# Adjusting health strategies

## to include women and children with least social support

*Key messages:* **Child mortality is clustered among a small proportion of women in rural communities in Northern Nigeria. Lack of individual social support is a key factor driving the skewed burden of ill health.**

1. Health programmes that ignore issues of social support may exacerbate divides among the poor and are likely to make slow progress towards achievement of maternal, newborn and child health targets.
2. A comprehensive and holistic approach to primary health care in Nigeria would place greater emphasis on social factors alongside improvements to service delivery.

### The challenge: finding evidence of clustering

Demographers have shown that in a variety of contexts child deaths tend to cluster among a few mothers (Das Gupta, 1997; Edvisson et al, 2005; Guo, 1993; Madise and Diamond, 1995; Meegama, 1980). Yet the reasons for the clustering are generally not well understood. As a result, health policy makers and programme staff lack information on how to respond appropriately.

The term 'clustering' is used to describe the skew of distribution of deaths to a particular part of a population – the skew implying that the distribution is not random.

The UK aid and Norwegian Government funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) was established to strengthen government capacity to provide quality maternal, newborn and child health (MNCH) services and to increase their use. In 2008 when the programme began, reliable evidence that clustering of mortality occurs in the northern states did not exist since the issue had not been investigated in surveys and studies.

A view that rural people were equally affected by service delivery failures and had equally poor access to health information and services was predominant among policy makers, based on a perception of generalised poverty across communities. So that health inequities could be better understood in the Northern Nigerian context, PRRINN-MNCH set out to fill the gap in the evidence base.

### The response: survey on extent of support

A child mortality clustering survey in Jigawa, Yobe and Zamfara states in 2009-10 was implemented in rural areas supported by PRRINN-MNCH and focused on communities that were uniform in their overall cultural, employment and wealth patterns. Most families had the same religion, level of education and household assets. Within each village studied, all the women who had had at least one live birth were surveyed – a total of 1,688 women.

It has long been recognised that the extent of social support and security have an enormous influence on health, and hence a variety of measures of support were examined as part of the survey. The survey looked at:

- Cognitive support (information and advice)
- Emotional support (support after quarrels, support in decisions)
- Practical support (child care, food preparation, household chores)
- Financial support (money, in-kind payments)

Survey respondents were asked about the extent to which the various types of support were given by co-wives, husbands, in-laws, their own relatives, adult children and outsiders. Women were also asked about the extent to which they felt respected by each of these groups. The appearance of the household, of the women themselves, and of their children, were assessed subjectively.

### The results: mortality clustered among least-supported women

The survey found that the burden of mortality and morbidity was indeed skewed in rural parts of Jigawa, Yobe and Zamfara. A small proportion of mothers and children suffered poor health and rarely used services. The skew happened irrespective of proximity to health facilities, poverty, level of education or household composition. The skew was very striking: 80% of child mortality was suffered by 20% of women. These women suffered multiple child deaths – an average of three deaths each (Fig 1).

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**65% of women in the survey sites had no child deaths, despite the fact that their general environment was so poor.**

If a relationship between poverty and child deaths exists, the expectation is that all women in a household will be similarly affected. To test this assumption, the survey examined whether clustering occurred within polygynous households. Clustering was indeed found to exist. In many households one of the wives suffered all (or nearly all) the child mortality, while the others had no deaths.

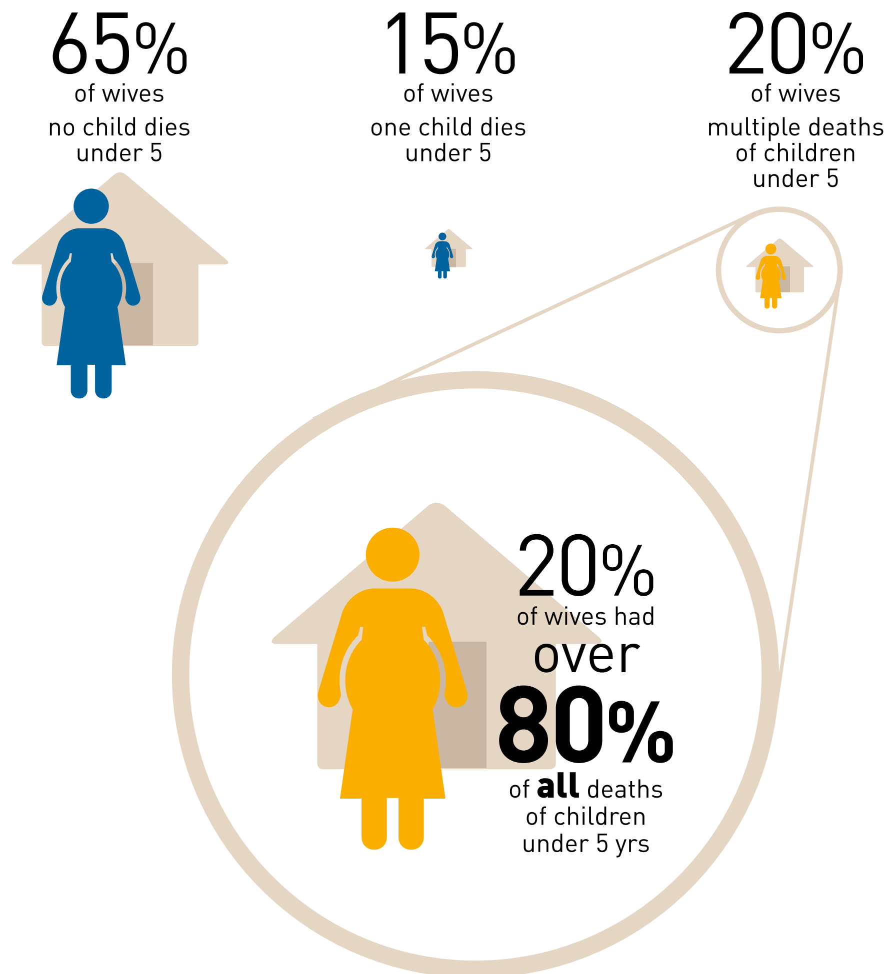
The survey also showed that within compounds of related families some of the families suffered child deaths while others did not. The clustering within compounds and polygynous families suggests that generalised socio-economic factors that affect the entire population (eg lack of education, lack of wealth, lack of resources, culture, beliefs) play a lesser role in explaining child deaths than the immediate social factors surrounding a woman.

In the survey sites, the likelihood of having any child deaths was strongly related to six factors:

- The woman rarely or never had anyone older to look after the children
- The woman had no-one to turn to for support if her children had difficulties
- The woman had no-one to turn to for support if she herself had difficulties
- The woman believed she had no or little respect from relatives, in-laws, husband or others
- The woman had almost no general support from her own relatives and in-laws
- The general appearance of the woman, the children and the household were very poor

**Fig 1: Clustering survey findings**

20% of women suffered 80% of child deaths.




## Implications for policy

The basic mechanisms through which social determinants impact on health are not simplistically related to poverty. Among societies that are generally poor, or which have poor access to amenities, services and opportunities, the 'moral economy' provides a very large part of the support needed to sustain life, health, functioning and security.

'Moral economy' refers to the agreements and support at community level that sustain life.

It is striking that such a large proportion of women in the study sites (65%) had no child deaths even though their general environment was so poor. The strong correlation between the appearance of the household, the woman, the children and the number of child deaths was both an indicator of lack of support and of the woman's mental health.

This is consistent with the findings of other studies that have linked mothers' mental health to child health (Ingram, 2003; Lanata, 2001; Lund, 2010).

Addressing the skewed burden of ill health in rural Northern Nigeria requires a change in primary health care strategy towards a more comprehensive and holistic approach which places greater emphasis on addressing the social factors that affect health. Practical steps taken by PRRINN-MNCH to address health inequities include:

**Supporting participatory group processes:** There is a growing body of evidence to suggest that participatory group processes can help improve both self-confidence and mental health and hence maternal and child health (Kawachi and Berkman, 2001; Campbell et al, 2004; Proust et al, 2013).

PRRINN-MNCH placed considerable emphasis on the formation of women's groups and on ensuring that the least-supported women were included in these. In many settings, the effect of group membership has proved to have a variety of positive effects for those who stay with a group. These improvements include: personal appearance and hygiene; care of self, children and family; communication with partners; improved mental health; and improved respect for others. Young women's support groups (YWSGs) in communities supported by PRRINN-MNCH are showing similar benefits.

**Training of front-line health providers:** In Europe and the USA there has been considerable emphasis recently on the training of health staff to consider the social background of people and to modify their communication and advice accordingly. This has been shown to impact positively on the self-esteem and ability of women to look after themselves and their children.

Health workers in Nigeria are not trained to take into account the social factors that affect health-seeking and decision-making or adherence to treatment. PRRINN-MNCH therefore worked with government partners to modify the training of a core group of front-line health workers – community health extension workers (CHEWs) – so that they were better able to recognise and interact with the least-supported women.

**Sensitisation of community health team:** PRRINN-MNCH developed the concept of a community health team where all those working to improve the health and well-being of the community were trained to have a strong focus on the least-supported.

**Working with religious leaders:** Religious leaders have considerable influence in rural Northern Nigeria and operate very effectively as mass communicators. PRRINN-MNCH involved religious leaders in the analysis of the clustering survey findings and worked with them to identify steps that could be taken at community level to address social exclusion and lack of support.

**Adjusting surveys:** PRRINN-MNCH ensured that any surveys that examined knowledge, attitudes and practices relating to health and health services included a methodology for analysing levels of support, social inclusion and the respect people feel they receive from others. The programme also advocated for government and other organisations to organise health-related surveys based on social factors.

*"A woman who is under-supported joined the group lately. She was always dirty together with her child. In fact she only tied a wrapper around her chest. But she has changed now, wears a dress, washes her child when coming to meetings, and participates a lot."*
*[Member of a Young Women's Support Group, Jigawa]*

**Adjustments to monitoring and supervisory processes:** Monitoring and supervisory processes for initiatives focused on increasing community demand for services were revised so that they were able to track the inclusion and level of participation of the least-supported women in group and other community processes.

**Advocacy to government:** Advocacy to government focused on the need to address social issues as part of a comprehensive and holistic approach to primary health care.

## Conclusion

Social issues at community and family level contribute to the inequities in health that result in high levels of maternal, newborn and child mortality in Nigeria. The failure to identify and address these distinctions within poor populations has important consequences and has stalled progress towards achievement of health targets.

PRRINN-MNCH has been increasing its use of social analysis since 2008 to ensure that the women and children who suffer a disproportionate burden of ill health are considered in all programme activities. Many of the practical strategies adopted by the programme can easily be replicated by government, civil society organisations and development partners.

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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.

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