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.

Improving Demand for MNCH Services in Northern Nigeria: Engaging with Tradition and Culture

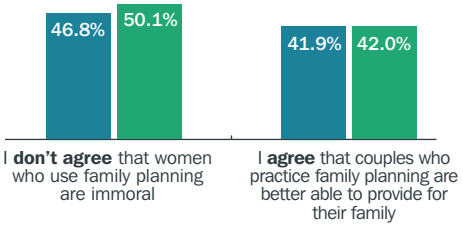
Despite years of investments in maternal, newborn and child health (MNCH), the demand for and use of women's health services in northern Nigeria has been consistently low. Health indicators in the region are among the poorest in the world. The five-year UK-government funded Maternal, Newborn and Child Health Programme in northern Nigeria (MNCH2) has seen some remarkable progress in the number of women, newborns and children accessing and receiving good quality health care. This learning brief looks at the role of traditional actors have played in improving MNCH outcomes.

BACKGROUND

Low cost, high impact health interventions, such as family planning services, or 'healthy timing and spacing of pregnancy' (HTSP), antenatal care and health facility delivery don't just improve health outcomes but contributes to overall social development. For instance, HTSP is central to women's empowerment, poverty reduction and to achieving sustainable development goals. In many parts of northern Nigeria, sociocultural factors significantly influence the uptake of MNCH services. Decisions around a woman's reproductive choices are often left to "God's will", which also influences contraceptive use[1]. Similarly, many women prefer to deliver at home because it gives them a sense of fulfilment and is seen as 'stoic' among their peers and relatives. Health facility delivery is perceived as the first choice only in an emergency.

This is compounded by supply side challenges: the lack of female service providers, for example, acts as a barrier where women and their families are uncomfortable with the idea of being attended by male healthcare workers.

PERCEPTIONS ABOUT CONTRACEPTION IN KADUNA AND KATSINA STATES:



Bashari Galadima (the second man on the left) is a community leader and a health ambassador in Gidan Dugus, Jigawa. Before carrying out naming ceremonies, he ensures that the babies' vaccination records.

[1] Sinai, I., Nyenwa, J., Oguntunde, O. 'Programmatic implications of unmet need for contraception among men and young married women in northern Nigeria' Open Access Journal of Contraception, 2018:9 81–90.

FROM A BARRIER TO A CATALYST

In northern Nigeria, traditional leaders are the custodians of tradition and culture. As informal gatekeepers, they shape public opinion and exert considerable influence on their community members.

The role of the traditional birth attendant (TBA) has also remained strong in the community, especially in the most rural areas. The majority of deliveries outside of the health facility in Nigeria were attended by TBAs (NDHS 2013).

The patriarchal nature of the society means that men hold influence at the household and community levels. Men control women's reproductive choices and access to education and healthcare. Women often need to seek their husband's permission to utilise services at a health facility for themselves and their children.

Despite the enormous potential in working with traditional and cultural spheres of influence to change health behavior, interventions have been largely vertical and uncoordinated. To reach communities, MNCH2 took a holistic socioecological approach. The approach integrated traditional institutions and interpersonal relationships to create culturally sensitive interventions along its supply side work.

Our three-pronged strategy involves establishing linkages between traditional leaders, traditional birth attendants and men as heads of households as catalysts for change. These three community gatekeeper groups work together to influence individuals and families at the community level towards a common goal of improving MNCH.

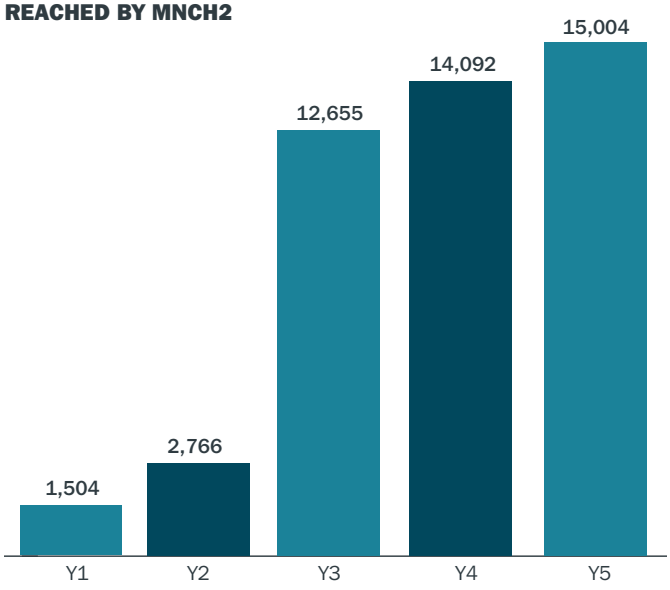
Traditional Leaders as change agents

Perhaps nowhere has the partnership with traditional leaders proven more fruitful in northern Nigeria than in the drive for the acceptance of polio immunisation. Following success, development programmes have continued to engage with traditional structures to achieve similar objectives in health and other sectors. These efforts have improved the uptake of health services, recognition of women's and girls' rights, education and overall contributed to positive behaviour change.

From its inception the MNCH2 programme has partnered with traditional leaders in communicating health messages. In the third year of the programme, these interactions matured into a strategic collaboration with the Emirate Health Committees to reach more communities. The Emirate Health Committees bring together traditional Muslim leaders at the Emirate to influence and monitor community health.

MNCH2 TAKES A SOCIOECOLOGICAL APPROACH TO IMPROVING DEMAND FOR HEALTH SERVICES.

PARTNERSHIP WITH EMIRATE HEALTH COMMITTEES FROM YEAR 3 LED TO EXPONENTIAL INCREASE IN COMMUNITIES REACHED BY MNCH2



KANO EMIRATE OPENS THE DOOR FOR MORE COLLABORATION ON HEALTH

Kano state is a pioneer in engagement with Emirate Health Committees on maternal and child health. The Kano Emirate Council Committee on Health and Human Development (KECCoH-HD) was initially established to assist in curtailing the spread of Ebola, but by the end of the epidemic, KECCoH-HD roles had expanded to all aspects of healthcare. MNCH2, for example, partnered with KECCoH-HD to train District Heads on data capturing and reporting.

At the MNCH2 learning event in February 2019, the Emir of Kano Mohammadu Sanusi II appealed to his peers and communities: "It is our role at the Emirate and also your role as members of the community to monitor the quality of health service delivery".

Traditional Birth Attendants bridge communities and facilities

TBAs are ubiquitous in many parts of northern Nigeria and community members value and have confidence in them. Normative guidance is clear about the linkage between high maternal and newborn mortality and TBA assisted births. Leveraging their social capital, TBAs provide a bridge between families and the health system. (In Kano state, the Emirate Health Committee was instrumental in re-orientating the TBAs, especially ensuring identification of danger signs and early referral of women to deliver at health facilities.)

TBAs can help address gaps in supply-side. For example, they can strengthen the MNCH referral system and have led initiatives to ensure availability of blood for obstetric complications by encouraging traditional leaders and other community members to join blood donor committees while also collaborating with other MNCH2-supported interventions such as the Emergency Transport Scheme (ETS).

Male Support Groups take MNCH messages to homes

Considering men's significant influence on their wives' health seeking behaviour, MNCH2 worked with the state authorities and traditional leaders to set up Male Support Groups (MSG) in communities. MSGs are made up of men married to young women and are led and mentored by trained volunteer male motivators, Male Support Group Volunteers (MSGV). Their activities focus on improving men's awareness of maternal and child health needs. They also discuss reproductive health, danger signs in pregnancy, safe delivery, child health, immunisation, health-related decision making and basic communication skills. Concrete outcomes include written standing approvals by husbands to allow their wives to access health services without the husband having to be present.

The efforts of MSGs have also resulted in increased awareness of available services and new blood donors. Results from a study by MNCH2 show that in communities with active MSGs, more men understood danger signs of pregnancy, labour and postpartum period and were generally better informed on the health of women and children.

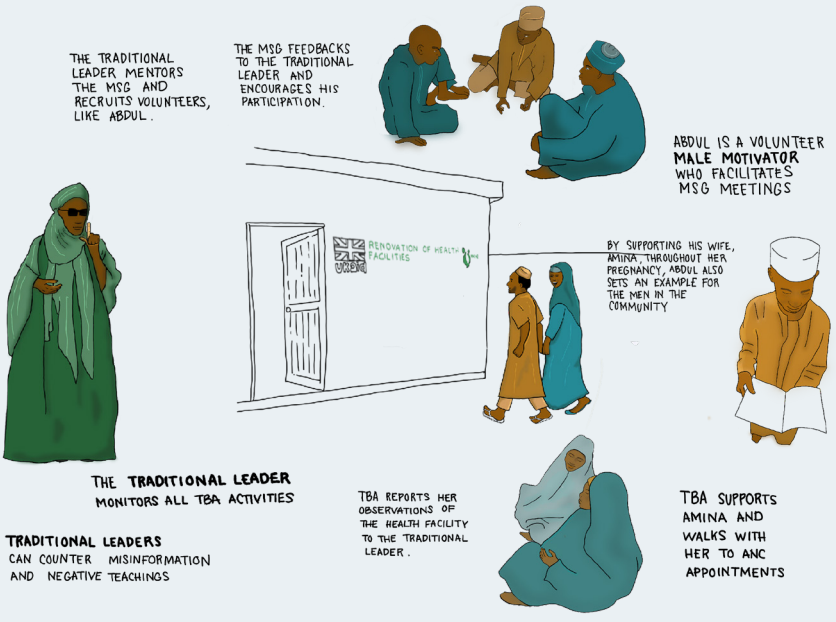
TRADITIONAL BIRTH ATTENDANT BECOMES A HOSPITAL PARTNER

Hajiya Hauwa is a renowned TBA in Tadeta Makoda LGA of Kano state, whose fame spreads to the neighbouring states of Jigawa and Katsina as a trusted and affordable birth attendant, midwife and herbalist. MNCH2, the State Ministry of Health and the LGA authorities became concerned with the number of preventable deaths among women with complications that were referred to the Dambatta General Hospital after visiting her clinic.

The programme organised a meeting with the Kano Emirate Council, the case was discussed and with the blessing of the leaders, MNCH2 Programme Officers reached out to Hajiya to educate her on the dangers of her practices. Hauwa realised that she could still be relevant to her community by referring and escorting pregnant women to health facilities. She is now one of the programme's advocates.

The National Union of Road Transport Workers (NURTW) identified and trained volunteer ETS drivers to work with Hauwa. The community mobilisation session organised in front of her home attracted about 120 people from the community and 91 accessed different MNCH services provided by the state Medical Outreach Team supported by MNCH2.

Hajia Hauwa (second left) with MNCH2 programme staff (left) and women from the community.



INTEGRATING TRADITIONAL INSTITUTIONS IS KEY FOR SUCCESS

Integrating the efforts of traditional leaders, TBAs and MSGs have been key to the success of the community interventions.

Because of their position, traditional leaders play a key role in supporting MSGs. They also participated in the recruitment of MSGVs and oversee their activities. MSGVs report to the traditional leaders and some traditional leaders join the MSGs themselves.

TBAs also provide feedback to traditional leaders through the Emirate Health Committees raising any pressing issues in their communities to ensure that these are addressed.

CHALLENGES

The main challenges facing community interventions in northern Nigeria boil down to resources and capacity. Across all the states, inadequate government funding remains a major obstacle. The Emirate Council Committees, for example, may not be able to sustain the current levels of activity after donor exit. Similarly, concerns exist about the committees' skills and capacity to handle, monitor and supervise activities as well as strategic coordination with government agencies, as technical support diminishes from development partners.

In addition, as the worth of traditional leaders is recognised by different actors, they are tasked with more agendas, which introduces coordination challenges and dilutes the potential impact.

The role of TBAs is increasingly accepted as critical to sustain improvements in antenatal care and skilled birth attendance in northern Nigeria. However, due to low literacy, their ability to document outcomes is quite limited. Again, competing demands from partners can overwhelm TBAs and further limit their capacity to support MNCH services.

In terms of MSGs, the lack of incentives for male volunteers and unpredictable funding were attributed to the relatively low traction in some MNCH2-supported states. The lack of commitment by the Government and its partners to sustain MSGs calls for better advoacy efforts, including better evidence on their impact.

RECOMMENDATIONS

In future programmes, traditional and religious leaders need to be involved from the conceptualisation

Involving traditional and religious leaders from the programme inception of will help programme designers gain deeper insight on how cultural beliefs and practices affect the programme implementation. Traditional and religious leaders can help in providing linkages between the programme and existing community structures. They can also facilitate the creation of new structures, where these are inadequate.

Support coordination

Piecemeal implementation and competing partner agendas can erode the effectiveness of community interventions. New programmes need to support the governments' coordination efforts.

In Jigawa, for example, the government-led Jakadan Lafiya ('Health Ambassadors') initiative was conceptualised in order to give the community a say over demand generation interventions and have all implementers work within a shared framework. It is becoming to be the focal convergence point needed to deliver health behaviour change activities and can possibly offer a good model for other states to follow.

Push for government ownership

Despite the recommendations to support the Emirate Council interventions across the 36 states in Nigeria that were made at the National Council on Health in Abuja in 2017, the institutionalisation of the Emirate Health Committees is yet to be finalised. Development partners should continue to advocate for the Government ownership and support to the capacity of the committees. The Saving One Million Lives (SOML) initiative by the Government has been an opportunity to transition most of MNCH2 community-level activities.

CONCLUSION

The MNCH2 three-pronged strategy to influence health seeking behaviour in northern Nigeria has helped to increase community ownership for maternal and child health outcomes; reinforce the message and by extension improved the chances of women to access MNCH services. However, as the MNCH2 programme gradually comes to an end, there needs to be continuing efforts to advocate and pressure for adequate funding to maintain and scale up activities; to ensure adequate capacity of the community actors to perform their ever increasing and more complicated different responsibilities.

Health Educators from the Local Government train members of the Male Support Groups on creating a supportive environment for women to access RMNCH services.

MNCH2
Empowering Communities
Strengthening Health Systems
Saving Lives

UKaid
from the British people

NATIONAL OFFICE
No. 17 Hospital Road
Nassarawa GRA
Kano State, Nigeria

communication@mnch2.com

MNCH2 is managed by Palladium and its partners: Axios, Marie Stopes International (MSI), Options Consultancy, Society for Family Health (SFH), MannionDaniels and Association for Reproductive and Family Health (ARFH)