

## Social development case study:

### Increasing access to safe motherhood services

A great deal is known at an international level about how to improve the clinical quality of emergency obstetric care services. However, it is difficult to generalise about how to address the factors at household and community level that prevent timely use of these services, given that barriers related to levels of awareness, access and affordability are often complex and specific to individual contexts. Designing culturally-appropriate strategies for increasing access to safe motherhood initiatives takes time and requires commitment to testing out different models before applying them on a larger scale.

Health Partners International has been supporting state and local governments in Kano and Jigawa in north-eastern Nigeria to develop culturally appropriate models for addressing barriers to safe motherhood services related to awareness, access and affordability. These two states have some of the highest maternal mortality ratios in Nigeria, if not in the world.

In both states, the work began by undertaking a rapid social assessment to find out more about why so many women were dying during pregnancy and childbirth. The 'Three Delays' model, developed by the Columbia University School of Public Health, New York, was used to analyse the factors contributing to maternal death. In the model the first two delays concern the ability of women to access health services and therefore relate to factors at the household and community level; the third delay relates to factors at the level of the health facility and concerns the ability of women to access appropriate treatment (see box).

### The Three Delays model

#### 1. Delay in deciding to seek care

The factors in the household and community that delay the decision to seek care.

#### 2. Delay in reaching appropriate care

The logistical factors that delay a woman in reaching a health facility.

#### 3. Delay in receiving appropriate care at facility level

The promptness with which a woman is seen and treated once she reaches a facility, which depends on the capacity and quality of the health services.

*Source: Maine D, Akalin MZ, Ward VM and Kamara A (1997) 'The Design and Evaluation of Maternal Mortality Programs', New York City: Centre for Population Health, School of Public Health, Columbia University*

The rapid social assessments carried out by Health Partners provided information that proved vital to the design of intervention strategies. In Jigawa, for instance, it was found that local expectations about the desired behaviour of newly married women play an important role in decisions to seek care. Young women in particular are expected to demonstrate 'kunya', or shyness, which requires them to hide the fact that they are sexually active. Many women cited this as a reason why they could not consider going to ante-natal care. In addition, polygyny is widely practised in the state and in this context it is usual for wives to compete with their co-wives for their husband's attention. This may lead them to not draw attention to themselves during pregnancy, a practice that slows down responses to any emergency that might occur.

The social assessments also challenged some commonly held perceptions about what needed to be done to improve maternal health. In Jigawa, for example, it was believed that traditional birth attendants (TBAs) played an essential role in assisting women during childbirth, and that building their capacity to deal with normal deliveries and to recognise complications would impact positively on maternal health. However, the social assessment found that women commonly deliver their babies alone, and that TBAs have a relatively minor role in the process. This meant that an intervention strategy that focused on supporting TBAs was unlikely to be effective.

In both states the findings of the rapid social assessments were discussed at stakeholder workshops comprising government and civil society representatives. These workshops were key landmarks in that they helped build confidence among participants that something could actually be done about a problem that had previously been seen as intractable. Agreement was made on the strategies required to tackle barriers of awareness, access and affordability. Building the stewardship capacity of government to oversee the increasing access to safe motherhood programme and manage the work of a broad range of implementation partners from civil society and non-governmental organisations (NGOs) was also seen as essential.

At community level intervention strategies in both states are focusing on:

- Raising community awareness of the danger signs of an obstetric emergency and of required actions to ensure a safe pregnancy and delivery.
- Changing community attitudes towards and behaviours during an obstetric emergency.
- Establishing an Emergency Transport System in focal communities, which transports women with an obstetric emergency to the nearest suitable health facility.
- Assisting individuals, groups and communities to save for costs incurred during an obstetric emergency and to donate blood.

The way in which these broad strategies are being translated into practical action differs at state level. For instance, in Jigawa priority has been given to increasing the physical access to safe motherhood services in hard-to-reach communities. The state is testing prototype motorcycle trailers that can transport women who live in remote areas that are inaccessible to cars to health facilities (see Diagram 1 below).

In addition, rather than introducing a ‘model’ for increasing access to money in the event of a maternal health emergency, communities in both states have developed their own strategies, building on systems and mechanisms that are already in place.

Institutional capacity to manage the safe motherhood programme has been built within the Ministry of Health in Kano, and the Ministry of Women’s Affairs and Social Development in Jigawa, as has the capacity of NGO implementing partners. These inputs have focused in particular on strengthening planning, budgeting and project management skills, and building capacity for high-level policy advocacy in support of demand-side safe motherhood issues.

### Results of the initiative

In both states emerging results from participating communities are encouraging. In Kano the findings of a recent survey indicate that the safe motherhood initiative has had a highly significant and sustained effect on knowledge and attitudes about safe motherhood among people involved in intervention. Men and women now both have a high level of knowledge of danger signs (including some of the less well recognised signs such as fever), and of the actions that they need to take in response to a danger sign. The common perception that attending ante-natal care lowers a woman’s risk of developing a complication is no longer apparent in intervention circles. The survey also found that 100 per cent of currently pregnant or post-partum respondents had put a safe motherhood plan in place in readiness for the onset of a pregnancy complication. Of the 37 per cent of respondents who reported that they had recently experienced a maternal danger sign, 95 per cent had responded by going to the hospital. Prior to the initiative few people went to the hospital when complications related to pregnancy occurred.

One woman in Yammawan-Fulani community in Dambatta Local Government Authority, Kano said: “There haven’t been any maternal deaths for a long time.” In Sakwaya community in Takai Local Government Authority, Kano, a woman reported: “There have been no maternal deaths here in recent months. Everyone goes to the hospital when a problem arises.”

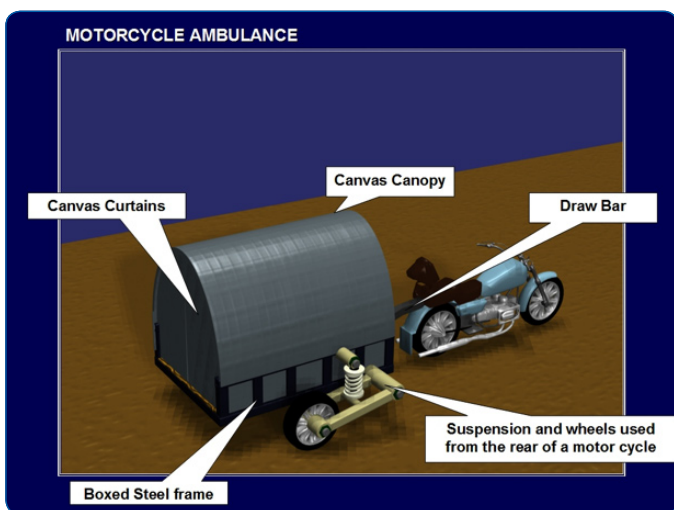


Diagram 1: Design for safe motherhood motorcycle ambulance trailer, Jigawa



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In Jigawa, monitoring data indicates a number of positive developments in participating communities. These include significant support among men and community leaders for acting to address maternal deaths; emergency safe motherhood transport schemes being used, including by neighbouring communities that have not so far participated in the safe motherhood programme; and community safe motherhood savings schemes having raised significant amounts of money.

Although in both states government support for and ownership of the safe motherhood demand-side work is high, ensuring the programmes' sustainability will depend on building provision for the work into state budgets. To do this, the lead ministries will require solid evidence showing the positive impact, and the skills with which to advocate effectively to support assured funding.