

Using community-based research to shape the design and delivery of maternal health services in Northern Nigeria

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Abstract: *Maternal mortality ratios in northern Nigeria are among the worst in the world, over 1,000 per 100,000 live births in 2008, with a very low level and quality of maternity services. In 2009, we carried out a study of the reasons for low utilisation of antenatal and delivery care among women with recent pregnancies, and the socio-cultural beliefs and practices that influenced them. The study included a quantitative survey of 6,882 married women, 119 interviews and 95 focus group discussions with community and local government leaders, traditional birth attendants, women who had attended maternity services and health care providers. Only 26% of the women surveyed had received any antenatal care and only 13% delivered in a facility with a skilled birth attendant for their most recent pregnancy. However, those who had had at least one antenatal consultation were 7.6 times more likely to deliver with a skilled birth attendant. Most pregnant women had little or no contact with the health care system for reasons of custom, lack of perceived need, distance, lack of transport, lack of permission, cost and/or unwillingness to see a male doctor. Based on these findings, we designed and implemented an integrated package of interventions that included upgrading antenatal, delivery and emergency obstetric care; providing training, supervision and support for new midwives in primary health centres and hospitals; and providing information to the community about safe pregnancy and delivery and the use of these services. © 2012 Reproductive Health Matters*

Keywords: antenatal care, midwifery, emergency obstetric care, maternal mortality, beliefs, norms and values, community-based programmes and interventions, northern Nigeria

Maternal health outcomes in northern Nigeria are among the worst in the world.^{1,2} The maternal mortality ratio is appreciably higher than the national average,³ with recent (2008) estimates for the north of over 1,000 per 100,000 live births, compared to below 300 per 100,000 live births for the southern region.⁴

High maternal mortality in northern Nigeria is associated with a very low level and quality of maternity services. Moreover, a decline in utilisation

of maternity services in the period between the 2003 and 2008 Nigeria Demographic & Health Surveys (DHS) raised concerns: the percentage of women in the northern states of Katsina, Zamfara and Yobe who received any antenatal services for pregnancies dropped from 36.9% to 31.1% in Katsina and Zamfara and from 47.3% to 43.0% in Yobe. Similarly, the percentage of women who had skilled assistance at delivery declined from 12.0% to 8.9% in Katsina and Zamfara and from 19.8% to

13.1% in Yobe. This was associated with deterioration in the delivery of essential health care services, particularly in that region.^{5,6}

Responding to the decline in use of maternal health services, in 2008 the Maternal, Newborn and Child Health (MNCH) Programme was established by a consortium led by Health Partners International (UK), Save the Children (UK), and GRID Consulting (Nigeria), with the Nigerian State Ministries of Health and local officials of Katsina, Yobe, and Zamfara states in northern Nigeria, where there was already an ongoing programme to promote routine childhood immunisations through revitalisation of primary care services. Funded by the Norwegian Government and DFID, the programme aims to teach women basic health education and the importance of utilising health facilities for their health and that of their children, increase demand for maternal and child health services, ensure that all women know maternal danger signs, deliver with skilled birth attendants and have access to emergency care.

The Programme conducted a baseline assessment of facilities in 2008 in the three states to assess the potential capacity of hospitals in those states to provide the continuum of care for maternal, newborn, and child health and in particular to provide skilled birth attendance and essential obstetric care. The survey included all public hospitals in each state. Results showed that these states had a serious health worker shortage, and fewer people living within ten kilometres of a health centre than in the south of the country. Further, although most hospitals in principle provided the key maternal, newborn and child health services, including antenatal, intra-partum and postnatal care, family planning and under-five clinics. many hospitals were unable to provide all of these. In 2003, no northern state met the minimum standard for basic emergency obstetric services and half the primary health care facilities offering antenatal or delivery care had no midwife. In the local government areas selected for intervention, there were no midwives at primary health centres and no facilities offered basic emergency obstetric care 24 hours a day. Moreover, only two facilities offered comprehensive emergency obstetric care, and there was no functional emergency transport scheme. Under 15% of women with recent pregnancies had had any antenatal visits.⁷

Differences in health care utilisation reflect larger structural factors. Northern Nigeria is Sudano-Saharan and dependent on subsistence agriculture.

It has higher levels of poverty and lower levels of infrastructure, education and health services. The north is also strongly patriarchal, while in the south there is more participation by women in decision-making. The north is predominantly Muslim, and practices aimed at protecting women from men – including polygyny, head covering and restrictions on public interaction – serve to further restrict women's access to needed services.^{8,9}

With co-funding from the UK Department for International Development and the Government of Norway, the Programme represents a strategic attempt to assist these states in reducing the high rates of maternal, newborn and child mortality through health systems changes, addressing issues of governance, human resources, access to health information, and community engagement alongside the strengthening of clinical services. This paper reports the findings of a study conducted in the first half of 2009 to provide empirical evidence on which to base these interventions, including the extent of utilisation of antenatal and delivery care among women with a pregnancy and delivery in the previous five years and associated factors, and socio-cultural beliefs and practices that influence – positively or negatively – women's access to these services.

Study population

At the 2006 census, Katsina, Yobe and Zamfara had populations of 5.8, 2.3 and 3.3 million, respectively. Among women aged 15–49 years in these states, 84% had no education compared to 63% of men, and compared to 36% of women nationwide. Only 38% were employed in the previous 12 months, compared to 59% of women nationwide. Only 33% of women were exposed at least weekly to any newspaper, radio or television, compared to 55% of the men in these states and 61% of women nationwide.⁵

Methods

The Programme selected local areas in each of the three states where integrated interventions focusing on improved emergency obstetric care services were to be implemented. Lower intensity, policy-based interventions were to be implemented in control areas of these states as well. Baseline data were collected across these areas in 2009 for comparison in studying programme impact after three years. Both quantitative and

qualitative methods were used to identify the specific programme elements needed to encourage women to attend the appropriate antenatal and delivery services to reduce maternal deaths.

The quantitative survey used some of the closed-ended questions from the 2008 DHS⁵ to facilitate comparability with other available data, modifying some questions and codes in line with specific Programme goals. To choose the women, we used a stratified two-stage cluster sampling plan. Each state was divided into two strata, sampled with a 2:1 ratio: the local areas with intensive Programme activities and those with less intensive activities. Forty-five enumeration areas were randomly selected to represent the local areas in these two strata, and in each, 47 households were randomly selected, one per house or compound, from which one woman (ever-married and aged 15–49) each was invited to complete the survey. There were a total of 7,442 eligible women. Trained interviewers visited the selected women at home and administered the questionnaire in the local language (Hausa or Kanuri).

The newly established ethics boards in each state's Ministry of Health granted ethical approval for the study. Prior to any fieldwork, the researchers met with the male and female village elders to explain the research goals, obtain local permission, and ensure that householders knew about and were ready for the interviewers. Women were informed that participation in the survey was voluntary and if they participated, they were free to skip any questions which they felt were uncomfortable.

Data analysis involved establishing statistical associations between maternal characteristics, antenatal care and delivery characteristics. T-tests were used to assess significant associations with age, parity, economic status, accessibility, literacy in any language, wife rank, history of infant death within one month of delivery, source of health advice for the woman or the baby during last pregnancy and experience of labour and delivery complications, with a separate variable for antenatal care versus advice on pregnancy or other maternal and child health issues from friends, family, traditional birth attendants or others in the community. Husband-wife communication about pregnancy or other health facility utilisation was proxied by the variable "discussion of immunisation with spouse". Preference for traditional healers was measured by reported use of them for any maternal and child health problems. Binomial logistic regression was used to assess the effect of various factors on

antenatal attendance and place of delivery. Stata 11.0 was used for the analyses and sampling weights were used to account for differences in sample sizes across the study areas.

The qualitative study comprised a rapid social assessment¹⁰ carried out over a two-week period in the intervention areas of each of the three states. We sought to better understand the cultural beliefs and practices relevant to demand for antenatal and delivery services. We conducted individual and group interviews with selected key informants, using purposive, diversity sampling to include people from communities with different degrees of access to maternal health services, based on their terrain, utilisation of primary and secondary health facilities, ethnicity and socioeconomic status. Thirty-six communities were selected and 119 in-depth interviews and 95 focus group discussions were conducted across the three states. Community and local government leaders, traditional birth attendants, traditional healers, maternity service patients and health care providers were interviewed individually. Focus group discussions (with an average of nine participants each) were held separately with women aged 15–49 years (including married adolescents), older women, and men – the latter due to their critical role in influencing or controlling pregnant women's decisions whether to seek health care.

In both the interviews and focus group discussions, women reported and discussed a broad range of beliefs, perceptions, knowledge, and practices related to maternal health. Interview teams consisted of trained and experienced local interviewers, both men and women. Transcripts were translated from the local language to English and then coded by trained researchers, reviewed to identify recurrent themes, and triangulated against findings from the household survey.

Findings

Of the 7,442 women selected for the survey, 42 could not be reached, 264 were not eligible (i.e. were never married or too old) and 254 did not complete the interview. The 6,882 completed questionnaires gave a response rate of 93% of all sampled women.

The average age of the surveyed women was 28.7. Most (73.1%) lived in rural areas, 63.4% were Hausa, 14.1% Kanuri, 16.6% Fulani and 5.9% from other groups. Only 18.8% had any formal schooling, of whom 53.0% had only some primary schooling.

Virtually all (97.2%) were married at the time of the survey, 80.5% monogamously or the senior wife in a polygamous marriage. Few (7.9%) owned a mobile phone. The median number of all pregnancies was 4.7, and 1,819 reported live births in the previous five years. Those with a recent birth were younger and had had 2.6 pregnancies, were more likely to be married, less likely to have had any formal schooling, and more likely to live over 10 kilometres from a health post.

Utilisation of antenatal care

Only 27.1% of women with a live birth in the previous five years (n=1,819) attended at least one antenatal consultation in their last pregnancy. However, this group had a mean number of antenatal visits of 4.9 (range 1–10), of which 24.5% were in the first trimester, 57.7% in the second trimester, and 17.1% in the third trimester. However, they did not receive all the requisite elements of care; only 87.2% had had their blood pressure taken, 85.0% were weighed, 81.2% received an anti-tetanus vaccination, 56.8% were counselled about breastfeeding, 58.3% were given information on newborn care, 64.9% received anti-malarial intermittent preventive treatment (which should be routine in this region), and 64.2% were counselled on danger signs of pregnancy and delivery and what to do about them.

Of those who had no formal antenatal care, only 30.8% said they sought advice about problems during pregnancy and delivery from friends, family or traditional birth attendants in their community. The interviews and discussions highlighted a persistent view of pregnancy as a normal part of married life and in no need of care. Pregnancy was commonly seen as “business as usual” and women neither received nor expected special food, assistance or care during pregnancy. Women in the focus groups said, for example, that pregnant women work till the day they deliver and that any attempts to reduce their family work would be considered humiliating. Antenatal care was viewed as being only for women who are sick. With normal and healthy pregnancies, there was no need for antenatal care: *“I just don’t want to attend, I feel pretty well.”*

The need to observe the separation of men and women in public spaces also constrained use of antenatal care, as women were loathe to seek care for themselves from a male health worker: *“If they say I have to see a male health worker, I simply return home.”* In addition, women said they were discouraged by the time and cost involved in

getting to a facility where they could actually be seen: *“There is nobody at the local health facility to attend to antenatal cases, so we have to go to the General Hospital. The distance is quite long. It takes an hour by motorbike because the road is bad, and it would cost us N300 (US\$1.90) for the return journey.”*

Bi-variate analysis of the survey data showed that the characteristics moderately associated with antenatal visits were Hausa ethnicity, living in a community with better access to maternity services, and literacy in any language. The only positive characteristic associated with antenatal visits confirmed in multivariate logistic regression was having sought advice for health problems from someone in the community ($p < 0.10$). Conversely, women were less likely to attend for antenatal care if they had experienced a neonatal death ($p < 0.10$), and 4.3 times less likely to attend antenatal care if they had consulted a traditional healer about any health problems ($p < 0.01$), confirmed as significant in multivariate logistic regression. No association was found with age, urban vs. rural residence, access to a cellphone, being employed (proxy for socioeconomic status), rank as senior or junior wife, or ever having had children (data not shown).

Delivery in a facility

In the study areas, the skilled birth attendants were all trained nurses or midwives, and they provided both antenatal and delivery care. We did not record any skilled deliveries being done at home. However, all of the women who delivered in a facility were attended by a trained nurse or midwife. Virtually none were assisted by a doctor. In some cases, some women referred to a “doctor” when in fact they had seen a nurse or midwife.

Whether or not they had attended for antenatal care, most women did not seek to deliver their babies in a health centre or hospital. Slightly over 60% of the women (n=1,819) prepared clean cloths to wrap the newborn in, but otherwise very few prepared any instruments (razor blade or sharp knife to cut the cord, not usually available in local facilities) (4–13%), food (3–9%), money (3–7%), or arranged for transport to be available (0.0–0.6%) in case they needed to go for help for complications during labour or delivery, whether they had attended an antenatal visit, talked to family or friends or sought no advice at all.

Only 13.1% of women gave birth to their most recent baby in a facility. The rest (86.9%) delivered at home, of whom 45.9% were attended by an

untrained traditional birth attendant (TBA), 13.3% by a trained TBA, and 23.1% by someone else, such as a friend, neighbour or family member. Two-thirds of those who delivered in a facility had had at least one antenatal visit, compared to less than one-third of those who delivered at home. Those who delivered in a facility were also more likely to have prepared for their delivery. In addition, bivariate analysis showed that those who delivered in a facility were somewhat more likely to reside in a city or not live over 10 km from the facility, and were Hausa, literate in any language, a second or higher rank wife, have three+ children, and had discussed health problems with friends or family. Multivariate logistic regression showed that after controlling simultaneously for these factors, those with at least one antenatal visit were 7.6 times ($p < 0.01$) and those who made birth preparations were 1.2 times more likely to have a skilled birth attendant ($p < 0.05$) and, unexpectedly, that junior co-wives were more likely to deliver with a skilled birth attendant ($p < 0.05$). Receiving advice about pregnancy and delivery from friends and family also increased the odds of having a skilled birth attendant ($p < 0.10$). As with antenatal care, no association was found with age, urban vs. rural residence, access to a cellphone, being employed, or ever having had children (data not shown).

The primary reason women gave for not delivering at a facility was being more comfortable at home (98.5%), distance to the facility (70.7%), believing a skilled attendant was not necessary (65.7%), and facility deliveries not being “customary” (56.6%). Almost half also cited lack of spousal permission and the perceived negative attitudes of health workers. Cost was a factor for only 28.3%. Those who delivered at a facility gave three basic reasons for this choice: complications, feeling safer at a facility, and considering facility deliveries to be “better”.

Qualitative data revealed a consistent view of childbirth as a normal, safe process: “*Our mothers gave birth at home; why shouldn't we?*” Women valued their privacy, and preferred delivering alone in the relative privacy of their own rooms, often saying they would squat at the edge of their rooms so they would not be seen. Deliveries in the health care system were seen as “alien”, filled with unknowns, and shameful (*kunya*), because they involved “exposing themselves” to male health professionals and staff.

These findings suggest that women who delivered their babies at home usually had very little

connection to the health system, had never sought advice for themselves or their baby and had never sought antenatal care or delivery at a health facility. The qualitative interviews elaborated upon this disconnect and added more reasons for it, related to great difficulty reaching a facility. Both women and men reported that they lived remote from services, with difficulty travelling over poor terrain, seasonal problems such as being cut off by fast-flowing rivers, difficulty flagging down commercial drivers, reticence of commercial drivers to accept a passenger with serious obstetric complications, lack of other transport options and security concerns at night. Even if obtained, the cost of transport to a health facility could range from N5,000 (US\$32) up to N15,000 (US\$95), depending on the time of day and distance.

Most of the health care providers interviewed described severe staffing shortages faced by their facilities, explained that the few existing staff had to provide all the services expected and were extremely over-worked, which greatly undermined their ability to provide quality care.

Discussion

Other studies, in Burkina Faso, Kenya and Tanzania, as well as in Nigeria, have found an association between using antenatal care and delivering with a skilled birth attendant,^{11–15} and one in Uganda that low quality maternity services were associated with low rates of antenatal visits.¹⁶

Multivariate analysis in this study showed that accessibility and socioeconomic status had no influence on the likelihood of women of using antenatal services for their most recent pregnancy, as has also been found in both Burkina Faso and India.^{11,17} The lack of use of these services even when they were accessible may, as in Uganda,¹⁶ reflect the low level and quality of services, especially in the rural areas of these three states. Hence, the Programme needs to focus on improving the quality and availability of both antenatal and delivery care, as well as emergency obstetric care, so that women will want to attend them. Our findings of no relation between socioeconomic status and antenatal or delivery attendance may reflect the relatively homogeneous economic status in the study communities, as in neighbouring Burkina Faso, where wealth differentials are also fairly narrow¹¹ in contrast to broader wealth differentials in southern Nigeria where there is a positive association.¹⁸

Patterns of advice-seeking about maternal health problems clearly influenced the use of antenatal care – family and friends tended to suggest that women with queries or problems attend for antenatal care while traditional healers did the opposite. Thus, once the quality and availability of services has improved, the Programme needs to reach out to the women who consult traditional healers to engage them and promote antenatal and delivery care, preferably with support for this message from traditional healers themselves. Community engagement plays a key role, creating a diverse set of opportunities where women can talk about health concerns. The findings further suggest that these conversations need to create awareness of changes being made in the configuration of health care services and staffing, so that women can feel that using these services will not compromise their privacy, their self-respect or their expectations as regards gender norms. For this to succeed, there is also work to be done focusing on health worker attitudes and far greater representation of women among all levels of maternity care staff.

We failed to ask women who reported an infant death why they were less likely to seek an antenatal consultation. However, based on their belief that pregnancy is not a time to do anything special to protect women or infants, women may not have perceived a connection between problems with their pregnancy and infant death, or know that skilled attention might have led to a live and/or healthier infant. Based on the findings of a study conducted in 2010 in the same states, which found that some households experienced a disproportionately high number of infant deaths compared with others in the same communities,¹⁹ the Programme particularly needs to target women who have had one or more infant deaths, to take all the steps necessary to reduce infant mortality risk.

Our findings indicate that social influence is important for encouraging women to seek both antenatal and delivery care. Particularly as the Programme takes steps to improve the quality of maternity services, existing informal social networks within the community can help in relaying back to pregnant women and the community how the health facilities have been improved and have become more “community-friendly” and comfortable for women. In addition, some of the antenatal counselling messages about birth preparations and recognizing and knowing how to respond to danger signs could be integrated into the

local social networks and groups, such as village women’s committees.

Women who made at least one kind of preparation for their baby’s birth were more likely to deliver with a nurse-midwife. Even if that did not include preparing to go to a facility for delivery, we believe that greater efforts to promote birth planning and preparation will increase the proportion of women who are ready and will go to a facility for delivery when they go into labour. As has been recommended by others in Nigeria,²⁰ not only does birth preparation need to be a consistent element of antenatal care, but it also needs to be incorporated into community-based information networks, so that women who do not attend antenatal care also know how to prepare for labour and delivery.

The finding that junior co-wives were more likely to deliver with a nurse-midwife is contrary to other evidence that junior wives may be discriminated against in terms of access to food for themselves and their children and tend to have poorer health prospects.²¹ Unfortunately, we also did not find out why this was the case, but will look into it further.

Lastly, we take seriously the fact that almost half the women surveyed said they did not have spousal permission to deliver in a facility. In the focus group discussions, it seemed that men’s approval or disapproval of pregnancy care was linked primarily with difficulties of access and the costs involved, which were sometimes to do with use of health services more broadly and in a very few instances with suspicion of a hidden agenda of reducing family size. The Programme therefore needs to work with men to address these responses.

Our findings show remarkably little change from the situation a decade ago in northern Nigeria.^{9,22} The Maternal, Newborn and Child Health Programme (MNCH) therefore needs to acknowledge the long-standing and intractable nature of these challenges, and the importance of long-term, innovative and vigorous strategies to address them.

MNCH Programme initiatives begun and in the pipeline

We have undertaken initiatives addressed both to women and their communities and with existing maternity services at primary and hospital levels.

Our first main objective has been to upgrade the quality of antenatal, delivery and emergency obstetric care, so that women are served by well-trained and well-supported nurses and midwives

and other female health workers, have 24/7 access to quality emergency obstetric care, and so that no woman is turned away for lack of staff or equipment. Before enhancing demand, we needed to make sure that services were of a high quality and that the provision of care is done with respect and gender-sensitivity. The Programme has worked with state and local authorities to recruit, train and support 194 midwives to date through the Midwife Service Scheme. These midwives have been posted by the National Primary Health Care Development Agency to the 58 primary health centres that previously had no midwife and to the 26 basic and 10 comprehensive emergency obstetric care facilities being upgraded in the intervention areas.

Antenatal visits have been incorporated into the services provided by community health extension workers in the community. The Programme is experimenting with performance-based financing options to increase antenatal visits, as well as deliveries by nurse-midwives, and also working with local authorities to integrate primary health centres, so as to put all their services “under one roof”. Almost half of all primary health centre staff (largely nurses or midwives) have received in-service training in integrated management of childhood illnesses, emergency maternity care, and kangaroo mother care and the Programme has been working to institutionalise these quality improvements through supervision and training structures.

Ten hospitals have upgraded their maternity services, and now meet the standards of comprehensive emergency obstetric care. In addition, the referral system has become functional, because the facilities with basic emergency care are now supported by a free emergency transport service, provided by members of the National Union of Road Transport Workers. Throughout the three states, communication strategies are being launched to help traditional leaders and community groups talk about emergency services and promote their life-saving use.

In the community, our objective has been to promote antenatal care and safe birth, provide information on danger signs in pregnancy and childbirth, the importance of planning for delivery and of standing permission from husbands to attend a facility, and to convey feedback about changes in both antenatal and delivery services that address concerns about gender, privacy, dignity, and quality of care. This is being implemented primarily through community health volunteers, who facilitate community discussion groups and

use participatory communication tools – a community engagement discussion guide, jingles, and “body tools” (e.g., using five fingers to demonstrate the number of visits required for a child’s immunisation). These activities are reinforced by an average of four health promotion jingles or spots per day on the radio for 12 weeks, and by reaching out to traditional and religious leaders to ensure an enabling environment for behaviour change. The community health volunteers had by December 2011 worked with local (ward) development committees at 323 community engagement intervention sites across the three states.

We are currently developing pictorial “job aids” for community health extension workers to use when counselling women about these topics. To strengthen social support for recognition and response to danger signs and to promote antenatal and facility-based deliveries, the Programme is helping communities to establish community emergency savings groups, community blood donor groups and community-based emergency transport systems, in order to address the key barriers of accessibility and affordability of services. Many of the community volunteers and health extension workers are themselves “innovators” in that they already use the maternity services, which helps them to promote utilisation by other women.

The baseline data reported here have provided a rigorous foundation for assessing programme impact, which we will do at the end of three years, its first phase of operation (December 2013). Service utilisation data to date already suggest that these measures are bringing about changes in women’s experience of pregnancy and delivery, and hopefully improving outcomes. We can report that in the two years since launching these interventions, 52% of pregnant women had had at least one antenatal visit, a five-fold increase over baseline levels, and the number of facility deliveries with a trained nurse-midwife had increased to 35% of all births, a four-fold increase since baseline. Lastly, there were approximately 588 referrals and transports to a hospital with comprehensive emergency obstetric care for complicated cases.

The Programme will continue to deploy its intervention activities in the target states until the first phase ends by taking advantage of the support structures that have been established and embark on other activities that will improve the lives of women and their children. For example, one of the critical issues in northern Nigeria is that women who marry young often find themselves

at the bottom of the social hierarchy. To address this challenge, the Programme will focus on young women in its ongoing activities to improve health equity by increasing married young women's access to essential maternal and newborn health services and to advise them on reproductive health and nutrition. Thus, we hope to equip the next generation in the target areas with information relevant to their own health and their pregnancies.

Acknowledgements

This research was conducted as part of the Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child

Health Programme, funded by UKAid (Department for International Development) and the Norwegian Government. The authors acknowledge the technical support of Dr Stephane Helleringer and Dr James F Phillips in the completion of the quantitative study; Fatima Abdulkadir and Umar Farouk Wada who supported the development and execution of the qualitative surveys, and the community leaders and respondents who participated in this study. We also acknowledge the support of Dr Rodion Kraus, Deputy National Programme Manager, and Dr Anthony Aboda, Maternal Newborn and Child Health Advisor, for leading the design of some of the interventions reported here.

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Résumé

Les taux de mortalité maternelle au nord du Nigéria sont parmi les plus élevés du monde, soit plus de 1000 pour 100 000 naissances vivantes en 2008, avec des services de maternité de qualité et de niveau très bas. En 2009, nous avons étudié les raisons de la faible utilisation des soins prénatals et obstétricaux chez des femmes ayant récemment été enceintes, et les croyances et pratiques socioculturelles qui les influençaient. L'étude incluait une enquête quantitative auprès de 6882 femmes mariées, 119 entretiens et 95 discussions de groupe avec des responsables locaux et communautaires, des accoucheuses traditionnelles, des patientes des services de maternité et des prestataires de soins de santé. Seules 26% des femmes interrogées avaient reçu des soins prénatals et à peine 13% avaient accouché dans un centre avec une assistance qualifiée lors de leur dernière grossesse. Néanmoins, celles qui avaient eu au moins une consultation prénatale avaient 7,6 fois plus de probabilités de bénéficier d'une assistance qualifiée lors de l'accouchement. La plupart des femmes enceintes avaient peu ou pas de contacts avec le système de santé en raison des coutumes, par manque de perception du besoin, du fait de la distance, de l'absence de transport, du manque de permission, du coût et/ou de la réticence à voir un médecin masculin. Sur la base de ces conclusions, nous avons conçu et mis en œuvre un ensemble intégré d'interventions qui incluait l'élargissement des soins prénatals, obstétricaux et d'urgence ; la formation, la supervision et le soutien des nouvelles sages-femmes dans les centres de santé primaires et les hôpitaux ; et la diffusion d'informations à la communauté sur une grossesse et un accouchement à moindre risque, et le recours aux services.

Resumen

Las razones de mortalidad materna en Nigeria septentrional figuran entre las peores del mundo, más de 1000 por cada 100,000 nacidos vivos en el año 2008, con un nivel muy bajo y baja calidad de los servicios de maternidad. En 2009, realizamos un estudio de los motivos por la poca utilización de atención antenatal y asistencia durante el parto entre mujeres con recientes embarazos, y las creencias y prácticas socioculturales que influyen en éstas. El estudio incluyó una encuesta cuantitativa de 6882 mujeres casadas, 119 entrevistas y 95 discusiones en grupos focales con líderes de la comunidad y del gobierno local, parteras tradicionales, mujeres que habían acudido a servicios de maternidad y profesionales de la salud. Solo el 26% de las mujeres encuestadas habían recibido atención antenatal y solo el 13% dio a luz en una unidad de salud con asistencia calificada durante el parto de su embarazo más reciente. Sin embargo, aquéllas que tuvieron por lo menos una consulta antenatal tenían una probabilidad 7.6 veces mayor de dar a luz con asistencia calificada durante el parto. La mayoría de las mujeres embarazadas tenían poco o ningún contacto con el sistema de salud por razones de costumbre, falta de necesidad percibida, distancia, falta de transporte, falta de permiso, costo y/o el hecho de que no estaban dispuestas a ver a un médico del sexo masculino. A raíz de estos hallazgos, creamos y aplicamos una serie integrada de las siguientes intervenciones: mejorar la atención antenatal, la asistencia durante el parto y los cuidados obstétricos de emergencia; ofrecer capacitación, supervisión y apoyo a nuevas parteras profesionales en centros de salud primaria y hospitales; y proporcionar información a la comunidad sobre el embarazo y parto seguros y el uso de estos servicios.