Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

CLUSTERING OF CHILD MORTALITY IN NORTHERN NIGERIA

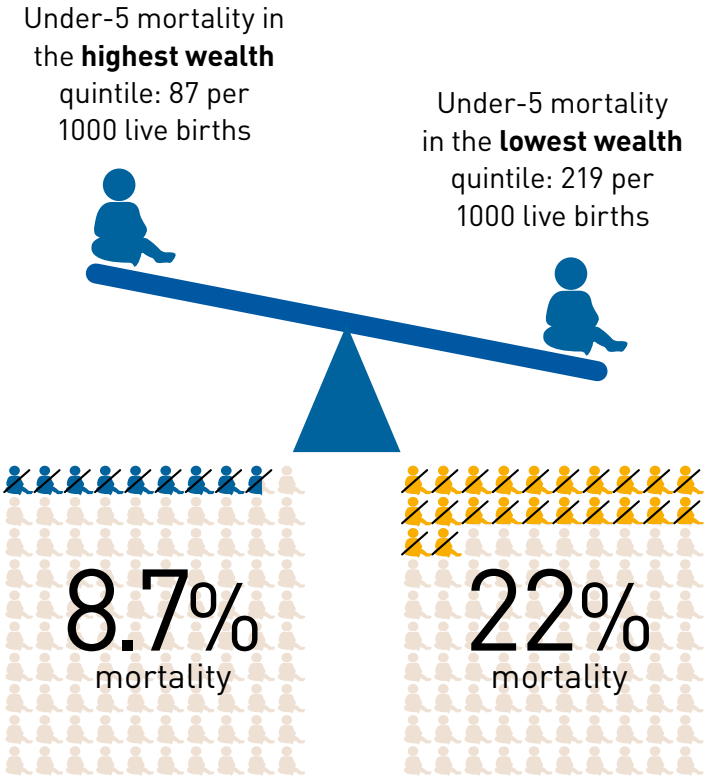
Implications for policy and practice

Introduction

The World Bank regularly publishes reports showing the disproportionately high child mortality suffered amongst the poorest. Even here though, child morbidity and mortality is clustered so that some families and some women bear a disproportionate burden – the poor-poor divide.

The known link between poverty and health drives our efforts to improve health in underserved areas. However, these public health measures tend to favour those who have the resources and self-confidence to use services or follow advice.

Fig 1. Under-5 Mortality - some families and some women bear a disproportionate burden



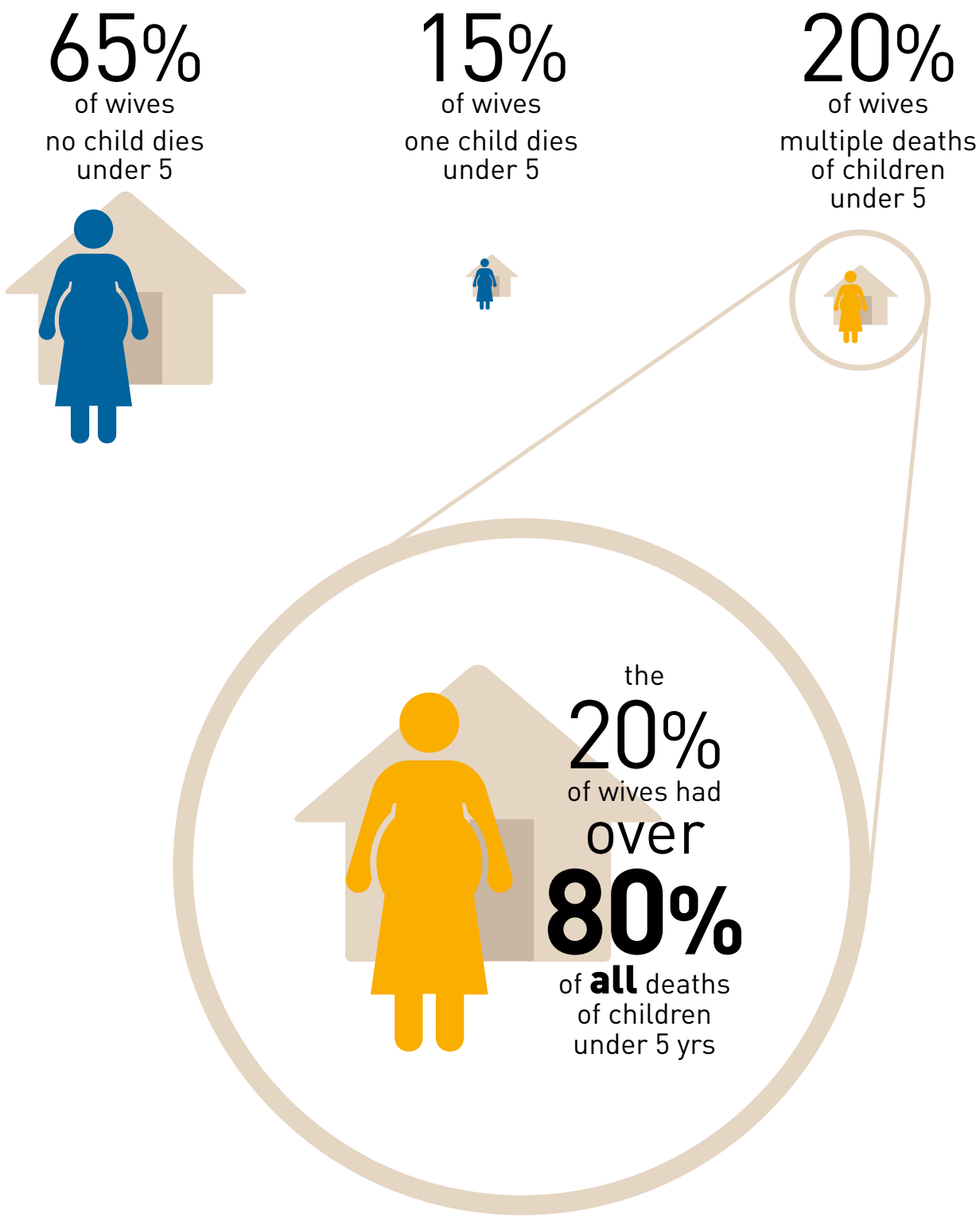
When the poorest use health services or try to follow medical advice, mortality and morbidity still remains higher than in the general population. This is often due to deep-rooted social divisions and the natural tendency of groups to exclude 'outsiders' in preference to 'insiders'[1]. Hence it is vital that strategies for improving health outcomes address the issue of social and health inequalities.

The Partnership for Reviving Routine Immunization in Northern Nigeria - Maternal Newborn and Child Health programme (PRRINN-MNCH) has been assessing the evidence of social exclusion and its impact on health and the use of health services.

Evidence of clustering of child deaths

A series of surveys implemented by PRRINN-MNCH and its partners in 2009 and 2010 set out to explore whether there was evidence of clustering of child deaths in rural communities in three states of

Fig 2. Clustering of under-five mortality: identifying vulnerable women and children



northern Nigeria (Jigawa, Yobe and Zamfara), and, if so, what the causes were. The surveys demonstrated that child deaths were indeed clustered among a small proportion of women.

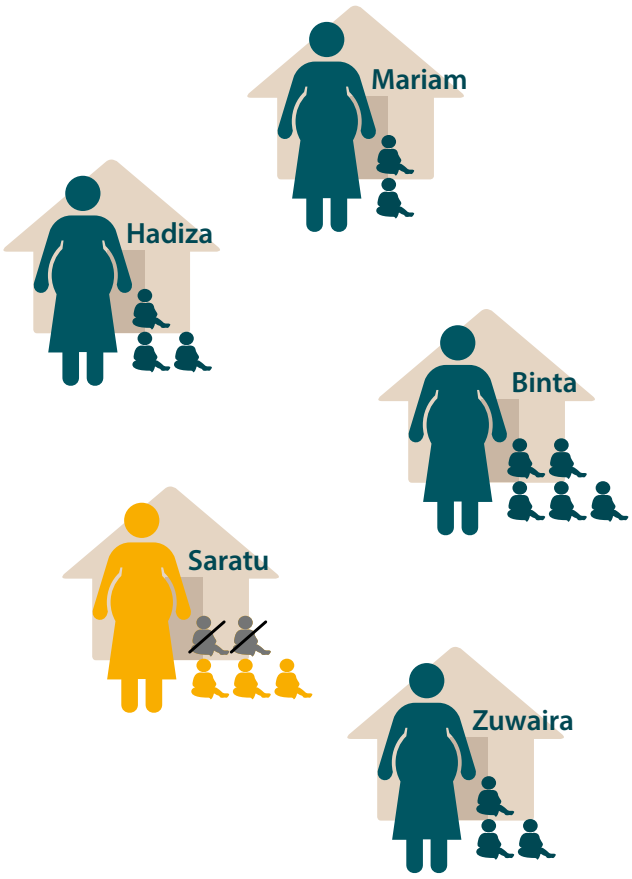
As Figure 2 shows, 65% of the survey respondents had no child deaths, 15% had one child death each and 20% had multiple child deaths (an average of three deaths per woman). Moreover, the 20% of women with multiple child deaths had just over 80% of all the deaths[2].

The clustering occurred even within polygynous households; some women and their children were affected and some were not.

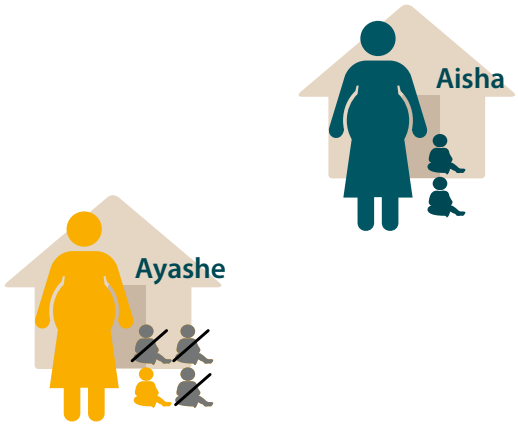
The heavy skew of child mortality was not related to child spacing, distance from health facility, religion, tribe education, culture polygyny, marital status, seclusion or employment. Rather a lack of respect and social support shown to a woman at family level were found to be highly important factors.

Fig 3. Mortality clustering within households: examples of two families from different compounds

Mallam's family: In Mallam's family there are five wives. Despite the high number of births only one wife, Saratu, has had two child deaths.



Usman's family: Usman's family consists of two wives. Aisha has had two births and no deaths whilst Ayashe has had four births and three deaths.



Mortality clustering within households, implies that:

- The least-supported have the disproportionate burden of ill health and death in the rural communities of northern Nigeria.
- Social issues at community and family level contribute to the inequities in health that result in high levels of child mortality.

The six factors that most strongly correlated to child deaths in the Clustering Survey occurred when the mother:

- rarely, if ever, had anyone older to help look after the children
- had no one to turn to for support if her children had difficulties
- had no one to turn to for support if she herself had difficulties
- believed she had no or little respect from relatives, in-laws, husband or others
- had almost no general support from her own relatives or in-laws
- and the children and the household had a very poor general appearance

Strategy Implications

The survey findings imply the need for a shift in strategy by the Nigerian Federal, State and Local Governments so that social issues are addressed as part of a comprehensive and holistic approach to Primary Health Care (PHC). There are many practical measures that can be taken by government and its partners to address these inequities in health. These should lead to greater social inclusion of women, to improved self-care and care of children, and ultimately to increased use of health services and improved health.

Three key strategies are:

STRATEGY 1:

Modify the Training of Community Workers

Modify the training of community workers, volunteers and institutions (from health and other development sectors) so that they can:

- Understand the relevance of social factors and social support systems to their work;
- Recognise when people lack confidence or may neglect their children or themselves as a result of lack of social support;
- Adapt their advice or interventions to be relevant to the capacities of the women or families in question;
- Advise women and their families on resources available locally that might help them in their need for support at particular times.

STRATEGY 2:

Develop Local Resources for the Least Supported

Assist communities to develop local resources that will be helpful to women in general, but particularly those with poor support – in particular for childcare, conflict resolution and savings schemes.

STRATEGY 3:

Promote Inclusiveness at Community Level

Stimulate the development of community mechanisms for including women with poor support in group and social activities. This will have a strong impact on the self-esteem and self-confidence of women whose belief in their capacity to improve their lives is low.

Balancing social changes

At present, the National Primary Health Care Strategy is limited by its focus on the health sector. The shift in focus from a medicalised model of PHC to one that balances social and service-based policies, and which supports communities to respond to MNCH barriers, represents a very significant change in direction.

In this fact sheet, we have addressed how poverty and social exclusion impact health. But it is important to also recognize the needs of socially under-supported people in other domains and how agencies can work together to improve the health of socially excluded people.

For a comprehensive and holistic Primary Health Care strategy to become a reality there must be a focused effort to strengthen interactions between the Ministry of Health and the Ministries of Religious Affairs, Water Resources and Rural Development, Agriculture and Natural Resources, Women Affairs, and Local Government. Donors also need to balance social policy with policies focused on service delivery improvements. In this way both public health needs and the health of socially under-supported people can be addressed in a holistic and integrated way.

1. Tajfel, H et al (1971) Social categorization and intergroup behaviour, European Journal of Social Psychology, Vol 1, Issue 2, pp 149-178, April/June 1971.

2. Klouda, A, Adamu, F. Clustering of Child Mortality and Links to Social Support in Northern Nigeria, PRRINN-MNCH, 2013

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