

# PATHS

Nigeria Partnership for Transforming Health Systems

## Technical Brief



## Increasing Access to Safe Motherhood Services

**DFID** Department for  
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# SUMMARY

- Tackling the catastrophically high number of maternal deaths in Nigeria requires action on a number of fronts: at household, community and facility level.
- However, priority is usually given to improving the coverage and clinical quality of safe motherhood services, and many states and local governments lack capacity, methodologies and tools to intervene effectively on the 'demand-side'.
- Concerned about the unacceptably high level of maternal mortality and morbidity among local women, two states in the north of Nigeria, Kano and Jigawa, decided to implement a series of interventions to tackle the household and community delays that were preventing timely use of safe motherhood services.
- Participating communities were involved in an innovative process of behaviour change, which was based on generating social approval for new behaviours. Community systems were established to tackle the household and community barriers of access to safe motherhood services, including emergency loan funds, emergency safe motherhood transport schemes, and blood donation groups.
- Significant behaviour change in relation to pregnancy and maternal complications occurred in the intervention communities, and communities and providers in both states reported that many maternal deaths and morbidities had been averted.
- The initiative focused on building institutional capacity within government to lead and sustain the work, and strengthening the technical and project management capacity of non-government implementing partners. Emphasis was also placed on use of advocacy and lobbying to leverage high-level political support for the work.
- The work took place against a backdrop of health systems strengthening activity, which helped to create a reform mindset among government implementing partners, while tangible service delivery improvements created receptivity among community stakeholders.
- Despite many challenges, the positive experiences in these two states show that it is possible to address barriers of access, affordability and acceptability of safe motherhood services even in contexts where the barriers are profound, resources are constrained, institutional capacity is weak and concepts of partnership working with organisations outside government are not very evolved.
- Experiences and lessons learned from Kano and Jigawa need to be widely disseminated so that other states, local governments and NGOs recognise the value of intervening on the demand-side to address the unacceptably high level of maternal mortality in Nigeria.



This document was written by Cathy Green based on case study material prepared by Claire Hughes, Mini Soyoola and Deborah Thomas. A full version of the Jigawa and Kano case studies, the first written by Deborah Thomas and Mini Soyoola and the second by Claire Hughes with contributions from Mini Soyoola, can be found on the CD-Rom that has been produced to accompany this Technical Brief.



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## Increasing Access to Safe Motherhood Services

Based on recent estimates<sup>1</sup> 59,000 maternal deaths, or 11 percent of all maternal deaths globally, occurred in Nigeria in 2005.<sup>2</sup> This translates into a one in 18 lifetime risk of Nigerian women dying during pregnancy or childbirth, a level of risk that is substantially higher for women living in the poorer northern parts of the country. This dire situation prompted the Federal Government to declare maternal health a national emergency in 2006.

Tackling the catastrophically high number of maternal deaths in Nigeria requires simultaneous action on a number of fronts, at household, community and facility level. Because many barriers of access, affordability and acceptability to use of emergency obstetric care (EOC) services exist in Nigeria, improvements in the coverage and quality of services need to go hand in hand with interventions that address low demand for these services.

This document describes the support provided by the DFID-funded Partnerships for Transforming Health Systems Programme (PATHS) to develop a replicable approach for increasing demand for, and access to, emergency maternal health services within the context of a large-scale health systems strengthening programme. Implementation has so far focused on two primarily Muslim Hausa states in the north west of the country, Jigawa and Kano, where the work has been implemented over a three-year and two-year period respectively. The intervention strategies and tools used in these states are sufficiently flexible to be adaptable for use in other parts of the country.

- 1 WHO, 2007, Maternal Mortality in 2005: Estimates Developed by WHO, UNICEF, UNFPA and the World Bank, Geneva: WHO
- 2 At 1100 the Nigerian national maternal mortality ratio (the number of maternal deaths per 100,000 live births) is surpassed by only eight other countries, all of which are currently or were until recently war-torn. The official FGON estimated MMR, at 800 per 100,000 live births, is lower than the WHO, UNICEF, UNFPA and World Bank 2005 estimate.

# The Challenge

Preliminary rapid social and clinical assessments were undertaken in Jigawa and Kano to assess the extent and quality of safe motherhood services and the factors at household and community level that were preventing timely use of these services. The 'Three Delays' Model, developed by Columbia University School of Public Health, was used as a framework for analysing the findings. The model categorises the barriers to timely use of safe motherhood services as follows:

## 1. Delay in deciding to seek care

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 getting to 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 health facility

The first two delays concern women's ability to access health services and therefore relate to factors at the household and community level. The third delay concerns women's ability to access appropriate treatment and therefore relates to factors at the level of the health facility.

## KEY STEPS: Rapid Safe Motherhood Assessment Methodology

Key institutions involved in the provision of safe motherhood services in Jigawa and Kano were assessed in terms of the extent and quality of service provision. The UN process indicators for Emergency Obstetric Care were used to assess area coverage of obstetric care. Facilities were assessed against a checklist of signal functions for basic and comprehensive emergency obstetric care (i.e. the medical services that are necessary to save the lives of women experiencing obstetric complications) to assess quality of care in hospitals and health facilities. A rapid assessment of client and community beliefs about maternal health and of the barriers of access to timely use of safe motherhood services was also undertaken. This looked at:

- Beliefs about special care during pregnancy;
- Health seeking behaviour in relation to ante-natal, normal delivery and post-partum care, including preferences for different providers;
- Knowledge of obstetric danger signs;
- Health seeking behaviour, including patterns of decision-making, in the event of an obstetric emergency;
- Physical, financial and social barriers of access to emergency obstetric care;
- Perceptions of the acceptability, appropriateness and quality of maternal health services.

Stakeholders from the key government Ministries, Departments and Agencies were fully involved in the assessment process. The assessment was conducted through:

- Interviews and discussion with the State Ministry of Health, Local Government Authorities and the Primary Health Care Agency
- Interviews with other Ministries, such as Women's Affairs and Social Development which has a mandate for promoting gender issues and women's development
- Identification of, and interviews with, private providers
- Meetings with international agencies and NGOs
- Visits to different catchment areas to assess provision of safe motherhood services at primary and secondary levels of care, involving staff interviews, record review and inspection of facilities
- Community visits, involving focus group discussions and individual semi-structured interviews with women, men, young people, traditional and religious authorities and community based organisations
- Review of published information

Stakeholder meetings comprising government and CSO stakeholders and members of the general public were held at the end of the rapid assessment process to discuss findings and agree a way forward.

The rapid assessment findings were striking. The three delays were contributing to numerous maternal deaths and much morbidity. The maternal mortality ratio<sup>3</sup> (MMR) in Kano, estimated in 2003 as 2,420 maternal deaths per 100,000 live births<sup>4</sup>, was more than three times the official government MMR of 800, and one of the highest ratios in the world. The MMR in Jigawa is unknown, but is likely

## Delays at Household and Community Level in Responding to Maternal Emergencies

"All of a sudden I started bleeding at home. I bled for around ten hours. It started in the middle of the night. I begged my people to bring me to hospital because I was afraid that I would die. Before then I was given 'rubutu' by a spiritual healer and herbs by a TBA. None of these treatments worked. So my mother, mother-in-law and husband's friend escorted me to the hospital. My husband did not come with us because he had to go to the market to sell two sheep so that the money could be used for my treatment. He came later with the money. I delivered normally, but the baby was dead....We are poor and live in a remote village....we have no money to pay except if we sell our animals..."

- Woman, Gumel Emirate, Jigawa, 2003

\* \* \*

"Our daughter who is married and living in another household started having a fit and was foaming at the mouth. Before this started she had been complaining of headaches and blurred vision. Her in-laws refused to inform us. They just kept her at home and gave her herbal treatment until someone came and gossiped to us. We went over to her house and she was in a poor state. We insisted that our daughter was taken to hospital....it took us more than 12 hours to get agreement....She spent 3 days in hospital before she finally gave birth to a stillborn baby."

- Woman, Hadejia Emirate, Jigawa, 2003

to be similar, if not higher, due to the mainly rural population and the higher incidence of poverty.

At household and community level awareness of maternal danger signs, and of the need to act quickly, was low. Few women were able to access care without first obtaining permission from their husbands or other male relatives. The cost of using emergency maternal health services was exorbitant for many, and lack of money was a factor in encouraging use of traditional or spiritual remedies as a first resort. Long distances to health facilities combined with difficult physical terrain in some areas slowed down maternal emergency response times.

In relation to the third delay - obtaining quality care at the health facility - severe and broad-ranging weaknesses, not only in clinical service delivery, but also in the systems underpinning service delivery, were identified in both states. Severe shortages of staff with maternal life-saving skills were evident, basic clinical protocols were not readily available, vital drugs and equipment to deal with obstetric emergencies were lacking, key services such as blood banks were absent, supervisory and referral systems were weak, and parts of the health infrastructure were not fit for purpose. In addition, weak health promotion capacity within the State Ministries of Health affected their capacity to provide an effective response to the low demand for maternal health care.

At policy level, although state poverty reduction strategy papers (SEEDS) committed both governments to meeting international maternal health MDG targets (this is to reduce maternal mortality by three-quarters by 2015), comprehensive strategies for progressing towards these targets were lacking, and commitments to safe motherhood were inadequately reflected in state health budgets. The wider governance backdrop was one of poor public accountability, weak citizen voice, and limited social pressure for change.

3 The number of maternal deaths per 100,000 live births.

4 Adamu Y.M et al 2003, 'Maternal Mortality in Northern Nigeria: A Population-based Study', European Journal of Obstetrics & Gynaecology, Volume 109, Number 2, 15 August 2003.

# The Response

## Process

These were the first comprehensive assessments of the safe motherhood situation in each state, and the findings served as a call to action. In response each state established a Safe Motherhood Initiative, overseen by a State Safe Motherhood Committee. Sub-committees were established to take the lead on supply- and demand-side issues. On the demand-side, using the three delays model and drawing on good practice regionally and internationally, 'increasing access strategies' were devised to address the household and community delays to emergency obstetric care.

Community interventions were piloted in a small number of sites initially. Intervening on a small-scale made sense at the beginning since there was limited information about culturally effective ways to engage with local communities, and government and NGO institutional capacity to lead and manage the work was weak. Experience from the pilot sites was used to refine intervention tools and methodologies before the work was rolled out to new sites. The pilot phase was also a period of advocacy, capacity- and relationship-building from which functional organisational and management arrangements emerged.

### Acceptable Entry Points for Intervening to Improve Maternal Health

Although key determinants of high maternal mortality, strategies focused on family planning or early childbearing were rejected as too sensitive to address within the implementation context. Instead, an emphasis on increasing women's access to emergency maternal care was accepted by a wide stakeholder group in both states.

Close geographical proximity combined with a willingness to share lessons learned allowed cross-fertilisation of ideas and tools between Jigawa and Kano. Soon after the establishment of the Kano Safe Motherhood Initiative in late 2005, key stakeholders involved in the demand-side work were invited to Jigawa to learn about the neighbouring state's safe motherhood initiative. Stakeholders from the

Jigawa SMOH, Ministry of Women's Affairs (MWA) and the State Health Communications Group (SHCG) gave a frank overview of what they had achieved and the challenges they had faced since the start of the initiative in 2003. The overview of lessons learned was extremely helpful to the Kano team as they were about to begin implementation. A little later Kano stakeholders were able to share the work they had done to develop a culturally-appropriate approach to community engagement with the safe motherhood team in Jigawa. The tools and materials were adapted to suit the Jigawa context and used to roll out community engagement activities in a large number of communities.

Once appropriate implementation approaches had been identified, subsequent phases of the initiative focused on how best to sustain the work beyond the lifetime of PATHS, both institutionally and financially. Activities focused on moving from predominantly NGO-led implementation at community level to a scenario where responsibility for training, monitoring and supervision of the community level work was integrated into the job descriptions of local government staff. Attention also focused on strengthening government leadership of the

### KEY STEPS:

#### *The Safe Motherhood Demand-side Approach*

- Initial rapid social assessment of the safe motherhood situation
- Stakeholder review and planning workshop
- Detailed design of safe motherhood 'increasing access' strategies
- Clarification of institutional framework for implementation
- Capacity needs assessment of institutional partners/on-going provision of capacity building support
- Initial design and implementation of intervention approaches in small number of pilot sites
- Review, refinement and roll-out of intervention approaches
- Development of advocacy skills to support policy change
- Building capacity to sustain the work
- Documentation and dissemination of lessons learned



*Women in a safe motherhood community, Kano*

## CASE STUDY:

### *Kano Strategy for Increasing Access to Safe Motherhood Services*

**Goal:** Reduced maternal mortality in Kano State

**Purpose:** To increase women's access to Emergency Obstetric Care in Kano State.

**Approach:**

- Mobilise communities and raise their awareness of EOC danger signs and safe pregnancy planning
- Assist communities to put in place community systems to enable individuals to translate their new knowledge into action. Community systems required include:
  - An emergency transport system to transfer women with an obstetric emergency to the nearest health facility offering Basic or Comprehensive Emergency Obstetric Care
  - Savings schemes to address financial barriers
  - Blood donors to provide a woman with blood on requirement
- Undertake advocacy to improve the implementation of Kano State's Free Maternal and Child Health Policy.

**Intended Outcomes:**

- Increased awareness of EOC danger signs, actions to be taken and the need for birth preparedness among communities
- Couples expecting a baby put in place a safe pregnancy plan (know the danger signs, save money, standing permission to go to the hospital, have a mother's helper, arrange blood, arrange transport)
- Increased referrals of women experiencing complications to health facilities
- Effective Emergency Transport System ensures women experiencing complications are transferred to EOC without delay
- Implementation of Kano State Free Maternal and Child Health Policy is improved, ensuring that those services/ supplies designated as free are delivered free to all who require them
- Effective community Emergency Loan Funds ensure that any delivery associated costs do not limit women's access to essential EOC

demand-side work as a whole, and ensuring that the interventions were 'on budget' and therefore had a better prospect of financial sustainability beyond the life of PATHS.

Sixty-five communities in Kano with an estimated population of 180,000 were participating in the safe motherhood demand-side initiative by late 2007. The work was rolled out to a further 28 communities in early 2008. In Jigawa, 90 communities, with an estimated population of 237,000 were participating in the initiative by late 2007, and plans were in place to roll out to a further 20 communities. Positive spin-offs from the work were evident in communities in the vicinity of the Jigawa safe motherhood communities, and one component of the work in this state - awareness-raising of commercial car drivers on the need to respond promptly to maternal emergencies - was rolled out state-wide.

The increasing access strategies were implemented alongside a programme of supply-side improvements which focused on strengthening coverage and quality of emergency obstetric care within the context of a broad-based health systems strengthening effort, support for safe motherhood related policy, planning and advocacy, and a communications programme which focused on safe motherhood as part of an integrated public health communication strategy. Lessons learned from the Kano and Jigawa experiences of improving the quality of safe motherhood services against a backdrop of health system strengthening are reported in the following Policy Brief: *Strengthening the Supply Side Aspects of the Safe Motherhood Programme*.

## Interventions to Address Challenges

In order to address the household and community delays that were preventing timely access to emergency maternal health services, interventions focused on a number of key areas. Although the general package of interventions in the two states was similar, differences in the socio-economic, cultural and institutional contexts meant that the relative importance of different elements of the package, the way in which they were implemented and in what order, varied both between and within the states.

## Lack of Knowledge

Poor knowledge of maternal danger signs and their causes, and of when and where to seek help when a complication occurs, was common at community level. These barriers were addressed via:

- Establishment of community discussion groups: discussion topics focused on the danger signs of an obstetric emergency, what to do when an obstetric emergency arises, where to seek help, planning for a safe pregnancy and the improvements made in local facilities
- Discussions led by religious leaders at the mosque: these reinforced the topics covered in the community discussion groups
- Home visits by community volunteers: these targeted households with pregnant women and encouraged families to plan for a safe pregnancy
- Mass communications: radio broadcasts, jingles and songs reinforced information disseminated within the community discussion groups, in the mosque, and during home visits. Information on safe motherhood-related issues was incorporated into written materials to be found at health facilities and other public spaces.

## Safe Pregnancy Plan

1. Know the danger signs of a maternal emergency
2. Save for a possible maternal emergency
3. A husband should give standing permission for his wife to rush immediately to the hospital should a complication arise
4. Pregnant woman should select a mother's helper who can help identify danger signs and raise the alarm if a complication arises
5. Arrange for blood donors
6. Arrange transport with an emergency transport scheme driver

## Cultural Practices

Reliance on traditional or spiritual remedies, a preference for home births, shyness ('kunya') which encouraged women to hide their pregnancy and to opt for lone birth, and fatalistic beliefs about ill-health also prevented women from using emergency maternal health services in a timely fashion. These barriers were addressed as follows:

- Community discussion to address cultural beliefs and practices: specific cases of maternal death in the community were reviewed as an entry point to examining attitudes and practices that resulted in delayed action
- Discussion of pregnancy and complications in public spaces: this challenged the deep-rooted taboos that prevented open discussion of pregnancy and complications within and outside the household
- Public endorsement of the community interventions by influential individuals: this created an enabling environment for implementation activities and facilitated the process of challenging unhelpful social norms

### Beliefs about the Causes of Eclampsia, Jigawa

"Fitting is caused by spirits ("Aljannu"). We have no medicines for it."

"Eclampsia is the madness of pregnancy ("borin haihuwa") and is caused by witches in the community."

"Fitting is caused by witches ("miyagu" or "mayu"), but in hospital they said it is the result of eating Maggi (salt-based food additive)."

An approach to community mobilisation based on the 'social approval' method was developed. The methodology was adapted and refined over time in response to implementation experience in the two states (see Box on following page).

## Concerns about Service Quality

Negative perceptions of the quality of public health services were pervasive. This barrier was addressed as follows:

- Improvements in the supply of quality health services: minimum standards for services and coverage were defined, training in maternal life-saving skills and inter-personnel communication skills for health workers was provided, essential equipment was supplied, and key underpinning systems, including financial management and sustainable drug supply systems, were strengthened
- Stronger linkages between communities and health facilities: the importance of strengthening linkages between facilities and their catchment communities was emphasised in wider systems strengthening efforts
- Introduction of identification card system: community safe motherhood volunteers were linked to facilities through an identification card system, which helped speed their access to, and strengthen their relationship with, health providers.



### CROSS CUTTING:

#### Strengthening Linkages between Facilities and Communities

Significant emphasis was placed within the broader systems strengthening work on the importance of health facilities promoting and sustaining an effective relationship with their catchment communities. This was actioned through facility performance appraisal and quality assurance approaches which promoted consultation with clients and communities as an integral component of quality improvement; via the involvement of community representatives in the management of facility-based sustainable drug supply and deferral and exemption systems; and via promotion of the concept of community involvement in health in communications activities.

## The Social Approval Approach to Community Mobilisation

The community mobilisation approach used in the safe motherhood communities in Kano and Jigawa recognised the need for the support and approval of religious leaders and elders, other influential members of the community, family members and peers if new behaviours relating to reproductive roles, family and spousal relationships were to be adopted in the intervention communities. The approach, facilitated by local NGOs, was based on intensive dialogue about the barriers of access to safe motherhood services originating at household and community level, generating social approval for healthier and safer health seeking behaviour and an acceptance of responsibility for change, and supporting community-identified activities to address these barriers. A strategy of 'saturation' of all parts of the community, including hard-to-reach groups, was pursued.

Community discussions with small groups of men and women, and facilitated by trained community volunteers, including the village imam and other religious leaders (men), CBO representatives and women were the main vehicle for promoting behaviour change. This diverse group of community volunteers enabled different parts of the community to be reached and messages to be endorsed at the mosque during Friday prayers as well as in religious schools. Pregnant women and their husbands were targeted through home visits to ensure that they were taking the recommended steps for a safe pregnancy. Finally, the same messages were aired on radio in drama programmes, jingles and songs.

At least six months worth of coaching of communities was needed to embed new behaviours and to support the establishment of effective community emergency maternal care systems. After these initial investments, coaching support visits decreased to around 3-4 a year.

Key steps in the approach were:

- Courtesy visit to LGAs to create an enabling environment for the work at community level
- Early involvement of district heads to pave the way for community ownership
- Use of a cascade training approach: a training of trainers for NGO implementing partners; training of lead community volunteer facilitators; and training of community volunteers
- Initial whole community interactive discussion on maternal mortality, using local case studies of maternal complications, and in-depth discussion of barriers of access
- Selection and training of male and female community volunteers to be at the forefront of the community interventions
- Facilitation by community volunteers of a series of small group discussions with community members on disabling and enabling factors affecting maternal mortality using the Emergency Maternal Care Discussion Guide
- Use of innovative techniques such as the whole body memory tool for recall of danger signs. This encourages participants to learn to 'do' the action and 'say' the message
- Support for individual and community action around dissemination of new knowledge, planning a safe delivery, establishment of community saving schemes, emergency transport schemes, and blood donation groups
- Use of male community volunteers and religious leaders to create social pressure in support of men providing standing permission for their wives to act in the event of a complication
- Individual visits to the homes of pregnant women (female volunteers) and discussions with the husbands of pregnant women (male volunteers) to reinforce key messages about danger signs, emergency preparedness, and standing permission
- Establishment of community action groups for emergency maternal care to act as a mechanism for community co-ordination, and monitoring of the increasing access work

## ***Distance and Difficult Physical Terrain***

Long distances to health facilities, especially from remote or otherwise hard to reach areas, poor road infrastructure, and a lack of accessible transport resulted in major delays to the use of emergency maternal health services. These barriers were addressed as follows:

- Establishment of community emergency transport scheme: volunteer drivers (car drivers in Kano and car and motorbike drivers in Jigawa) were trained to respond quickly to maternal emergencies
- Piloting of emergency motorcycle trailers: prototype motorcycle trailers were built and piloted in a small number of hard to reach communities in Jigawa



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### ***Men practising danger sign poses, Jigawa***

## ***Women's and Men's Capacity to Address Safe Motherhood Issues***

Women's lack of scope for independent decision-making on health issues, and their need to be chaperoned when moving in public spaces were identified as important. These barriers were addressed as follows:

- Male involvement in community discussion groups: men were involved as a key target group in community interventions. Significant emphasis was placed on men giving wives permission to act without delay in the event of a complication
- Safe pregnancy plans emphasized gender considerations: safe pregnancy plans emphasised the need for families to identify a 'mother's helper' who could accompany a woman to the health facility in the event of a complication
- Emergency transport schemes were designed with gender in mind: emergency transport drivers were trained to carry chaperones where pregnant women were travelling to a health facility in the absence of a close male family member.

## **Community Emergency Transport Scheme**

The National Union of Road Transport Workers (NURTW) played a key role in the community emergency transport schemes in both states. NURTW car drivers selected for participation in the scheme were trained by NURTW trainers on the safe motherhood situation, the need to respond quickly to maternal emergencies, how to carry a pregnant woman, where to take them, and the need to keep a supply of petrol within the community at all times. Families using ETS drivers paid a fixed amount to be transported to the health facility, and could pay in arrears if necessary. Drivers were given identification cards to ensure that they were not held up by police at road-blocks, and to facilitate their access once at the health facility. The NURTW leadership in both states played a major role in managing and monitoring the scheme. In Jigawa the head of the NURTW rolled out the safe motherhood training to drivers working from motor-parks across the state, thereby ensuring a critical mass of drivers with the awareness to respond promptly to maternal emergencies.

## Financial Costs

The costs associated with accessing emergency maternal health care, including transport to and from a health facility, were high for many, and catastrophic when significant medical intervention (e.g. caesarean section) was required. These barriers were addressed via:

- Establishment of community emergency maternal care funds: communities were encouraged to establish their own savings schemes for safe motherhood emergencies
- Prices were fixed within the community emergency transport scheme: emergency drivers were encouraged to agree a fixed price with local communities for transferring women to a health facility (to cover fuel costs)
- Blood donation groups were encouraged: these helped offset the high costs associated with purchasing blood
- Advocacy in support of free emergency maternal care: key individuals involved in the safe motherhood work in Jigawa undertook political advocacy in support of free emergency obstetric care

## Institutional Arrangements

Institutional arrangements for the demand-side safe motherhood work differed in the two states, although both recognised the importance of multi-sectoral partnerships in order to turn the safe motherhood situation around. In Jigawa a coalition of government and NGO stakeholders, led by the Ministry of Women's Affairs, was initially set up to lead the work on tackling the first two delays. A separate committee under the leadership of the SMOH was established to oversee the strengthening of emergency obstetric care services. In addition, the State Health Communications Group oversaw communications activities. All three institutions reported to an overarching SMOH Safe Motherhood Committee, which provided a mechanism for co-ordination of the different components of work.

Over time the need for a clearer-cut institutional home for the demand-side initiative became evident, and the loose-knit coalition eventually gave way to a set of institutional arrangements that anchored the initiative more firmly to the Ministry of Women's Affairs, clarifying the Ministry's leadership role.

In Kano an Increasing Access Strategy Co-ordinating Group, comprising government and NGO representatives was established at the start of the initiative, chaired by the head of the SMOH health communications unit.<sup>5</sup> This group reports to a multi-sectoral State Safe Motherhood Committee chaired by the SMOH and comprising representatives of the public and private sectors, training colleges and NGOs. As in Jigawa, the Safe Motherhood Committee was intended to provide the mechanism through which supply and demand-side activities could be co-ordinated. These committees have unfortunately never really functioned as intended (see Results).

Local NGO implementing partners were contracted to lead on the community engagement work, while the Union of Road Transport Workers (NURTW) led the work to establish emergency transport schemes. The contracting of NGOs was undertaken initially by PATHS, although the aim was to transfer this responsibility to the respective lead Ministry once their capacity to absorb this function had been built. Significant additional capacity building support was provided by PATHS to ensure effective management, leadership and co-ordination of the partnerships comprising the safe motherhood initiative.

### Safe Motherhood Implementing Partners

Implementing partners in Jigawa are: National Union of Road Transport Workers (NURTW) and ACOMOROM (motorcycle riders union) and four NGOs: Gumel Youth Movement (GYM), Popular Theatre for Health Education (POTHE), Society for Community Health and Mobilisation (SOCHAM), and Jigawa State People's Congress (JSPC).

Implementing partners in Kano are: NURTW and three NGOs: Community Health Research Initiative (CHRI), Grassroots Health Organisation of Nigeria (GHON) and Sustainable Development Initiative Centre (SUDIC).

<sup>5</sup> Known as the Health Education and Communication Training and Information Centre (HECTIC).

## CASE STUDY:

### *Evolution of Institutional Arrangements for the Safe Motherhood Work, Jigawa*

The safe motherhood demand side work in Jigawa has evolved through a number of phases. The initial phase from 2004 to 2005 was one of experimentation and piloting. During this period the initiative functioned as a project managed by a Director within the State Ministry of Women's Affairs and Social Development, and involved a variety of actors from government and civil society in training and supervision. Government institutional ownership was minimal and the project fed off the drive and commitment of one or two individuals. Although the multi-sectoral group that led the pilot phase of work played an important role in launching the programme, as a loose band of individuals they operated without the institutional frameworks necessary to expand and deepen activities.

From a set of pilot activities the initiative evolved into a more institutionally grounded programme of work led by the Commissioner of the SMWASD and implemented by NGO partners. Leadership of the initiative excelled and institutional ownership was embraced by the SMWASD. This provided a platform from which to take community activities to scale, and to establish clearer and more efficient implementation and management roles and responsibilities. Contracting out implementation responsibilities to non-government bodies and the private sector and working in partnership was a breakthrough for the Ministry. These new partnership and contractual relationships created opportunities for the Ministry to strengthen their management capacities and to focus their efforts on monitoring, management and oversight, networking and advocacy.

The change in Government and re-organisation of departments following the 2007 elections set the stage for further institutional evolution

as new ministries were created and the remits of existing ones such as SMWASD and SMOH were amended. The aftermath of the election presented drawbacks and opportunities. The Commissioner was replaced and officers that had been driving the initiative moved out of the Ministry. More positively, newly created ministries presented potential avenues for institutionalising safe motherhood community based activities into government structures, and handing over responsibility for training, support, coaching and monitoring to LGA based government staff. The sideways and upwards appointment of safe motherhood champions from the earlier-SMWASD to new government agencies has been an important enabler in this regard.

From its experience of partnership working, the newly-named State Ministry of Women's Affairs was ready to focus on oversight and policy, and create the space for a wider group of line ministries to take responsibility for implementation of community based activities under its leadership. This new role for the SMWA aligns well with their evolving role as advocates and advisers for gender issues and women's rights and their move away from service delivery.

The shifting institutional arrangements for the safe motherhood demand-side work have demanded careful management. The shifts evolved in response to the changing governance environment, internal leadership, and the capacities and will of government and civil society to work for safe motherhood. The changes illustrate the need for flexibility and pragmatism in establishing institutional arrangements to deliver demand side activities, and the need to seize opportunities for institutional gain as they arise.

# Results

## Impact on Maternal Mortality

The implementation timeframe - three years in Jigawa and two years in Kano - has been too short to roll out the safe motherhood demand-side activities on a significant scale. Nevertheless, results from the work so far indicate that the community engagement approaches developed in both states appear to be both culturally appropriate and effective.

Sufficient evidence has been generated through the safe motherhood demand-side monitoring and evaluation systems to suggest that significant behaviour change in relation to pregnancy and maternal complications has occurred at community level. Reports from intervention communities and health providers also suggest that many lives have been saved and morbidities averted as a result of the safe motherhood interventions at community level. In Jigawa, after a year of operation in the first batch of 36 villages, a decline in maternal and newborn deaths was evident, and the percentage of maternal complications that resulted in a maternal death had halved.

### Reported Obstetric Complications, Maternal and Newborn Deaths, Jigawa

	First Batch of 36 Villages: Second half of 2006	First Batch of 36 Villages: First half of 2007	First Batch of 36 Villages: Second half of 2007	Second Batch of 36 Villages: Second half of 2007
Number of women with obstetric complications	86	191	209	181
Number of maternal deaths	10	29	16	19
Number of newborn deaths	42	68	49	62
% of maternal deaths out of the number of complicated cases	11.6%	15.2%	7.6%	10.1%
% of newborn deaths out of the number of obstetric complicated cases	48.8%	35.6%	23.4%	33%

In the table above the scale of the problem of maternal and newborn deaths in Jigawa is clear. The increase in reporting of complications over time in the first batch of 36 villages in the first half of 2007 probably reflects heightened awareness and more thorough reporting as the initiative took root, rather than an increase in incidence.

A decline in maternal and newborn deaths is evident in the first batch of villages in the second year of operation; the percentage of maternal complications that resulted in a

maternal death was halved in the second half of 2007 compared to the previous 6-month period. The percentage of newborn deaths linked to an obstetric complication also dropped noticeably but less steeply than maternal deaths.

The second batch of 36 villages has a lower baseline of deaths from complicated cases compared to the first batch. One explanation for this is that there are far fewer villages in the second set from hard-to-reach areas, and more are relatively close to towns with easier access to hospital care.

## Evidence From Communities of Lives Saved

A woman in Yammawan-Fulani, Dambatta LGA, Kano said: "there haven't been any maternal deaths for a long time."

In Sakwaya, Takai LGA, Kano a woman reported "There have been no maternal deaths here in recent months. Everyone goes to the hospital when a problem arises."

Unguwar kaya village in Roni LGA, Jigawa is hard to reach. The track from the main road to the village is long and of poor quality, transportation is limited to motorcycles. In this remote village a young woman delivered her first baby at home, it was a normal delivery. A week after the birth her husband and family sensitised to the danger signs of pregnancy and childbirth felt that she was not well and took the decision to take her to Kazaure General Hospital. The woman was suffering from severe anaemia. She was donated 2 pints of blood from the community EMC blood donors' group, and funds were given from the male EMC fund to acquire a third pint. Two weeks after this emergency the monitoring team visited the woman in hospital and spoke to the midwife in-charge. She confirmed the severity of the young woman's condition, the life-saving action of the husband, and the support given by the community.

However, weaknesses in facility level record keeping and the relatively small-scale of the interventions so far mean that the end result - the overall impact of the demand-side work on maternal mortality and morbidity - cannot be known for certain. This highlights the importance of building a robust evaluation mechanism into the design of future safe motherhood community level interventions.

## Results at Community Level

### Changes in Attitudes and Behaviour

The techniques used in the community discussion groups, including the use of poses and songs to recall key messages, and the emphasis on reinforcing

### Changes in Knowledge, Attitudes and Behaviours Towards Emergency Maternal Care

A post-intervention knowledge, attitudes and practices survey undertaken in a selection of Kano safe motherhood communities in December 2006\* found the following:

#### Knowledge

- 99% of respondents were able to identify 6 danger signs
- 99% of respondents were able to identify at least 4 elements of the safe pregnancy plan
- 98% of respondents identified the following statement as true: "Even if a woman attends ANC, she can still develop complications."

#### Attitudes

- 100% of respondents thought that their spouse believed that a husband of a pregnant woman should prepare for a possible maternal emergency
- 100% of respondents thought that their relatives believed that a husband of a pregnant woman should prepare for a possible maternal emergency

#### Behaviour

- 98% of pregnant or post-partum respondents reported that they, their husbands and their family made at least 4 plans for a possible maternal emergency
- 95% of post-partum respondents reported going to the hospital when a danger sign arose

\* The survey was undertaken in half (3 out of 6) the focal communities in each of 5 LGAs. In each community 20 respondents were interviewed. The total number of respondents was 300.

key messages during home visits, in public meetings, in the mosque, and on the radio, enabled community members to retain and internalise accurate information on maternal danger signs. Men and women in the intervention communities 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 once common perception that attending ANC lowers a woman's risk of developing a complication is no longer evident in the intervention communities, and the tendency to resort to traditional medicine in the event of a complication has diminished.

Open discussion about pregnancy – an issue previously kept in the private domain – became

much more common, between spouses, between family members, and at community level. The promotion of key messages by influential members of the community, including religious and traditional leaders, helped to promote wide social acceptance of the need for behaviour change.

The emphasis on male involvement in the community engagement approach proved vital to the shift in attitudes and behaviour. In both states husbands are reported to be giving standing permission for wives to attend health facilities for both ANC and emergency maternal care, and there is evidence in both states that couples are compiling safe pregnancy plans. Wider changes in social norms are also evident. For instance, men and women are meeting together to discuss issues relating

## Changes in Safe Motherhood Knowledge and Attitudes, Jigawa

The Jigawa baseline Knowledge, Attitudes and Practices Survey was undertaken in June 2007 in the second batch of 36 safe motherhood communities. The endline survey was undertaken in the same communities in February 2008.

	Baseline survey Results (%)	Endline survey Results (%)
<b>Knowledge of the danger signs</b>		
Severe bleeding after birth	19.68	84.09
Fitting	18.88	65.91
Swollen feet	33.73	60.91
Severe headache	26.51	75.91
Pale hands, lips or eyelids	12.45	53.64
Severe fever	25.70	70.00
Prolonged labour of 12+ hours	24.10	79.09
Delay of placenta	7.23	63.64
Part of the baby other than head comes first	8.43	67.73
Knowledge of 6 or more	4.02	79.09
<b>Attitudes to birth preparations: "what should a pregnant woman do to prepare for a possible emergency?"</b>		
Learn the danger signs	2.41	50.00
Save money	35.74	95.45
Know a woman who will help her identify danger signs	3.61	50.45
Obtain standing permission	25.70	89.09
Know a driver in the community to help get to hospital	10.44	54.09
Know that her family knows men willing to donate blood	2.41	37.27
4 or more suggestions	1.20	60.45

to safe motherhood whereas previously issues of community interest tended to be discussed in single-sex groups. Some women have suggested that their participation in activities that once fell into the primarily male public domain has been empowering.

## Changing Community Responses to Maternal Complications

“At present, the majority of the population are turning away from traditional medicines to solve EMC (emergency maternal care).

*Female community volunteers, Malikawa community, Bichi LGA, Kano*

\* \* \*

Before this programme, we know these problems exist but we relate them to tradition but now there is a change, as soon as we see the signs we go to the hospital because we now know that they can be cured. For example bleeding during pregnancy, we used to think that the child is being cleansed and the skin of the child will be fairer as a result of the bleeding.

*Male community member, Barandau Village, Dutse LGA, Jigawa*

\* \* \*

“Most cases that were considered as complications now were not seen as complications before the intervention, and any difficulty related to pregnancy and child birth was usually referred to the traditional birth attendant. Complications were only referred to the hospital as the last option.”

*Male community volunteers, Rogo Ruma Community, Rogo LGA, Kano*

\* \* \*

“Issues that were not considered important like the high number of the death of women of child bearing age are now considered as a serious matter. And we can also differentiate complications from physiological changes during pregnancy.”

*Male community volunteer, Rogo Ruma Community, Rogo LGA, Kano*

## Shifts in Social Norms

“Before the safe motherhood work started in the community, there was nothing like this. Men and women only met at ceremonies... Gradually men and women moved together – the idea was that we could learn from each other. At the beginning, the women just used to put their head down and say nothing. We don’t do this any more. Other women in nearby communities don’t have meetings like this and are not as empowered.”

*Women, Yammawan Fulani Village, Danbatta LGA, Kano*

## Performance of Community Systems

The establishment of community systems to deal with maternal health emergencies enabled individuals and households to act on their new knowledge. There was evidence in both states that community emergency savings schemes, emergency transport schemes and community blood donor groups were being actively used.

### Emergency Transport Systems

Training of emergency transport scheme drivers has resulted in greater willingness to transport women suffering a maternal complication to a health facility. There is also evidence among drivers of a willingness to forfeit payment if passengers are very poor. In Kano an average of 154 women per month were recorded as having used the emergency transport scheme over the period June 2006 to September 2007, although inconsistent reporting by drivers means that the number of beneficiaries is probably

## An Emergency Transport Scheme Success Story

In Ndabo community, Wudil LGA, Kano, community members reported that one of the ETS drivers had his vehicle loaded with passengers and was about to depart when some community volunteers rushed to him to alert him that a pregnant woman was experiencing a complication. The driver asked all his passengers to get off the vehicle explaining to them that he had to give priority to the maternal emergency as it is an “officially urgent assignment”.

higher. In Jigawa, an average of 174 women per month were recorded as having been transported by ETS drivers over the period March to December 2007, although under-reporting is an issue in this state too. Finding effective ways to maintain driver interest in record-keeping has been challenging and requires more attention in future.

The performance of the motorcycle ambulance trailers, piloted in four communities in Jigawa, has, however, been disappointing. The prototype trailers, which were designed for use in remote, hard-to-reach communities have not been robust enough to cope with the difficult terrain, and are financially unsustainable.

## Piloting of Motorcycle Ambulance Trailers in Jigawa

In remote and hard-to-reach areas in Jigawa emergency health cases are often transported by bullock cart to the nearest road where transport can be found. The Ministry of Women's Affairs, with support from the UK NGO TRANSAID, commissioned the local design and manufacture of four prototype safe motherhood motorcycle ambulance trailers to serve hard-to-reach areas. Operational testing of the trailers in four villages began in April 2007. To guard against misuse the trailers were handed over to the emergency maternal care leaders to be managed on behalf of the community. The experience of the ambulance trailer has been disappointing and all the ambulance trailers are operating sub-optimally. One problem relates to the mechanical fragility of the ambulances for the rough terrain they are intended to ply, making them unfit for purpose. In all four of the villages, the motorcycle

is more often used alone to alert commercial vehicles or transport women to motorparks. In one village, Ruruma, the cost of repairing the ambulance trailer has made it unaffordable for the village to sustain and although it is a highly valued asset, without external financing the community cannot afford to operate it. Approaches made by the safe motherhood community volunteers to the local LGA to help finance operating costs have been unsuccessful. Transportation in remote or hard-to-reach areas remains one of the most serious operational challenges to the demand side programme. Alternative approaches such as government financed transport subsidies for emergency obstetric cases from hard-to-reach areas, which build on local partnerships with transport drivers and motorcycle riders, may be a more cost-effective strategy than ambulance trailers.



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## Community Savings Groups

Saving groups have been set up in all participating communities and are being accessed when maternal complications arise. In Kano over N1.5 million Naira<sup>6</sup> was saved within these schemes and 750 individuals accessed funds from them over the 18-month period from June 2006 to December 2007. In Jigawa, it appears that all individuals, including the very poor who may not have been able to contribute to the schemes, have managed to access emergency funds, suggesting that there is a growing sense of shared responsibility for maternal health at community level.

### **Saving for Maternal Emergencies**

A group of 15 men in Rogo Ruma, Rogo LGA, Kano have established a savings group for emergency maternal care. Each of them save 50 Naira weekly. The money is kept by the Community Volunteer. The group has established some basic rules for the scheme including: i) the money can only be used for emergency maternal care; ii) money is given as a loan and must be repaid within 4 weeks; iii) whilst the scheme's capital is relatively small, the maximum amount that can be loaned is 2,000 Naira.

## Blood Donor Groups

Volunteer blood donation groups have also been established in the communities involved in the safe motherhood initiative. Community members are reportedly much more willing to donate blood than was previously the case, even to individuals outside the immediate family. In Jigawa records kept by the 36 safe motherhood communities involved in the first phase of implementation show that 373 pints of blood were donated over the 18 month period from July 2006 to end December 2007. In Kano 41 women are recorded as having benefited from community blood donations made in the safe motherhood communities since the start of the initiative.

### **Changing Attitudes to Blood Donation**

"Before, the pregnant women and even their husbands were afraid of hospitals but now their fears have changed. I could never donate blood before, I preferred to pay whatever I could to buy blood, but now I do donate blood".

*Emergency Maternal Care Team Leader,  
Nanimawa, Yankwashi LGA, Jigawa*

\* \* \*

Community members reported how a woman, who had just given birth, was experiencing heavy bleeding. Her husband sought assistance from one of the community volunteers. He borrowed 1,350 Naira from the savings group and took his wife to hospital. Members of the blood donor group accompanied them. Two of them donated blood. The woman's husband used the money loaned to buy a blood bag and to pay for blood tests. Both mother and child survived. The woman's husband has since joined an EMC discussion group to learn more about pregnancy related complications.

*Community Members, Mainike community,  
Gwarzo LGA, Kano*

6 About US\$12,200.

## Other Outcomes

The safe motherhood demand-side work was not set up to tackle issues of weak community voice and poor accountability between communities, health providers and policy makers. However, there are instances where the safe motherhood work, sometimes in combination with other reform initiatives, appears to have stimulated a greater willingness within communities to demand improvements in health services more generally (see below).

### Safe Motherhood Communities Demand Change from Local Government

The government in Kano had introduced a policy whereby non-indigenes of the area were to be retrenched from the health service. This included a Senior Nursing Officer based at a secondary health facility in Tudan Wada LGA who had been a major support for women suffering maternal complications. The safe motherhood community volunteers called the provider to a meeting and asked him if he would commit to staying on at the health facility if they lobbied on his behalf. He agreed. The community approached the Local Government Head of Community Development, who had been a great supporter of the safe motherhood demand-side work. He arranged a meeting with the PHC Co-ordinator, who was very receptive to the community's demands, and immediately arranged for the group to meet the Local Government Chairman. The Chairman's response was that "if this is what the people from this community want, they can have it". The Nursing Officer got his job back and has since returned to work.

There is also evidence to suggest that being a community safe motherhood volunteer has helped build leadership skills, including among individuals who have not traditionally played leadership roles at community level. The emergence of 'new leaders' is promising – it could help challenge the tendency for community elites to 'capture' key leadership positions, and ensure that a wider mix of 'community voices' is heard when decisions affecting the community as a whole are made.

Another unexpected outcome is the strength of the commitment within the safe motherhood communities to tackling maternal deaths, and the

willingness and drive to share their new knowledge and experience with neighbouring communities (see Box below). In Jigawa the safe motherhood work has been rolled out – by community safe motherhood volunteer teams – to 18 villages in close proximity to villages involved in the first phase of implementation. Although the training appears less systematic than when led by NGOs, the approach is less costly, is valued locally, and has the added benefit of promoting social cohesion across villages.

### Communities Act to Roll Out the Safe Motherhood Work

The safe motherhood community volunteers in Rogo Ruma Village, Rogo LGA, Kano had received training on simple advocacy and lobbying skills. The villagers rehearsed what they wanted to say to the local government Chairman. The next day a group of 60-70 community members, men and women, accompanied the District Head to the Local Government Secretariat. Their spokesperson, a women's leader, explained the work the community had been doing to raise awareness of safe motherhood and to prepare the community to act appropriately in the event of a complication. She asked the Chairman to support the rollout of the safe motherhood community engagement work to ten new communities; the volunteers were keen to share their knowledge and skills with neighbouring communities. The Chairman agreed to the requests, promising logistical support in the form of a venue, refreshments and budget for transport. As the local government elections approached, however, support for the proposals waned. The community resolved to begin their lobbying again once the new government had settled in.

### Assisting a Neighbouring Community

"One of our neighbouring villages rushed to us with a case of a girl who had early marriage and so she was under age and she was suffering to deliver her baby. They came to us for help, we helped them with our ambulance to the hospital, the girl delivered but the baby died as there was a delay before they called us to assist them".

*Safe motherhood community team leader,  
Ruruma Village, Kazaure LGA, Jigawa*

## Increased Capacity and Leadership

Capacity to work on safe motherhood issues, and to apply these skills to other health or development problems, has increased at community level and among NGO implementing partners in both states. In terms of government ownership and leadership of the work, experience varies considerably between the two states.

### Increased Capacity for Resolving Community Problems

“Community volunteers have learnt a systematic way of teaching people how to solve their own problems with their own resources.”

*Female Community Volunteer, Rogo Ruma community, Rogo LGA, Kano*

\* \* \*

“Working as a team at community level is a great factor for reaching more people and also, by involving community leaders and influentials in solving community problems. We also learnt that it is only when there is joint effort through the community that one can achieve what is aimed. Learning the simple skills of transferring knowledge between those who have never gone to school as well making them to take action. The facilitator acts not as a teacher, but rather to encourage learning from each other.”

*Male Community Volunteers, Malikawa community, Bichi, Kano*

\* \* \*

“We have learnt community group work, and problems related to pregnancy including how to resolve it. We have also learnt a way of teaching people how to solve community problem, by taking the issue in a step-by-step method.”

*Male Community Volunteers, Yarmaraya community, Tudun Wada LGA, Kano*

## Community Volunteers

Although some members of the safe motherhood communities had previously been involved in polio-related work, none had received systematic training on how to effectively mobilise communities to solve community-wide problems. Training and on-going supervisory support provided to community volunteers is reported to have built their community mobilisation skills considerably. The efforts that are being made by community volunteers to roll the work out to neighbouring communities - with limited or no support - indicate a growing confidence in their own knowledge and skills, and a sense of responsibility to support wider social change.

### NGO Implementing Partners

NGO implementing partners have reported increased competency and capacity in a number of key areas as a result of their involvement in the safe motherhood initiative.

Jigawa NGOs reported:

- Stronger facilitation skills
- Better networking between NGOs and communities, leading to increased performance in other community development activities
- Stronger community trust in NGOs
- Better motivation of NGO staff

Kano NGOs reported:

- Increased technical competency to work on safe motherhood
- Improved skills in health education
- Stronger facilitation skills and better capacity to mobilise communities effectively
- Stronger organisational management skills
- Greater emphasis on being results-oriented
- Improved financial management systems
- Greater staff confidence and improved interpersonal skills
- Increased organisational profile in Kano State

NGOs have also gained experience of proposal writing and budgeting, skills that are intended to

increase their capacity to generate new income streams in order to fund future activities. Because many of these skills have been built from a very low base (in Jigawa in particular), finding effective ways to sustain the gains will be key.

The profile of the NGOs involved in the safe motherhood work has also increased. However, there have also been challenges. In both states the NGOs are involved in other PATHS supported work, and as organisations with small staff capacity, this has led to an over-dependence on PATHS funding. Moreover, having staff tied up on PATHS supported work has made it difficult to source additional funding.

## **Government**

Significant investment in strengthening government capacity to manage and lead the safe motherhood demand-side work was made in both states. Support focused on strengthening project management and planning and budgeting skills, building capacity for effective political advocacy, and nurturing leadership capacity.

In Jigawa, the Ministry of Women's Affairs' ownership and leadership of the safe motherhood demand-side work is widely recognised within and outside the state, and this has enhanced the Ministry's standing. In 2007 the Ministry successfully defended a budget request for N33 million for its safe motherhood activities, and N3 million of these funds have since been released. This was a significant step in the direction of ensuring financial sustainability for the demand-side work. In early 2008 the Ministry learned that a proposal that it had developed as part of an overall state submission to the federal MDG fund had been successful, and the funds that have been promised (N37 million) will help sustain the safe motherhood work into the future. A further development in Jigawa in 2007 was an allocation of N10 million for free emergency obstetric care by the new state government. This can be attributed to a large degree to the co-ordinated and sustained efforts of the Ministry of Health and Ministry of Women's Affairs to present a convincing case for reducing the financial barriers of access to safe motherhood services.

Aside from these positive developments, significant technical capacity gaps are still apparent within the Ministry of Women's Affairs, for example in relation to monitoring and information management, and a tendency to rely on PATHS to gap-fill remains. The latter will continue to be an issue in the short- to medium-term because of the large-scale transfer of staff out of the Ministry as a result of the 2007

civil service restructuring efforts. In addition to addressing overall human resource constraints, a more comprehensive and longer-term package of capacity building support to the Ministry – as is happening in the health sector – is required if the safe motherhood demand-side work is to be managed effectively and sustained.

In Kano efforts to build government leadership of the demand-side safe motherhood work have been less effective, and the high-level political support enjoyed in Jigawa has been less of a feature. Although the state has a safe motherhood operational plan, which provides a framework for co-ordinated implementation of supply and demand-side safe motherhood activities, in practice co-ordination across the two components has been poor. This is partly due to the capacity and resource constraints faced by the SMOH's health education unit, HECTIC, which is the focal organisation for all demand-side health-related activity in Kano, and whose head is the chair of the Increasing Access Strategy Co-ordination Group. It is also partly a symptom of weak political support for the work in general. A number of activities were underway in late 2007 to address these constraints (see Box below).

### **Strengthening Political Leadership and Institutional Capacity for the Safe Motherhood Work in Kano**

A programme of capacity building support to HECTIC is currently underway, with the aim of improving its technical health promotion capacity and its leadership of demand-side health related activities in general. Attention is also focusing on how to build high-level political support for the safe motherhood work. In late 2007 NGO implementing partners initiated an advocacy campaign calling on the Government to increase its commitment to addressing the three delays to women receiving appropriate emergency maternal health care. A strategic health planning process initiated in late 2007 also holds potential for ensuring better integration of demand-side health issues into a medium-term health reform programme.

## Prospects for Sustainability

In a context where citizen-state relationships are fragile, being able to demonstrate strong government support for and recognition of community level efforts to tackle safe motherhood delays via on-going supportive supervisory visits is essential if community motivation is to be sustained. In both states monitoring and coaching support for the community level safe motherhood work is currently being transferred to field-level government staff such as Health Educators, Women Development Officers, or Community Development Inspectors. The idea is that the cost of supportive supervisory activities is absorbed into routine service delivery budgets. The transfer of responsibility is at an early stage, and it remains to be seen whether this approach will be effective and can be institutionalised.

Finding other ways to sustain the gains at community level will be key. Introducing new priority health issues into the approach, once communities have been saturated with safe motherhood messages and community emergency maternal care systems are up and running, will help sustain community interest in engaging on health issues. In Kano, for example, future plans are to build a focus on post-natal care and exclusive breast-feeding onto the tail-end of the safe motherhood approach. However, as long as attention is paid to the limits of community absorptive capacity, there is no reason why more complex issues such as routine immunisation cannot be built into the approach in future.

In areas that are particularly remote or hard to reach, sustaining the gains at community level will likely involve additional government attention to the very substantial physical access barriers faced by these communities. This could, for instance, involve improving feeder roads or reimbursing the transport costs incurred by women from these communities (e.g. in Jigawa this would involve extending the provisions of the free EOC policy, and in Kano building a strong equity focus into the free MCH policy).

In terms of institutional sustainability, as indicated above much still needs to be done in both states to strengthen government capacity to effectively oversee the work. In Jigawa, the newly established Safe Motherhood Demand Side Co-ordination Group, which is led by the Ministry of Women's Affairs, and whose membership comprises representatives from all the institutions whose field staff will play a role in sustaining the community

level work, is a very positive step.<sup>7</sup> This committee will play a vital role in ensuring institutional sustainability, but has yet to prove its effectiveness. In Kano, no such co-ordination function exists at present, and without a dramatic improvement in political support for and leadership of the safe motherhood demand-side work the prospects of sustaining the initiative remain poor.

In terms of financial sustainability, despite high start-up costs, scaling up the safe motherhood community mobilisation approach will be relatively low-cost now that methodologies and tools have been designed and piloted and a core team of facilitators has been trained. For instance, in Jigawa rolling out the community level work to new villages will cost approximately N70,000 or £285 per village. Considering the very complex issues that the safe motherhood demand-side interventions are attempting to address, this represents a relatively modest investment. However, until the states begin to increase their spending on health to a level that is closer to the target of 15% of government funds agreed at the African Heads of State meeting in Abuja in 2003, it is likely that state funding for safe motherhood demand-side activities will need to be boosted by additional donor or FGON funding (e.g. such as federal MDG funds).

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<sup>7</sup> The *Gunduma* Directorate, State Ministry of Rural Infrastructure and Community Development, State Ministry of Health, State Ministry of Local Government, NURTW, and NGO representatives.

# Lessons Learned

This section highlights some of the major lessons learned from the safe motherhood demand-side work so far. It is anticipated that these lessons will be of interest to other states that are planning to intervene to address household and community delays to utilisation of EOC services. Alongside the successes, many challenges, weaknesses and mistakes that are specific to the individual states have affected and shaped the work. These are described in more detail in two detailed state-specific case studies that have been produced alongside this Technical Brief.<sup>8</sup>

1. The experiences of Kano and Jigawa demonstrate that it is possible to intervene effectively to address barriers of access, affordability and acceptability of safe motherhood services, even in contexts where the barriers to utilisation of EOC services are profound, where health-related resources are constrained, and where institutional capacity is weak. Investing adequate time and resources in careful situational analysis and design work, paying particular attention to social and cultural traditions, beginning implementation on a small-scale in order to test and refine methodologies and tools (and resisting pressure to scale up activities too quickly), and working flexibly and opportunistically, all contributed to the good progress made in the two PATHS-supported states.
2. Both states established a monitoring and evaluation system for the safe motherhood demand-side work, and these generated some evidence about behaviour change in some key areas. However, neither M&E system was robust enough to demonstrate a statistically significant relationship between the community level work and wider changes in maternal mortality or morbidity. This was partly because of the relatively small-scale of the work, and partly because of weaknesses in the health management information system. As the safe motherhood demand-side work is taken to scale, more attention to establishing robust M&E systems is required.
3. The safe motherhood work was facilitated by the broad-based systems strengthening work underway in Kano and Jigawa. This created a 'reform mindset' among government implementing partners, while tangible service delivery and systems improvements, including improved drug supplies and better provider attitudes, helped create a receptive environment for the interventions at community level.
4. Tackling the first two delays to use of emergency maternal health services are issues that lie outside the capacity of the health sector to work on alone. Partnerships with ministries and agencies outside the health sector, and with civil society and private sector organisations, can significantly expand the pool of resources and competencies available for implementation, and increase opportunities for working at scale. Although the work in Jigawa and Kano did not reach the stage where government was contracting NGO partners, moving in this direction needs to remain a medium-term goal.
5. Opening up space for non-government stakeholders to engage in policy and programme management discussions creates a new dynamic within the health sector, and allows new competencies to be drawn on by government. Likewise, increased opportunities for dialogue between communities and providers, through the safe motherhood work, and reinforced via other reform initiatives, has been an important force for change.
6. The question of where leadership for demand-side safe motherhood activities 'belongs' institutionally – within or outside the health sector – is perhaps less important than whether clear mechanisms are put in place for effective co-ordination of activities across different institutions. Two different approaches emerged in Jigawa and Kano, and both have their pros and cons. The 'outside the health sector' approach adopted in Jigawa resulted in stronger government leadership of the work than was the case in Kano. However, it has also highlighted the need for far more comprehensive and sustained systems strengthening support to the Ministry of Women's Affairs (especially in the key areas of general management, financial management, budgeting, planning etc) similar to that provided to the SMOH in Jigawa to ensure that gains can be sustained. Careful thought needs to be given to what scope there might be for involving key partners outside the health sector more centrally in systems strengthening work in future.

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8 Detailed safe motherhood demand-side case studies for Kano and Jigawa can be found on the accompanying CD-Rom.

7. In contexts where health-related activity has historically focused on the supply-side, it is important to keep reinforcing a vision of how investments in demand-side activities can enhance and support supply-side improvements. The broadening of the skills-set found within state Ministries of Health to include individuals with skills in community development, social science and anthropology, and health promotion (as opposed to the narrower technical area of health education) will help ensure that in-house focal persons 'for the demand-side' begin to influence policy and plans.
8. One of the key strengths of the safe motherhood work in the two states was PATHS' commitment to building the capacity of local partners (communities, implementing partners, and government) to drive the work, even if this resulted in compromises over the technical quality of the work or in delays in implementation. Implementation also had to respond to the pace at which activities could be absorbed by government and its NGO implementing partners.
9. High-level political support for safe motherhood is a significant enabler – in its absence it is difficult to progress beyond pilots or to sustain implementation gains. Being able to identify drivers of political support and effective entry points to engage at policy level is key. Sometimes this means knowing when not to pursue certain activities. For example, a planned political advocacy campaign in support of the free MCH policy in Kano by key demand-side safe motherhood stakeholders was abandoned at a time when sensitive discussions were underway about where and how free services might fit with parallel work to strengthen sustainable drug supply systems.
10. Evidence from some of the intervention communities implies that the safe motherhood work has contributed to increased community voice on health issues and a greater willingness to demand change from health providers and local government. Although this is heartening, community confidence for demanding change can easily dissipate if voices are not heard or are not responded to. Wider health reform efforts in Kano and Jigawa have resulted in a stronger emphasis on strengthening accountability to clients at facility level. However, finding ways to increase public accountability at local government level remains a significant challenge.
11. In the early stages of implementation opportunities for greater integration between the demand-side safe motherhood work and broader health systems strengthening efforts were missed, partly due to weak capacity locally to co-ordinate activities across different units, departments and ministries. Over time, however, as different reform initiatives took root and proved to be effective, opportunities for integration and more joined-up working became more tangible. Allocating resources within health budgets for - and investing time in - the co-ordination of different systems strengthening activities is absolutely crucial.
12. Weak political leadership in Kano undermined efforts to build capacity for effective management and co-ordination of the safe motherhood demand-side work, and meant that little headway was made to get the costs of the initiative 'on budget'. Finding effective ways to leverage political support for safe motherhood demand-side activities – and finding ways to sustain this interest – is absolutely crucial to the success of these initiatives.
13. Opportunities may have been missed to feed lessons learned from the Jigawa and Kano safe motherhood demand-side experiences into federal level strategies such as the 2007 *National Integrated Maternal, Newborn and Child Health Strategy* and the 2006 *Ward Minimum Health Care Package in Nigeria*. Identifying timely ways to disseminate state level implementation experiences at federal level will require more attention in future.

## List of Resources

A CD-Rom has been produced to accompany this Technical Brief. This contains a number of key resources developed by the Kano and Jigawa safe motherhood demand-side teams. These materials will be important resources for states, local governments and NGOs that are planning to intervene to address the household and community barriers of access to safe motherhood services.

### General

1. Emergency Maternal Care Discussion Guide

### Specific to Jigawa

2. Jigawa Safe Motherhood Demand Side Case Study
3. Jigawa Emergency Transport Scheme Manual
4. Overview of Safe Motherhood Community Mobilisation Approach, Jigawa
5. Jigawa Monitoring and Evaluation Tools

### Specific to Kano

6. Kano Safe Motherhood Demand Side Case Study
7. Kano Emergency Transport Scheme Manual
8. Overview of Safe Motherhood Community Mobilisation Approach, Kano
9. Safe motherhood IEC materials
10. Guidelines for Emergency Safe Motherhood Savings Schemes
11. Kano Monitoring and Evaluation Tools

Electronic copies of materials listed above are available on the PATHS website at [www.pathsng.org](http://www.pathsng.org)



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