, UNFPA will further probe how safe they feel in the shops as well as during the trip to and from the shops.
- In the future, consultations with women through focus group discussions, women's spaces and community health workers will inform the theory of change for the CVA programme, as the existing evidence on incentives to increase health-seeking behavior comes mainly from development settings.

CVA as a Complement to SRHR Awareness-Raising and Support

- Further campaigns and awareness-raising will be conducted on the importance of antenatal care, and safe delivery campaigns will be conducted in health facilities during the time of the voucher assistance programme implementation.
- UNFPA noted that having regular group sessions and consultations with women could promote the continued use of healthcare facilities after the CVA services ended.

Further campaigns and awareness-raising will be conducted on the importance of antenatal care and to encourage facility-based deliveries.

Delivery Mechanism

- During the programme, UNFPA encountered 214 cases of fraud where women attempted to receive vouchers at two different health facilities (primary and referral level facilities), or twice in the same month for an antenatal consultation to access multiple vouchers. QR codes helped to identify the recipient and ensure they only received one voucher per scheduled antenatal consultation. UNFPA also established specific "voucher redemption" times when women could access the shops, trying to match these with health facility visits, with those vouchers to limit attempts to use a copy. The voucher use period was part of the information stored in the QR code on the vouchers, which allowed programme staff to identify similar IDs during registration, mark the double registrant and inform implementing partner staff at the redemption point.
- In the beginning of the intervention, recipient ID number was not included in the QR code, considering that ID number might be sensitive for the refugee to provide. After several cases of double registration, the recipient ID number was added as an additional triangulation point of information. For future implementation, fingerprints can be used as recipient ID to minimize the chance for double-counting and double-registration.
- Future iterations of the program will also ensure that no personal data is held by shopkeepers.

Coverage and Coordination

- UNFPA was able to cover only a small percentage of women from both refugee and host communities with this pilot programme. In the future, UNFPA hopes to set up a single-payment platform and prioritize inter-agency collaboration to save time and expand services to a wider group of women in both communities.
- Another existing UN e-voucher system could not be used due to the urgency of the project and the need for expanded coverage. UNFPA will consider this option in the future, and will work with other agencies to determine the feasibility of piggybacking on the existing system to allow for an expanded group of recipients.

Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled

Authors
UNFPA Bangladesh and
UNFPA Humanitarian Office, Geneva

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✉ ho-cva@unfpa.org

bangladesh.unfpa.org
www.unfpa.org
twitter.com/unfpa