

# NIGERIA END OF PROGRAM REPORT

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April 1, 2009 – June 30, 2014

Submitted on: 30<sup>th</sup> June 2014

Submitted to: United States Agency for International Development under Cooperative Agreement # GHS-A-00-08-00002-000

Submitted by: Prof. Emmanuel Otolorin, Country Director

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supported programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encouraged opportunities for integration. Cross-cutting technical areas included water, sanitation, hygiene, urban health and health systems strengthening.

MCHIP brought together a partnership of organizations with demonstrated success in reducing maternal, newborn and child mortality rates and malnutrition. Each partner took the lead in developing programs around specific technical areas:

Jhpiego, as the Prime, led maternal health, family planning/reproductive health, and prevention of mother-to-child transmission of HIV (PMTCT);

- JSI—child health, immunization, and pediatric AIDS;
- Save the Children—newborn health, community interventions for MNCH, and community mobilization;
- PATH—nutrition and health technology;
- JHU/IIP—research and evaluation;
- Broad Branch—health financing;
- PSI—social marketing; and
- ICF International—continues support for the Child Survival and Health Grants Program (CSHGP) and the Malaria Communities Program (MCP).

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID), under the terms of the Leader with Associates Cooperative Agreement GHS-A-00-08-00002-00. The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

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Map of Nigeria showing location of project States

## COUNTRY SUMMARY: NIGERIA

### Selected Health and Demographic Data for Nigeria<sup>1</sup>

GDP per capita (USD)	\$1,496 (World Bank 2011)
Total Population	162,471,000 (UN estimate)
Maternal Mortality Ratio	545/100,000 live births
Skilled birth attendant coverage	39%
Antenatal care, 4+ visits	44.8%
Neonatal mortality rate	40/1,000 live births
Infant mortality rate	75/1,000 live births
Under-five mortality	157/1,000 live births
Treatment for acute respiratory infection	22.5%
Oral rehydration therapy for treatment of diarrhea	36.7%
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)	32.8%
Modern contraceptive prevalence rate (%)	10%
Total fertility rate	5.7 children per woman
Total Health Expenditure per capita (USD) <sup>2</sup>	\$94 (World Bank estimate 2012)

## PROGRAM ACTIVITIES:

<sup>1</sup> Nigeria 2008 DHS

<sup>2</sup> Worldbank 2014

## COMMUNITY INTERVENTIONS

- Use of community health volunteers to lead community engagement efforts
- Use of household counselors to educate women and their families on danger signs in pregnancy, during and after childbirth and in their newborns
- Use of Male Birth Spacing Motivators (MBSMs) to increase male involvement in family planning
- Establishment of Mothers' Savings and Loans Clubs to provide alternative funding for maternal and newborn health care
- Establishment of an Emergency Transport System (ETS) and Community Mobilization Teams (CMTs) and Community Core Groups (CCGs) to lead the community engagement efforts

## FACILITY INTERVENTIONS

- Renovations, donation of essential obstetric equipment and strengthening of record keeping systems
- Capacity building of birth attendants for emergency obstetric and newborn care, including production of numerous newborn care videos in partnership with Global Health Media Project<sup>3</sup>
- Capacity building of non-physicians in anesthesia for emergency obstetric and newborn care and for management of neonatal sepsis
- Kangaroo Mother Care for the management of low birth weight babies
- Capacity building for newborn resuscitation in the 'Helping Babies Breathe' program
- Increasing access to long-term contraception through family planning outreaches

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<sup>3</sup> <http://globalhealthmedia.org/newborn/videos/>

<b>Program Dates</b>	April 1, 2009 – December 31, 2011					
<b>Total Mission Funding to Date by Area</b>	\$6,150,000					
<b>Total Core Funding to Date by Area</b>	\$0.00					
<b>Geographic Coverage</b>	<b>No. (%) of States</b>	3 states (8.3% of 36 States)	<b>No. of districts</b>	28 local government areas (3.6% of 774 LGAs in country)	<b>No. of facilities</b>	57 facilities
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## ACRONYMS AND ABBREVIATIONS

ACCESS	Access to Clinical and Community Maternal, Neonatal, and Women’s Health Services	Jhpiego	Affiliate of Johns Hopkins University
AED	Academy for Education Development	KMC	Kangaroo Mother Care
AFRO	Africa Regional Office (of WHO)	LAM	Lactational Amenorrhea Method
AMTSL	Active Management of the Third Stage of Labor	LGA	Local Government Area
ANC	Antenatal Care	LMP	Last Menstrual Period
BCC	Behavior Change Communications	LOP	Length of Project
BCS	Balanced Counseling Strategy	LSS	Living Saving Skills
BEmONC	Basic Emergency Obstetric and Newborn Care	MBSM	Male Birth Spacing Motivators
BEOC	Basic Essential Obstetric Services	MCHIP	Maternal and Child Health Integrated Program
BHC	Basic Health Care	MDGs	Millennium Development Goals
BP/CR	Birth Preparedness and Complication Readiness	MIP	Malaria in Pregnancy
CAC	Community Action Cycle	MMR	Maternal Mortality Rate
CBMBC	Community-Based Mother-Baby Care	MMSH	Murtala Mohammed Specialist Hospital
CCG	Community Core Group	MNCH	Maternal, Newborn and Child Health
CEmONC	Comprehensive Emergency Obstetric and Newborn Care	MNH	Maternal and Neonatal Health
CHC	Comprehensive Health Care	MOU	Memorandum of Understanding
CHEWs	Community Health Extension Workers	MSN	Maries Stopes Nigeria
CM	Community Mobilization	MSS	Midwives Service Scheme
CMD	Chief Medical Director	NHIS	National Health Insurance Scheme
CMO	Community Mobilization Officer	NHMIS	National Health Management Information System
CMT	Community Mobilization Team	NMCP	National Malaria Control Program
CNO	Chief Nursing Officer	NMR	Neonatal Mortality Rate
COMPASS	The Community Participation for Action in the Social Sector Project	NNS	Neonatal Sepsis
COP	Chief of Party	NPHCDA	National Primary Health Care

CYP	Couple years of protection	NURHI	Development Agency Nigerian Urban Reproductive Health Initiative
		NYSC	National Youth Service Corps
DFID	Department for International Development	O & G	Obstetrics and Gynecology
DHS	Demographic and Health Survey	PATHS	Partnerships for Transforming Health Systems
DOTS	Directly Observed Treatment, Short-Course	PDQ	Partnership-Defined Quality
DQA	Data Quality Assessment	PE/E	Pre-Eclampsia/Eclampsia
EDD	Expected Date of Delivery	PHC	Primary health Care
EmONC	Emergency Obstetric and Newborn Care	PHCDCs	Primary Health Care Center Director
EMNC	Essential Maternal and Newborn Care	PMTCT	Prevention of Mother to Child Transmission of HIV
ENBC	Essential Newborn Care	PNC	Postnatal Care
ENHANSE	The Enabling HIV/AIDS+TB and Social Sector Environment Project	PPC	Postpartum Care
EOC	Essential Obstetric Care	PPFP	Postpartum Family Planning
ETS	Emergency Transportation System	PPH	Postpartum Hemorrhage
FBOs	Faith-based Organizations	PRRINN	Partnership for Reviving Routine Immunization in Northern Nigeria
FCT	Federal Capital Territory	QIT	Quality Improvement Team
FMOH	Federal Ministry of Health	SBA	Skilled Birth Attendant
FP	Family Planning	SBM-R	Standards-based Management and Recognition
FY	Fiscal Year	SDPs	Service Delivery Points
GH	General hospital	SFH	Society for Family Health
HBB	Helping Babies Breathe	SHOPs	Strengthening Health Outcomes through the Private Sector Project
HCPs	Health Care Providers	SIO	Strategic Information Officer
HECTIC	Health Education, Communication, Training and Information Centre	SMOH	State Ministries of Health
HHCC	Household-to-Hospital Continuum of Care	SOGON	Society of Gynecology and Obstetrics of Nigeria
		SOM	School of Midwifery

HHCs	Household Counselors	Sphyg	Sphygmomanometer
HMB	Hospital Management Board	TBAs	Traditional Birth Attendants
HMH	Honorable Minister of Health	TMMD	Tallafi Mata Masu Dubara
HOD	Head of Department	TOT	Training of Trainers
HR	Human Resource	TSHIP	Targeted States High Impact Project
HTSP	Healthy Timing and Spacing of Pregnancies	UNFPA	United Nations Population Fund
IGA	Income Generating Activities	UNICEF	United Nations Children's Fund
IMCI	Integrated Management of Childhood Illness	USAID	United States Agency for International Development
IMNCH	Integrated Maternal, Newborn and Child Health	USG	United States Government
IPAS	IPAS	VDCs	Village Development Committees
IPCC	Interpersonal Communication and Counseling	WAHO	West African Health Organization
ISS	Integrated Supportive Supervision	WCFHS	Women and children friendly health services
IUD	Intrauterine Device	WDCs	Ward Development Committees
		ZAIHAP	Zamfara and Akwa Ibom HIV/AIDS Project

## ACKNOWLEDGMENTS

This report was made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of the Maternal and Child Health Integrated Program (MCHIP) and do not necessarily reflect the views of USAID or the United States Government.

Several people contributed to the successful implementation of the MCHIP Program in Nigeria, including staff from USAID, international non-governmental organizations (INGOs) and private consultants. MCHIP would like to acknowledge the close collaboration and contributions of the Federal Ministry of Health and its different departments such as: Family Health and Planning Research and Statistics Departments throughout the life of MCHIP's projects in Nigeria. MCHIP would like to acknowledge with gratitude the time, expertise and support given by the numerous institutions, stakeholders and individuals that contributed to the successful achievements of the MCHIP program particularly:

- States' Ministries of Health in Kano, Katsina and Zamfara States
- State Hospital Management Boards in Kano, Katsina and Zamfara States
- Local Government Area authorities in project states

We would like to give special thanks to the Director of USAID/Nigeria and the Health team including, Ms. Nancy Lowenthal, Ms. Karla Fossand, Ms. Sharon Epstein HPN Team Leaders, Dr. John Quinley (Acting Deputy Team Leader), Mr. Abdullahi Maiwada, Mr Kayode Morenikeji and Dr. Joseph Monehin, Activity Managers for their support and guidance.

MCHIP/Nigeria also appreciates Dr. Koki Agarwal, Dr. Catherine McKaig, Elaine Charurat, Nancy Caiola, Nancy Ali, James BonTempo, Dr. Joseph de Graft-Johnson, Lindsay Morgan, Barbara Rawlins, Edgar Necochea and Alishea Galvin for their technical and programmatic advice.

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## EXECUTIVE SUMMARY

The 2008 Nigeria Demographic and Health Survey revealed that while Nigeria had made some progress in maternal, newborn and child health indices, this progress was inadequate. These findings reinforced the opinion that Nigeria belonged to the group of countries making “insufficient” progress towards the attainment of MDGs 4 and 5<sup>4 5</sup>, especially in the Northwest geopolitical zone of Nigeria. This zone has a particularly high maternal mortality ratio of 1,025 compared to the national average of 800 per 100,000 live births<sup>6</sup>. Skilled attendance at birth, antenatal care (ANC) attendance and contraceptive prevalence rate were also very low in this zone while the total fertility rate was high. As

#### **Textbox 1: Summary of achievements**

- Implemented evidence-based EmONC interventions in 3 States (representing 8.3% national coverage) in continuation of the ACCESS Project.
- Supported 57 health facilities in 28 local government (LGA) areas.
- Project trained skilled birth attendants (SBAs) supervised 879,385 antenatal visits, 183,355 institutional deliveries, provided active management of third stage of labor (AMSTL) to 156,498 women, used the partograph for 81,437 deliveries and provided essential newborn care to 175,906 newborns seen within three days of birth.
- 449 trained male birth spacing motivators counselled and referred 11,371 men of whom 28.3% accepted an FP method for themselves or their spouses. CPR for modern methods in the region is 2.5%
- 477 trained female household counsellors reached 32,926 women and referred 12,481 to health facilities
- 2919 members of 109 Mothers’ Savings and Loans Clubs that were established raised over US\$155,000 to be used as loans for small scale businesses or for health care
- 352 health care workers were trained in the ‘Helping Babies Breathe’ program and 60 NoeNatalie models were donated.
- Long acting reversible contraception (LARC) were provided to 466 women through FP outreaches.
- More than 20 videos on newborn care produced in partnership with Global Health Media Project (all now online through WHO’s Reproductive Health Library website).

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<sup>4</sup> Countdown to 2015, 2008 Report.

<sup>5</sup> Nigeria Demographic and Health Survey, 2008: Preliminary report

<sup>6</sup> Countdown to 2015, 2008 Report.

outlined in the National Integrated Maternal, Newborn and Child Health (IMNCH) strategy and Midwifery Service Scheme (MSS), the Government of Nigeria (GoN) is committed to improve health outcomes for pregnant women and their families.

The goal of USAID's Maternal and Child Health Integrated Program (MCHIP) in Nigeria was to contribute to the reduction of maternal and neonatal mortality by achieving its life-of-project (LOP) objective of increased utilization of quality emergency obstetric and newborn care (EmONC) services by pregnant women, mothers and their newborns in selected local government areas (LGAs) in three states, Kano, Zamfara and Katsina. MCHIP was well-positioned to support the GoN to address MNCH interventions, drawing on technical and programmatic expertise from the previous ACCESS Nigeria program. MCHIP continued the implementation of ACCESS Program's integrated community and facility-based essential maternal and newborn care interventions focusing on antenatal care (ANC), comprehensive and basic EmONC, postpartum care, and family planning for healthy timing and spacing of pregnancies using a Household-to-Hospital Continuum of Care (HHCC) approach.

MCHIP advocated for supporting high-impact and evidence-based interventions as well as building the country's capacity in MNCH and FP working with the GoN. Thanks to a strong partnership with the GoN and other implementing partners and support from USAID, many achievements were observed throughout the duration of the project (see textbox 1 above).

MCHIP supported and worked with a variety of MCH/FP/RH stakeholders to develop National Performance Standards for EmONC and family planning (FP) which led to an increase in the quality of care consciousness in the health sector. Additionally, the program advocated with other implementing partners for the creation of the Midwifery Service Scheme to increase the number of skilled birth attendants deployed throughout the country. Concurrently, MCHIP reviewed the pre-service midwifery curriculum in project states to ensure the inclusion of evidence-based EmONC and FP interventions. MCHIP also participated in the Family Planning Action Group (FPAG) which successfully advocated for the GoN policy change in FP commodities in April 2011, making access to FP commodities free of charge. These are some of the many interventions that may have contributed to the reduction in Nigeria's maternal mortality rate.

In order to increase access and improve the quality of care, MCHIP trained 2,678 people on health related subjects. Eighteen health centers were refurbished and basic obstetric

equipment was donated. The skilled birth attendants (SBAs) from 57 facilities supervised 879,385 antenatal visits, 183,355 institutional deliveries, provided active management of third stage of labor (AMSTL) to 156,498 women, used the partograph for 81,437 deliveries and provided essential newborn care to 175,906 newborns seen within three days of birth<sup>7</sup>.

The program also established 19 community mobilization teams (CMTs) to guide communities to prioritize maternal, newborn and FP issues and to leverage additional resources (emergency transport and communication) and support from philanthropists and traditional/political leaders<sup>8</sup>. Through 477 trained household counselors (HHCs) and 449 male birth-spacing motivators (MBSMs), the program was able to increase knowledge of pregnant women about danger signs in pregnancy, during and after childbirth and inform couples on healthy timing and spacing of pregnancies and use of modern contraception.

After the end-of-project financial adjustments, available funds were used, at the request of the USAID, to conduct a baseline assessment of selected health facilities in three States' (Akwa Ibom, Benue and Imo) on their readiness to provide basic and comprehensive emergency obstetric and newborn care to pregnant women and their newborns. This led to an assessment of 30 health facilities' infrastructure and human and material resources as well as knowledge and skills assessment of about 118 frontline health care workers. Details of the assessment findings are available in a separate report<sup>9</sup>.

The MCHIP programs have demonstrated that the implementation of a HHCC approach consisting of a package of community and facility interventions can lead to increased knowledge of communities about maternal and newborn health issues and increased utilization of health facilities for maternal, newborn and family planning services. However, these efforts need to be sustained and scaled-up statewide and nationally for the full impact of the interventions to meet the 2015 targets of the Millennium Development Goals. MCHIP leaves a legacy of competent frontline health workers to provide basic maternal and newborn services and empowered community mobilizers. All the training materials and job aids developed by MCHIP have been provided to the GoN at the national and county level as well as other implementing partners so they can continue to implement the program long term.

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<sup>7</sup> MCHIP/Nigeria Routine Service statistics template

<sup>8</sup> MCHIP progress report

<sup>9</sup> MCHIP Nigeria. Project report: An assessment of health facilities in Akwa Ibom, Benue and Imo States on their readiness to provide emergency obstetric and newborn care.

## INTRODUCTION

### USAID & MCHIP'S APPROACH IN NIGERIA

The 2008 Nigeria Demographic and Health Survey revealed that while Nigeria had made some progress in maternal, newborn and child health indices, this progress was insufficient. These findings reinforced the opinion that Nigeria belonged to the group of countries making “insufficient” progress towards the attainment of MDGs 4 and 5<sup>11,12</sup>. As shown in Table 1, this situation was found to be worse in the Northwest geopolitical zone of Nigeria, where all the MCHIP Project states are situated.

State/ Region	Total Fertility Rate (children per woman)	Current Use of Contraception (%)		Maternal health indicators (%)	
		Any Method	Modern Methods	ANC with SBA	Delivery with SBA
National	5.7	14.6	9.7	57.7	38.9
Northwest	7.3	2.8	2.5	31.1	9.8
Katsina	7.2	0.8	0.7	14.4	4.7
Kano	8.1	2.3	2.1	49.8	12.7
Zamfara	7.5	2.5	2.1	13.1	7.7

Consequently, the Government of Nigeria (GoN) put in place measures to arrest and reverse this trend. A National Integrated Maternal, Newborn and Child Health (IMNCH) strategy was drafted and now informs the main thrust of MNCH activities in Nigeria. In addition, Nigeria participated in the continental launching of the Campaign for Accelerated Reduction of Maternal Mortality in Africa (CARMMA) in 2009, followed shortly thereafter by a national

<sup>10</sup> Nigeria Demographic and Health Survey, 2008: Preliminary report

<sup>11</sup> Countdown to 2015, 2008 Report.

<sup>12</sup> Nigeria Demographic and Health Survey, 2008: Preliminary report

launching. In the same year, the Midwifery Service Scheme (MSS) was established to address the shortage of skilled birth attendants nationwide and especially in Northern Nigeria. The NHIS/MDGs MCH Project was also launched by the National Health Insurance Scheme to provide free medical care for pregnant women and children under-five years of age.

The ACCESS Nigeria program, a USAID funded project that commenced in January 2006, was designed to help reduce the high burden of maternal and newborn mortality in the North West Zone of the country. This zone was chosen because of the particularly high maternal mortality ratio of 1,025 compared to the national average of 800 per 100,000 live births<sup>13</sup>. Skilled attendance at birth, antenatal care (ANC) attendance and contraceptive prevalence rate were also very low in this zone while the total fertility rate was high<sup>14</sup>. While the ACCESS Program commenced activities in two local government areas (LGAs) in each of Kano and Zamfara states, the successor MCHIP Nigeria program supported 57 facilities in 28 LGAs in the three North West states of Kano, Katsina and Zamfara. MCHIP Nigeria's LOP objective and results contributed to USAID Nigeria's strategic objective 13, *Increased Use of Child Survival and Reproductive Health Services*. MCHIP contributed to the reduction of maternal and neonatal mortality by achieving its life-of-project (LOP) objective of *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*. To achieve its LOP objectives, MCHIP implemented interventions at the community and facility levels (see Textbox 2 below).

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<sup>13</sup> National Bureau of Statistics, 2000

<sup>14</sup> National Population Commission (NPC) and ORC Macro. 200r. *Nigeria Demographic and Health Survey 2003*

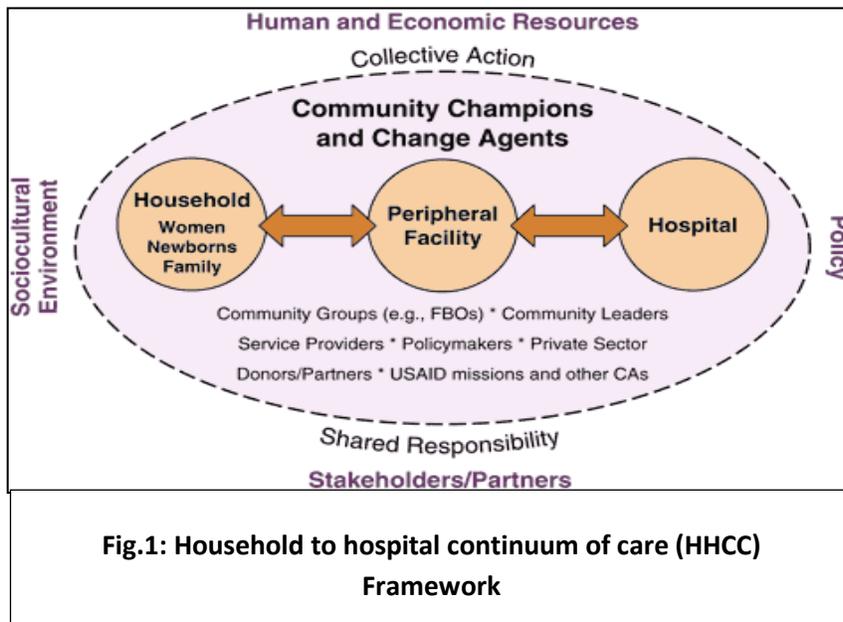
## **Textbox 2: Summary of program activities**

- Community Interventions
  - Use of community health volunteers to lead community engagement efforts
  - Use of household counselors to educate women and their families on danger signs in pregnancy, during and after childbirth and in their newborns
  - Use of Male Birth Spacing Motivators (MBSMs) to increase male involvement in family planning
  - Establishment of Mothers' Savings and Loans Clubs to provide alternative funding for maternal and newborn health care
  - Establishment of an Emergency Transport System (ETS) and Community Mobilization Teams (CMTs) and Community Core Groups (CCGs) to lead the community engagement efforts
- Facility Interventions
  - Capacity building of birth attendants for emergency obstetric and newborn care, including the production of over 20 videos on newborn care in partnership with Global Health Media Project.
  - Capacity building in anesthesia for emergency obstetric and newborn care and for management of neonatal sepsis
  - Kangaroo Mother Care for the management of low birth weight babies
  - Capacity building for newborn resuscitation in the 'Helping Babies Breathe' program

The key program approach to achieving the MCHIP Nigeria Program's objectives was a continuation of the implementation of ACCESS Program's integrated community and facility-based essential maternal and newborn care interventions focusing on antenatal care (ANC), comprehensive and basic EmONC, postpartum care, and family planning for healthy timing and spacing of pregnancies using a Household-to-Hospital Continuum of Care (HHCC) approach (see Fig.2 above). The HHCC approach recognizes the importance of a successful maternal and

newborn care program to systematically address maternal and newborn issues of the community and facility together using evidence-based interventions and best practices.

The HHCC (see framework below) addresses all three delays<sup>15</sup> associated with maternal and newborn deaths by improving household and care-seeking practices, empowering the community to create and maintain an enabling environment for increased utilization of maternal and newborn care services, whether public or private, and improving the quality of care provided at the peripheral and district (LGA) levels.



#### MCHIP/NIGERIA PROJECT: GOALS AND OBJECTIVES

As stated earlier, the main technical intervention is the improvement of EmONC services as an entry point to postpartum contraception transitioning to long acting reversible contraception, which was a continuation of the ACCESS program. The six program objectives were:

- Objective 1:** Improved enabling environment and scale-up of best practices for EmONC at National and State levels
- Objective 2:** Increased availability and distribution of EmONC trained health care workers in selected LGAs
- Objective 3:** Improved quality of EmONC services in selected LGAs

<sup>15</sup> The 3 delays are: 1) delay in recognizing complications; 2) delay in reaching a medical facility; and 3) delay in receiving good quality care at the facility.

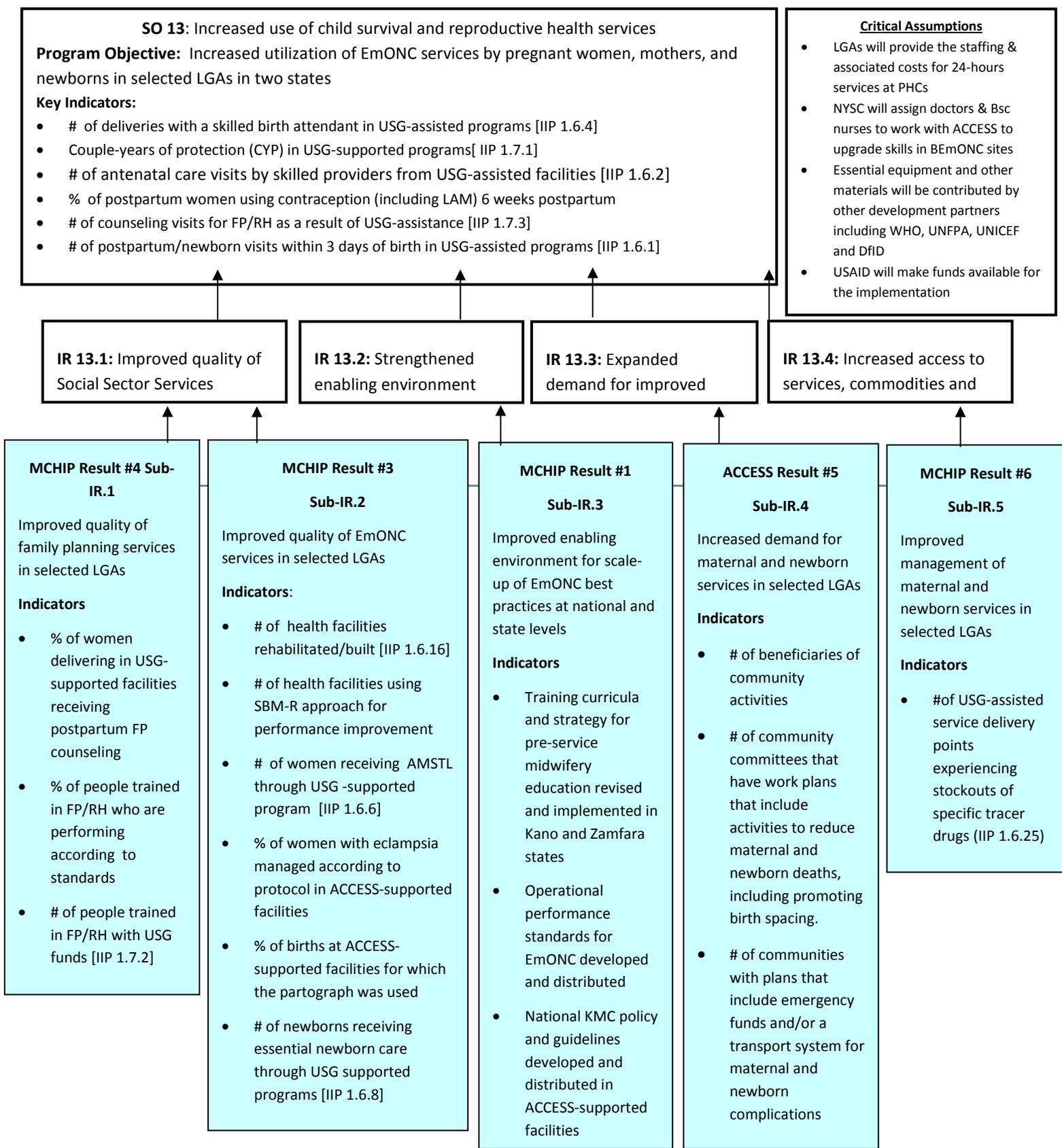
**Objective 4:** Improved quality of FP services in selected LGAs

**Objective 5:** Increased demand for maternal and newborn services in selected LGAs

**Objective 6:** Improved management of maternal and newborn services in selected LGAs

In addition, a **baseline assessment of selected health facilities in three Nigeria States** for their readiness to provide emergency obstetric and neonatal care (EmONC) was conducted.

FIG. 2: MCHIP PROGRAM RESULTS FRAMEWORK



## MAJOR ACCOMPLISHMENTS

### OBJECTIVE 1: IMPROVED ENABLING ENVIRONMENT AND SCALE-UP OF BEST PRACTICES FOR EMONC AT NATIONAL AND STATE LEVELS

#### Achievements

##### *1.1 Establishment of structures for preparing and facilitating the scale up of EmONC*

MCHIP predecessor (ACCESS) worked at the national and state levels to support the GoN efforts at improving safe motherhood in Nigeria. ACCESS contributed significantly to the formulation of the National Integrated Maternal, Newborn and Child Health (IMNCH) Strategy document, which now informs the main thrust of MNCH activities. MCHIP participated in the monthly Core Technical Committee (CTC) meetings of the IMNCH secretariat. The CTC held 84 such meetings. ACCESS was also at the forefront of the advocacy for increasing skilled birth attendance in Nigeria culminating in the birth of the National Midwifery Service Scheme (MSS) project. In pursuit of sustainability of its interventions, MCHIP continued to support the National Primary Health Care Development Agency (NPHCDA) in its MSS program, sharing training materials which were used to train midwives in the MSS project and linking the agency up with trained BEmONC trainers in project states. MCHIP continued to advocate at all levels for the scale-up of selected evidence-based interventions e.g. active management of the third stage labor of (AMTSL), use of Misoprostol for PPH prevention, helping babies breathe (HBB) program, community distribution of chlorhexidine and focused ANC including malaria control in pregnancy. The NPHCDA has trained at least 4000 midwives in over 1000 health facility clusters using adapted Jhpiego materials.

##### *1.2 Explore alternative financing mechanisms for the poor to access EmONC services*

The MCHIP project established 109<sup>16</sup> Mothers Savings and Loans Clubs (called *Talaffin Mata Masu Dubara* or TMMD in Hausa language) to provide alternative financing mechanisms for the poor to access EmONC and FP services. These clubs have grown beyond the project's expectation and have economically empowered many women, considered a very welcome development by their spouses. It is noteworthy that MCHIP did not give any seed grant money to start these clubs! The women themselves saved all the money in the clubs. Funds saved have

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<sup>16</sup> MCHIP, Nigeria dissemination report, 2011

been used as loans for members to access health care services for themselves and their newborns or to establish small scale businesses. The latter seems to be a major output of this intervention. MCHIP also took advantage of the weekly gathering of club members to have MNH and FP education talks by household counselors.



Mothers' Savings and Loans Club members counting contributions at one of their meetings in Kano State

As of 30 September 2011, the 2,919 members in the 109 TMMD clubs formed had collected over N24 million (approximately \$155,000) out of which, contrary to expectations, only about 5 percent<sup>17</sup> was used to access emergency obstetric or newborn health care. Most loans were taken to establish small scale businesses for members. This program has been widely embraced by the members' spouses and traditional leaders. Interestingly, a village head had observed that the program had resulted in a sharp decline in divorce cases in his domain.

### *1.3 Define National EmONC performance standards for SBM-R*

ACCESS worked with a variety of MCH/FP/RH stakeholders to develop National Performance Standards for Emergency Obstetric and Newborn Care (EmONC) and Family Planning (FP). The standards were later used in ACCESS project sites. This helped to raise the *quality of care consciousness* in the health sector. MCHIP supported the newly established SQHN which is a private sector led initiative. The Chief of Party (COP), Prof. E.O Otolorin, was later elected into the Society for Quality of Health Care in Nigeria (SQHN) Board and has continued to play a significant role in the education of healthcare workers in quality of care<sup>18</sup>. The Family Planning standards have also been adopted for use in other programs like TSHIP, NURHI and SHOPS. The

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<sup>17</sup> Records of Contributions and Loans to women

<sup>18</sup> SQHN website: <http://sqhn.org/>

ANC standards for PHCs were also used in the ExxonMobil funded malaria control program (MIP) in Akwa Ibom State.

## OBJECTIVE 2: INCREASED AVAILABILITY AND DISTRIBUTION OF EMONC TRAINED HEALTH CARE WORKERS IN SELECTED LGAS

### Achievements

#### *2.1 Pre-placement BEmONC training of National Youth Service Corps (NYSC) physicians*

The ACCESS/MCHIP oriented over 700 NYSC doctors to basic EmONC interventions during the life of the project. These orientations focused on the key interventions to prevent maternal mortality e.g. use of Magnesium Sulphate for treatment of eclampsia and AMTSL for the prevention of PPH. The doctors were also given job-aids and memory joggers to support their efforts. Hence, irrespective of where these NYSC doctors were posted within the project states, they were able to provide evidenced-based management for the common causes of maternal mortality.

#### *2.2 Advocacy for employment and rational deployment of EmONC Staff in selected LGAs*

As stated in 1.1 above, advocacy from implementing partners (including ACCESS/MCHIP) eventually led to the creation of the Midwifery Service Scheme (MSS) project which has been mainly funded by the GoN using MDG funds and managed by the National Primary Health Care Development Agency (NPHCDA). Under the MSS project, 1,000 clusters of health facilities have been supported. Each cluster has one hospital overseeing four PHCs. Since 2009, at least 4,000 nurse-midwives (four per PHC) have been employed and deployed in the program. Perhaps this is just one of the many interventions that have contributed to the reduction in Nigeria's maternal mortality ratio from 800 to 545 deaths per 100,000 live births. Under the Subsidy Reinvestment and Empowerment Program (SURE-P) a new GoN initiative emanating from the removal of fuel subsidy in the country, 2,000 additional midwives are expected to be employed and deployed in 500 additional clusters, while village health workers (VHWs) are to be trained as household counselors. This is evidence that ongoing advocacy for the household to hospital continuum of care approach is becoming entrenched in the Federal Ministry of Health (FMOH).

#### *2.3 Strengthening pre-service midwifery education*

ACCESS/MCHIP helped review pre-service midwifery curricula to ensure the inclusion of evidence-based EmONC and FP interventions (use of MgSO<sub>4</sub>, AMTSL, safe and clean births, use of partograph, use of IPTp and ITNs etc.). MCHIP also donated numerous anatomic models and basic obstetric equipment to three midwifery schools (one per state) and updated the school faculty on basic EmONC and FP knowledge and skills.

## Achievements

### *3.1 Upgrade facilities of selected LGAs to provide EmONC services*

ACCESS/MCHIP renovated 18<sup>19</sup> health facilities during the life of the project and also donated basic obstetric equipment (delivery kits, episiotomy repair kits, Caesarean section kits, IUD insertion kits as well as adult/newborn resuscitation equipment.)

### *3.2 Strengthen the performance of health care workers (physicians, nurses, anesthetists, midwives) in EmONC services in both public and private sectors*

ACCESS/MCHIP trained over 600 nurse-midwives to provide one of the following EmONC services:

- Basic Emergency Obstetric and Newborn Care
- Anesthesia for EmONC
- Essential newborn care including “helping babies breathe”
- Kangaroo mother care
- SBM-R
- FP courses (see Objective 4.2 below)

During the life of the projects, the ACCESS/MCHIP Program trained 2,678 people on health-related subjects, including 608 nurse/midwives and 59 community health extension workers (CHEWs). The skilled birth attendants from 57 USG-supported health facilities subsequently supervised **879,385 antenatal visits, 183,355 institutional deliveries**, provided active management of third stage of labor (AMTSL) to 156,498 women (**94.9% of all normal vaginal deliveries**), used the **partograph** for 81,437 deliveries (**44.4% of total deliveries**) and provided essential newborn care to **175,906 newborns seen within three days of birth.**<sup>20</sup>

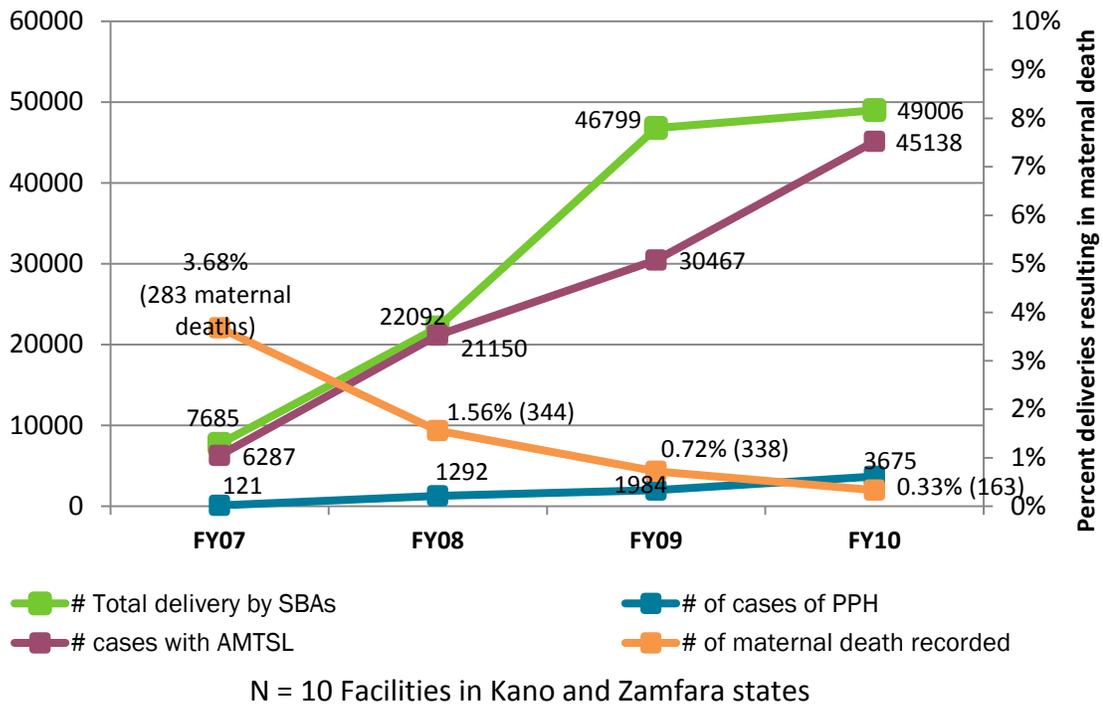
Figure 3. Below shows a composite graph spanning ACCESS/MCHIP programs and showing a relationship between the number of institutional deliveries, use of AMTSL, cases of PPH and maternal mortality in 10 project-supported hospitals in Kano and Zamfara States.

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<sup>19</sup> Program progress report, 2011

<sup>20</sup> MCHIP/Nigeria Routine Service Statistics data template

**Fig. 3: PPH and use of AMSTL compared with maternal deaths and deliveries for 10 hospitals\* in Nigeria (2007-2010)**

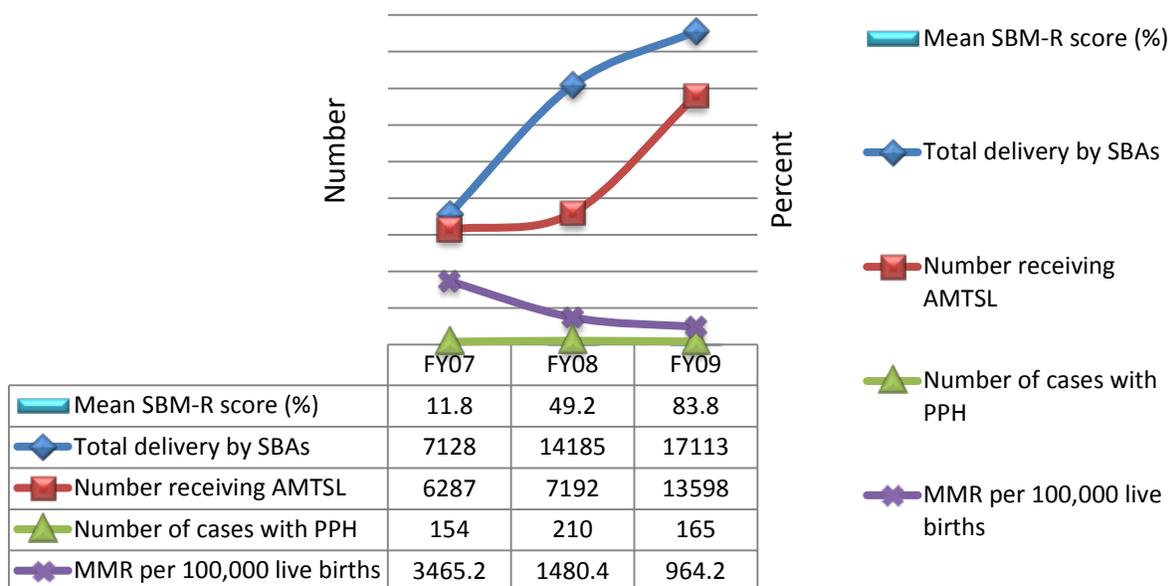


**3.3 Introduce Standards Based Management and Recognition (SBM-R) tools and approaches at ACCESS-supported facilities**

ACCESS/MCHIP introduced the SBM-R approach to 30 health facilities and trained health care workers and supervisors in its use. ACCESS conducted baseline assessments in 19 facilities and at least two follow-up assessments in 11 facilities.

A further review of six of the hospitals referred to in Fig. 3 above that had SBM-R scores data (Fig. 4 below), showed that increasing compliance with set performance standards including the use of AMSTL to prevent PPH was associated with reduced maternal mortality in the health facilities. While accepting that the data requires cautious interpretation, it is certainly a pointer to the fact that institutional maternal mortality ratios can be reduced through the adoption of evidence based interventions at scale.

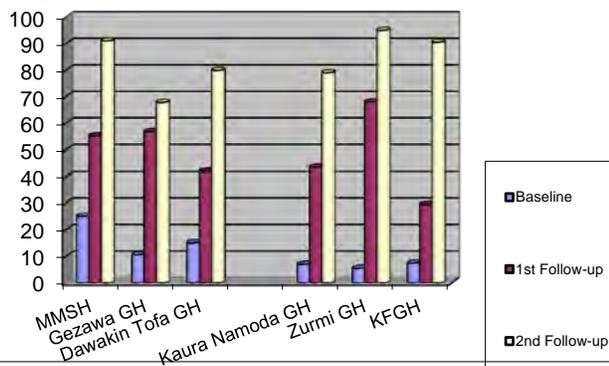
**Fig. 4: SBM-R Scores and Selected Service Statistics in 6 Hospitals under the ACCESS Program: 2007-2009**



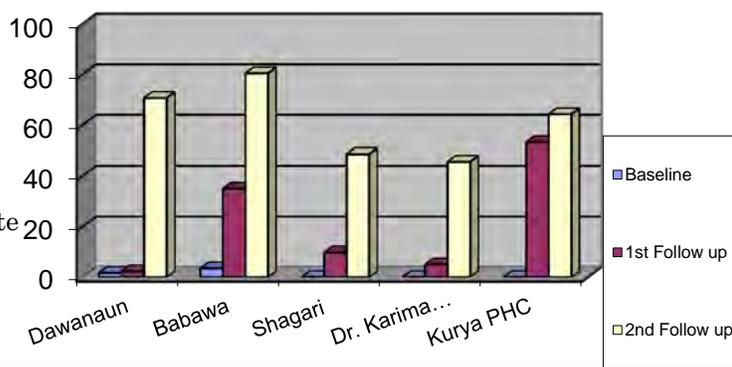
Illustrative results included<sup>21</sup>:

- An increased compliance with set EmONC standards in initial hospitals from a mean of 11.8 percent to 83.9 percent after two follow-up assessments (see Fig 5 below).
- An increased compliance with set EmONC standards in initial PHCs from a mean of 1 percent at baseline to 61.9

**Fig. 5: EmONC Performance Scores in Hospitals**



**Fig. 6: EmONC Scores for PHCs**



<sup>21</sup> MCHIP/Nigeria SBMR data template

percent after two follow-up assessments (see Fig. 5 and Fig. 6 below).

- An increased compliance with set FP standards at MMSH from 63.2 percent to 82.5 percent.

At the ACCESS/MCHIP training center, the Murtala Mohammed Specialist Hospital, while the mean SBM-R score for EmONC increased from 25.1 percent at baseline to 91 percent after two follow-up assessments, the maternal mortality ratio (MMR) in the hospital fell from 2,678 to 836 per 100,000 live births.

The large number of set performance standards (199 in hospitals and 173 in PHCs), as well as the large human resource requirements to implement the process were a challenge to the institutionalization of the process in all facilities. Hence the project chose to consolidate its gains from previous SBM-R implementation sites while deciding to modify the assessment tool to reduce the number of standards. This concept was later carried into the TSHIP program which is USAID Nigeria's bilateral award for RMNCH. Set standards for ANC, labor and delivery and postnatal care were reduced from 91 to 45 while infection prevention standards were also reduced from 34 to 23. Family planning standards were reduced from 56 to nine in the integrated IMNCH program.

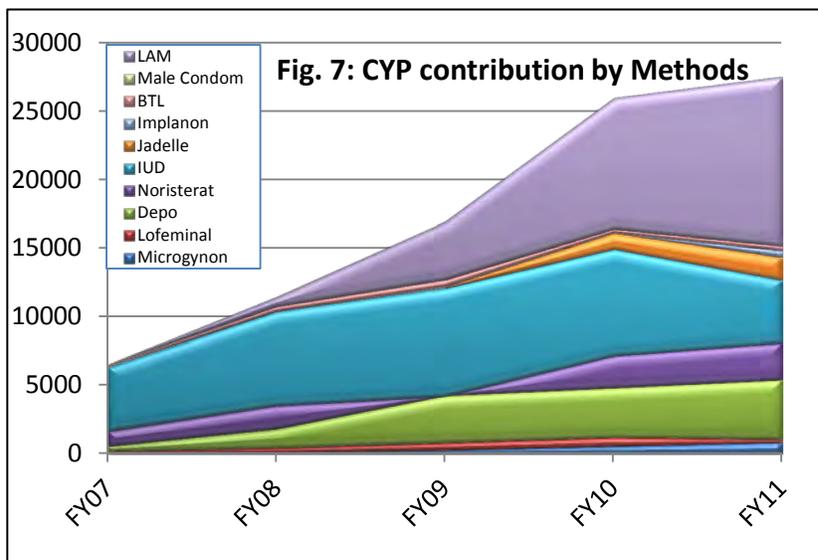
**OBJECTIVE 4: IMPROVED QUALITY OF FP SERVICES IN SELECTED LGAS**

**Achievements**

*4.1 Upgrade facilities of selected LGAs to provide FP services*

The family planning clinic of each MCHIP supported facility

was included in the refurbishment plan. By the end of the ACCESS/MCHIP project, all 57 project-supported facilities were providing FP services compared to 15 at the start of the ACCESS project. Where needed, MCHIP donated equipment (IUD and Jadelle implant insertion /removal kits) in order to help broaden the contraceptive method mix in these facilities. Fig. 7 shows increasing CYP over the life of the project. Frequent stock out of FP commodities in 2011 had some impact on the use of long-acting methods (IUD, Implanon and Jadelle).



#### *4.2 Strengthen the performance of health care workers (physicians, nurses, anesthetists, midwives) in FP services in both public and private sectors*

In addition to the provision of FP equipment, MCHIP trained over 600<sup>22</sup> health care workers to provide FP services. Courses included:

- Contraceptive technology updates for doctors, midwives and nurses
- Balanced counseling strategy (BCS) for mid-wives and CHEWs
- Postpartum FP (including LAM) for midwives and CHEWs
- Long-acting reversible methods provision (specifically IUD and Jadelle implants insertion/removal) for midwives and physicians

These trained health care providers provided FP services at static service delivery sites and also participated in FP outreaches. A variety of job aids and FP IEC materials were developed, printed and distributed. MCHIP also participated in the Family Planning Action Group (FPAG) that organized the first National FP conference and developed the new RAPID advocacy tool. Evidence of success of the FPAG advocacy efforts include the GoN declaration of free FP commodities policy in April 2011 and provision of \$3 million to the UNFPA for procurement of contraceptives. At the FP2020 conference in London the GoN also committed to providing \$8.35 million annually for life-saving MNCH commodities.

As part of its effort to address the unmet need for family planning in Northwest Nigeria, the MCHIP organized **model family planning outreaches** which aimed to scale up the use of long-acting reversible family planning methods through the expansion of the method mix for contraception. Activities conducted included community mobilization and group education and counseling sessions to inform and empower couples to take decisions on healthy timing and spacing of pregnancies and use of modern contraception. During four of such outreaches, the following services were provided to 466 women. Two hundred and eighty-two (282) women had Jadelle insertions, 139 women had injectable contraception, 27 women had IUD insertions, 17 women accepted oral contraceptive pills while one couple chose to use condoms. Ten other women received no method while five were diagnosed to be already pregnant during the outreaches<sup>23</sup>.

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<sup>22</sup> MCHIP Training date template

<sup>23</sup> MCHIP/Nigeria Activity Report and records

### *4.3 Improve supervision of family planning services*

MCHIP conducted numerous supportive supervision trainings for health facility and SMOH staff. The programs also supported joint (MCHIP/MOH) quarterly supervisory visits to project-supported facilities to provide oversight for the implementation of the FP performance standards. These visits helped SMOH and SHMB staff to become familiar with some of the challenges that health care workers are facing in the health facilities and to take decisions to solve some of the problems limiting quality of care. Regrettably, dependency on the project to facilitate these visits was of great concern. Hence there is ongoing advocacy for SMOH budgetary provision to institutionalize these supportive supervision visits.

## OBJECTIVE 5: INCREASED DEMAND FOR MATERNAL AND NEWBORN SERVICES IN SELECTED LGAS

### Achievements

#### *5.1 Strengthen community capacity in planning and implementing EMNC activities*

ACCESS/MCHIP established 19 community mobilization teams (CMTs) in the 28 project LGAs to guide communities to prioritize maternal, newborn and FP issues in community activities and to leverage resources from philanthropists and traditional/political leaders in their communities to support maternal and newborn care. ACCESS/MCHIP also established 52 community core groups (CCGs) around project-supported health facilities to work with health care workers to address issues of maternal and newborn health in their domain. The program also **trained 477 household counselors (HHCs)** to educate women and their families about pregnancy and child birth and **449 male birth-spacing motivators (MBSMs)**<sup>24</sup> to educate men about the benefits of healthy timing and spacing of pregnancies and the use of contraception. All the community engagement groups were made up of volunteers. They were however given transport money to attend monthly data collation meetings in the state capital.

The MCHIP trained 449 MBSMs educated fellow men about the benefits of healthy timing and spacing of births and the use of modern contraceptive methods. These MBSMs counseled and referred 11,371 men, 5,534 of whom gave feedback on their visit to the family planning clinic. Of the 11,371 men 3,216 (28.3% of those counseled) accepted an FP method for themselves or their spouses, 1,789 accepted the injectable, 730 accepted oral pills, 450 accepted to use

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<sup>24</sup> MCHIP/Nigeria Training records

condoms while 253 accepted an IUD. This result demonstrated the value of male engagement in family planning.

Similarly, the 477 trained volunteer household counselors educated pregnant women and their families about the danger signs in pregnancy, during and after delivery and in their newborns. These women documented 7,302 women reached and referred 5,179 for a variety of services including 1,487 for focused antenatal care (FANC), 628 for institutional delivery, 279 for recognized danger signs in their newborns, 394 for injectable contraception, 114 for IUD insertion and 611 for oral contraceptive pills<sup>25</sup>.

The findings from the previous ACCESS/MCHIP endline survey provided evidence of increased knowledge of pregnant women about danger signs in pregnancy, during and after childbirth as well as in the newborn years. The endline survey also showed improved birth preparedness and complication readiness on the part of the pregnant women, as well as increased use of ANC and FP services<sup>26</sup>.

### *5.2 Strengthen linkages between community, primary and secondary health facilities*

The CMTs, CCGs, HHCs and MBSMs were linked with the health facilities. Some served on the joint facility-community committees. These committees helped to inform CMTs and CCGs about the needs of the health facilities thereby providing information for the advocacy visits to philanthropists and other charitable organizations in the community. These community committees successfully leveraged material and financial support from individuals and organizations in their communities to address gaps identified in service delivery. Examples of success include donation of ambulances, construction or renovation of buildings, donation of essential drugs, insecticide treated bednets, medical equipment and consumable supplies, provision of water tanks, patients' benches and provision of accommodation for health care workers posted to health facilities (see photos below).

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<sup>25</sup> MCHIP Progress report

<sup>26</sup> ACCESS Nigeria Project Report



CMT and CCG Members in Gezawa LGA of Kano State



Donation of water tank in Babawa local government area.



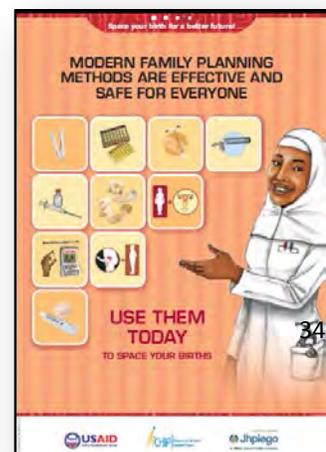
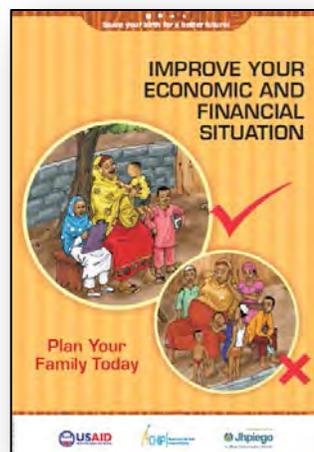
Donated ambulance



Renovated doctors quarters

*5.3 Implement evidence-based behavior change interventions to increase community recognition of maternal and newborn danger signs*

This was achieved by all the community engagement groups listed in 5.1. above, especially the HHCs and MBSMs who used project-designed flipcharts and



models to educate the community beneficiaries, notably pregnant women and their families. IEC materials in English and Hausa languages were developed and disseminated in all project supported facilities. The endline ACCESS survey findings demonstrated the effectiveness of this approach. For example, the percentage of women who could identify at least four danger signs during pregnancy and childbirth and in the newborn increased from 53 percent at baseline to 79.5 percent at endline. Similarly, percent of women making birth preparedness plans increased from 31.8 percent at baseline to 68 percent at endline<sup>27</sup>.

## OBJECTIVE 6: IMPROVED MANAGEMENT OF MATERNAL AND NEWBORN SERVICES IN SELECTED LGAS

### Achievements

#### *6.1 Strengthen leadership, managerial and advocacy skills of LGA/ Health Management Team (HMT)*

This was achieved through regular involvement of the health leadership and management staff in most of the MCHIP activities including training in supportive supervision. Maintaining a high level of interest from this sector was a bit of a challenge as MCHIP did not pay *top-up* salaries nor contributed to MNH basket funding in the State MOH. Other programs that did this tended to elicit more interest from this cadre of staff. MCHIP conducted supportive supervision trainings and provided transportation for joint (SMOH and MCHIP staff) quarterly supervision visits to project sites. Facility managers and SMOH staff were also trained in the SBM-R process while the formation of facility Quality Improvement Teams (QITs) was supported by the program. Initial enthusiasm for the QI process was however difficult to maintain because of frequent transfer of project-trained staff away from the sites. Managers were also trained on the use of data for decision making.

At inception, the record-keeping systems in most of the facilities were virtually non-existent. In continuation with the ACCESS Program, MCHIP worked with the SMOH to adapt the national HMIS forms and registers for use in the state. MCHIP thereafter printed and disseminated the HMIS tools, trained focal M&E staff on their use and supported monthly data collation meetings of the M&E staff in the state capital. With the success of this approach, the states later held HMIS tool harmonization workshops leading to the adaptation of the MCHIP forms and

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<sup>27</sup> ACCESS endline survey report

registers for use in the two of the states, Zamfara and Katsina, while Kano was still in the process at the time of close-out. Interestingly, these harmonized forms later influenced a national review of HMIS tools.

#### *6.2 Strengthen the necessary logistic transport and communication system for EmONC.*

MCHIP worked through the CMTs and CCGs to advocate for community action plans that included emergency transport and communication. All supported CMTs included such interventions in their action plans. In addition, MCHIP later worked with a sister NGO, TransAID, to select and train driver members of the National Road Transport Union of Nigeria to establish an Emergency Transport System (ETS) to carry pregnant women in labor or those women experiencing life-threatening complications to go promptly to health facilities. Under the scheme, a total of 141 pregnant women were documented as having been so transferred by the NURTW.

#### *6.3 Improve supervision and support of SBM-R of EmONC services*

As stated in 6.1 above, the programs conducted numerous supportive supervision trainings for staff of the SMOH, SHMB and heads of health facilities to provide oversight for EmONC, FP and SBM-R services

#### *6.4 Recognize high performing EmONC champions, communities and facilities*

The program identified individual champions who contributed significantly to the success of the MCHIP programs and rewarded them with recognition plaques. Some of these MNH/FP champions have since been hired by other programs as technical advisors.

#### *6.5 Strengthen health management information system relevant for EmONC*

ACCESS and MCHIP worked with the national and state HMIS teams to adapt existing national registers and forms for use in the project facilities. As stated earlier in 6.1 above, at the state levels, routine data reporting systems were virtually non-existent at project start up. Recognizing the gaps in the data tools, additional data items were negotiated and added to the registers and forms before they were printed and disseminated by ACCESS/MCHIP. The project also supported monthly data collation meetings in the three states. Zamfara and Katsina states later organized HMIS harmonization meetings with all implementing partners which eventually produced tools that were more or less a replica of the ACCESS/MCHIP tools. The project also held workshops on the use of data for decision-making.

In addition to the above objectives, MCHIP conducted an assessment of readiness to provide emergency obstetric and newborn care in 30 health facilities in three states, namely Akwa Ibom, Benue and Imo States.

## ABSTRACT<sup>28</sup>

### *Background*

Nigeria's health and development indicators are among the worst in the world, especially in the Northern states. Even though Nigeria contributes only 2.4% to the world's population of 7 billion, it contributes over 40,000 deaths (14%) to the global maternal mortality burden. In addition, about 241,000 newborns die annually in Nigeria. This represents about 25% of all under-5 deaths. Given the fact that the single most important programmatic intervention for the reduction of maternal and newborn mortality is increasing access to quality skilled attendance at birth, the readiness of health facilities to do so is critical. Hence, the primary purpose of this assessment was to determine the readiness status of selected public and private health facilities in 3 Nigeria States (Akwa Ibom, Benue and Imo) to provide evidence-based interventions to mothers and newborns experiencing life-threatening complications in pregnancy, during childbirth, or in the postnatal and neonatal periods.

### *Methodology*

This EmONC readiness assessment was conducted in 30 public and private health facilities selected from all three senatorial districts in the project States including Tertiary Hospitals, General Hospitals, and Primary Health Care centers (PHCs). The study participants included 118 frontline health care workers in the maternity unit (physicians, nurse/midwives and community health extension workers) as well as 30 facility managers. The managers were interviewed about the types of services being provided, the available infrastructure and human resources, and the status of consumable supplies and equipment. The frontline health providers knowledge of common life-threatening complications of pregnancy and child-birth and skills in performing selected procedures on anatomical models namely normal delivery, manual removal of placenta and neonatal resuscitation were also assessed by data collectors (6 OB-GYNs and 6 nurse/midwives) who were trained in the use of an Android-based online data collection APP, XLSForm, CIETmap to input data using tablets. CIET provided initial data analysis

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<sup>28</sup> Full report available in separate document. Contact [Emmanuel.Otolorin@jhpiego.org](mailto:Emmanuel.Otolorin@jhpiego.org)

based on dummy tables provided by the study team. Thereafter, the data was exported to SPSS and Excel software. Only descriptive quantitative and qualitative analyses were required to respond to the research questions. Quantitative analyses included the reporting of: percentages, percent distributions, means and medians.

### *Findings*

Most of the assessed health facilities were government owned (76.7%) while the private sector owned 16.7%. There was a perceived shortage of nurse/midwives and physician-anesthetists given the disparity between established positions and the number of those in employment. Double qualified nurse/midwives were the staffing cadre most likely to be available 24 hours a day, 7 days a week, while Community Health Officers (CHOs) are the least likely to be available. While many facilities were well ventilated and had adequate lighting for daytime services, in many, provision for night-time lighting was poor. Most health facilities provided parenteral antibiotics and uterotonics, HIV counseling and testing services as well as intermittent preventive therapy (IPTp) for the control of malaria in pregnancy.

While 100% of health facilities were open 24 hours a day, 7 days a week (24/7) for labor and delivery, only about half of the facilities provide laboratory and anesthesia services 24/7. Furthermore, only 23.3% of health facilities provide blood transfusion services 24/7. Lack of running water was a problem in about two-thirds of health facilities. Also, only about half had a functional toilet for clients attached to the labor ward and oftentimes these toilets did not have a hand-washing station. Of major concern is the fact that in over 80% of the health facilities, relatives are saddled with the responsibility of providing food for their loved ones on admission. Regarding some outdated obstetric practices, most health facilities have abandoned obsolete obstetric practices like routine shaving of the patients' pubic hair in labor as well as routine enema and episiotomy.

The study showed that health care workers were quite familiar with the signs and symptoms of labor, generally used personal protective wears for procedures and will examine the placenta after delivery. However, the study also revealed major gaps in their knowledge and skills. Significant proportions of health care workers were unable to list all critical signs and symptoms of life-threatening complications and the actions to be taken when they occur. Demonstrations of selected clinical skills showed a significant lack of competency. For example, most health care workers could not achieve a good seal with the Ambu bag and mask in order to get air to enter the baby's lungs. Also most health care workers did not think that prophylactic antibiotics and sedatives were needed for manual removal of placenta.

### *Conclusions*

The assessment in the three States has shown significant room for improvement in the provision of quality emergency obstetric and newborn care as well as under-utilization of available services. These findings are a pointer to the need for a two-pronged approach to RMNCH programming in the states, namely facility interventions for quality services and community interventions for improved service utilization.

## PROGRAM REPORT CONCLUSION

The MCHIP program implemented between 2009 and 2012 contributed to reduction of maternal and newborn mortality in most of the project supported facilities thereby contributing directly or indirectly to the reduction in national maternal mortality and newborn mortality in the country.

## CROSS-CUTTING THEMES

The MCHIP Nigeria program addressed a number of the cross-cutting themes during its implementation, such as:

### EQUITY

The ACCESS/MCHIP project covered three states out of 36 (**8.3%**), 29 LGAs out of 92 available in the three states (**31.5%**) and served a population of 6,874,797 people out of 18,436,106 in the three states (**37.3%**). The allocation of LGAs in each of the states was done in consultation with the SMOH and other implementing partners in the states. It is our opinion that lessons learnt from this partial coverage in project states informed the 'total state' coverage approach of the new USAID funded TSHIP project being implemented in two states (Sokoto and Bauchi). The latter should increase the probability of having state-wide impact for the relevant interventions.

### SCALE-UP

The ACCESS/MCHIP programs started in four LGAs of Kano and Zamfara States. These LGAs were selected for the program by the State Ministries of Health based on information about the activities of other implementing partners in the state. Over the length of the project, the interventions were scaled up to 57 health facilities in 28 LGAs across three states (Kano, Katsina and Zamfara States), as stated earlier, this only covered 37.3 percent of the population of the states). Throughout the life of the program, evidence-based interventions for MNH/FP were prioritized and implemented in accordance with national and international standards.

## INTEGRATION

A postpartum systematic screening (PPSS) study covering postnatal care, antenatal care, FP (including counseling on postpartum FP), immunization and other relevant services was piloted in Northern Nigeria and an evaluation was conducted. The aim of the study was to determine the effectiveness of PPSS as a means to increase service use, particularly postpartum FP. The evaluation used pre- and post- intervention approach and sources of data included: observations of provider-client interactions, provider interviews, client exit interviews and service statistics. With the PPSS checklist, clients attending immunization, newborn care and pediatric/sick baby services were more likely to be screened for FP, postnatal care and immunization services (17 vs. 68 percent, 13 vs. 57 percent and 47 and 89 percent, respectively). In response to high unmet need of FP (88 percent), the majority (73 percent) of trained providers knew at least three FP methods which are suitable for postpartum women. While FP referral increased dramatically, few women (15 percent) said they would go for referrals on the same day. The investigators concluded that the results demonstrated the feasibility and practicality of this integrated approach but more needs to be done to address referral and potential scale-up issues.

MCHIP worked with FHI-GHAIN, USAID's HIV/AIDS bilateral award to integrate malaria in pregnancy (MIP) training into PMTCT training. GHAIN was selected by USAID because of its country-wide network of PMTCT service delivery points (over 170 at the time). Jhpiego was selected because of its experience in both training and MIP which included its MIP program in Akwa Ibom State funded by Exxon Mobil. While Jhpiego helped to develop the MIP curriculum and trained national trainers, GHAIN helped to step down the training to its numerous service delivery points. GHAIN later reported that a total of 260 health workers at ANC clinics in 77 facilities (59 secondary and 17 PHCs) received MIP stepped down training.

## COMMUNITY

The community component of the MCHIP program has been described under Objective 5 above.

## QUALITY

Quality of care issues are discussed under Objective 3 above.

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## RECOMMENDATIONS AND WAY FORWARD

### CONCLUSIONS

The MCHIP programs have demonstrated that the implementation of a household-to-hospital continuum of care (HHCC) program consisting of a package of community and facility interventions can lead to increased knowledge of communities about maternal and newborn health issues and increased utilization of health facilities for maternal, newborn and family planning services. The program's multidimensional approach to community mobilization (e.g. use of household counselors and male birth spacing motivators for interpersonal communication, financial empowerment of women through the establishment of numerous mothers' savings and loans clubs as well as the establishment of community core groups to leverage resources within the community for facility improvements) were particularly effective. Similarly, the training of frontline staff to provide basic maternal and newborn services and provision of needed resources (basic equipment, refurbishments and job aids) improved the supply arm of the health systems. Finally, the setting of performance standards and implementation in selected sites has raised the quality of care consciousness in the region leading to increased compliance and resultant decreased maternal mortality and morbidity.

However, these efforts need to be sustained and scaled-up statewide and nationally for the full impact of the interventions to lead to a significant improvement of the country's efforts to meet the 2015 targets of the Millennium Development Goals.

## CHALLENGES

Challenges of the program included poor basic infrastructure at the health facilities, shortage of skilled birth attendants and frequent transfer of project-trained staff out of project areas, frequent stockouts of family planning commodities and other life-saving commodities, widespread ignorance and poverty in the region. Others included the challenge of sustaining motivation among unpaid volunteers trained for community mobilization and inadequate commitment of government at state and LGA levels to provide budgetary allocations to continue and/or scale-up positive lessons learnt from the projects. They continue to depend on the FMOH and donors working through the MSS and SURE-P projects.

## OPPORTUNITIES

Opportunities for project scale-up include the Midwifery Service Scheme (MSS) managed by the National Primary Health Care Development Agency that has established over 1,000 hospital-PHC clusters nationwide for skilled birth attendance. The program has so far recruited and deployed over 4,000 midwives to 1,000 PHCs. Attention now needs to be turned to quality assurance of the services being provided by these midwives. Other opportunities include the new national policy of free family planning commodities which has removed the barrier of user fees, the inclusion of a budget line item for procurement of FP commodities through the UNFPA system and the new Subsidy-Reinvestment and Empowerment Program (SURE-P). One of the key activities under the SURE-P program is the Conditional Cash Transfer (CCT) project which provides cash incentives to patients who attend at least four ANC visits while pregnant, deliver in health facilities and bring their children for postnatal/infant welfare services. This project is already attracting more clients to health facilities and promises to significantly affect the provision of skilled attendance to those who need it. Future programs need to support the GoN to implement the program in a way that will ensure benefits to end users.

## RECOMMENDATIONS

1. Advocacy for the passage of the National Health Bill must be intensified. This bill has been in the national assembly for 8 years. When passed, it will provide approximately 2 percent of the national budget for primary health care and is intended to support the national health insurance scheme, procure essential drugs and medications, and renovate dilapidated PHC structures while developing the capacity of health care workers within the PHC system. If

passed and implemented as designed, this will address the problem of under-funding of the PHC system in the country and reduce donor-dependency while bringing quality basic health care nearer the people.

2. In the interim, the findings from this project and other similar projects which emphasize the importance of skilled attendance at birth should be disseminated widely at national and sub-national levels for replication. State Governments must take advantage of the MSS and SURE-P projects initiated by the Federal Government and replicate the positive lessons learnt in their states. By and large, this means establishing additional 'hospital-PHC clusters' and attracting nurse-midwives who will be deployed like in the MSS program. Thereafter and using the funds from the National Health Bill, build the capacity of frontline health care workers in PHCs to provide basic emergency obstetric and newborn care.
3. Advocacy for the approval of the proposed Jhpiego supported and MacArthur funded National Task Shifting policy by the National Council on Health (NCH) to allow CHEWs to provide basic emergency obstetric and newborn care. In states with an acute shortage of midwives, community health extension workers (CHEWs) should be identified and trained to provide BEmONC. Hospitals that are attached to the MSS clusters should be made functional to provide comprehensive EmONC sites which will include Caesarean delivery, blood transfusion and anesthesia services.
4. While the implementation of the SBM-R framework helped raise quality of care consciousness, the sheer number of set standards and numerous verification criteria has made SMB-R implementation highly human resource intensive. Therefore, the performance monitoring tools should be revised to significantly reduce the number of standards and verification criteria to a manageable number. For example, an expansion of WHO's new one-page Safe Birth Checklist will be a good starting point. The use of these tools should be tied to output indicators such as use of active management of the third stage of labor and use of magnesium sulphate.
5. Future programs should assist States to implement the recently approved Maternal and Perinatal Death Reviews of the GoN.
6. Critical interventions for the prevention and/or treatment of the common causes of maternal and newborn mortality should be prioritized for scale up. These should include the following:
  - a. Scale-up of AMTSL, including use of misoprostol at home births to prevent PPH.
  - b. Scale-up of the application of chlorhexidine at home and institutional births to prevent umbilical cord sepsis
  - c. Scale-up of use of Magnesium Sulphate for the prevention and treatment of eclampsia. This will involve the enactment of the task-shifting or task-sharing policy that will allow CHEWs to provide these services at PHCs before referral to general hospitals.

- d. Use of the partograph to monitor active labor and to identify slow progress for intervention before adverse events like obstructed labor occur.
- e. Scale-up of essential newborn care and the 'Helping Babies Breathe' program with provision of infant Ambu bags and Penguin bulb syringes to all health facilities
- f. Scale-up of the use of MVA for evacuation of products of conception in unsafe abortion.
- g. Scale-up of appropriate infection prevention practices including use of parenteral antibiotics for treatment of puerperal and neonatal sepsis.
- h. Focused antenatal care which integrates malaria in pregnancy and PMTCT interventions should be scaled up to all LGAs in all the states.
- i. Education of the community about healthy timing and spacing of pregnancies (HTSP) and use of family planning to achieve this should be a priority. Promotion of exclusive breast feeding in the postpartum period which will assure lactational amenorrhea as a contraceptive method transitioning to long-acting methods after six months. Training of nurse/midwives and CHEWs to provide long-acting reversible contraception (LARC) will be a critical intervention for HTSP.
- j. States should map out existing community coalition groups and select volunteers to be trained as household counselors, male birth spacing motivators and community champions for maternal and newborn health care. These community groups should be empowered to leverage resources from within and outside the community to improve access to quality services. CBOs may be engaged to implement this arm of the HHCC framework given their integration in the community. A basket on incentives to retain trained community health volunteers should be designed and implemented.
- k. Efforts should be made to enforce GoN's new free FP commodity policy. In order to remove the often quoted excuses for continuation of formal and informal user fees, GoN should invest in the procurement of essential consumables for providing these contraceptive services e.g. gloves, lotions, gauze swabs, local anesthetics etc. Funds should also be provided for transporting the commodities out of the Federal Government's Central Medical Stores to State Medical Stores and eventually to the end user clinics. The release of funds committed by the GoN for FP during the 2012 FP2020 conference in London requires continuing advocacy to the FMOH, the Federal Ministry of Finance and the Appropriation Committee of the National Assembly.

## ANNEX 1: INDICATOR MATRIX

### Emergency Obstetric and Newborn Care in Kano, Katsina and Zamfara States<sup>29</sup>

	FY09 (Targets) Achieved	FY10 (Targets) Achieved	FY11 (Targets) Achieved	Explanation for variance or why not reported during the reporting period
<i>Operational Plan</i> <i>Standardized indicator: #</i> of deliveries with a Skilled Birth attendant (SBA)	(22,000) <b>39,677</b>	(50,000) <b>49,006</b>	(55,000) <b>57,755</b>	Community directed activities by trained CHEWs promoting institutional deliveries probably contributed tremendously to the total achieved over the reporting period for this indicator.
<i>Operational Plan</i> <i>Standardized indicator: #</i> of Antenatal Care (ANC) visits by skilled Providers from USG-assisted facilities	(120,000) <b>218,267</b>	(220,000) <b>245,841</b>	(250,000) <b>265,266</b>	Information relating to birth planning and complication readiness provided by household counselors probably contributed to the total achieved.
<i>Operational Plan</i> <i>Standardized Indicator:</i> Number of postpartum/newborn visits within 3 days of birth in USG-assisted programs	(25,000) <b>33,533</b>	(35,000) <b>51,221</b>	(40,000) <b>56,659</b>	This data includes all women delivering in the health facilities and those who delivered at home and were reviewed within 3 days of delivery.
<i>Operational Plan</i> <i>indicator : Couple-years of</i>	(20,000)	(17,000)	(18,500)	Improved availability of FP commodities after declaration of a

<sup>29</sup> MCHIP PMP and routine data template

	<b>FY09</b> (Targets) <b>Achieved</b>	<b>FY10</b> (Targets) <b>Achieved</b>	<b>FY11</b> (Targets) <b>Achieved</b>	<b>Explanation for variance or why not reported during the reporting period</b>
protection in USG-supported programs (CYP)	<b>11,354</b>	<b>27,041</b>	<b>27,509</b>	free national FP policy and outreach FP activities in the project states contributed to the total achieved.
<i>Operational Plan Standardized Indicator: # of USG-assisted service delivery points providing FP counseling or services.</i>	(40) <b>48</b>	(54) <b>57</b>	(60) <b>57</b>	MCHIP supported provision of FP services in all its supported health facilities.
<i>Operational Plan Standardized Indicator: Number of people trained in FP/RH with USG-funds (disaggregated by gender)</i>	(500) <b>583</b>	(500) <b>567</b> <b>378F/189M</b>	(550) <b>683</b> <b>381F/302M</b>	This total includes all cadres of health care workers, male birth spacing motivators and household counselors trained to counsel and/or provide FP services.
<i>Operational Plan Standardized Indicator: Number of counseling visits for family planning/Reproductive health as a result of USG assistance</i>	(60,000) <b>42,387</b>	(55,000) <b>74,044</b>	(60,000) <b>134,278</b>	FP counseling visits were scaled-up in order to attract more new acceptors and community directed activities of male motivators contributed to the total achieved.
<i>Operational Plan indicator: # of health facilities rehabilitated</i>	(6) <b>6</b>	(12) <b>6</b>	(0) <b>0</b>	Only maternity units and FP clinics in health facilities received support for renovations.
<i>Number of persons that have seen or heard a specific USG-supported</i>	Indicator drooped by USAID due to ambiguity of measurement			Indicator dropped by USAID

	<b>FY09</b> (Targets) <b>Achieved</b>	<b>FY10</b> (Targets) <b>Achieved</b>	<b>FY11</b> (Targets) <b>Achieved</b>	<b>Explanation for variance or why not reported during the reporting period</b>
<i>FP/RH message</i>				
<i>Program Indicator: # of health facilities using SBM-R approach for performance improvement</i>	(30) <b>30</b>	(30) <b>30</b>	(0) <b>0</b>	Implementation of the SBM-R assessments was considered labor intensive and was not always carried out as designed. In only 11 facilities (6 hospitals and 5 PHCs) were follow-up assessments done after the baseline.
<i>Operational Plan Standardized Indicator: # of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs.</i>  <i><b>Precise Definition:</b></i> <i>Number and percent of women in facilities and homes where the woman received AMTSL by SBAs in targeted areas in a specified time period. This includes vaginal deliveries only.<sup>30</sup> Targeted areas are those where the United States Agency for</i>	(22,000) <b>30,476</b>	(35,000) <b>45,138</b>	(40,000) <b>50,574</b>	Availability of Oxytocin and training of service providers on AMSTL were responsible.

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<sup>30</sup> Does not include Caesarean -Section or abortion

	<b>FY09</b> (Targets) <b>Achieved</b>	<b>FY10</b> (Targets) <b>Achieved</b>	<b>FY11</b> (Targets) <b>Achieved</b>	<b>Explanation for variance or why not reported during the reporting period</b>
<i>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</i>				
<i>Program Indicator: % of women receiving Active Management of the Third Stage of Labor (AMSTL) through USG-supported programs</i>	<b>81.1%</b>	<b>97.6%</b>	<b>98.2%</b>	Based on routine data using <b>vaginal deliveries</b> for which AMSTL was applied as numerator and total vaginal deliveries by SBAs as denominator.
<i>Program Indicator: # of births at ACCESS-supported facilities for which the partograph was used</i>	(22,000) <b>30,467</b>	(30,000) <b>23,200</b>	(33,000) <b>23,744</b>	Though MCHIP printed partographs for health facilities and trained service providers on its use in monitoring labor and delivery, use was only reported in 52% of the 146,438 deliveries . Late admission in labor and shortage of staff were the reasons often given for this low performance.
<i>Program Indicator : Training curricula and strategy for pre-service midwifery education revised and implemented in Kano and Zamfara</i>	(2) <b>2</b>			Completed in FY09

	<b>FY09</b> (Targets) <b>Achieved</b>	<b>FY10</b> (Targets) <b>Achieved</b>	<b>FY11</b> (Targets) <b>Achieved</b>	<b>Explanation for variance or why not reported during the reporting period</b>
states				
<i>Program Indicator:</i> Operational performance standards for EmONC distributed in ACCESS-supported facilities.	(600) B	(0) <b>0</b>	None because distribution was completed	Request for more copies by different stakeholders was responsible.
<i>Program Indicator :</i> National KMC training manuals distributed in ACCESS-supported facilities	(300) <b>486</b>	Activity completed in FY09		Request for more copies by different stakeholders was responsible.
<i>Operational Plan Standardized Indicator: #</i> of newborns receiving essential newborn care through USG supported programs	(20,000) <b>29,033</b>	(30,000) <b>46,041</b>	(35,000) <b>55,012</b>	Though the set target for this indicator was surpassed, it only represents 88.8% of the 146,438 deliveries. This may be due to under-reporting by health care workers as essential newborn care has become routine in all MCHIP supported health facilities.
<i>Common indicator: # of</i> beneficiaries of community activities [C 20.10]	(30,000) <b>21,674</b>	(42,000) <b>28,132</b>	(44,000) <b>46,770</b>	These include beneficiaries of all community directed activities e.g. male birth spacing motivators, household counselors, women's savings and loans clubs etc.
<i>Program Indicator: # of</i> community committees that have work plans that include activities to reduce maternal and	(24) <b>27</b>	(51) <b>51</b>		All community core groups around supported health facilities developed work plans.

	<b>FY09</b> (Targets) <b>Achieved</b>	<b>FY10</b> (Targets) <b>Achieved</b>	<b>FY11</b> (Targets) <b>Achieved</b>	<b>Explanation for variance or why not reported during the reporting period</b>
newborn deaths				
<i>Program Indicator:</i> # of communities with plans that include emergency funds and/or a transport system for maternal and newborn complications	(24) <b>27</b>	(51) <b>51</b>		Ditto
<i>Common/Operational Plan Standardized indicator:</i> # of people trained in maternal/newborn health through USG-supported programs	600 <b>356</b>	600 <b>760</b> <b>438F/332</b> <b>M</b>	600 <b>784</b> <b>550F/23</b> <b>4M</b>	Includes all frontline health care workers and community health volunteers trained in one MNH intervention or the other.
<i>Program Indicator:</i> Caesarean sections as a percentage of all births in USG-supported facilities	15% <b>(4.9%)</b>	15% <b>(4.9%)</b>	15% <b>(4.5%)</b>	

## ANNEX 2: SUCCESS STORIES

### SAVING NEWBORNS IN NIGERIA



Abubakar Bello was born to Umma Usman, a full-time house wife living in Kano. She was married at 14, and by the time she turned 27, she had already delivered seven children. Unfortunately, four of her children passed away before their first birthday, three of whom died following illnesses that were treated at home. The survival and full

Dr. Nnamdi and Matron Salamatu with Umma and her baby.

recovery of Abubakar changed her perception about receiving care at a health facility.

Barely four days after birth, had Abubakar begun struggling for his life. His immune system was overwhelmed with infectious agents resulting in fever, jaundice, and multiple episodes of convulsion.

He was delivered at a maternity hospital in Kano after several hours of labor. He cried immediately after birth and received routine care. He and his mother were discharged because there were no obvious problems. However, as the day of his naming ceremony approached, his mother observed that Abubakar had a fever and yellowish discoloration of the skin, and was making jerky body movements and crying excessively. Without delay, she went back to the hospital where she had delivered and was referred to Murtala Muhammad Specialist Hospital (MMSH) in Kano, an MCHIP-supported health facility. Abubakar was admitted and treated for neonatal sepsis. After two weeks he recovered fully and was sent home again.

Abubakar was cared for by Dr. Nnamdi, who was trained by MCHIP to manage newborn problems and help babies breathe. At the post-training follow-up visit, he said, “I find the training extremely helpful as it has changed the way we manage sick newborns in this unit. I am now confident about the appropriate doses of medications and routes of administration, as well as oxygen therapy. The update has also helped me to stop some of our old practices. I strongly believe we will have better neonatal outcomes now.”

While Abubakar is one of many newborns saved on a daily basis at MMSH, as many as 241,000 babies die annually within the first month of life in Nigeria; which is the highest newborn mortality rate in Africa. To curb this rapidly increasing burden, MCHIP will continue to work with its partners to increase the pool of health care providers competent in managing newborn problems, especially in low-resource, hard-to-reach rural settlements of northern Nigeria and to ensure a more equitable distribution of skilled personnel. MCHIP and its partners are also working to increase community awareness about newborn danger signs and the importance of promptly seeking help at health care facilities.

Umma offered this advice to other mothers, “Once they notice their babies are sick, they should rush to the hospital on time before they become critically ill because I lost four babies who were being treated with traditional medications at home. More so, with the information I received on child spacing, I want to rest for at least two years to take good care of my baby.”

## FAMILY PLANNING USE SIGNIFICANTLY INCREASES THROUGH INNOVATIVE, IMPROVED SERVICES IN NORTHERN NIGERIA

BY NASIR BASHIR AND MAIRO ALI RANO

After a series of long and difficult home births, Maryam Abubakar found herself pregnant again. This time, however, she decided to seek prenatal care and give birth in a health facility near her home in northern Nigeria.

Like millions of other women in sub-Saharan Africa, Abubakar had married young—at age 13—and knew little about family planning. Over the years, the babies arrived despite her desire to let more time go by between pregnancies. At the antenatal care clinic at Sir Muhammad Sanusi Specialist Hospital in Kano, Abubakar received information and help that she previously lacked.

As part of her care during pregnancy, Abubakar and her husband were counseled about family planning methods and options. The couple—parents of seven children—decided the best course for them would be a long-acting or permanent contraceptive method. After undergoing an emergency cesarean section, Abubakar opted for and received a tubal ligation. She went home with a healthy baby girl named Amina, free from worry that she would be pregnant again soon.

“If I had known about this method of family planning, I would have stopped delivering long ago because I believe quality of life for my children is more important than number of children,” said Maryam, a 35-year-old tailor.

The Abubakar’s are just one of thousands of couples who have received potentially lifesaving family planning information and counseling through the U.S. Agency for International Development (USAID) flagship Maternal and Child Health Integrated Program (MCHIP) program. An estimated 30,000 women die annually from complications of childbirth in Nigeria.



MCHIP-TRAINED HOUSEHOLD COUNSELORS DELIVER HEALTH MESSAGES TO WOMEN IN THREE STATES IN NORTHERN NIGERIA.

Jhpiego, through MCHIP and partners, has helped strengthen reproductive and maternal health and family planning services in three states in northern Nigeria over the past four years. This is part of Jhpiego's ongoing efforts to partner with countries in building the capacity of health care workers and strengthening health systems to prevent the needless deaths of women and families. The organization develops innovative, low-cost technologies to address today's global health challenges and works with communities to increase frontline health workers' ability to deliver lifesaving care.



MATERNITY NURSE IYAH HALLIRU  
RECOMMENDS MCHIP TRAINING IN FAMILY  
PLANNING COUNSELING.

"I would recommend that all nurse-midwives should be trained in family planning by MCHIP so that they can have the knowledge and skill to counsel and provide better services to clients," says Iyah Halliru, the nurse in charge of the maternity unit at Sir Muhammad Sanusi Specialist Hospital. "I am really thankful to USAID/MCHIP for updating my knowledge on modern techniques of family planning."

Jhpiego's work in Nigeria dates to the 1970s when it first helped to strengthen pre-service education in medical and nursing colleges and to update knowledge and skills of health workers. Since 2006, Jhpiego, initially through the USAID-funded Access to Clinical and Community Maternal, Neonatal and Women's Health Services (ACCESS) Program, focused on increasing the use of high-quality emergency obstetric and newborn care and reproductive health services, including family planning.

Today, in many places around the world, family planning during the first year following the birth of a child has been largely neglected, even though this is the period of highest risk for mother and baby. Recent findings show that postpartum family planning (PPFP) can help reduce the number of deaths in mothers and children. In countries with high birth rates—if family planning had been better promoted and women were able to access family planning and pregnancy spacing services—32 percent of all maternal deaths could have been avoided.

Through its recent work with the Nigerian Ministry of Health, Jhpiego and partners have achieved steady and significant gains in women's visits to antenatal care clinics, skilled birth attendance, active management of the third stage of labor, essential newborn care and use of

long-term family planning in three states. Jhpiego has achieved these gains through a variety of innovative strategies that included: establishing community mobilization teams to engage women and their families in healthy behaviors, using male volunteers to increase male involvement in family planning, employing household counselors to educate pregnant women and their families on danger signs (in pregnancy, during and after childbirth and in their newborns), and developing an emergency transport system.

“The implementation of the household-to-hospital continuum of care framework in Nigeria was like a balancing act between demand creation and service supply. It also demonstrated that pregnant women and their families will recognize a quality service when they see it and will embrace it when they need it,” said Professor Emmanuel ’Dipo Otolorin, Jhpiego Country Director for Nigeria.

As part of these efforts, Jhpiego, through ACCESS and MCHIP, identified and trained 449 male pregnancy spacing motivators who visited and counseled 11,371 men on the benefits of healthy timing and spacing of pregnancies and the use of modern contraceptive methods. Of those counseled, 3,222 (28.3 percent) accepted a family planning method for themselves or their spouses; 1,789 accepted injectable contraceptives; 730 decided on oral pills; 450 opted for condoms; and 253 chose an IUD.

A network of 477 household counselors, women often seen walking to and from women’s homes in their signature blue HIJABS (traditional Muslim head coverings), educated 7,302 pregnant women and their families about the danger signs in pregnancy and risks for complications. They also referred 5,179 women for a range of services including focused antenatal care, family planning and giving birth in a health facility.

To help improve the quality and delivery of emergency obstetric and newborn care services at health facilities, the programs introduced a Jhpiego-developed quality improvement approach called Standards-Based Management and Recognition (SBM-R<sup>®</sup>) to providers in the three states. The approach engages health workers in leading the changes at their workplace and recognizes them when change occurs.

At the ACCESS/MCHIP training center, the Murtala Mohammed Specialist Hospital, while the mean SBM-R score for emergency obstetric and newborn care increased from 25.1 percent at baseline to 91 percent after two follow-up assessments, the maternal mortality ratio in the hospital fell from 2,678 to 836 per 100,000 live births over a three year period.

## PROVISION OF JADELLE IMPLANT METHOD OF CONTRACEPTION TO A GRAND MULTIPAROUS WOMAN

With funding from USAID, the ACCESS-MCHIP program, increased access to quality family planning services in northern Nigeria by training and providing health care providers with the basic equipment and job aids to provide family planning services in rural and urban settlements.

Mariya Abdulrahman is one of the many women that benefited from the use of a long acting method of family planning in an MCHIP supported health facility. Mariya is a 39 year old primary school teacher living at Rurum village in Rano Local Government area of Kano. She is in her third matrimonial home within the span of 24 years and has a total of 9 children, three of which were delivered by caesarean section. Following her recent delivery at the health facility, she was counseled on the use of family planning by the midwife using the balanced counseling strategy and she opted for Jadelle, being a long acting method of family planning.



Mariya and her husband being counseled at the family planning unit of Rurum PHC

At six weeks postpartum, she was accompanied by her husband to the family planning unit of Murtala Muhammad Specialist Hospital where she had her Jadelle inserted. She intends to use the method until the onset of menopause as she does not desire to have more children.



Matron Fatima Abubakar, in-charge of family planning unit of Murtala Muhammad Specialist Hospital, Kano.

*Mariya: "I got married at the age of 15 years to a farmer. My first pregnancy ended up in a surgical delivery because of prolonged labor with severe abdominal pain. Subsequently, I had two normal deliveries after which I was divorced by my husband. So far, I have been married three times, had a total of eleven pregnancies and nine children alive. I have always wanted to stop conceiving after my third caesarean section but have been afraid of using family planning. But now that I have full information on my family planning choices, the benefits and side effects, I have chosen to have Jadelle inserted. I will continue to practice family planning*

*until I reach menopause so that I will not put myself in danger of another pregnancy complication and death”.*

Mariya had her Jadelle inserted by Matron Fatima Abubakar, who is the head of family planning unit of Murtala Muhammad Specialist Hospital, Kano. As one of the beneficiary of USAID/ACCESS trainings, she had this to say: *“The ACCESS program has been quite helpful to me by building my capacity to provide family planning services to clients and providing me with the equipment to render the services. I have been trained to the extent that I am now a trainer for many service providers and NGOs and I am on my way to becoming a qualified Jhpiego trainer”.*

Jhpiego/Nigeria will continue to build the capacity of more healthcare providers and provide them with the resources to provide quality family planning services especially to women living in hard to reach rural communities.

STORY OF A MOTHER SAVED FROM PPH AT USAID/MCHIP SUPPORTED HEALTH FACILITIES IN KANO STATE.

“Doctor, please help me release the garment tied around my legs”. These were the first words of Yarisa as she slowly regained consciousness in the admission ward of Murtala Muhammad Specialist Hospital, Kano.

Yasira is a 23 year old lady married to a carpenter living in Gwagwarwa ward of Kano. She received antenatal care at Gwagwarwa primary health center where she was counselled on the importance of delivery with a skilled birth attendant. At the onset of labor, Yasira was accompanied by her husband and relatives to the labor and delivery unit of Gwagwarwa PHC in anticipation of the new family member. Following the delivery of her baby boy, she had severe blood loss resulting in loss of consciousness. Being a PHC, Gwagwarwa had only the capacity to provide her with basic emergency obstetric care. She was immediately commenced on intravenous fluids, wrapped in an anti-shock garment and referred to Murtala Muhammad Specialist Hospital, an ACCESS supported health facility.

At Murtala Muhammad Specialist Hospital, she was assessed for the cause of her bleeding, uterine atony was diagnosed and she was immediately commenced on oxytocics which stopped the bleeding. She was resuscitated and transfused with two pints of blood during which she gradually regained full consciousness and her vital signs stabilized. Prior to her discharge, she was reminded of the importance of delivery with a skilled birth attendant and counselled on family planning. As she has never used a family planning method before, she immediately accepted lactational amenorrhea method (LAM) with a promise to transition to a longer acting method after 6 months of exclusive breast-feeding.

Yasira: “I delivered my first child 3 years ago at the primary health center without any complication and never anticipated any problem in this pregnancy. I was tempted to deliver at home but decided to deliver at the health facility because of the repeated messages on the importance of hospital delivery through radio programs, community campaigns and during group health education sessions at the health center. Immediately after delivery I started



Yasira Musa and her baby at the postnatal ward of Murtala Muhammad Specialist Hospital.

bleeding profusely and passed out. I did not know when I was transferred to Murtala Muhammad Specialist Hospital. I just woke up and saw doctors and nurses standing by the side of my bed. I was wrapped tightly with rubber which I had never seen and was being given blood transfusion. If this problem had happened at home, maybe I would have been dead by now. I really thank God and the effort of the healthcare providers. Now I truly know the importance of hospital delivery and I will advise my family and friends to always deliver at a health facility”.

Several women continue to die by the minute as a result of pregnancy and its complications. Postpartum hemorrhage still remains top on the list of causes of maternal mortality globally and in Nigeria. Delivery with a skilled birth attendant saves many lives from primary postpartum hemorrhage and death. Yasira was saved from an untimely death because of the strengthened referral system between Gwagwarwa PHC and MMSH, both of which are MCHIP supported health facilities, use of anti-shock garment and availability of healthcare providers trained on emergency obstetric and newborn care. Jhpiego will continue to pay emphasis on the training of healthcare providers to provide emergency obstetric and newborn lifesaving interventions as well as healthy timing and spacing of pregnancies because “the health risks associated with contraceptive use are by far lower than the health risks of pregnancy-related complications”.

## ANNEX 3: LIST OF PRESENTATIONS AT INTERNATIONAL CONFERENCES AND PUBLICATIONS

- **Kenya 2009:** *Community empowerment for improved maternal and Newborn health (MNH) care in Northern Nigeria* by Samaila Yusuf
- **2009 Annual Conference of the Society of Gynaecology and Obstetrics of Nigeria (SOGON):** *Integrating Family Planning into Essential Maternal and Newborn Care in Northern Nigeria* by Emmanuel Otolorin, Samaila Yusuf, Elaine Charurat and Catharine McKaig
- **2009 Annual Conference of the Society of Gynaecology and Obstetrics of Nigeria (SOGON):** *Strengthening Monitoring and Evaluation Systems for Maternal and Newborn Health* by Ishola G, Abdullahi H, Tsafe AA, Otolorin EO.
- **November 2010 APHA Conference:** *Safe motherhood in northern Nigeria: Results of a program to improve access to and quality of maternal and newborn care services* by Barbara Rawlins, Emmanuel Otolorin, Gbenga Ishola, Uche Abanihe, Lydia Airede and Tunde Segun
- **2010 Global Maternal Health Conference in India:** *Improving Maternal and Newborn Health through Income Generating Activities (IGA) of Mothers Saving and Loan Clubs in Northern Nigeria* by Tunde Segun, Samaila Yusuf, Gbenga Ishola and Emmanuel Otolorin
- **2010 Annual Conference of the Society of Gynaecology and Obstetrics of Nigeria (SOGON):** *The role of the community in maternal health* by William R Brieger, Emmanuel 'Dipo Otolorin and Bright Orji
- **2010 Women Deliver International Conference:** *Ensuring High Quality Basic Emergency Obstetric Care In Nigeria* by Emmanuel Otolorin, Gbenga Ishola, Barbara Rawlins, Tunde Segun and Lydia Airede
- **2011 National Midwifery Services Scheme Conference in Abuja, Nigeria:** *Options for Scaling Up Skilled Birth Attendance (SBA) in Nigeria* by Emmanuel Otolorin
- **38<sup>th</sup> Annual International conference on Global Health, 2011:** *Testing a FP/MNCH Integration Model: Postpartum Systematic Screening in Northern Nigeria* by Lydia Airede, Nasir Bashir, Shittu Abdu-Aguye, Elaine Charurat and Emmanuel Otolorin
- **2011 International Conference on Family Planning, Dakar, Senegal:** *Use of Male Birth Spacing Motivators to Mobilize Communities for Family Planning Acceptance in Northern Nigeria* by Zaynab Nyako, Samaila Yusuf, Tunde Segun, Lydia Airede and Gbenga Ishola and Emmanuel Otolorin
- **Keynote address at the 2012 Global PMNCH Conference in Abuja:** *Saving the lives of mothers and newborns in Nigeria: The Journey so far* by Emmanuel Otolorin

## ANNEX 4: LIST OF MATERIALS AND TOOLS DEVELOPED OR ADAPTED BY THE PROGRAM

- Pathway to Implementation of Pre-Eclampsia/Eclampsia Management at Scale job aid
- Nigeria: Prevention and Management of Postpartum Hemorrhage, Pre-Eclampsia and Eclampsia - poster
- Pathway to Implementation of Postpartum Hemorrhage Prevention and Management at Scale - job aid
- Modern Family Planning Methods are Effective and Safe for Everyone - Use Them Today to Space Your Births- poster (English and Hausa)
- Improve Your Economic and Financial Situation - Use Modern Contraceptives to Space Your Births. Visit Your Family Planning Clinic Today – poster (English and Hausa)
- Spacing Your Pregnancies Saves Lives: Wait at least two years after a birth before getting pregnant again. Visit the nearest family planning center for more information. – poster (English and Hausa)
- Encourage Your Partner To Practice Dual Protection to Prevent Unplanned Pregnancy and Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV). – poster (English and Hausa)
- Tell Your Partner About the Benefits of Birth Spacing - Birth Spacing Saves Lives - poster
- Improve Your Economic and Financial Situation - Plan Your Family Today. – poster (English and Hausa)
- Birth Spacing Methods. There is a Suitable Method for Everyone. – poster
- MCHIP Dissemination Report: Strengthening Emergency Obstetric and Newborn Care and Family Planning in Northwest Nigeria, 2012.
- Report of the Rapid Assessment of Readiness to Provide Emergency Obstetric and Newborn Care in Three States of Nigeria: June 2014.