Community interventions

to improve access to maternal, newborn and child health services

The challenge: barriers to MNCH services

A wide range of barriers prevent rural communities in Northern Nigeria from using maternal, newborn and child health (MNCH) services, including routine immunisation (RI). Baseline studies in Katsina, Yobe, and Zamfara states undertaken by the UK aid and Norwegian Government funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) found the following:

- Poor home-based care of pregnant women and newborns
- Lack of preparedness for safe pregnancy and delivery
- Low use of RI services, and in some areas, outright opposition to immunisation
- Poor male involvement in women's and children's health
- Many physical access barriers that delayed the response to maternal emergencies
- Concerns about the high cost of emergency health care
- Perceptions of poor quality care at health facilities

Child deaths were clustered among a minority of women who lacked social support and respect at household level, making it imperative to find a way to reach these women. Awareness of rights to quality health services was low among rural people, and there were few formal mechanisms that could be used to hold health workers and government to account for poor performance.

Key messages:

1. Improving access to MNCH services in rural Northern Nigeria requires a strategy that addresses all household and community level barriers simultaneously.
2. PRRINN-MNCH and its partners scaled up community MNCH interventions to an estimated population of 4.3 million in four years. 'Scalability' was an important consideration from the outset.
3. Restructuring of the health sector so that primary health care is 'under one roof' will help to ensure a properly resourced institutional home for community MNCH activities.

At government level, health managers, administrators and health workers lacked the know-how and resources to address the low demand for services. The lack of attention to demand-side issues in health policies, plans and budgets was an issue.

The response: a combined approach

PRRINN-MNCH and its partners had to find a way to tackle the wide range of cultural, social, economic and physical access barriers that prevented communities from accessing the services they needed, while at the same time building policy support for these issues within government and the capacity to address them.

The programme had to work on a number of levels:

Downstream: within communities, to devise an acceptable and appropriate approach to community engagement (CE) that would increase access to essential MNCH services for all women and children.

Midstream: at the interface between communities and health facilities in order to promote increased responsiveness by health workers to community needs.

Upstream: with health policy makers and planners to ensure that the community engagement work could be put on a firm and sustainable financial and institutional footing.

At community level a number of interlinked interventions were used to address MNCH access barriers:

Community mobilisation:
A participatory community mobilisation approach created demand for MNCH services and promoted effective home-

Box 1. A problem-solving approach to initiate social change

The community discussion groups were loosely modelled on a participatory action cycle approach. Community members came together to examine a problem and the underlying causes. Facilitated by community volunteers, the groups worked together to find solutions to the problem and to put in place strategies to deal with it. These strategies were later adjusted as necessary. Hence the community volunteers were far more than health educators – they were facilitators of a process of social change.

based care. The approach involved generating community-wide social approval for behaviour change using discussion groups. Involving men and gaining the approval of traditional and religious leaders were important strategies. The community mobilisation process was facilitated by trained community volunteers.

Community emergency systems: Communities were supported to set up systems to address access, affordability and other barriers and to ensure that all women could access these. This included: emergency savings schemes; community-based emergency transport schemes; 'mother's helpers' who knew the maternal and newborn danger signs and how to access the community emergency systems; and community blood donor schemes.

Other community structures: In some sites, Women's Support Groups and Young Women's Support Groups were established to reach out to women who would otherwise be excluded from participation in community-level change processes.

Community monitoring system: A community monitoring system generated data on the activities and changes at community level, including use of the community emergency systems.

To improve links between communities and health facilities, facility health committees were established, building wherever possible on pre-existing village committees. These played an important role in channelling community voices on health issues, demanding accountability for service delivery failures, and supporting and monitoring the community-based MNCH response.

Upstream, local government area (LGA) health departments were supported by PRRINN-MNCH staff to build 'demand creation teams' of key primary health care personnel. Together with representatives of state ministries, including Health Promotion Officers, these teams provided ongoing mentoring and coaching support to communities, ensuring that they were able to turn their increased awareness into action.

The idea was to ensure local leadership for the community-level MNCH response. Both the states and local governments were supported to include community-based MNCH activities in their health plans and budgets, thereby helping to put the work on a sustainable footing.

Considering the complex and challenging implementation environment, it was essential to adopt a flexible approach to implementation. Hence early intervention approaches were adjusted to suit the local context; new components or activities were introduced in response to identified needs as the programme progressed; and over time emphasis was placed on integrating the various components of the strategy.

The results: increased use of MNCH services

Coverage

By September 2013 PRRINN-MNCH was supporting community engagement activities in 2,400 communities in 45 LGAs in Katsina, Yobe and Zamfara states, covering an estimated population of 4.3 million. Some of these communities received direct support from PRRINN-MNCH and its partners, while others benefited from a process of local dissemination, where community volunteers in the original sites shared what they knew and their emergency systems with neighbouring communities.

56% coverage with community engagement activities was achieved in Katsina intervention LGAs, 40% in Yobe, and 39% in Zamfara over three years.

The community interventions were first piloted in nine LGAs for 18 months. Over the next 17 months, 36 new LGAs were added. The creation of a core group of community engagement trainers in each state, use of a cascade training approach, adoption of a community health volunteer approach and a strategy of local dissemination, enabled the activities to be scaled up rapidly.

Behaviour change

A household survey tracked knowledge and changes in behaviour in the three states between 2009 and 2013:

- Antenatal care use rates increased from 25% to 51%
- Skilled birth attendance rates increased from 11% to 27%
- Women with permission to get health care for a sick child increased from 40% to 83%
- Children who had received DPT3 vaccine increased from 5% to 42%

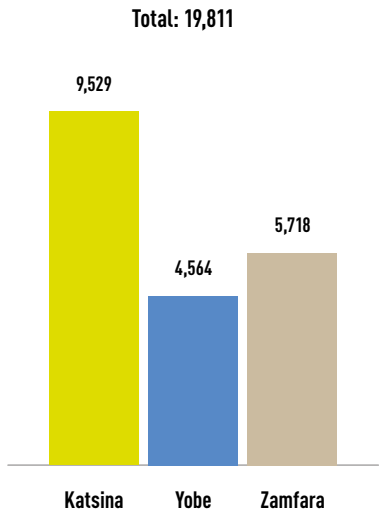
Young Women's Support Groups, established to reach and support hard-to-reach women, had a positive effect on health-related knowledge and practice. A knowledge, attitudes and practices (KAP) survey in 2013 found that members of these groups were more likely than non-members to:

- Know four or more maternal danger signs
- Know when to put a newborn to the breast for the first time
- Give birth in a health facility
- Know the correct immunisation schedule
- Have the complete set of vaccinations

Data generated by the community monitoring system provided further

evidence of behaviour change. Community emergency systems were well used. Just under 20,000 women with a maternal complication were supported by community emergency transport schemes between December 2009 and September 2013 (Fig 1).

Fig 1: ETS transfers by state, Dec 2009 – Sep 2013



Almost 20,000 women across the three states were helped by ETS drivers.

Intervention communities saved ₦39 million (UK £157,000) to support women with maternal emergencies, and just under 9,000 women (52% of reported maternal complications) were assisted by these schemes. 4,337 women, a quarter of all women reporting a maternal complication, were supported by community blood donors. Use of these schemes helped to avert many potential maternal and newborn deaths.

Hence communities were proactively identifying maternal danger signs and referring women for urgent treatment. The results contrast with the relatively low increase in knowledge of four or more maternal danger signs reported in the PRRINN-MNCH 2013 household survey (from 10% to 33%). This may have been something to do with the design of the survey: this question required enumerators to wait while respondents recalled what they had learned. Time pressures may have resulted in enumerators not doing this.

Challenging service delivery failures

A 2013 review of the PRRINN-MNCH-supported facility health committees found that they were meeting regularly, had maintained their membership, had matured over time and were functioning across the breadth of their remit.

Despite refresher training which focused specifically on improving the quality of women's participation on the committees, the review also identified ongoing gaps in women's visibility and voice on these committees. PRRINN-MNCH will focus on how to address this in its final phase of operations.

Box 2. Government successfully challenged by a facility health committee

In Maska community, Funtua LGA, Katsina state, there were numerous complaints by ANC clients of abuse and insults from the midwife posted to the community. The review team was informed that the midwife instructed women not to seek care from her without having a bath and wearing perfume. The FHC made several attempts to reprimand her but she remained adamant.

The FHC eventually raised the issue with the Village Head who personally led a team to the LGA Chairman to register the complaint. The erring health worker was instantly transferred and replaced by another midwife.

In some areas the committees were inviting all individuals responsible for community health – the 'Community Health Team' – to their meetings so that the different activities could be co-ordinated. The committees also challenged government about service delivery failures. In the past, many attempts to demand improvements in health services from government had fallen on deaf ears. By 2013, many of the committees were able to share advocacy efforts with positive outcomes (Box 2).

Extent of institutionalisation

By September 2013, community interventions to improve MNCH were included in state strategic health plans and budgets, demonstrating the states' commitment to addressing demand-side MNCH barriers. At local government level, demand creation teams had accrued substantial capacity to oversee and monitor community-level MNCH activities.

Each LGA had master trainers with the capacity to oversee further expansion of the community engagement work to

new parts of the LGA. Nevertheless, as the programme drew to a close, few of the LGAs had committed funds to sustain or expand the community engagement work after the end of PRRINN-MNCH.

The experience in Katsina, Yobe and Zamfara states contrasts with Jigawa state, where PRRINN-MNCH community-level interventions had focused on RI rather than a broader safe motherhood agenda. This state had undergone a process of health sector restructuring, where the previously fragmented system had been replaced with a system that put 'primary health care under one roof' (PHCUOR). The Gunduma health system councils established to run health services in different parts of the state received regular funds for community MNCH interventions, and institutional responsibility for demand-side health activities within the councils was clear.

Policy implications

The PRRINN-MNCH community engagement approach had many positive effects on MNCH-related knowledge and behaviour. By September 2013, there were signs that the intervention sites were on the cusp of a more substantial shift in health-seeking behaviour. The high use of community systems for maternal emergencies, the fact that these systems had been sustained for up to four years in some sites, the reports of reduced maternal and newborn mortality from communities and the increasing use of emergency transport schemes to support normal deliveries suggest that the foundations for change had been built.

By September 2013 some aspects of the community engagement approach needed more time to 'bed in'. For example, after a year, the Young Women's Support Groups had not reached the level of coverage necessary

to ensure that all under-supported young women in the community had been reached (these groups were initiated part-way through 2012). A longer implementation time frame, and a sustained emphasis on inclusion at community level, will be required to ensure complete coverage. The facility health committees also required more support so that they create space for female members to participate fully.

PRRINN-MNCH's experience to date suggests the following:

Working at scale: PRRINN-MNCH and its partners achieved a population coverage of 4.3 million in three states in four years – 45% of the entire population of the intervention LGAs. The size of the states means that there is some way to go to achieve state-wide coverage. The methodologies used by the programme and its partners – a community health volunteer model, a cascade training approach, and a strategy of local dissemination to neighbouring communities – are inherently 'scalable'.

A comprehensive approach: For MNCH behaviour to change in rural communities all demand-side barriers need to be addressed simultaneously in a comprehensive approach. Standalone interventions such as emergency transport schemes are unlikely to work effectively unless other barriers are addressed at the same time.

Minimum package of interventions: So that policy makers have the evidence that they need to scale up at state level, more work needs to be done to clarify and cost the minimum package of interventions needed to stimulate MNCH behaviour change. PRRINN-MNCH will be focusing on these issues during its final phase of operations.

Institutional home for demand-side MNCH activities: Health sector fragmentation is likely to continue to undermine efforts to place demand-side MNCH activities on a sustainable institutional footing in future. Without a shift to 'primary health care under one roof', local governments are likely to find it difficult to adequately resource and support the community MNCH response. Institutional responsibility for community-based MNCH activities needs to be clarified, adequate staff need to be in place to support these activities, and an appropriate amount of funding needs to be allocated if these activities are to be sustained over time.

Conclusion

PRRINN-MNCH demonstrated that it is possible to devise an effective and culturally appropriate community engagement approach to address demand-side MNCH barriers in a challenging environment. Communities in the PRRINN-MNCH sites recognised the short and long-term health and other benefits to be derived from the community systems they have established and are likely to try to sustain these.

Establishing a clear institutional home for these efforts within government will be vital going forward – and will be facilitated by wider health sector restructuring efforts.

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

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

www.prrinn-mnch.org
Email: info@prrinn-mnch.org

ROYAL NORWEGIAN MINISTRY OF FOREIGN AFFAIRS
UKaid from the British people

The PRRINN-MNCH programme is funded and supported by UK aid from the UK Government and the State Department of the Norwegian Government. The programme is managed by a consortium of Health Partners International, Save the Children and GRID Consulting, Nigeria.