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STRENGTHENING EMERGENCY OBSTETRIC AND NEWBORN CARE AND FAMILY PLANNING IN NORTHERN NIGERIA

FY10 Q3 REPORT

Presented to USAID/Nigeria
30th July 2010

JHPIEGO in partnership with
JSI, Save the Children, PATH,
JHU/IIP, Broad Branch, PSI
and Macro International

USAID/Nigeria QUARTERLY REPORT

Apr – Jun 2010 (Q3 FY10) Report

ACTIVITY SUMMARY
Implementing Partner: MCHIP Nigeria
Activity Name: Emergency Obstetric and Newborn Care in Northern Nigeria
Activity Objective: Increased utilization of quality Emergency Obstetric and Newborn Care (EmONC) services (including birth spacing) by pregnant women, mothers and their newborns at selected LGAs in Kano, Katsina and Zamfara States.
USAID/Nigeria SO13: Increased use of child survival and reproductive health services
Life of Activity (start and end dates): April 1, 2009 – September 30, 2010
Total Estimated Contract/Agreement Amount: $5,050,000 committed
Obligations to date: $5,050,000 committed as of July 29, 2010
Current Pipeline Amount: $2,535,229 as of June 30, 2010
Actual Expenditures this Quarter: $1,011,132 for April 1 – June 30, 2010
Estimated Expenses Next Quarter: $973,883 for July 1 – September 30, 2010
Monthly Burn Rate (last 3 month): $337,044
Report Submitted by: Emmanuel Otolorin, COP **Submission Date:** 29th July 2010 **Name and Title**

Acronyms

ACCESS	Access to clinical and community maternal, neonatal and women's health services
AMTSL	Active Management of the Third Stage of Labour
ANC	Antenatal care
BCS	Balanced Counseling Strategy
CAC	Community Action Cycle
CCG	Community Core Group
CHEWs	Community health extension workers
CM	Community Mobilization
CMT	Community Mobilization Team
COP	Chief of Party
CYP	Couple years of protection
DQA	Data Quality Assessment
EmONC	Emergency obstetric and newborn care
FGDs	Focus Group Discussions
FP	Family planning
FY	Fiscal year
HMH	Honorable Minister of Health
HOD	Head of department
HTSP	Health timing and spacing of pregnancies
IGA	Income generating activities
Jhpiego	Corporate name, no longer an acronym
LAM	Lactational amenorrhea method
LGA	Local Government Area
LOP	Life of Project
MBSM	Male birth spacing motivators
MCHIP	Maternal and Child Health Integrated Program
MDG	Millennium Development Goals
MIP	Malaria in Pregnancy
MMSH	Murtala Mohammed Specialist Hospital
MNCH	Maternal, Newborn and Child Health
MSS	Midwives Service Scheme
PHC	Primary health care
PMTCT	Prevention of Mother to Child Transmission of HIV
PPFP	Postpartum family planning
PPH	Postpartum hemorrhage
PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
QIT	Quality improvement team
SBM-R	Standards Based Management and Recognition
SMOH	State Ministry of Health
TMMD	Tallafi Mata Masu Dubara
TOT	Training of Trainers
USAID	United States Agency for International Development
ZAIHAP	Zamfara and Akwa Ibom HIV/AIDS Project

Narrative section

I. Background

MCHIP is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program, which focuses on reducing maternal, neonatal and child mortality and accelerating progress toward achieving Millennium Development Goals (MDGs) 4 and 5. In Nigeria, MCHIP has continued the goals and objectives of the ACCESS Program which is to strengthen emergency obstetric and newborn care in Northern Nigeria as an entry point to postpartum family planning transitioning to long-acting contraception. USAID/Nigeria is funding MCHIP to focus on increasing the use of high quality Emergency Obstetric and Newborn Care (EmONC) services in 3 states in Northern Nigeria, namely Zamfara, Kano and Katsina States. MCHIP Nigeria's LOP objective and results continue to contribute to USAID's strategic objective 13, *Increased Use of Child Survival and Reproductive Health Services.* MCHIP contributes to the reduction of maternal and neonatal mortality by achieving its life-of-project (LOP) objective, *increased utilization of quality emergency obstetric and newborn care (EmONC) services by pregnant women, mothers and their newborns in selected LGAs in three states, Kano Zamfara and Katsina***.**

II. Quarter 3 FY10 achievements

During this quarter, MCHIP completed the following activities:

1. ACCESS End line Survey

During the quarter, the Consultant hired to conduct the ACCESS Endline Evaluation submitted his report. A draft executive summary is attached in Annex 1. A plan to share lessons learnt at the 2010 SOGON Annual Conference scheduled for 17-21st November 2010 is being put together.

Results of the endline household survey in four LGAs in Kano and Zamfara States provide measures of changes that have occurred in knowledge and practice of emergency obstetric, newborn and family planning services after three years of program intervention in the selected locations. The endline survey shows a general improvement in knowledge of danger signs or risk factors associated with pregnancy, labor and delivery, two-day postpartum, and care for newborns in the first seven days after birth over the results of the baseline survey. There was also a significant improvement in knowledge about birth preparedness which can be attributed to the program intervention. The percentage of women who made any arrangement before the birth of their last child more than doubled at the endline. The tremendous improvement both in knowledge and action with respect to birth preparedness is expected to have positive pregnancy outcome in the predominantly rural setting covered by the survey. The endline survey found that about 74% of the women received at least one ANC visit during their last pregnancy, up from 42% at baseline, indicative of a substantial increase in accessing ante-natal care between the two periods. The component of care received during ANC visits showed a more superior outcome at the endline period, with anti-malaria drug receiving the highest improvement.

Rather worrisome is that a vast majority of deliveries in the two states still took place at home (about 80%), virtually the same rate with the baseline, and only slightly lower than 90% found by 2009 NDHS for North West Zone, where the two states are located. Given that about 73% of women visited a health facility for a least one ANC service, it seems that even though women have realized the importance of ante-natal care, they still preferred to have their babies at home. This is perhaps supported by the large percentage of women (78.5%) who claimed to have planned to give birth where they did; only 20.4% did not plan to have their babies where they eventually had them.

Important barriers to seeking care during pregnancy and birth documented by the survey are financial, socio-cultural and logistical in nature. While some women reported that lack of funds is the primary constraint, socio-cultural factors and norms, such as gender roles and conservative religious beliefs, obstruct other women's ability to seek the health care services they desire. Strikingly, husband's disapproval of facility-based care did not seem to be the driving force behind the decision to give birth at home (in fact, 76% of those who delivered at a facility were accompanied by their husbands), and most women reported making the decision about where to give birth with their husbands or on their own, while about one-third of the women said that no one ever made a decision in this regard. This is likely a reflection of a cultural norm of giving birth at home.

There is a significant improvement in knowledge and use of family planning at the endline. However, apart from the pill and injectables, the level of knowledge of other family planning methods remains low. Only five women were using a family planning method at the baseline in the four LGAs, but the number of current users of FP increased to 67 at the endline. The three methods mostly used are LAM, injectables and pills. Despite the fact that most women did want another child but did not want to become pregnant again soon, the vast majority were not using any method of contraception. The primary barrier to use of FP appeared to be a culturally fatalistic approach to fertility—with a belief that "God will decide" on the number of children.

An evaluation of the level of program presence in the community indicates that 58% of the respondents knew about a committee or group set up by the ACCESS program, slightly more in Kano. Those who knew about the community groups identified mother's health, baby's health and FP as the main issues they deal with, with only about one-fifth actually receiving some help from them. The data suggest that ACCESS health workers provided to the communities the requisite services they were trained to provide, but it seems they have not covered all the communities or their membership or available resources are inadequate to do so. Given the low level of facility use in the areas as well as the relatively low level of knowledge of birth preparedness, danger signs and family planning, the activities of ACCESS trained health workers and counselors should be supported by the local and state governments. This will greatly improve awareness of danger signs and utilization of maternal and newborn services, and reduce the high levels of maternal and newborn deaths being experienced in the area.

2. Contraceptive Technology Update Training for Doctors and Nurse/Midwives

In order to address the dearth of FP knowledge and skills among newly posted health care providers, a 5-day contraceptive technology update training for doctors and nurse/midwives was held in Kano during the quarter. This training aimed at improving the competence of doctors and midwives in the provision of family planning counseling and services in MCHIP supported facilities in Kano, Katsina and Zamfara States. A key objective of the training was to introduce and integrate the *balanced counseling strategy* to doctors and midwives providing family planning counseling and services. This was more so as most of the midwives trained were from the Midwifery Service Scheme (MSS) posted to Primary Health Care facilities where the scope of family planning service provision was limited. The training used a variety of approaches including illustrated lectures, discussion, case studies, role plays, brainstorming and clinical practice in the FP clinic during which all the participants had the opportunity to counsel clients using the balanced counseling technique. The training also included a session on the USAID policy requirements for FP service provision at USAID-supported facilities. A total of 28 participants were trained – 16 from Kano State (3 doctors, 13 midwives), 6 from Zamfara state (4 doctors, 2 midwives) and 6 from Katsina State (4 doctors, 2 midwives). One doctor from Katsina State was an NYSC doctor, while 8 of the midwives were participating in the Midwifery Service Scheme (MSS) program. Participants trained had extensive role play practices followed by clinical experience in the use of the Balanced Counseling Strategy Technique. The counseling cards, algorithm and brochures were made available to all participants. There were six trainers including Jhpiego staff and consultants previously trained by Jhpiego. All the trainees were quick on the uptake with regards to the balanced counseling strategy technique. They clearly enjoyed using it and their mastery of it in such a short time was quite remarkable. At the end of the training, the participants drew up action plans with regards to improvement of family planning services at their respective facilities and host communities. They were informed that it was optimal to use the Community Core Groups for any community related activity.

Participant counseling a client using the balanced counseling strategy

3. Postpartum Family Planning (PPFP) Training for Community Health Extension Workers (CHEWS)

As the Intermediate Result 4 of the MCHIP program is “Improved quality of family planning services in selected LGAs”, activities aimed at achieving these include training of health care providers to improve their knowledge and skills in FP counseling and service provision. To this end, CHEWs working in MCHIP supported facilities in Kano, Katsina and Zamfara States also received training on postpartum family planning counseling and service provision. A key objective of the training was to introduce and integrate the

balanced counseling strategy to CHEWs providing family planning counseling. A total number of 20 CHEWs were trained from the 3 States.

Participants doing a role play using the balanced counseling strategy

The PPFP training aimed at increasing the knowledge and skills of CHEWs in order to improve FP counseling and service provision in the supported PHC facilities. The training was competency-based and was very interactive. It also included clinical practice in the FP clinic during which all the participants had the opportunity to counsel clients using the balanced counseling technique. The training also included a session on the USAID policy requirements for FP service provision at USAID-supported facilities. Training and practice on the WHO Medical Eligibility Criteria for Contraceptive Use was also carried out. The counseling cards, algorithm and brochures were made available to all participants, as was the Quick Reference Chart for the WHO Medical Eligibility Criteria. At the end of the training, participants drew up action plans with regards to improvement of family planning services at their respective facilities and host communities.

4. IUD and Jadelle training for Midwives

A participant inserting Jadelle

In recognition of the need for long-acting contraception after the post-partum period, MCHIP organized a focused IUD and Jadelle training for midwives during the quarter. The training aimed at increasing knowledge and skills of providers in IUD and Jadelle method provision in order to increase the contraceptive method mix available to clients. The hands-on training was competency based and relied heavily on the use of anatomic models prior to clinical practice in the FP clinic. The training also included a session on the USAID policy requirements for FP service provision at USAID-supported facilities. There were a total of 20 participants comprising 8 nurse/midwives from Kano State, 6 nurse/midwives from Zamfara State and 6 from Katsina State. The Kano State FP Coordinator and 2 Jhpiego interns also participated. An abridged training on the Balanced Counseling Strategy was also held, which served as an introduction for those who had never heard of it and a refresher for those who had been previously trained on it. The training was conducted by Jhpiego staff and consultants who had been previously trained by Jhpiego. The baseline knowledge of IUD and Jadelle among participants was variable with pretest scores ranging from 30% to 70%. However all

participants showed improvement by the end of the training with five scoring 100% in the post test. At the end of the training, Participants drew up action plans with regards to initiation of, and in some cases, improvement of IUD/Jadelle and other FP services at their various facilities.

5. Visit of the USAID/Nigeria Desk Officer in Washington, Ms. Dana Alzouma

During the quarter, the USAID/Nigeria Desk officer in Washington, Ms. Dana Alzouma visited the MCHIP supported facilities and communities in Kano State. She was accompanied by Mr. Abdullahi Maiwada, Senior Programme Manager Reproductive Health, USAID-Nigeria. At the MCHIP field Office, a detailed presentation was made by the State Program Officer on the MCHIP household-to-hospital continuum of care approach for improving maternal and newborn health, which addresses the issues of the community and health facilities together systematically, and in close collaboration with the stakeholders. The Senior Community Mobilization Officer also made a presentation on the community interventions by USAID/MCHIP in communities around MCHIP supported facilities. This include the setting up of CMT/CCG structures with members of the community who were trained using the Community Action Cycle (CAC) and empowered to explore MNH problems in the community and act together to tackle them with technical support from MCHIP. The MCHIP record keeping and reporting formats and the details of the data capturing process from the facilities to the Head Office was also presented by the Strategic Information Officer while the FP coordinator gave a brief overview of activities conducted to increase access to quality family planning services in MCHIP supported facilities.

MCHIP State Program Officer making a presentation on the work of ACCESS/MCHIP in Kano

At **Sheikh Muhammad Jidda General Hospital (SMJGH)** The USAID/MCHIP team was received by the Medical Director and other hospital management staff. The medical Director, on behalf of the hospital management, expressed his joy and satisfaction with the tremendous input made by MCHIP towards staff capacity building, donation of equipment and job aids and, most of all, the renovation of the hospital, which were carried out not only at SMJGH but also at Murtala Muhammad Specialist Hospital and other facilities in the State. He stated that since the construction of the hospital by the colonial masters in the early 20th century, this is the first time the maternity unit of the hospital had a major renovation work. He went further to state that the State Commissioner of Health was impressed with the renovation by USAID/MCHIP and felt compelled to make her own input by bringing 30 medical equipment including delivery beds with mattresses, and incubators in order to show her appreciation and complement the work done by MCHIP. The hospital management also initiated the construction of a barrier wall around the wards in order to protect the work done by MCHIP from vandalization.

USAID/MCHIP team at the labor ward of SMJGH

The members of Fagge CCG set up by MCHIP were not left behind as they also renovated the toilets used by clients and their relatives at the hospital. After taking the USAID team round the hospital to appreciate the work done at the facility, the members of Fagge Male Birth Spacing Motivators (MBSM) made a drama presentation to Ms Alzouma on a birth spacing visit. The desk officer expressed her delight with their activities targeting men as stakeholders and encouraged them to keep up their commitment. The Desk Officer interacted with Fagge CCG members and commended them for their effort towards community development, empowerment and behavior change communication to improve MNH.

At **Murtala Muhammad Specialist Hospital (MMSH),** the matron in-charge of the maternity unit and the Head of OB-GYN Department made a brief presentation on the support given to MMSH by MCHIP by way of staff capacity building, donation of equipment, job aids and national guidelines, establishment of a Kangaroo Mother Care (KMC) unit and renovation of the National Diarrhea Training Unit to serve as EmONC training centre for MCHIP. The USAID officials were taken round the maternity unit to appreciate work being done at the unit and the need for continued support from development partners such as MCHIP.

At the **State Ministry of Health** the USAID/MCHIP team was received by senior government officials of the Ministry. Due to the absence of the Honorable Commissioner of Health, a meeting was held with the Permanent Secretary. The Permanent Secretary, Director of PHC and other Directors of the Ministry commended USAID for its support to

the State government through funding programs such as ACCESS, MCHIP and COMPASS which have played and continue to play a major role in complementing the efforts of the government towards developing the health sector.

Meeting with officials of the SMOH

At **Dawanau community**, the USAID/MCHIP team had a warm reception by the CMT/CCG upon their arrival. The village head of Dawanau, the Chief Imam and other elders from the community were all in attendance to receive them. The head of Dawanau CCG made a presentation on how ACCESS/MCHIP supported them through training on the Community Action Cycle (CAC) to work together and explore and tackle MNH problems in Dawanau community. He stated that with the coming of ACCESS/MCHIP into Dawanau, they were now better informed about the causes of maternal and newborn mortality and the steps they can take towards addressing some of the problems in the community. Members of Dawanau community now appreciate the importance of ANC attendance which has increased following community mobilization efforts, the need for birth preparedness and complication readiness, delivery at the health facility, postnatal care and healthy spacing of pregnancies. He also stated that the community members work with the health care providers at the facility to identify women with anemia in pregnancy and other medical problems and provide them with the necessary support through home visits to ensure compliance with medications and intake of healthy diets. They also work in close collaboration with public transport owners to ensure that women are transported on time to the health facilities when emergencies arise. The head of the TMMD club explained how she was supported by ACCESS/MCHIP through training and technical support starting at Zamfara State to set up the TMMD club. Over a period of 48 weeks, they have saved over ₦220,000 (about $1500) through weekly contribution of ₦100 per member. They also have ₦20,000 (about $135) set aside for assisting club members in case of any medical emergency. After demonstrating the procedure for making contributions, she stated that the funds generated have so far been utilized for setting up small scale businesses by club members such as making groundnut oil, dying of fabrics for sale, selling food items, etc. They also used the funds to hire teachers from the community to teach them how to read and write, and as a result some of the club members can now read and write. They have also acquired five (5) acres of land which they will cultivate during the next farming season using the club's funds and share the proceeds among club members.

Group picture with Dawanau CCG/HHCs

Several of the club members narrated success stories of how they benefited from the club by utilizing the funds for medical emergencies and through creation of awareness on reproductive health. The household also demonstrated a counseling visit using flip chart. Ms Alzouma was impressed with the work of Dawanau community and commended them for their effort towards financial empowerment and improving their MNH by utilizing services at the health facility and practicing and promoting healthy spacing of pregnancies. She then proceeded to visit Dawanau PHC to see the renovation done by USAID/ACCESS and encouraged the health care providers to continue to provide optimal care to the clients.

TMMD club members demonstrating club activities

At the end of her visit, Ms. Dana Alzouma stated in no uncertain terms that she was very impressed with the work of ACCESS/MCHIP in Nigeria and encouraged the field staff to intensify their efforts towards implementing and monitoring program activities that will improve the lives of women and their children in the communities and reduce maternal and newborn mortality. She went further to state that ***"it is these kinds of field visits that help to change the long held misconceptions about the project because they serve as opportunities to see what MCHIP is doing in the field rather than reading reports".***

6. ACCESS-FP Technical Consultation in Washington DC

During the quarter, and in recognition of the immense importance of Family planning as one of the key strategies of ultimately reducing maternal mortality, the MCHIP Senior Technical Officer and the TSHIP Quality Improvement Manager (who was formerly the Kano State Senior Program Officer) were invited to Washington DC to attend the ACCESS-FP Technical Consultation meeting. The objectives of the meeting were to share lessons learned and concepts of PPFP over the past five years and to continue to build momentum for the future of FP/MNCH integrated programming.

TSHIP Quality Improvement Manager making her presentation

There the team made a presentation titled "*Integrating LAM into an MNH program in Northern Nigeria*" which was very well received. The meetings concluded that integration of PPFP into MNCH including PMTCT programs is feasible, practicable, effective and beneficial and that various models of integration exist and are applicable to different situations.

7. Clinical training skills course

As part of MCHIP's Strategy to build sustainability into its programs in Nigeria, MCHIP embarked on capacity building of a selected group of FP/RH champions during the quarter. One of such activities was the implementation of Jhpiego's new and improved Clinical Training skills course in Abuja. Participants included Jhpiego staff, Consultants and SMOH staff. The workshop, which was facilitated by Jhpiego/Nigeria Country Director, Prof. Emmanuel Otolorin, and Dr Willy Shasha, (Baltimore), aimed at preparing participants to be competent clinical trainers who will be conducting a variety of competency-based clinical skills courses. The 5-day course succeeded in building the capacity of the participants in planning, organizing and conducting/facilitating clinical training skills courses, competency assessment, managing problems that arise during workshops and workshop evaluation. Action plans for conducting mentored workshops that will enable the trainees to become fully qualified Jhpiego trainers were developed at the end of the workshop.

MCHIP COP demonstrating newborn resuscitation

During the workshop, the trainers also introduced the new and inexpensive anatomic model used by the Helping Babies Breathe (HBB) consortium to teach neonatal resuscitation.

8. Jhpiego Country Directors and Field Representatives Meeting

During the quarter, the annual meeting of Country Directors and Field Representatives of Jhpiego world wide was held in Rwanda in May. This was the first time ever that the meeting would hold outside Baltimore. The Country Director and MCHIP Nigeria Senior Program Manager attended the 6-day meeting. This year's meeting also coincided with Jhpiego's preparation of its next 5-year strategic plan. Of particular interest to note was that the Chief Financial Officer while giving his report on the internal control reviews conducted in different countries commended Nigeria as a shining example of good financial practices.

9. Staff Transitions

During the quarter, the MCHIP Senior Program Manager was appointed to the vacant position of Deputy Country Director for Jhpiego.

10. Data Quality Assessment

During the quarter, and in continuation of the exercise from the last quarter, the MEMS team went to assess data quality in Zamfara State. The main objective was to ascertain the authenticity of the data coming from MCHIP supported facilities as well as provide technical support on how to improve the quality of data the facilities are reporting and provide technical support on how best to track essential data to be reported to USAID. The activity was facilitated by MEMS while MCHIP staff provided explanations on issues raised. The visiting team interacted with service providers responsible for completing the various registers and monthly summary forms in all the facilities visited and also interacted with records officers especially in General Hospitals. Activities undertaken and issues discussed included, review of data reported and submitted by the facilities on selected indicators (SBAs, FP/RH Counseling visits, Essential newborn care, CYP, AMTSL from October to December, 2009, counting of the data for the indicators on the registers to determine their accuracies, determining the reliability and validity of the data submitted by MCHIP to USAID for the first quarter of FY10 as well as determining the data flow system for the project. Generally, it was observed that the 2010 DQA exercise was better than the one conducted in the previous year. The data submitted for most of the indicators during the quarter reviewed was adjudged reliable, timely and of high integrity. Suggestions made by the MEMS team at the end of the exercise included continuous supportive supervision and on-the-job training for service providers and record officers by the newly employed MCHIP Strategic Information Officers and program officers, and re-structuring of the monthly data collation meetings. Staff were advised that the summary forms should be screened and data entered should be compared with those in the registers during the data collation meetings. Conduct of outstanding record keeping re-fresher training for service providers and record officers in Zamfara was also discussed. A formal report of the DQA was sent and an action plan to address the issues observed was also forwarded to USAID.

MEMS Officer reviewing data with USAID Staff

11. State-based Activities

Kano

i. **SBM-R Module 1 training.** In order to improve the quality of EmONC services in ACCESS-MCHIP supported facilities and reduce the burden of maternal and newborn morbidity and mortality, a three-day training workshop was conducted

to orient facility managers, healthcare providers and representatives of the state government on the implementation of SBM-R as a quality improvement process for improving EmONC services and promote its institutionalization and sustainability in Kano State. The training, which was conducted in three (3) batches, included illustrated lectures on SBM-R, quality concepts, the process of setting standards, implementing standards, scoring and summary of results, gap identification, feedback and operational action plan. Emphasis was also placed on change management, identification of stakeholders and stakeholder analysis, setting of key implementation teams as well as promotion and agreement. The training also included discussions and practical exercises on scoring at the antenatal clinic of Murtala Muhammad Specialist Hospital, brainstorming on causes of identified gaps and suggestion of practical solutions. There were a total of 46 participants consisting of 2 doctors, 25 nurse-midwives, 14 CHEWs, 3 officials of the SMOH, MFG and HMB and 2 WAHO Interns. The particpants came from 18 out of the 22 MCHIP supported facilities in the State. There were 3 trainers, all of which were Jhpiego staff. At the conclusion of the 3 batch trainings, participants had been oriented on SBM-R as a practical approach for improving quality of emergency obstetric and newborn care services (as well as family planning). The various stakeholders in attendance appreciated the quality and content of the performance standards text, field tested the use of the tool and expressed their commitment to improving quality of EmONC using SBM-R in order to reduce maternal and newborn morbidity and mortality. As a way forward, representatives of the SMOH, Ministry for Local Government and Hospitals Management Board will be incorporated into the SBM-R Coordinating body to monitor progress made and support the health care providers, advocate for resources (human and material) for the facilities and participate in formalization of the Recognition process for any facility that achieves an overall score of 80% and beyond.

MCHIP COP facilitating SBM-R Module 1

Participant performing AMTSL as others assess her using direct observation method

ii. **Improving contraceptive security in MCHIP supported facilities -** As part of ongoing efforts to improve contraceptive security in MCHIP supported facilities through Health Care Providers capacity building, creating demand and utilization by clients and ensuring availability of contraceptive commodities, more FP service providers where able to procure commodities in sufficient quantities (through forecasting) from the State FP coordinator. Because cost barriers affects clients' ability to access FP services as observed in some of the supported facilities, the direct linkage between the service providers and the State FP coordinator has helped to cut down the multiple layers of middle managers that sky-rocket the cost of commodities, thereby making contraceptives available at very low cost to clients. Success has been achieved in bringing down the cost price for various commodities by 300-500% and assurance has been gotten from the Health Care Providers that the commodities will be made available to clients at low profit margin to increase access and demand and improve MNH. Furthermore, the Country Director also led a team of FP/RH stakeholders to meet the new Honourable Minister of Health to advocate for free FP services in the country (see details below).

State FP Coordinator donating IUD insertion kit to Rurum PHC

iii. **Donation of IUD insertion kits to Burumburum and Rurum PHCs –** Following the IUD and Jadelle workshop conducted in Kano, where the capacity of MSS midwives and other midwives working in selected MCHIP supported facilities to provide IUD and Jadelle insertion and removal services were built, it became imperative to enable them to provide the services to women in the rural communities. To this end IUD insertion kits, were donated to Rurum and Burumburum PHCs where the MSS midwives work in Kano State. A team led by the MCHIP FP Coordinator with representatives of the State Ministry of Health and Ministry for Local Government, donated the kits to Rurum and Burumburum PHCs to initiate service provision at the facility and to expand the contraceptive method mix available to women in the communities. This resulted in a renewed commitment by the Ministry for Local Government to provide additional resources to the facilities as the MCH Coordinator immediately demanded for a list of other items required by the facilities, including beds and couches, to be supplied by the Ministry.

iv. **Community activities** – During the quarter, a number of community oriented activities were carried out. These included the activation and roll-out of module 1 of the TMMD (Mothers Savings and Loans Clubs) operational and implementation guidelines at Fagwalawa, Danbatta, Yako and Kiru catchment communities, commissioning of Rano, Kiru and Dawakin Tofa Male Birth

Spacing Motivators, strengthening of the capacity of the Tudun Wada CCG and TMMD Training at Tudun Wada and Rano. Data collection meetings were also conducted with the Household counsellors in Dawakin Tofa and Gezawa LGAs as well as the Male Birth Spacing Motivators working at Fagge and Gezawa LGAs.

v. **Inauguration of IMNCH Partnership/Forum in Kano State** - In recognition of the immense contribution of ACCESS-MCHIP towards improving MNH and FP services in the State, the State Ministry of Health nominated MCHIP State Program Officer to serve as member of one of the working groups (WG) that will look at how to improve the MNCH in the State. A total of four working groups (WG) were inaugurated by the Honourable Commissioner and the SPO will work in the **LGA and Facilities Rollout support working group.** This WG will among others, ensure coherence between policies and objectives and work plans of the IMNCH partnership with those of their respective programmes and organizations, coordinate the implementation and monitoring of the plans on State and LGA level implementation, support capacity building for programme management and service delivery, develop plans for IMNCH roll out to LGAs. And support situation analysis and needs assessment for implementation of IMNCH strategy.

vi. **Meeting with Director Inspection, Ministry for Local Government** - Because of the frequent transfer of health care providers at the PHCs, a meeting was held with the Director of Inspection, who supervises activities at the PHCs and coordinates staff postings. The Director commended MCHIP for its effort towards improving MNH in the State and promised total support for MCHIP. He immediately nominated the MCH Coordinator to work closely with MCHIP on SBM-R and supportive supervision and ordered for immediate compilation of a list of health care providers working in MCHIP supported facilities to avoid transfer out of the facilities.

vii. **Meeting with JHU CCP** - As a follow up to the Packard Foundation's 11th Grantees meeting on strengthening partnerships, a meeting was held with CCP-Ku Saurara, working on RH/FP, on collaborative efforts that can be made to increase access to RH/FP messages to women living in MCHIP supported communities.

Zamfara

i. **Commissioning of Male Motivators** – The Male Birth Spacing Motivators in Anka LGA were commissioned. At the ceremony, the Director PHC gave opening remarks and encouraged the men to do the work diligently and thanked MCHIP for starting the initiative. He recognized the fact that there was an unmet need for Family Planning in their communities, as he owns a patent medicine store where women always patronize him requesting for injectables and pills to delay their pregnancies without the knowledge of their partners. He expressed the belief that involving the men will be the answer to the problem. After the commissioning ceremony, the Male Motivators were reoriented on how to fill the visit forms. This was the last Male Motivators Commissioning

Ceremony to be conducted. All the 120 men trained in the 6 LGAs have since commenced work.

ii. **CCG quarterly meeting** – the CCG quarterly meetings were held for the 18 CCGs in the State in 2 batches. Present at the meetings were the CCG Chairmen and their Secretaries as well as the CMT Chairmen and Secretaries and MCHIP staff. The aim of the quarterly meeting was to bring together all the CCGs from all the LGAs to interact and get to know each other, share experiences/challenges, achievements, to enable the CCGs to learn from each other and to stimulate healthy competition amongst them. The CCGs were reminded of their roles and responsibilities which are to educate community members on the importance of seeking for care in the health facilities while in need, and to take advantage of the various structures the MCHIP program has put in place like the Household Counselors, Male Birth spacing Motivators and Tallafi Mata Masu Dubara (TMMD) in their various communities, to partner with the health providers in the various health facilities in their communities to advocate to government and community members for upgrades in the standards of health facilities through the provision of basic infrastructure and staffing and also to serve as links between community members and the health facility. All the CCGs present presented their achievements from January to date which ranged from renovation of doctors' quarters, donation of generator by one of the LGAs, purchase of routine ANC drugs, to purchase of a motorcycle for referral. After much deliberation it was agreed that during the next quarterly meeting, the best CCG would be selected using criteria such as timely submission of quarterly work plan, timely submission of monthly activity report and how well the work plan is being implemented. In terms of the way forward, each CCG will form a committee comprising CCG Members, Household Counselors, Male Motivators and TMMD and will share their activity plan while all CCG secretaries will collect monthly ANC, family planning and delivery data at the health facility to share with the CCGs and the new committee in order to monitor the impact of their mobilization activities. Each CCG secretary will submit monthly reports on or before 5th of the following month and if logistically possible, will bring all the CCGs from the 6 LGAs together to hold one meeting.

iii. **Formation of TMMD Clubs** – during the quarter, 7 new TMMD clubs were formed and were properly oriented on the workings and operations of the clubs. It was noted that the TMMD clubs are being accepted in all the communities where they have been introduced while there was an increased demand for forming more. The supervisory visits conducted provided an avenue for correcting irregularities in the clubs e.g. some clubs that had more than 30 members were divided into 2, and those that were contributing more than twice the average sum contributed by members were asked to withdraw. The concept of emergency funds was introduced to all the newly inaugurated clubs.

iv. **SBMR Managerial and Health Facility Trainings** – During the quarter an SBM-R training for senior managers in health services was conducted in the State. The participants included Directors of Nursing, PHC, Hospitals Inspection Services, and the two Deputies for RH/FP from the State Ministry of Health.

The Deputy Director PHC, from the Ministry for Local Government represented the Director PHC. The Director Nursing Services, Deputy Director Nursing and Director Medical Services represented the State Health Services Management Board along with 9 PMOs and 9 CNOs from the MCHIP supported Facilities in the State. The aim of the training was to reactivate the SBM-R process in the State with a view to ensure a stronger and more sustainable supervisory team for the process in the State. It was also aimed at providing an opportunity for senior management of health system in the State to become acquainted with the National Performance Standards for EmONC, to be able to acquire more knowledge and skills necessary for carrying out assessments and supportive supervisory activities to ensure quality of service delivery in the State through the establishment and/or reactivation of Quality Improvement Teams(QITs) in all the MCHIP Supported Facilities that are implementing the SBM-R Process. The 3 day training was fully participatory and interactive with lots of illustrative lectures, brainstorming, group exercises and presentations, practical demonstrations and role plays. It was successfully accomplished with the support of Dr. Tunde Segun, the Senior Program Manager from MCHIP Abuja Office.

v. **TMMD Step down training Gusau, Shinkafi and Anka LGAs** – during the quarter, TMMD step down trainings were conducted in Gusau, Shinkafi and Anka LGAs. The trainings were aimed at equipping participants with knowledge to facilitate the formation of Tallafi Mata Masu Dubara clubs (TMMD) across ACCESS/MCHIP health facility catchment communities. These mothers clubs for savings and loans are specifically developed for women at the community level who will be oriented to form associations to increase access to funds contributed weekly by members to enable them engage in small scale businesses with the aim of improving their economic status and ultimately improving their health seeking behavior and reduction in maternal and newborn mortality. The training was facilitated in a very interactive and participatory way using interactive training

Participants at the training

Participants during a practical session

techniques such as brainstorming, small working groups, case studies and demonstration. Each participant was given opportunity to facilitate a topic using the TMMD training module while a field visit was also conducted to Mada community during the course of the training. Two (2) clubs were observed and participants were given the opportunity to learn and have a practical understanding of how the TMMD model operates. They were also given opportunity to conduct and facilitate some sessions using the TMMD training manual. Observations and questions were raised and clarifications made as feedback. The trainings took place in 2 LGAs simultaneously while the third took place a week after, with the 3 trainers and the CMO as facilitators. It lasted for 6 days each. A total of 30 participants were adequately equipped with knowledge to form and nurture TMMD clubs to maturity in their respective communities in each of the LGAs (Gusau, Shinkafi and Anka) using the TMMD Field Manual which contained step-by-step guidelines in organizing and supporting a club through its "cycle" which takes about 8 months and 17 visits divided into 3 phases. The first 3 months require the facilitator to visit weekly, constituting a total of 12 visits during the nurturing period. The second cycle is also 3 months and requires the facilitator to visit 4 times, twice in the first month and once in the second and third months i.e. during loan taking and repayment exercises. The third phase is 2 months and requires the facilitator to visit once to solve and mediate conflicts, if any, in the clubs. The trainees will serve as catalysts for improving essential maternal and new born care through the mothers clubs by ensuring that women generate and use financial resources to pay for MNH/RH services, purchase medicines/drugs, and support delivery in a health facility. At the end of the trainings, the trainees were to link up with CCG members to pay advocacy visits to the community leaders to seek for support and cooperation for the formation of TMMD clubs as required by the guidelines.

vi. **Joint Supportive Supervision Visits** – During the quarter, supportive supervision visits were made to selected MCHIP supported health facilities. This was jointly carried out by MCHIP Technical Officers and officials of Zamfara State Ministry of Health and Health Services Management Board. The objective of the exercise was to provide support to trained service providers for the implementation of best practices in Emergency Obstetric and Newborn Care (EmONC), Family Planning (FP) and to begin to institutionalize supportive supervision for EmONC and FP services in Zamfara State. A total of 9 facilities were visited. The skills assessed included ***General Family Planning Counseling Skills, LAM Counseling Skills, IUD Insertion and Removal Skills***.

An MSS Midwife in Bilbis PHC being assessed

Checklists from the ACCESS/MCHIP Supervision Manual were used to assess providers' (randomly selected) skills in these areas. ***Guided Provider Interview*** or ***Direct Provider Observation*** methods were used. The IUD Checklist was administered only at Hospitals and the LAM Checklist was administered at PHCs. This round of supportive supervision visits also provided an opportunity to gain field experience with the ***Management Systems*** Checklist (Area 8) of the National EmONC Performance Standards at all the facilities visited. In addition, activities, skills and challenges of Midwives serving at MCHIP supported facilities under the National ***Midwifery Service Scheme (MSS)*** were assessed. All providers interviewed or observed were given on-the-job mentoring on counseling and clinical skills for the areas assessed. Some providers demonstrated excellent counseling and clinical skills in the areas for which they were assessed. MSS Midwives have integrated well into the PHCs and communities where they are serving and there is a general improvement in the number of clients accessing services and the quality of services being provided. The increased patronage at the health facilities may be attributed partly to community mobilization activities carried out by the midwives aimed at increasing demand for services and some innovative approaches to providing care for mothers and newborns. Worthy of note is the fact that all MSS midwives have been trained on Life Saving Skills (LSS) and Integrated Management of Childhood Illnesses (IMCI) by Zamfara State MOH; a few have also been trained on Postpartum Family Planning (PPFP) by MCHIP. MSS Midwives and other service providers at the facilities visited generally found the supportive supervision visits useful to their work and were encouraged by it

vii. **Record Keeping Training** – During the quarter a record keeping refresher training was done in two batches. It aimed at increasing the knowledge and skills of providers and the Records Officers in order to improve and expand the scope of data reporting in the MCHIP supported sites. The first batch had a total of 29 participants from 12 MCHIP focal sites. The 2nd batch training followed immediately with 31 participants from 9 focal sites. The actual training was carried out for two days and the third day was used for the usual monthly data collection activity. The training included illustrated lectures, discussions, case scenarios, brainstorming and role plays generally on record keeping and reporting and data quality issues with introduction and explanation on the various MCHIP data tools.

One of the club members collecting her shares and dividends

viii. **The annual sharing of savings and interest by TMMD clubs** – The quarter coincided with the annual sharing of savings and interests by TMMD clubs in Mada and surrounding communities. The ceremony was attended by some MCHIP Staff. Due to the excitement of the day, it was tagged as 'Eid'

or ‘Sallah’ day celebration. The occasion was chaired by the District Head of Mada who mentioned that even divorce rate and couple disputes had decreased in his community as a result of TMMD activities. The Counselor for Mada Area Development Council, CCG members and MCHIP Team comprising the CMO, SIO and ZAIHAP Clinical Officer were all in attendance. After the opening ceremony, one of the clubs - *“Da sannu kan zama babba”* - was the first to share their savings and interest. The club has 24 members with 14 contributing ₦200 weekly and 10 women contributing ₦400 weekly. The 14 women contributing ₦200 each went home with ₦20,000 and the 10 contributing ₦400 each got ₦40,000. The club bought a piece of land worth ₦180,000 as property. The ceremony was aired on Zamfara Radio. In all, 40 clubs comprising 1850 members shared their savings and interest worth ₦5.5 Million ($36,667) for year 2009/10. Some clubs bought sewing machines for their members, others bought land, while some bought cattle to rear out of their profits.

Katsina

i. **Formation of State SBM-R Coordinating Committee** – During the quarter and as a follow up to the SBM-R training conducted in the previous quarter, the State SBM-R Coordinating Committee was formed and the first meeting held to discuss the functions of the Committee. Members were drawn from the SMOH, Hospital Services Management Board, State Primary Health Care Development Agency, LGA Inspectorate and College of Health Sciences. Some of the priority assignments of the Committee are to ensure the conduct of State level step down SBM-R training as well as take stock of facilities that had previously benefitted from SBM-R Module 1 training. During a visit to all MCHIP supported heath facilities to take stock of health facilities that had undergone Module 1 SBM-R training, only three facilities Comprehensive Health Centre Mai Adua, General Hospital Daura and PHC Zakka had previously sent staff to attend the training. However, it was discovered that all the staff that attended the previous training had been transferred out of the health facilities while one had retired.

ii. **SBM-R Step down training** – During the quarter, Step down trainings were conducted in two batches. The first batch was organized for Chief Nursing Officers-in-charge of 7 General Hospitals and Officers-in-charge of maternity units while the second batch was for Community Health Officers-in-charge of Comprehensive Health Centers, PHCs and MCH Clinics and their heads of maternity units. The trainings lasted for three days each. Methodology

Group photo of participants & trainers during the first batch

used included illustrated lectures, group work presentations and role plays. A total of 36 senior health managers and providers from 15 MCHIP supported health facilities were trained. The trainers comprised Dr. Tunde Segun, Senior Programme Manager MCHIP, Amina S. Sule – MCH Coordinator MCHIP and Fati Garba, Katsina State RH Coordinator. Active participation was observed among the participants throughout the conduct of the trainings and participants showed readiness to implement the standards and perform their baseline assessments within four weeks. The performance standards and lecture handouts were made available to all the participants.

iii. **CMT Training Workshop on Community Mobilization CAC Phases 1-3** – During the quarter, in an effort to reinvigorate community mobilization activities in Katsina State, 3 more LGAs were added, namely Malumfashi, Funtua and Rimi LGAs. This Community Mobilization Team training workshop was conducted as part of the plan to implement the CAC process in MCHIP LGAs of Rimi, Malumfashi and Funtua in Katsina State. The 3 training workshops focused on developing the CMT capacity to form and train the Community Core Groups (CCG) at the Comprehensive Health Care (CHC) village catchment areas in rolling out the community action cycle (CAC). Prior to the trainings, a one-day planning meeting with the LGA CMT facilitators was held at the MCHIP field Office Katsina. A total of twenty seven (27) CMT trainees and 6 LGA CMT facilitators attended the trainings. Two state trainers and the MCHIP CMO also attended the training. The trainings were facilitated in a very interactive and participatory way. Using interactive training techniques such as brainstorming small working groups, case studies and games, the participants were able to share experiences, learn from each other and make some decisions on how they were going to improve what they have been doing on ground. Moreover, the simulation exercises were an opportunity for each of the participants to

CMT members at the end of CAC phase 1 training at Rimi LGA

Group picture showing District Head Malumfashi (Justice Mamman Nasir) with CMT Members during the orientation

role play the community's orientation meeting, the MNH issues exploration and the CMTs training. After completion of the training on the fifth day, the CMT embarked on an orientation meeting as part of its contact with the village head and opinion leaders. The purpose of the meeting was to build local leaders support and get them to buy into the MNH Initiative. In Malumfashi 3 meetings were held, one with the district head and 2 with the 2 village heads separately. The chief Imam of Malumfashi central mosque, a Reverend Father, Chairman and deputy of Malumfashi Da'awa group, 9 Ward Heads and over 20 community influencers attended the orientation meetings. The leaders vouched their support in mobilizing their subjects to patronize MNH services. In Rimi LGA, the Vice Chairman who represented the Chairman at the opening of the workshop promised the LGA's unflinching support to the CMT whenever they were approached. During the orientation meeting, the village head in company of 5 ward heads that are the host communities, showed appreciation for the MNCH project that honored them and taught them to organize their communities for self development and thereby promised to support the team whenever it was needed. In Funtua 3 orientation meetings were held with the District head and his chiefs, village head of Makera, and another meeting with Director PHC and the Supervisory Councilor for health. The LGA PHC Director and the Supervisory Councilor for Health promised to support the CMT in all their endeavors. In all the 3 LGAs, various concerns and questions were raised by the community ranging from stakeholders role expectations, present condition and nature of service delivery in the focal health facilities to attitude of health workers. All the concerns and questions raised were responded to by the CMT members. The communities were also told to promote best practices to improve maternal and new born child health in their communities. While expressing their satisfaction with MCHIP MNH Initiative, they told the team that they were confident that the program will contribute positively to improving the life of their women and children.

iv. **Out Reach Programme with Marie Stopes** – During the quarter an outreach program on family planning was conducted by MCHIP in collaboration with Marie Stopes Nigeria and the Hospital Services Management Board. The one day program was conducted at the Family planning clinic of the General Hospital Katsina by a team of technical staff from Marie Stopes Nigeria and MCHIP. 66 clients who had been mobilized from MCHIP supported health facilities and communities had Jadelle insertions. The Jadelle was supplied by Marie Stopes and offered at very highly subsidized prices.

v. **Meeting with SMOH, State Action Committee (SACA) on HIV/AIDS and Development Partners** – The MCH Coordinator represented MCHIP at a one-day meeting with SMOH, SACA and Development Partners to develop a two year strategic plan for HIV/AIDS control in Katsina State. A draft document provided by SACA was used as a guide for the HIV work plan. Other partners present were WHO, UNICEF, PRRINN, Rotary international, Pathfinder and local NGOs.

vi. **Monthly data collection meetings** – During the quarter, monthly meetings were held in four zones of the State, namely Katsina, Daura, Funtua and Dutsen

Ma for data collection. At all the meetings, data entries into registers were checked and compared with the monthly summaries, all necessary corrections were made and additional on-the-job training was done.

12. Renovation of more Health Facilities

During the quarter, building engineers were sought for and given bill of quantities so as to be able to assess 9 health facilities which have been identified for renovation. These facilities comprising General Hospitals and PHCs are spread across the 3 States. This is part of MCHIP's efforts to provide an enabling environment for health care providers to do their work and for patients to have satisfaction during service delivery.

13. Participation in other project related activities

During the quarter, MCHIP participated in the following activities:

i. **Women Deliver Conference** – during the quarter, the MCHIP COP, Senior Program Manager and the Senior Community Mobilization Officer, attended the 2nd Global Conference of Women Deliver. This took place in Washington DC. There the COP made a presentation.
ii. **MCHIP Field Exchange Meeting** – Immediately after the Women Deliver Conference, the 3 Nigeria MCHIP staff joined other country MCHIP staff in a one-day meeting held in Washington DC to share lessons being learnt in MCHIP programs globally. There the 3 officers sat at panels sharing Nigeria's MCHIP experiences.
iii. **Global Health Council Meeting** – During the quarter the MCHIP COP and the Senior Community Mobilization Officer attended the Global Health Council Meeting. There the Senior CMO made a presentation on *FP/MNCH Integration in Nigeria: Perspective from the community*. The COP was also trained as a master trainer for the USAID-supported "Helping babies Breathe" project. The HBB project will be rolled out across all MCHIP supported facilities as soon as the inexpensive anatomic model developed for the project becomes commercially available.
iv. **SBM-R Workshop for TSHIP** – During the quarter, MCHIP collaborated with TSHIP in the introduction of the SBM-R process. Dr Edgar Necochea, Director for Health Systems Strengthening in Jhpiego Baltimore and MCHIP COP went to Bauchi to facilitate the 3-day workshop for TSHIP. The training examined the concept of quality, reviewed a variety of quality improvement approaches and concluded that the standardization approach to quality improvement was the most appropriate for Nigeria given the very high level of health systems dysfunction in the country.
v. **Mentor's workshop for Young Professional Internship Programme (YPIP) organized by West African Health Organization (WAHO)** – During the quarter, the West Africa Health Organization (WAHO) supported the Kano State Program Officer to attend the 2-day YPIP mentor's workshop that took

place in Bobo Dioulasso. Subsequently, two interns were posted to Nigeria and have since reported to Kano State, to be supervised by the Deputy Country Director (Dr. Tunde Segun) and the Kano State SPO (Dr. Nasir Bashir).

vi. **Nigerian Health Campaign Round Table Meeting** – During the quarter, MCHIP was invited to participate in the Nigerian Health Campaign Round Table Meeting under the platform of the "White Ribbon Alliance & One Voice Campaign for Safe Motherhood". The MCHIP team at the meeting included the Country Director/MCHIP COP - Professor Emmanuel Otolorin, MCHIP Senior Technical Officer - Dr Lydia, MCHIP Senior Community Mobilization Officer –Mr. Samaila Yusuf and the Katsina CMO – Mr. Umar Imam.

MCHIP staff with MCHIP Activity Manager (Ms. Stella Akinso) at MCHIP Exhibition Stand

The goal of this year's campaign was to help lay the ground work for an accelerated response to maternal and newborn mortality in Nigeria and around the globe. The major focus for the 2010 campaign is the **September MDG Review Summit** and the staging posts in the run up to it, including the Africa Union/G20 & G8 Summits and the Women Deliver Conference. The International partners and organizations that will constitute the "One Voice Nigerian Health Campaign" include Jhpiego, IPAS, CEDPA, USAID, DFID, The Wellbeing Foundation, The White Ribbon Alliance and EngenderHealth. The organizers, particularly the chair person of the planning meeting (The First Lady of Kwara State), expressed satisfaction and appreciation for all contributions made by the participating IPs at the meeting. She particularly singled out Jhpiego and thanked Professor Emmanuel Otolorin for making an outstanding presentation on practical points that will facilitate the implementation of the September 2010 Health Campaign. After the deliberations by participating IPs, a consensus was reached to initiate and coordinate action by campaign supporters and champions along 4 themes:

The First Lady of Kwara State showing interest in MCHIP materials at MCHIP Exhibition Stand

1. Leveraging more resources for maternal, newborn and child health.

2. Making maternal mortality a key indicator of a functioning health system.
3. Training, recruiting and retraining more health workers to address the global gap in skilled care for women and newborns during and after pregnancy and childbirth.
4. Removing barriers to quality health care for women and children.

The First Lady of Kwara State and other IPs at the meeting visited the Jhpiego Exhibition stand.

vii. **ZAIHAP Community Mobilization Training** – During the quarter, the Zamfara State Office played host to the ZAIHAP community mobilization training. Mr. Telesphore Kabore from Save the Children, Uganda and the MCHIP CMOs facilitated the training.

viii. **TSHIP Community Mobilization Strategy Development Workshop** – during the quarter, the MCHIP Senior Community Mobilization Officer was invited by TSHIP to participate in its community mobilization strategy development workshop. At the meeting, an inventory of various community mobilization approaches was conducted. The aim was to adopt an approach which would yield the desired high impact, large scale coverage, cost effectiveness, having sustainability plans and ownership. At the end of the meeting, ACCESS/MCHIP's Community Action Cycle (CAC) CM strategy was adopted for TSHIP

ix. **Meeting with the Honorable Minister of Health** – During the quarter, the MCHIP COP led a number of NGOs and development partners working on maternal, newborn and child health to meet with the Honorable Minister of Health, Prof. Onyebuchi Christian Chukwu, to discuss a number of issues related to MNCH in Nigeria. For maximal focus and usage of time, only two items were tabled before the HMH. These were: the recurrent stockouts of contraceptive commodities nationwide and the stalled IMNCH secretariat in the FMOH. While the HMH committed the FMOH to budget for FP commodities in the 2011 budget (estimated to be worth $9.5m), he could not do the same to meet the shortfall of $3m needed to bridge shortages in 2010. Thereafter, the team members committed to embarking on advocacy visits to the National Assembly members and to the Senior Special Assistant to the President on MDGs. The HMH agreed with the team that it was quite unfair for women to receive maternity and under-5 child health services free of charge only to have to pay for FP services. The HMH promised the team that he will have further discussions with his staff with a view to remove the FP user-fee being charged the FMOH as implementation costs.

x. **Meeting with USAID Officials from Washington DC** – During the quarter, 2 officials from USAID Washington, Dr Scott Radloff and Dr Sarah Harbison visited Nigeria and met with heads of USAID IPs in country. Issues of repositioning FP, the role of IPs working in country, advocacy to Government and what USAID Washington can do, were extensively discussed.

14. FP policy and legislative procedures activities

During the quarter, the FP coordinators continued to supervise FP activities in all MCHIP supported facilities to ensure that there were no violations of the FP policy and legislative procedures. All the trainings on FP also had sessions on the policy and legislative procedures.

III. CHALLENGES AND OPPORTUNITIES

1. Even though there has been deployment of some MSS midwives to MCHIP supported facilities, challenges of coverage of the facilities they work in for 24 hours a day, 7 days a week still persist. This is because in some of the places posted, there has been poor response by the LGA Officials in ensuring that the Midwives are given suitable accommodation. This has resorted to some of the MSS midwives working on "call" as they cannot stay in the immediate vicinity of the PHCs they are posted to. Advocacy is on-going with the executives at the LGAs to ensure that these midwives are properly accommodated.
2. Contraceptive stock-outs only improved slightly during the quarter, as some innovative ways of getting them were made especially in Kano State where "middle men" were cut off leading to a reduction in the user-fee costs to the clients. Outreaches conducted in partnership with organizations like Marie Stopes provide an alternative opportunity to address this problem and MCHIP will continue to engage in this type of partnership.
3. Usage rate of the partograph in MCHIP supported facilities improved slightly as a result of some training and reprinting of the maternity record booklet, which contains the partograph. Advocacy is on-going to SMOH to ensure that these maternity record booklets are printed by the State.

IV. ACTIVITY CHANGES

There were no major activity changes during the quarter.

V. MCHIP STAFF UPDATE

The staffing status of the MCHIP program during the quarter is shown in the table below. The hire of strategic information officers for each of the project states is follow-on to issues raised in last years portfolio review. Furthermore, the disengagement of Ms. Hannatu Abdullahi to join TSHIP led to the appointment of Dr. Nasir Bashir as the Kano State Program Officer. During the quarter also, Dr. Tunde Segun was appointed as Jhpiego Deputy Country Director/DCOP, a position which reinforces his MCHIP program management responsibility. Dr. Segun is expected to increase his oversight of the MCHIP program next quarter as the COP's technical role in TSHIP deepens.

S/No.	Name	Position	Location	Email address
1.	Prof. Emmanuel Otolorin	Country Director/ COP	Abuja	eotolorin@jhpiego.net
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3.	Dr. Lydia Airede	Senior Technical Advisor	Abuja	lairede@jhpiego.net
4.	Dr. Gbenga Ishola	Senior Monitoring and	Abuja	gishola@jhpiego.net

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		Evaluation Officer		
5.	Dr. Nasir Bashir	State Program Officer	Kano	nbashir@jhpiego.net
6.	Dr, Shittu Abdu-Aguye (50% LOE)	State Program Officer	Zamfara	sabdu-aguye@jhpiego.net
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8.	Mr. Samaila Yusuf	Senior Community Mobilization Officer	Kano	syusuf@jhpiego.net
9.	Ms. Zaynab Nyako	Community Mobilization Officer	Zamfara	znyako@jhpiego.net
10.	Umar Imam	Community Mobilization Officer	Katsina	uimar@jhpiego.net
11.	Ms. Amina Bala	State Family Planning Coordinator	Zamfara	abala@jhpiego.net
12.	Ms. Salamatu Bako (50% LOE)	Clinical Officer	Zamfara	sbako@jhpiego.net
13.	Ms. Mairo Ali Rano	State Family Planning Coordinator	Kano	mairoali72@yahoo.com
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22.	Musa Abdullahi	Strategic Information Officer	Katsina	mabdullahi@jhpiego.net
23.	Emmanuel Olumorin	Driver	Abuja	
24.	Rabiu Adamu	Driver	Katsina	
25.	Suleiman Adamu	Driver	Kano	
26.	Mohammed Kabiru Ibrahim	Driver	Zamfara	
27.	Ekeh Alfa	Receptionist	Abuja	
28.	Ms. Fidelia Yerima	Office assistant	Abuja	

V. SUCCESS STORIES

Quotable quotes

1. Galadiman Malumfashi Village head of Malumfashi:

   'Abin haushi ne ace har yanzu mutanen mu suna cikin duhu, mata da yara nata mutuwa akan ciwuwuka da matsalolin da ake iya karewa, mu da hukumomin mu bama yin isasshen abin da yakamata muyi, ACCESS/MCHIP ta tuno damu ta neme mu ta kuma jagoranci tsamo mu daga wannan matsala, ashe wjibi ne kenan mu karbi aikin, mu shige gaba har sai mun canza al'amarin da kammu.'

Meaning:
'It is sad that till this moment our communities are still ignorant, women and children dying from preventable conditions and problems and neither the community nor the government is doing enough to salvage the community until now that ACCESS/MCHIP come to our rescue, it is therefore necessary that we not only grab and accept these efforts, but rather take over, lead and own the program until we adequately reverse the situation'

2. Village head of Makera, Funtua LGA;
   '*My appeal to you is that you should sacrifice your time and energy to do this work diligently as it is really a shame that we fail to do what is right over long period of time and always waiting for donors to come and do every thing for us its really bad and we must appreciate the MCHIP efforts in this regard'*
3. Dawanau Community Member:
   *"Before the involvement of USAID/ACCESS now MCHIP into this area (Dawanau), our community was the headquarter of eclampsia, anemia and bleeding after delivery and most women with these complications died. But today as a result of intervention by your organization, the number of women lost became history…it is not happening any more". **Sani Musa Bagadawa***
4. Dawanau Community Member:
   *"Our perceptions on family planning/child-spacing are completely changed. We thought it was aimed at reducing our number; but now with knowledge gained through intervention our knowledge, attitude and practice are the ones guided by the objective of eradicating the preventable deaths of pregnant mothers that as well means healthy family and society". **Uwa Mustapha***

VI. NEXT QUARTER RESULTS

MCHIP will continue to work with the SMOH and LGA officials to support the 57 health facilities in 28 Local Government Areas within the 3 supported States. MCHIP will continue its support for the joint quarterly supervisory visits to all facilities and the implementation of the SBM-R process. MCHIP will pay special attention to capacity building of newly posted staff on record keeping and use of data for decision-making.

MCHIP will also intensify its community mobilization efforts in under-served communities, particularly for skilled birth attendance and postpartum family planning. To this end more household counselors and male birth spacing motivators who will reach out to hard to reach groups will be trained and commissioned for work. MCHIP will also continue to form CMTs and CCGs around supported health facilities where none exists especially in Katsina State. More TMMD clubs will be formed to meet demands and to further empower the women and give them financial access for emergencies. MCHIP will continue its partnership with Maries Stopes Nigeria to conduct joint outreaches for clients on waiting lists for long-acting FP methods taking advantage of greatly subsidized and available FP commodities at MSN.

Given the challenges to contraceptive use acceptance in the 3 project states, MCHIP will continue to expand the contraceptive method mix in all its supported FP sites by training more health workers to provide long acting methods like IUD and Jadelle. MCHIP will donate additional IUD insertion kits where needed. MCHIP will also scale-up its advocacy for the adoption of the Population Council's Balanced Counseling Strategy (BCS) for FP counseling. MCHIP will train CHEWs and midwives in infant welfare clinics to use systematic screening method to identify those who can benefit from family planning counseling and services.

MCHIP will also continue to build the capacity of service providers to provide basic emergency obstetric and newborn care and post-partum family planning. MCHIP will continue its collaboration with the Nigeria Society for Neonatal Medicine to implement activities for community based management of neonatal sepsis.

MCHIP will finalize its endline evaluation report and prepare presentations for dissemination during the November 2010 SOGON Annual Conference in Abuja.

MCHIP Quarterly Report: Emergency Obstetric and Newborn Care in Kano, Katsina and Zamfara States

	This year target	**This year actual**	**This quarter target**	**This quarter actual**	**Explanation for variance or why not reported during this quarter**	**Next quarter target**	**09.30.11 target**
Project Objective: Increased utilization of quality Emergency Obstetric and Newborn Care (EmONC) services (including birth spacing) by pregnant women, mothers and their newborns at selected LGAs in two states, Kano and Zamfara.							
Operational Plan Standardized indicator: # of deliveries with a Skilled Birth attendant (SBA)	50,000	35,267 (71% of target)	13,000	14,538	The completion of renovation works in 6 General Hospitals facilitated the attainment of the actual target set for the reporting quarter. MCHIP is therefore now on track to meet the year's set target for this indicator.	15,029	55,000
Program Indicator: % of births attended by Skilled Birth attendants (SBA)							
Operational Plan Standardized indicator: # of Antenatal Care (ANC) visits by skilled Providers from USG-assisted facilities	220,000	176,978 (80.4% of year's target)	60,000	63,443	MCHIP is on track to achieve the target for this indicator by the end of the year.	45,000	250,000
Program Indicator: % of pregnant women who received at least four antenatal care visits							
Operational Plan Standardized Indicator: Number of postpartum/newborn visits within 3 days of	35,000	37,649 (107.6% of target)	12,000	16,612	In reporting this indicator, the project revisited the WHO	15,000	40,000

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
birth in USG-assisted programs					definition of this indicator which includes Postpartum/newborn visits within the first 4 hours of delivery and the deliveries within the first 3 days. The first definition qualifies all deliveries in GHs to be included while the second definition includes those who delivered at home but came for follow up visits within 3 days of home delivery.		
Operational Plan indicator : Couple-years of protection in USG-supported programs (CYP)	17,000	19,218 (113% of target)	6,000	7,454	All the 57 MCHIP-supported facilities are providing an expanded method-mix of modern contraceptives. During the reporting period, MCHIP partnered with the Marie Stopes Nigeria Project (in view of frequent commodity stockouts) to provide	7,000	18,500

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
					Jadelle at affordable cost to clients in few facilities in Katsina State. Within this partnership, MCHIP did the counseling and outreach activities while MSN provided the Jadelle implants and partnered MCHIP to provide services. . CYP attained for LAM also contributed to the total attained for this indicator. LAM contributed 2,917 to the total CYP attained during the reporting period.		
Program indicator: % of caretakers seeking care from sick care providers for sick newborns							
Program indicator: % of postpartum women using contraception (including LAM) at 6 weeks postpartum							
Sub-I.R. 1: Improved quality of family planning methods in selected LGAs							
Operational Plan Standardized	54	57	57	57	All MCHIP supported	Nil	60

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
Indicator: # of USG-assisted service delivery points providing FP counseling or services.					facilities including PHCs and the new hospitals are providing FP counseling services and method provision.		
Operational Plan Standardized Indicator: Number of people trained in FP/RH with USG-funds (disaggregated by gender)	500	365 (73% of the year's target)	110	154 F=110; M=44	MCHIP is on track to achieve the set target for this indicator by the end of the year.	135	550
Operational Plan Standardized Indicator: Number of people that have seen or heard a specific USG-supported FP/RH message							
Operational Plan Standardized Indicator: Number of counseling visits for family planning/Reproductive health as a result of USG assistance	55,000	55,751 (101% of target)	7,000	17,075	Additional on-the-job training and supportive supervision has ensured that all women who delivered in MCHIP facilities are counseled on LAM and other FP methods immediately after delivery. Record keeping for these counseling interactions significantly improved. In addition, household counselors' activities	12,000	60,000

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
					were expanded in the coverage areas.		
Sub-I.R. 2: Improved quality of EmONC services in selected LGAs							
Operational Plan indicator: # of health facilities rehabilitated	12	6	6	Nil	The contracting process for renovations of 9 facilities (3 per state) is ongoing. Engineers assessments and the actual renovations will be concluded in the next quarter	9	
Program Indicator: # of health facilities using SBM-R approach for performance improvement	30	30 (100%)	30	30	The 30 facilities are the ones using the SBM-R approach up till the end of FY09. No new ones are added	30	
Operational Plan Standardized Indicator: # of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs. ***Precise Definition:*** *Number and percent of women in facilities and homes where the woman received AMTSL by SBAs in targeted areas in a specified time*	35,000	32,484 (92% of target)	9,500	13,610	The posting of midwives (SBAs) from the MSS program to 12 MCHIP supported PHCs has resulted in the reporting of this indicator from many PHCs. This is in line with the WHO and POPPHI definition of the	12,500	40,000

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
period. This includes vaginal deliveries only.[1] Targeted areas are those where the United States Agency for International Development partner and Cooperating Agency (CA) maternal and child health projects are implementing AMTSL interventions – these include public and private health facilities, rural and urban health facilities, as well as home births with SBAs					indicator. This is largely responsible for the over-achievement of this quarter's target		
Program Indicator: % of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs.							
Program Indicator: # of births at ACCESS-supported facilities for which the partograph was used	30,000	16,211 (54% of target)	5,000	6,910	This quarter witnessed some improvement in the use of the partograph to monitor labor primarily due to additional in-service training and re-printing and supply of maternity record forms (which contain the partograph) to MCHIP supported sites. MCHIP continues to advocate to the SMOH to take over the printing of the	7,500	33,000

[1] Does not include Caesarean -Section or abortion

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
					maternity record forms in the interest of sustainability.		
Sub I.R. 3: Improved enabling environment for scale-up of EmONC best practices at national and state levels							
Program Indicator : Training curricula and strategy for pre-service midwifery education revised and implemented in Kano and Zamfara states	Nil	Nil	Nil	Nil	MCHIP completed this activity in FY09. Additional anatomic models for obstetric and neonatal skills development have been ordered and will be delivered in the next quarter.	Nil	Nil
Program Indicator: Operational performance standards for EmONC distributed in ACCESS-supported facilities.	Nil	47	Nil	47	MCHIP did not set target for distribution of this manual because it was widely distributed in FY09 and thus was not re-printed. However, few remaining manuals were issued out on request to other development partners during the reporting quarter	Nil	Nil
Program Indicator : National KMC training manuals distributed in ACCESS-supported facilities	Nil	Nil	Nil	Nil	Distribution of this training manual was	Nil	Nil

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
					completed in FY09		
Sub-I.R. 4: Improved management of maternal and newborn services in selected LGAs							
Operational Plan Standardized Indicator: # of USG-assisted service delivery points experiencing stock-outs of specific tracer drugs[2].	24	31	24	31	Stockouts of essential obstetric tracer drugs remain a challenge. Since MCHIP has no control over the availability of these tracer drugs, it continues to advocate to the SMOH on the importance of its oversight functions for the drug logistic management system.	24	28
Operational Plan Standardized Indicator: # of newborns receiving essential newborn care through USG supported programs	30,000	34,237 (114% of set target)	12,000	13,773	Supportive supervision on record keeping provided by the newly employed State-based Strategic Information Officers (SIOs) in the 3 Project States has improved record keeping on this indicator. Many of the newly posted	7,650	35,000

[2] Tracer drugs selected are: Oxytocin, Hydrallazine, Diazepam, Ampiclox, Gentamicin, Metronidazole, Sulphadoxine-Pyrimethamine (SP), Iron/Folate tabs.

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
					service providers are now familiar with the procedures for recording data on this indicator in the labor and delivery register.		
Sub-I.R. 5: Increased demand for maternal and newborn services in selected LGAs							
Common indicator: # of beneficiaries of community activities [C 20.10]	42,000	28,132 (67% of target)	8,500	8,902	MCHIP is planning further expansion of community directed activities' during the next quarter. These will include the activities of the male motivators, household counselors and Mothers Savings and Loans Clubs, in order to meet the target set for the year.	14,000	
Program Indicator: # of community committees that have work plans that include activities to reduce maternal and newborn deaths	57	56 (98% of target)	7	7	Seven new Community Core Groups (CCGs) were formed in Katsina state and they all developed work plans	3	
Program Indicator: # of communities	57	56 (98%	7	7	7 new CCGs in Katsina	3	

	This year target	This year actual	This quarter target	This quarter actual	Explanation for variance or why not reported during this quarter	Next quarter target	09.30.11 target
with plans that include emergency funds and/or a transport system for maternal and newborn complications		of target)			State developed emergency transport plans.		
Sub-I.R. 6: Improved availability of EmONC health workers in target/Selected LGAs							
Common/Operational Plan Standardized indicator: # of people trained in maternal/newborn health through USG-supported programs	600	478 (80% of target)	220	161 F=76; M=85)	MCHIP is on target to meet this indicator for the year.	220	600
Program Indicator: Caesarean sections as a percentage of all births in USG-supported facilities	15%	6%	5%	1%	The total attained for this indicator is within the accepted international standard of deliveries by Caesarean sections. However, additional information is provided in the attached annex on the proportion of CS done in the estimated population	5%	15%

The information in this table is to be based on the IP's Mission-approved PMP and work plan, and should focus on whether targets were met, not met or have been exceeded during the reporting period. The table is designed to summarize in one convenient location the progress the IP has made. The table supports the narrative and in no way replaces it.

The IP should report on all of the targets in the PMP and work plan, as well as the Common Indicators it tracks for the Mission's Annual Report. Where reporting is not applicable or possible, the IP may enter "N/A" and explain why in the "Explanation for variance" column (e.g., this data is collected and reported on annually). Discrepancies between targets and actuals must be explained.

Please report according to the USG financial year calendar: Q1 = Oct-Dec 2005, Q2 = Jan-Mar 2006, FY 2006, etc. The IP is expected to develop its own table, using a numbering system that is based on its PMP and work plan. Refer to the sample table below only as a guide.

Annex 1:

Executive Summary of ACCESS Endline Household Survey

Introduction

In November and December 2006 the ACCESS Nigerian Program conducted a household survey of women who had given birth in the past year (recent mothers) in Kano and Zamfara states, located in the North West Zone of the country. This survey examined recent mothers' reported utilization of maternal and newborn health services, knowledge of target behaviors and danger signs, and reported barriers to accessing care to establish baseline measures and provide information for program design. This household survey was part of a larger ACCESS Program evaluation study carried out in four Local Government Authorities (LGAs) in Kano and Zamfara, which also included a facility survey. In November 2009, after three years of program intervention in the four LGAs, another study was conducted, using the same instrument, but with some modifications, to provide endline measures of changes that have occurred in knowledge of emergency obstetric, newborn and family planning services as well as target behaviors among recent mothers. This report presents the findings of this endline evaluation, and comprises findings from the household survey and qualitative data derived for focus group discussions (FGDs).

Nigeria's health and development indicators are among the worst in the world, especially in the northern states. The national maternal mortality ratio (MMR) is estimated at 545 per 100,000 live births and the neonatal mortality rate (NMR) is estimated at 46 per 1,000 live births (NPC and ICF Macro 2009). With a total fertility rate of 7.3 in the North West zone, higher than the 5.7 for the entire country, women are repeatedly exposed to the risks associated with childbearing.

The high levels of maternal and newborn deaths in Nigeria are reflections of low utilization of maternal and newborn services due to inadequate availability and accessibility of these services. Skilled attendance at birth in the North West is the lowest of all six geopolitical zones in the country: only 9.8% of women delivered with a skilled attendant relative to 38.9% nationally (NPC and ICF Macro 2009). Only 31% of pregnant women in the North West Zone received antenatal care (ANC) from a trained health provider (nationally 57.7%). The contraceptive prevalence rate in the North West is only 2.8%, with 2.5% of married women using a modern method of family planning (FP). The corresponding figures for Nigeria are: 14.6% and 9.7%. Educational levels of females in Nigeria are low, with only about 64% having at least some primary school education (only 25.8% in the North West Zone), a variable known to be associated with use of health services.

The United States Agency for International Development (USAID)/Nigeria awarded the ACCESS Program funds to design and implement a three-year program to increase the use and quality of emergency obstetric and newborn care (EmONC) and FP services beginning with two northern states: Zamfara and Kano. The program initially targeted two LGAs in each state, but has now been expand to Katsina States. Although the Project initially commenced implementation in four LGAs in Kano and Zamfara States, the total coverage as at the time of

the endline evaluation was 22 LGAs in three States including Katsina. The ultimate health goal of the ACCESS Nigeria Program is to "reduce maternal and neonatal mortality in Nigeria." To achieve this objective, the ACCESS Nigeria Program is implementing community- and facility-based interventions focusing on comprehensive and basic EmONC, FP, ANC and postpartum care. The present report is an evaluation of three years of project implementation in two original states: Kano and Zamfara.

Methodology

The evaluation study consists of a cross-sectional pre-/post-intervention design. The two major components of the study are: 1) a survey at the household level to ascertain knowledge, practices and coverage associated with evidence-based maternal and newborn health care behaviors and services; and 2) a facility survey to ascertain the quality of delivery, especially EmONC, postpartum and FP services. The surveys were conducted in the four start-up LGAs in the two states, which were selected with stakeholder input: Dawakin Tofa and Gezawa in Kano and Gusau and Kaura Namoda in Zamfara. A multi-stage sampling procedure was used in the selection of eligible women, starting with a random selection of five enumeration areas (EAs) from each of the four target LGAs in the two states. Fieldwork was carried out during November 2009.

Verbal informed consent was obtained for all study participants and confidentiality was ensured by protecting both the respondent and the data collected. At the individual level, confidentiality was protected by: private interviews, appropriate training for interviewers and adequate field supervision. Once the data were collected, confidentiality was protected by limited access to completed data collection forms, and lack of individual identifiers in the electronic data sets. The completed data collection forms were stored in a secured cabinet and only staff involved in this study have access to the data.

Key findings

This report presents the findings from the endline household survey of women who delivered in the past year. A total of 444 women were included in the final analysis.

Socio-Demographic Characteristics of Respondents:

- Mean age of respondents was about 27 years
- Mean parity was 4 children
- Respondents had 444 live births
- A total of 19 women were pregnant at the time of the survey.
- Respondents were predominantly rural, poor, uneducated and illiterate, and of Hausa ethnicity. About half of the women lived in Kano and half in Zamfara.

Knowledge of Danger Signs and Essential Newborn Care:

- Knowledge of danger signs and essential newborn care was significantly higher at the endline than the baseline.

- The percentage of women who could identify at least four danger signs across the four periods of analysis (pregnancy, labor and delivery, postpartum and newborn) was significantly higher at endline (from 53% at baseline to 79.5% at endline). Urban women, women with six or more births, those who were educated/literate, and those lived in Kano State were more knowledgeable than others.
- For elements of essential newborn care, 91% of respondents knew to dry and wrap the baby immediately, 65% knew to practice clean cord care and 41% knew to breastfeed within one hour of birth. The corresponding figures at baseline were 72.5%, 62.6% and 26.5% respectively.

Knowledge and Practice of Birth Preparedness

- More than eight out of ten women (83.6%) at endline had heard about birth preparedness relative to only 46.5% at baseline. As at the baseline women identified purchasing clothes for the baby and purchasing clean delivery kits/items as the top two birth planning steps (both at 84.4%).
- Women with formal education or literate, and those living in Kano were more familiar with the concept of birth preparedness than others at endline.
- About 68% of the women reported making any birth preparedness arrangements at endline; only 31.8% of respondents did so at baseline. The most common arrangement was saving money for birth at a facility or at emergency (92.9%), identification of a skilled provider (45%) and identification of a means of transportation (40.3%). This is a very significant improvement in knowledge from the situation at the baseline.

Perceptions of Local Health Facilities

- Overall, 76.2% of respondents were able to mention at least one public or private facility where a woman could give birth with a skilled attendant, up from 62.9% at baseline. Among these women about 79% ranked the services as excellent or good (compared with 62.7% at baseline). There was a more positive perception of facilities at endline in Kano than Zamfara, among illiterate than literate women, among rural than urban women and among those with no formal schooling than those who has a formal education.
- The three most important reasons for positive rating of facility include 'facility always open', 'doctor always there', and 'staff treat women with respect.'

Experience and Care during Last Pregnancy

- At baseline about 42% women received at least one ANC visit during their last pregnancy. This increased to 74% at endline. Among those who had at least one ANC visit, the mean number of visits was 5.8 at baseline and 4.5 at endline. The mean number of months pregnant at first visit was 4.7 at baseline and 4.8 months at endline.
- About 53% of the women received 4 or more ANC visits at endline; only 34.3% of women did so at baseline.
- Women who did not receive ANC said the main reasons were "health facility too far" (21.1% of the women, down from 31.4% at baseline), "too expensive" (15.5% at endline and 9.6% at baseline) and "do not know where to go" (9.9% at endline and 8.1% at baseline).

- Government hospitals were the most important source of ANC for study respondents who received ANC at the endline (78.4%), followed by PHCs (14.4%). The corresponding figures at baseline were 72.4% and 26.3% respectively.
- A higher percentage of women received each of the six key components of ANC services at the endline than the baseline period, but the greatest change was observed for anti-malaria drugs and FP, especially in Kano.
- The proportion of respondents who received advice for each of the birth preparedness issues doubled between the baseline and endline periods, with 'where to give birth,' 'where to go if there are danger signs,' and 'danger signs of serious health problems' as the most discussed.
- Only 43 women (10.9%) reported that they experienced a serious health problem during their last pregnancy at baseline compared with 32.9% at endline. The four top health problems experienced by the women at endline were: severe headache, high fever, severe abdominal pain and severe weakness.

Experience and Care during Labor and Delivery

- Of the respondents, 25.3% reported having a skilled attendant (doctor, nurse/midwife or clinical officer) at endline. Among those assisted by others or who did not respond, 14.3% said they would have preferred that someone else assisted with the birth instead of the person who actually did it.
- Most women delivered their last child at home, about 80% at both baseline and endline. This is very high, but lower than 90% found by 2008 NDHS for North West zone where the two states are located.
- Only two women delivered by cesarean section at baseline, and only seven women said they experienced severe health problems, such as severe bleeding and prolonged labor. At endline there were six cesarean sections, and 54 women reported severe health problems.
- Among women who reported at baseline that a final decision about where to deliver was made by someone, it was either made by jointly by her and her husband or by the woman herself in most cases. At endline the final decisions were made jointly by the woman and her husband or by the husband alone. Nearly 30% of the women at baseline said that no one made any decision, only 15% of women said so at endline.

Experience and Care during the Postpartum Period

- About 51% of women at endline reported that someone checked on their health after they gave birth, up from 22% at baseline. Nearly 80% of those whose health was checked on by someone were seen within minutes or hours after delivery (67.8% at baseline).
- Significantly higher percentages of women at endline than baseline were given Vitamin A and iron supplements during their postpartum visit.
- Forty-eight women or about 23% of those who received postpartum care selected an FP method during their postpartum visit at endline. Only five did so at baseline. Most reasons for not choosing a method were husband-related.
- Only 21.1% of women with live births (80 women out of 379 women with live births) reported that someone checked their babies within the first six weeks after birth. A total of

63.0% of those were checked minutes or hours after giving birth. Urban women, Zamfara women, women with some education, literate women and women with parity two or higher were more likely to have their babies checked within six weeks after birth.

- A total of 27 women at baseline (6.8%) said they experienced a serious health problem during the two days after birth, including bleeding, headache, blurred vision, swollen hands/face and difficulty breathing. At endline 55 women or 13.2% experienced a serious health problem. About 78% of these women sought medical assistance (68% at baseline). Those who did not seek assistance thought it was not necessary or used home-made remedies.
- There is a significant increase in the proportion of women whose children were examined by someone within the first six weeks after birth. Only nine women at baseline and 35 women at endline said their baby experienced a serious health problem within seven days of birth.
- Virtually all the women at baseline and endline said they breastfed their most recent baby; 88% of the women fed their babies with the first liquid that came from the breasts, up from 66% at baseline.

Fertility Preferences and Knowledge, Use and Perceptions of Family Planning

- Only 11 women (2.8%) at baseline and 43 women (9.8%) at endline did not want any more children. About 80% of women at baseline and endline would like to have a/another child. A sizable proportion of women (15.1% at baseline and 10% at endline) were undecided as to whether or not they would have another child.
- Knowledge of FP methods was generally low at baseline, except for pills and injectables. There is a significant increase in knowledge of most of the FP methods at the endline.
- Current use of FP among non-pregnant women was extremely low, with only five women reporting they were using a method at baseline; 67 women reported current use of FP at endline. The three most common methods were LAM, injectables and pills.
- Almost 30% of respondents at baseline thought their husbands should decide about whether or not to use FP and 19.4% supported a joint decision between the husband and wife. The corresponding figures at endline were 47% and 37% respectively. While 32.6% of the women said they 'don't know' who should make decisions about FP, only 2% said so at endline.

Exposure to community action groups and household counselors

- About 58% of respondents (60% in Kano and 55.6% in Zamfara) knew about a committee or group in the community working towards improving the health of pregnant women and their babies. Those who had such knowledge stated that the group had been working in the communities for an average of 15.8 months. Only about 15% of the respondents said they or a family member were members of the community groups.
- The three main issues the committees or groups addressed were identified as: mother's health (95.2%), baby's health (92.4%), and family planning (63.2%).
- Among women who knew about the community committees or groups, 24.4% said they received some help from them, and most of them (62.2%) received health talk; 22% received transport support and 12.2% received financial support.

- About one-half of the women reported that a community health worker visited them in their home during their last pregnancy; 46% of the women were not visited by any community health worker.
- About 47% of women reported that a community health worker visited their home after delivery to check on the baby, 49% in Kano and 46% of Zamfara. Most of health workers who came to their homes to visit their babies were ACCESS trained household counselors (86%).
- The majority of the women (86%) reported that the health workers who visited their homes carried the blue bag designed for ACCESS trained health workers. About 16% of the women were visited once by ACCESS trained workers before the birth of their baby, 22.3% were visited twice and 9.3% were visited three or more times; 45.6% were never visited by ACCESS trained workers. ACCESS trained health worker (with grey bag) visited about 15% percent of the women once within the first week of delivery, 21.4% were visited twice and 6% more than twice; About 52% of the women were not visited by the health workers.
- About 71% of the women stated that ACCESS Counselors discussed 'birth preparedness' during their visit. Most of them (79%) were able to give examples of messages related to birth preparedness which they learnt through the counselors. About 73% of women in Kano and 84% of those in Zamfara discussed what they learnt about birth preparedness someone, mostly their husbands.
- About 84% of the women said they took action related to birth preparedness after learning about it from ACCESS counselors. The action mostly taken included: 'arranged money' (90.6%), 'arranged skilled provider' (25%), and 'arranged transportation' (16.4%).
- The most prevalent things the health workers did when they visited were to ask about the health of the mother (84.5%), the newborn (83.6%), and to counsel on danger signs for the baby (42%).

Discussion

Results of the endline household survey in four LGAs in Kano and Zamfara States provide measures of changes that have occurred in knowledge and practice of emergency obstetric, newborn and family planning services after three years of program intervention in the selected locations. The endline survey shows a general improvement in knowledge of danger signs or risk factors associated with pregnancy, labor and delivery, two-day postpartum, and care for newborns in the first seven days after birth over the results of the baseline survey. There was also a significant improvement in knowledge about birth preparedness which can be attributed to the program intervention. The percentage of women who made any arrangement before the birth of their last child more than doubled at the endline. The tremendous improvement both in knowledge and action with respect to birth preparedness is expected to have positive pregnancy outcome in the predominantly rural setting covered by the survey. The endline survey found that about 74% of the women received at least one ANC visit during their last pregnancy, up from 42% at baseline, indicative of a substantial increase in accessing ante-natal care between the two periods. The component of care received during ANC visits showed a more superior outcome at the endline period, with anti-malaria drug receiving the highest improvement.

Rather worrisome is that a vast majority of deliveries in the two states still took place at home (about 80%), virtually the same rate with the baseline, and only slightly lower than 90% found by 2009 NDHS for North West Zone, where the two states are located. Given that about 73% of women visited a health facility for a least one ANC service, it seems that even though women have realized the importance of ante-natal care, they still preferred to have their babies at home. This is perhaps supported by the large percentage of women (78.5%) who claimed to have planned to give birth where they did; only 20.4% did not plan to have their babies where they eventually had them.

Important barriers to seeking care during pregnancy and birth documented by the survey are financial, socio-cultural and logistical in nature. While some women reported that lack of funds is the primary constraint, socio-cultural factors and norms, such as gender roles and conservative religious beliefs, obstruct other women's ability to seek the health care services they desire. Strikingly, husband's disapproval of facility-based care did not seem to be the driving force behind the decision to give birth at home (in fact, 76% of those who delivered at a facility were accompanied by their husbands), and most women reported making the decision about where to give birth with their husbands or on their own, while about one-third of the women said that no one ever made a decision in this regard. This is likely a reflection of a cultural norm of giving birth at home.

There is a significant improvement in knowledge and use of family planning at the endline. However, apart from the pill and injectables, the level of knowledge of other family planning methods remains low. Only five women were using a family planning method at the baseline in the four LGAs, but the number of current users of FP increased to 67 at the endline. The three methods mostly used are LAM, injectables and pills. Despite the fact that most women did want another child but did not want to become pregnant again soon, the vast majority were not using any method of contraception. The primary barrier to use of FP appeared to be a culturally fatalistic approach to fertility—with a belief that "God will decide" on the number of children.

An evaluation of the level of program presence in the community indicates that 58% of the respondents knew about a committee or group set up by the ACCESS program, slightly more in Kano. Those who knew about the community groups identified mother's health, baby's health and FP as the main issues they deal with, with only about one-fifth actually receiving some help from them. The data suggest that ACCESS health workers provided to the communities the requisite services they were trained to provide, but it seems they have not covered all the communities or their membership or available resources are inadequate to do so. Given the low level of facility use in the areas as well as the relatively low level of knowledge of birth preparedness, danger signs and family planning, the activities of ACCESS trained health workers and counselors should be supported by the local and state governments. This will greatly improve awareness of danger signs and utilization of maternal and newborn services, and reduce the high levels of maternal and newborn deaths being experienced in the area.

Recommendations

The substantial improvement in knowledge, attitude and behavior with respect to maternal and newborn health situation in the four LGAs where the ACCESS/Nigeria Program was implemented is an indication the project has been a success, and should therefore continue for a longer duration in the initial project areas, as also be scaled up to other States in the North..

The Community Action Groups and Household have been greatly instrumental for the positive changes observed in the communities. They are acceptable in the communities and pose little threat to the people. They have free access to the women and are able to discuss freely with them, also being responsive to their concerns and needs. This is a great positive reinforcement which should continue to be encouraged. Because the ACCESS Program is a short-term intervention, the community should strongly identify with it and show ownership so that the gains from the project will continue after its termination. To sustain the gains of this project, therefore, LGAs and community-based organizations should be encouraged to see reduction of maternal and neonatal mortality through increased utilization of quality EmONC services by pregnant women, mothers and their newborns as a priority which more than compensates for any investment put into it. To achieve this there is need for continuous information dissemination to all segments of the population, especially among men whom the studies have revealed to be the main decision makers in the home.

Annex 2

1. Newspaper write-up on the TMMD Clubs

ALBISHIR **Mata-masu-dabara ta yi gangamin zaburarwa - A Dawanau gari**

Takai ta sake gwangwaje ɗalibanta - Da Naira miliyan 9

... Masu sana'ar kaji na neman ɗaukinta

A Kano: NUT ta bayyana aikace-aikacenta

FOMWAN ta shirya taron wayar da kai - Kan zaɓen shugabanni nagartattu

LOKATAN SALLAH A KANO

"The Dawanau TMMD club in Dawakin Tofa LGA of Kano State, under the leadership of Mrs. Uwa Mustapha has celebrated its annual profit sharing ceremony under the mother's savings and loans scheme initiated by ACCESS/USAID. In her opening remarks, the leader of the club explained the circumstances that led to the establishment of the club which included women's lack of money to assess health care and to engage in profitable business ventures. She also pleaded with men to allow their wives to join and participate in the clubs activities. A total of ₦287, 000 was generated as annual profit which was shared

among investors (club members). Other items produced as part of the skill acquisition program such as groundnut oil and dye clothing materials were displayed during the occasion. She thanked all the traditional leaders present at occasion for their maximum support and cooperation. Similarly, she thanked ACCESS/MCHIP for providing all the training support and thereafter the ceremony ended with a closing prayer”.