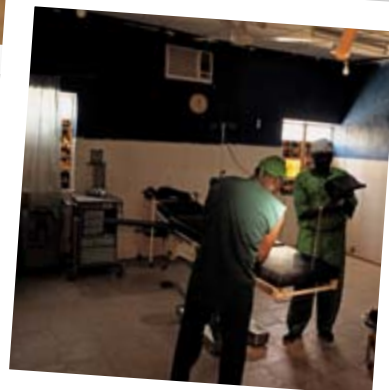




Partnership for Reviving Routine
Immunisation in Northern Nigeria;
Maternal Newborn and Child Health Initiative

Technical briefs: Sharing the lessons learned in Northern Nigeria



The writing of this set of Technical Briefs has drawn on the work of all the PRRINN-MNCH employees and consortium members, and the commitment and contribution of health workers and communities at LGA, state and federal levels. For this we are extremely grateful.

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Design by Atyeo Linklater. Photographs largely supplied by Okikiola Akinkugbe.

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Overview

This set of Technical Briefs highlights key achievements from the PRRINN-MNCH programme in Northern Nigeria under one of four streams of work: Governance and systems; Health service delivery; Community engagement and Evidence for decision-making. This is part of a package of materials including a Final Report and a set of Knowledge Summaries.

Covering a population of over 19 million, PRRINN-MNCH was an innovative DFID/Norwegian Government funded programme (2006-2014), established to address these health issues. The consortium managing PRRINN-MNCH consisted of three partners (Health Partners International as lead partner, with GRID Consulting Ltd and Save the Children) as well as several associates.

The programme combined health systems strengthening with routine immunisation and maternal, newborn and child health interventions, merging horizontal and vertical approaches simultaneously. PRRINN-MNCH aimed to revitalize Primary Health Care and improve the availability, quality and utilization of maternal, newborn and child health services, including ante-, peri- and post-natal care, emergency obstetric newborn care, essential care for newborns and infants, young child feeding and nutrition, and routine immunisation against preventable diseases.

PRRINN-MNCH assisted each state (Katsina, Zamfara, Jigawa, Yobe) to achieve significant improvements in health indicators, by supporting many federal, state and local government health systems strengthening and service delivery initiatives, in combination with community engagement efforts.

Independently verified Evidence of significant programme impact includes dramatic reductions in the infant mortality rate, reduced from 90 to 56 per 1000 live births, while the under five year mortality rate was reduced from 160 to 90 per 1000 live births. There was a significant increase in fully immunised children coverage from 2.2% to 19.3% and births attended by skilled birth attendants increased from 11.2% to 26.8%.

Some communities in Katsina are now celebrating two years of no maternal mortality, results that can be directly attributed to the work of PRRINN-MNCH.

PRRINN-MNCH has consistently exceeded expectations and the programme 'made outstanding achievements in a very difficult environment'¹.

1. DUBY, Fiona (August 2012) PRRINN-MNCH Annual Review 2011: DFID Report

Reducing the gap between uptake of antenatal care and skilled attendance at birth

The challenge: little ANC and very few SBAs at birth

There is little evidence that antenatal care prevents maternal mortality¹⁻³ but its potential to reduce maternal morbidity and improve newborn survival and health has been widely acknowledged⁴. Antenatal care also provides an excellent platform to reach pregnant women with prophylactic medication, vaccinations, diagnosis and treatment of infectious diseases, as well as with health education programs⁵.

Evidence-based antenatal interventions include: provision of malaria prophylaxis, anti-tetanus vaccination, prevention of mother-to-child transmission of HIV (PMTCT) and serological screening for syphilis^{6,7}.



The antenatal period also presents a good opportunity to give advice on complications of pregnancy, danger signs, how to seek medical care and emergency preparedness. These areas of advice form key strategies to reduce delay in seeking skilled care should complications arise^{1,8}. Furthermore, ANC offers the chance to promote the use of skilled attendance at birth and healthy behaviours such as breastfeeding, early postnatal care, and planning for optimal pregnancy spacing.

Increasing the number of births assisted by skilled birth attendants (SBAs) is an important factor in reducing maternal deaths. A clinically competent health care provider will be able to recognise, manage or refer complications when they arise during delivery. Evidence shows that women are more likely to

give birth with an SBA if they have had at least one ANC visit. Studies in Asia and sub-Saharan Africa have found a positive association between the level of care obtained during ANC and skilled attendance at birth^{9,10}. In sub-Saharan Africa, women having four ANC visits are over seven times more likely than those with no antenatal care to deliver at a health facility¹⁰.

But the situation is different in Nigeria where there is a significant gap between the uptake of ANC and delivery with an SBA. Use of ANC by Nigerian women is 61%, with 86% of women in urban areas attending ANC compared with 47% of rural women. Use of ANC also varies by region with women in North-Western Nigeria having the lowest ANC attendance at 41% (Fig 1).

Key messages: Targeted strategies are helping to improve the gap between receiving antenatal care and the presence of a skilled birth attendant at birth.

- 1** In Northern Nigeria, only 41% of pregnant women have any antenatal care (ANC) and as few as 12% deliver with the assistance of a skilled birth attendant (SBA).
- 2** Births with SBAs are safer, and efforts by PRRINN-MNCH to increase these numbers have been extremely successful with a 14-fold increase in annual ANC numbers and an almost nine-fold increase in deliveries with SBAs between 2008 and 2013.
- 3** Household surveys show the gap between ANC and delivery with an SBA is narrowing, albeit slowly.
- 4** Targeted strategies to address barriers to SBA use can accelerate progress and improve the quality of ANC by ensuring necessary equipment and drugs are in place, reducing the cost to families and obtaining support from men in the community.

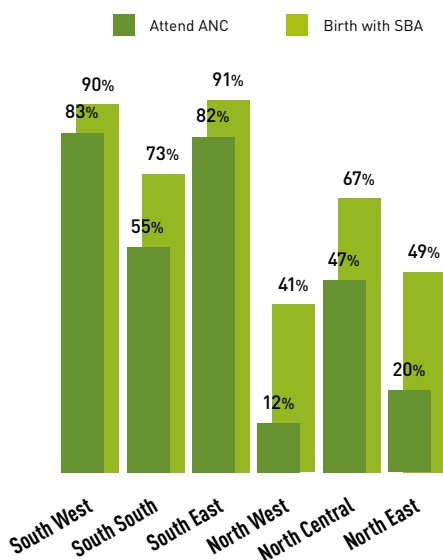


The figures for ANC, although low, are however significantly better than those for skilled attendance at delivery with only 38% of women being assisted at birth by an SBA¹¹. Again, this figure is much lower for Northern Nigeria at only 20% for the North East zone and 12% for the North West.

Fig 1: Use of ANC and SBA by region

The most pronounced gap between overall ANC and attendance by SBAs is in Northern Nigeria.

Source: DHS 2013



The response: improve ANC and boost SBAs in rural areas

To increase the low use of skilled maternal health care, the government of Nigeria adopted the focused antenatal care (FANC) model promoted by the World Health Organisation (WHO) and launched the Midwifery Service Scheme (MSS) in 2009. The FANC model emphasises the importance of quality rather than quantity of antenatal visits and promotes goal-oriented and women-centred care by skilled providers.

Adoption of the FANC model led to the development of FANC training by the Federal Ministry of Health (FMoH) and reorientation of health care providers. The MSS programme, on the other hand, is meant to address the SBA shortage in rural areas.

Since 2008, PRRINN-MNCH has supported the government of Nigeria to improve maternal newborn and child health (MNCH) services in four northern Nigerian states: Jigawa, Katsina, Yobe and Zamfara. Three key outputs of the programme focus on improving human resource policies and practices in the primary health care (PHC) system; improving demand for routine immunisation (RI) and MNCH services and their delivery.

The PRRINN-MNCH programme

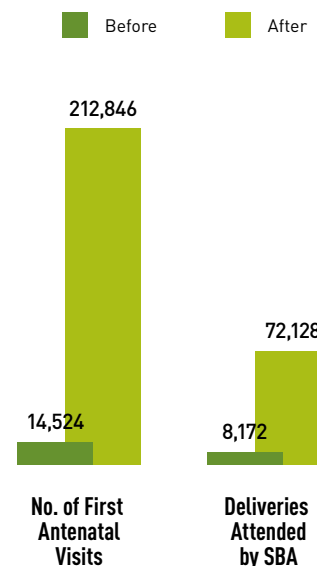
developed an integrated training manual on FANC, postnatal care and family planning in 2011¹² which has been used to cascade training of health workers in three states (Katsina, Yobe and Zamfara)^{13,14}. Various capacity building activities on emergency obstetric care, interpersonal communication and counselling skills were provided to SBAs. Job aids, protocols and guidelines on ANC and delivery care were also developed and distributed in all supported facilities.

The results: still not enough deliveries by SBAs

Training in FANC has led to an increase in the capacity of health workers, and improvement in the quality and use of ANC in targeted facilities. A significant increase in deliveries conducted by SBAs has also been noted in all targeted facilities though the SBA figure is generally still low when compared with that of ANC (Fig 2).

Fig 2: Increasing access to services in PRRINN-MNCH targeted states

Both ANC and attendance at birth by SBAs has increased significantly



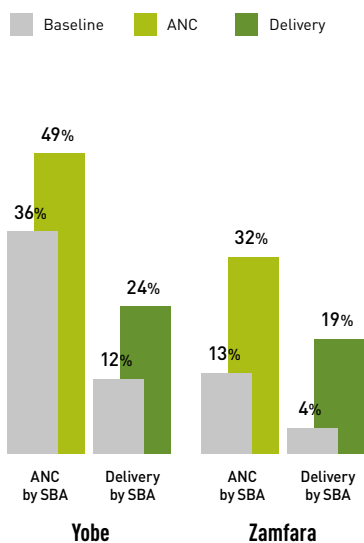
Before: Baseline data 2008 After: Endline data 2013

Reducing the gap

In addition to collecting facility data, PRRINN-MCNH's household surveys confirmed that the percentages of women receiving ANC and being delivered by an SBA have both increased with early indications that the gap between ANC attendance and deliveries is narrowing. However it seems to be narrowing more in some states than others.

Fig 3: Exploring the ANC versus SBA delivery gap – Yobe and Zamfara

The dropout rate between ANC and delivery by SBA reduced significantly



Baseline – HHS data 2009 ANC – HHS data 2013
Delivery – HHS data 2013

In Yobe state in 2009 36% of women attended ANC but only 12% were delivered by an SBA. Thus nearly two thirds 'dropped out'. However, in 2013, the number attending ANC had increased to 49% while nearly 24% were delivered by an SBA. Thus the 'dropout' rate had reduced to nearly 50% (from the two thirds or 66% previously).

Similarly, in Zamfara the gap had reduced from a 'dropout' of more than two thirds (13% to 4%) to a 'dropout' of approximately 40% (32% to 19%).



Factors affecting SBA use

A study in rural Katsina¹⁵ identified these predictors for SBA use:

- Maternal education
- Husband's occupation
- Presence of complication
- Previous place of delivery

Barriers:

- Not enough skilled birth attendants
- Lack of equipment and supplies
- Poverty

Enablers:

- Availability of staff
- Husband's approval
- Affordable service

Policy implications

Continue improving the quality of ANC to encourage more deliveries with SBAs – this strategy is working.

Complement quality of care improvements with initiatives to improve the availability of equipment and drugs.

Consider alternative health financing measures to attract clients to health facilities and reduce their costs eg voucher schemes, health insurance, performance-based payments to health workers.

Continue and expand demand-side activities to increase involvement of men and obtain their support for health facilities and access to SBAs.

Conclusion

Improving delivery rates assisted by SBAs requires much more than simply enhancing the skills of health care providers. While some factors lie outside the direct influence of the health sector (eg education levels of women), there are many areas where health managers and providers can make a difference.

Women are more likely to use health facilities where there is wider availability of skilled personnel working in an enabling environment and with effective interventions to remove user fees.

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This set of Technical Briefs highlights key achievements from the PRRINN-MNCH programme in Northern Nigeria under one of four streams of work: Governance and Leadership, Health Service Delivery, Community Mobilisation, and Evidence for Decision-making.

PRRINN-MNCH worked with the federal, state and local governments, and in close consultation with local communities, to strengthen Primary Health Care services in four states, covering a population of over 19 million. PRRINN-MNCH helped each state achieve significant health-related goals, and improved the quality and availability of health services including antenatal and postnatal care, safer deliveries, care for newborns and infants, better nutrition, and routine immunization against preventable diseases.

www.prrinn-mnch.org

www.healthpartners-int.co.uk

www.save-the-children.org.uk

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