MNCH2
Empowering Communities
Strengthening Health Systems
Saving Lives

LEARNING BRIEF

The Maternal, Newborn and Child Health Programme in Northern Nigeria (MNCH2) is a UK government-funded five-year programme designed to strengthen health systems and improve maternal and child health outcomes in six states: Jigawa, Kaduna, Kano, Katsina, Yobe and Zamfara. The series of learning briefs looks at the lessons from working towards a stronger health system and more empowered communities.

Everyone counts: improving accountability for health

With a maternal death taking place every ten minutes and 528 newborns dying every day, Nigeria (particularly the North) has some of the poorest reproductive, maternal, child and newborn health (RMNCH) outcomes in the world. Inadequate healthcare funding coupled with weak health systems and sub-optimal translation of laws, policies and strategies into practice retards progress. Unpredictable and unsustainable healthcare financing increases households' out-of-pocket expenditure leading to a cycle of poverty.

FHC, Jigawa, show tree saplings donated through collaboration with Ministry of Agriculture to improve shade at facility

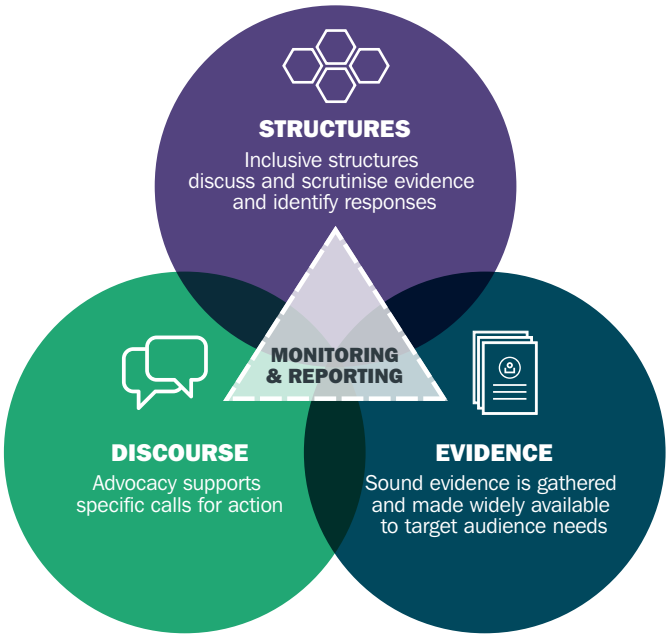
GLOBAL AND NATIONAL PRESSURE TO IMPROVE ACCOUNTABILITY

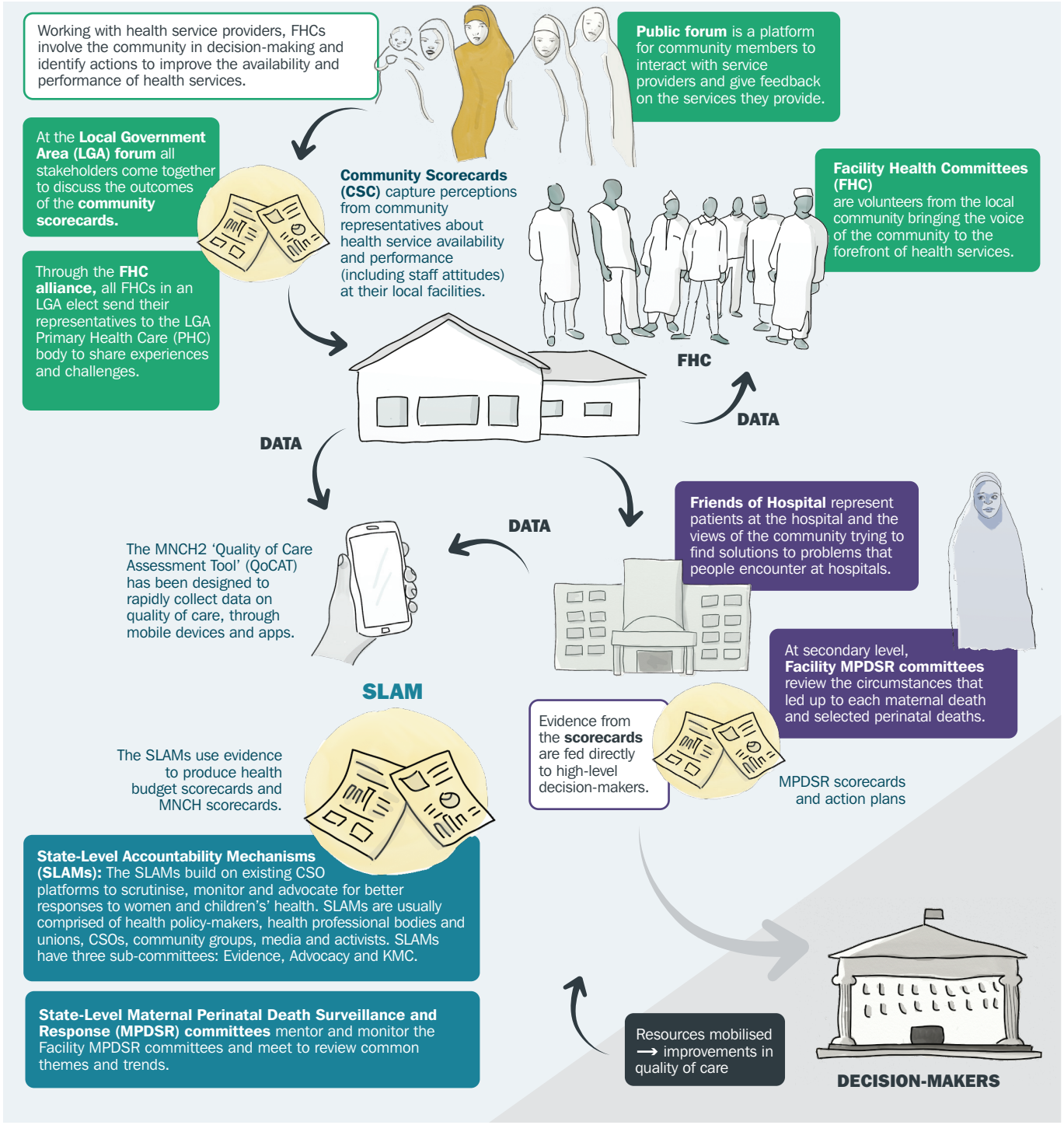
Against the grim outlook, the Nigerian government has prioritised maternal and child health. It has increased the health budget and developed new strategies and policies, such as the Integrated Maternal, Newborn, and Child Health strategy and the Saving One Million Lives initiative. At the same time, the development and implementation of accountability frameworks at the global level have further catalysed momentum for new national, state, and community level efforts. The Country Accountability Frameworks (CAFs) as well as stronger independent efforts by civil society in Nigeria have led to increased dialogue between state actors, healthcare providers, and citizens.

However, despite the national initiatives, in a highly devolved governance structure the geographical disparities in health outcomes cannot be addressed without a focused action at the state and community levels.

MNCH2 APPROACH TO IMPROVING ACCOUNTABILITY IN COMMUNITIES AND STATES

The MNCH2 approach to improving accountability involves three inter-linked components: structures, evidence, and discourse. Structures refer to organisational arrangements and clear roles for their members in a way that promotes accountability in a complex system. The work is guided by a wide array of quality information that is used for advocacy and agenda-setting (discourse). Monitoring and reporting underpins the interplay between the three elements. For a truly accountable system, the three components must be present at all levels of the system.





Box 1 | CASE STUDY: FHC's resolve to improve patient experience

The Primary Health Centre Unguwar Rimi in Kaduna North lies just next to an open mosque. The centre become a hang-out place for some young men who engaged in all type of antisocial behaviour. Efforts to tackle the behaviour were futile – even a court order didn't make a difference. Visitors to the facility – most of whom were women and children – were scared. The leaking overhead tank only added to their discomfort. Some of the women stopped visiting the facility completely.

The facility lacked resources and had already lost support from the local community. The Facility Health Committee (FHC) decided to tap into the Central Bank of Nigeria (CBN) Corporate Social Responsibility programme. With funding, they built a fence to increase security and reported the antisocial behaviour to the Local Government Department of State Services office. Plain clothed security officers were deployed and this finally scared away the offenders.

The CBN decided to add a borehole to the project. The tank was fixed for 15,000 naira. The community also wanted a maternity ward. Without enough funds, the FHC managed to negotiate to pay the balance with the proceeds from the sale of wood.

Working as a team, the FHC overcame various obstacles to improving the facility. The determination of the members in ensuring that the project was completed demonstrates that the community took ownership for its health facility. Their efforts have paid off in increased attendance.

SUSTAINABLE STRUCTURES

Voluntary FHCs are making significant improvements to quality and access to care

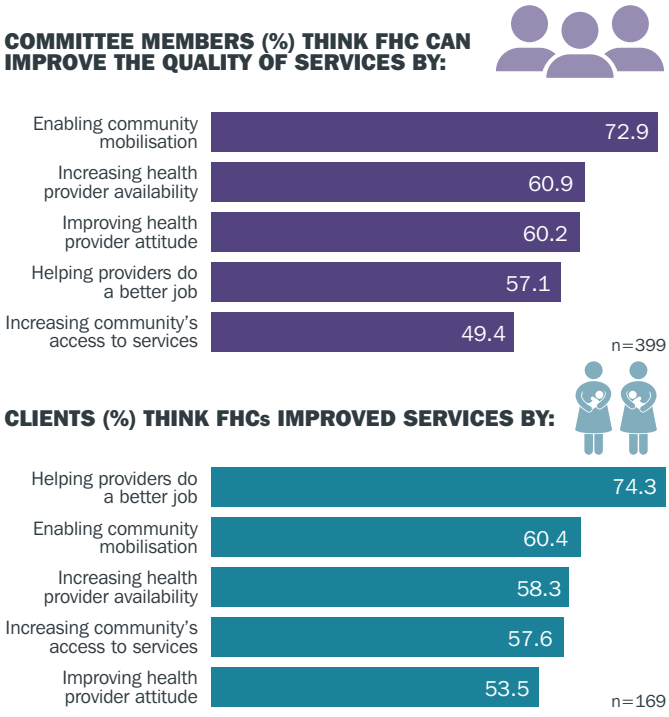
The Facility Health Committee (FHC) is a core MNCH2 intervention. The programme has established and supported 817 committees across the six states. As gatekeepers to community, the FHCs are an essential platform for improving quality of care and accountability.

As FHCs are voluntary, they do not need direct funding to be sustainable.

FHCs use evidence to promote improvements in quality of care through change and ensure that the community has a platform that allows people to express their needs to their local facility. Typical issues include concerns about staff availability and attitudes; infrastructure and environment; and communication with the community. FHC members are also part of the MNCH2 demand-side groups and have proven to be effective in encouraging community members to use facility services when the quality of care has improved *(see Box 1)*. The committees have been proactive in promoting family planning. Future programmes could tap into this by integrating Healthy Timing and Spacing of Pregnancy (HTSP) in the FHC member training to encourage uptake of services.

Efforts are currently underway to promote drug monitoring through the FHCs as a mechanism to encourage more secure supplies. For example, the Kano State Government is working with FHCs to improve the monitoring of its relatively advanced Drug Revolving Fund scheme, which has the potential to be replicated in other states.

Our assessments show that communities appreciate the value of FHCs in improving the quality of their facilities. The strength of community identity and social capital in northern Nigeria gives FHCs a strong foundation in terms of sustainability, which can be more challenging with less closely-knit structures at the state level.



Source: Oguntunde et al.BMC Health Services Research (2018) 18:104

State level mechanisms need realistic advocacy goals

State-Level Accountability Mechanisms (SLAMs) bring together the government, CSOs and the media at the level of the state. The collaboration between the different actors has had a number of benefits, including:

- Joint understanding of health issues among all stakeholders.
- Evidence-informed advocacy.
- Stronger relationships between CSOs and the media to amplify advocacy.
- Better cooperation between the government, civil society and facility health committees.

Advocacy planning can be difficult as it often comes with long-term and challenging goals such as universal health coverage. If a committee lacks strategic focus, progress will be slow. By uniting members from within and beyond the health sector through a shared and realistic goal amplifies the committee's voice and increases pressure on state governments. These long-lasting coalitions will continue to monitor efforts and progress to health commitments long after MNCH2 has ended.

EXPANDING EVIDENCE AND DISCOURSE

Advocates often find a lack of reliable and up-to-date data on maternal mortality and morbidity. Maternal deaths are not routinely recorded, particularly outside the facility settings. Estimates produced by international bodies come with wide error margins and are viewed with suspicion by local officials. CSOs face difficulties in accessing important documents and may not have the skills to analyse the data. Hence, in addition to improving the health management information system, MNCH2 has been strengthening the use of triangulated, high-quality data for evidence-based decision making and to improve accountability.

Listening to the community

The Community Scorecard (CSC) assessments are conducted twice a year and capture evidence from communities and health workers about their perceptions of health services at local facilities. The FHCs have been integral in acting on findings from the score cards and in developing and implementing responsive action plans.

The CSC is currently the only data source for capturing how people in the community feel about health services – essential for informing RMNCH interventions. The assessment does, however, require investment of time and resource to gather, analyse and interpret findings to sustain.

More discourse on quality of care at state level

The Quality of Care Assessment Tool (QoCAT) provides a information to guide resource-allocation all 945 MNCH2-supported facilities across the six states. Biannual data collection uses mobile technology, evidence is collected biannually and offers an overview of the quality of care at health facilities. This enables a real-time snapshot of issues that affect quality of care, such as delays in referrals. QoCAT is an invaluable advocacy tool, particularly at the National Primary Health Care Development Agency level, where there is stronger capacity to use and disseminate the evidence generated from the QoCAT assessment. There is potential for the QoCAT to be used more widely, for example, at the State Ministry level to address fragmentation between primary and secondary levels. To do this, we are working with Departments of Research and Statistics as well as SLAMS in all states to strengthen active dissemination planning.

Action and resources for maternal death review

The Maternal and Perinatal Death Surveillance and Response (MPDSR) committees are functioning as effective accountability platforms producing quality evidence about maternal mortality. MNCH2 has established and strengthened MPDSR committees in 121 secondary health facilities and six state-level MPDSR committees. Findings and recommendations from the reviews are shared with high-level decision-makers, which has resulted in many policy level changes, such as new blood banks.

While the use of data is becoming the norm in health sector planning, it is equally important that there are strong, feasible action plans.

The programme continues to strengthen MPDSR committees through training and mentoring. This is institutionalised through the National MPDSR Training of Trainers model where the programme collaborates with the Society of Gynaecology and Obstetrics of Nigeria (SOGON).

The training of the trainers in collaboration with SOGON helps institutionalise capacity building of the MPDSR committees.

As a result of our support, 94% of all maternal deaths are reported and investigated, yielding evidence to inform recommendations to prevent further deaths and improve quality of care. Supporting the committees is not enough to ensure sustainability, however, and MNCH2 is working with the MPDSR committees and through the SLAMs to ensure long-lasting change. A key challenge is that states have not budgeted for the implementation of MPDSR action plans. MNCH2 has focused on building the capacity of the SLAMs in resource mobilisation and advocacy for budget releases. Continued involvement of government officials in the exercise is necessary to promote ownership.

FHC, Jigawa, presenting borehole with pump constructed through their resource-mobilisation efforts

RECOMMENDATIONS

Build the legitimacy of FHCs to demand better quality of care

Programmes need to support FHC participation in health governance and planning. This includes working directly with health departments to ensure the role and function of FHCs is well understood and integrated, and that FHCs are included in planning processes. We are now recognising the role of the FHC in demand-creation in targeting training on and other demand-side activities.

Improve SLAMs' effectiveness through media

SLAMs are effective in influencing decision-making in state planning processes. MNCH2 has been effective in strengthening their capacity in analysis and dissemination. We are increasingly involving the media as stakeholders in advocacy action planning and budget tracking and strengthening the knowledge management sub-committee. Investigative reporting on health issues will increase public awareness of the urgency to address maternal, newborn and child morbidity and mortality, which will carry weight in government advocacy, particularly during election periods.

Training SLAMs on independent resource mobilisation is to ensure the implementation of action plans will be sustained.

From evidence to coordinated action

Our tools and assessments are carefully designed to include community and other stakeholder views. For these to be useful, it is important to strengthen the quality of the relevant action plans. The programme will continue mentoring the MPDSR committees, for example, through review and feedback to ensure that MPDSR action planning is 'SMART', specific, measurable, actionable, time-bound and timely. We are also strengthening links between the MPDSR committees, SLAMs and other health planning forums in action planning and resource mobilisation to ensure that states are budgeting for the plans.

CONCLUSION

The MNCH2 approach to improve accountability at all levels through structures, evidence and discourse is valued and there is demonstrable commitment from the government to continue using the tools beyond the end of the programme. Their sustainability cannot rely solely on the institutions they are designed to hold accountable, however, and the programme is focussing its support on weaving these tools into existing community structures (e.g. FHCs) or facilitating institutional collaboration (e.g. SOGON) support to MPDSR. An indicator of success is therefore to have each structure with strong capacity to use evidence and discourse for independent resource mobilisation to continue action planning, implementation and follow-up.

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