Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

## Technical briefs:

# Sharing the lessons learned in Northern Nigeria

The writing of this set of Technical Briefs has drawn on the work of all the PRRINN-MNCH employees and consortium members, and the commitment and contribution of health workers and communities at LGA, state and federal levels. For this we are extremely grateful.
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## Overview

This set of Technical Briefs highlights key achievements from the PRRINN-MNCH programme in Northern Nigeria under one of four streams of work: Governance and systems; Health service delivery; Community engagement and Evidence for decision-making. This is part of a package of materials including a Final Report and a set of Knowledge Summaries.

Covering a population of over 19 million, PRRINN-MNCH was an innovative DFID/Norwegian Government funded programme (2006-2014), established to address these health issues. The consortium managing PRRINN-MNCH consisted of three partners (Health Partners International as lead partner, with GRID Consulting Ltd and Save the Children) as well as several associates.

The programme combined health systems strengthening with routine immunisation and maternal, newborn and child health interventions, merging horizontal and vertical approaches simultaneously. PRRINN-MNCH aimed to revitalize Primary Health Care and improve the availability, quality and utilization of maternal, newborn and child health services, including ante-, peri- and post-natal care, emergency obstetric newborn care, essential care for newborns and infants, young child feeding and nutrition, and routine immunisation against preventable diseases.

PRRINN-MNCH assisted each state (Katsina, Zamfara, Jigawa, Yobe) to achieve significant improvements in health indicators, by supporting many federal, state and local government health systems strengthening and service delivery initiatives, in combination with community engagement efforts.

Independently verified Evidence of significant programme impact includes dramatic reductions in the infant mortality rate, reduced from 90 to 56 per 1000 live births, while the under five year mortality rate was reduced from 160 to 90 per 1000 live births. There was a significant increase in fully immunised children coverage from 2.2% to 19.3% and births attended by skilled birth attendants increased from 11.2% to 26.8%.

Some communities in Katsina are now celebrating two years of no maternal mortality, results that can be directly attributed to the work of PRRINN-MNCH.

PRRINN-MNCH has consistently exceeded expectations and the programme 'made outstanding achievements in a very difficult environment'[1].

1. Duby, Fiona (August 2012) PRRINN-MNCH Annual Review 2011: DFID Report

# Community interventions

## to improve access to maternal, newborn and child health services

### The challenge: barriers to MNCH services

A wide range of barriers prevent rural communities in Northern Nigeria from using maternal, newborn and child health (MNCH) services, including routine immunisation (RI). Baseline studies in Katsina, Yobe, and Zamfara states undertaken by the UK aid and Norwegian Government funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) found the following:

- Poor home-based care of pregnant women and newborns
- Lack of preparedness for safe pregnancy and delivery
- Low use of RI services, and in some areas, outright opposition to immunisation
- Poor male involvement in women's and children's health
- Many physical access barriers that delayed the response to maternal emergencies
- Concerns about the high cost of emergency health care
- Perceptions of poor quality care at health facilities

Child deaths were clustered among a minority of women who lacked social support and respect at household level, making it imperative to find a way to reach these women. Awareness of rights to quality health services was low among rural people, and there were few formal mechanisms that could be used to hold health workers and government to account for poor performance.

*Key messages:*

1. Improving access to MNCH services in rural Northern Nigeria requires a strategy that addresses all household and community level barriers simultaneously.
2. PRRINN-MNCH and its partners scaled up community MNCH interventions to an estimated population of 4.3 million in four years. 'Scalability' was an important consideration from the outset.
3. Restructuring of the health sector so that primary health care is 'under one roof' will help to ensure a properly resourced institutional home for community MNCH activities.

At government level, health managers, administrators and health workers lacked the know-how and resources to address the low demand for services. The lack of attention to demand-side issues in health policies, plans and budgets was an issue.

### The response: a combined approach

PRRINN-MNCH and its partners had to find a way to tackle the wide range of cultural, social, economic and physical access barriers that prevented communities from accessing the services they needed, while at the same time building policy support for these issues within government and the capacity to address them.

The programme had to work on a number of levels:

**Downstream:** within communities, to devise an acceptable and appropriate approach to community engagement (CE) that would increase access to essential MNCH services for all women and children.

**Midstream:** at the interface between communities and health facilities in order to promote increased responsiveness by health workers to community needs.

**Upstream:** with health policy makers and planners to ensure that the community engagement work could be put on a firm and sustainable financial and institutional footing.

At community level a number of interlinked interventions were used to address MNCH access barriers:

**Community mobilisation:**
A participatory community mobilisation approach created demand for MNCH services and promoted effective home-

## Box 1. A problem-solving approach to initiate social change

The community discussion groups were loosely modelled on a participatory action cycle approach. Community members came together to examine a problem and the underlying causes. Facilitated by community volunteers, the groups worked together to find solutions to the problem and to put in place strategies to deal with it. These strategies were later adjusted as necessary. Hence the community volunteers were far more than health educators – they were facilitators of a process of social change.

based care. The approach involved generating community-wide social approval for behaviour change using discussion groups. Involving men and gaining the approval of traditional and religious leaders were important strategies. The community mobilisation process was facilitated by trained community volunteers.

**Community emergency systems:** Communities were supported to set up systems to address access, affordability and other barriers and to ensure that all women could access these. This included: emergency savings schemes; community-based emergency transport schemes; 'mother's helpers' who knew the maternal and newborn danger signs and how to access the community emergency systems; and community blood donor schemes.

**Other community structures:** In some sites, Women's Support Groups and Young Women's Support Groups were established to reach out to women who would otherwise be excluded from participation in community-level change processes.

**Community monitoring system:** A community monitoring system generated data on the activities and changes at community level, including use of the community emergency systems.

To improve links between communities and health facilities, facility health committees were established, building wherever possible on pre-existing village committees. These played an important role in channelling community voices on health issues, demanding accountability for service delivery failures, and supporting and monitoring the community-based MNCH response.

Upstream, local government area (LGA) health departments were supported by PRRINN-MNCH staff to build 'demand creation teams' of key primary health care personnel. Together with representatives of state ministries, including Health Promotion Officers, these teams provided ongoing mentoring and coaching support to communities, ensuring that they were able to turn their increased awareness into action.

The idea was to ensure local leadership for the community-level MNCH response. Both the states and local governments were supported to include community-based MNCH activities in their health plans and budgets, thereby helping to put the work on a sustainable footing.

Considering the complex and challenging implementation environment, it was essential to adopt a flexible approach to implementation. Hence early intervention approaches were adjusted to suit the local context; new components or activities were introduced in response to identified needs as the programme progressed; and over time emphasis was placed on integrating the various components of the strategy.

## The results: increased use of MNCH services

### Coverage

By September 2013 PRRINN-MNCH was supporting community engagement activities in 2,400 communities in 45 LGAs in Katsina, Yobe and Zamfara states, covering an estimated population of 4.3 million. Some of these communities received direct support from PRRINN-MNCH and its partners, while others benefited from a process of local dissemination, where community volunteers in the original sites shared what they knew and their emergency systems with neighbouring communities.

56% coverage with community engagement activities was achieved in Katsina intervention LGAs, 40% in Yobe, and 39% in Zamfara over three years.

The community interventions were first piloted in nine LGAs for 18 months. Over the next 17 months, 36 new LGAs were added. The creation of a core group of community engagement trainers in each state, use of a cascade training approach, adoption of a community health volunteer approach and a strategy of local dissemination, enabled the activities to be scaled up rapidly.

### Behaviour change

A household survey tracked knowledge and changes in behaviour in the three states between 2009 and 2013:

- Antenatal care use rates increased from 25% to 51%
- Skilled birth attendance rates increased from 11% to 27%
- Women with permission to get health care for a sick child increased from 40% to 83%
- Children who had received DPT3 vaccine increased from 5% to 42%

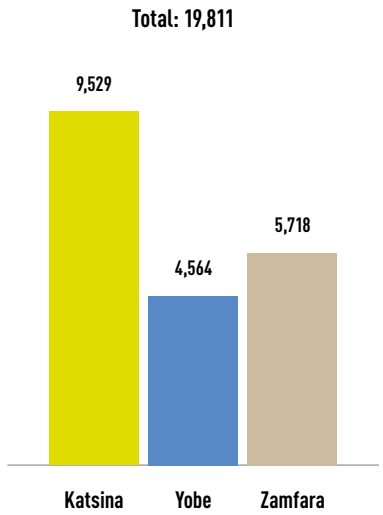
Young Women's Support Groups, established to reach and support hard-to-reach women, had a positive effect on health-related knowledge and practice. A knowledge, attitudes and practices (KAP) survey in 2013 found that members of these groups were more likely than non-members to:

- Know four or more maternal danger signs
- Know when to put a newborn to the breast for the first time
- Give birth in a health facility
- Know the correct immunisation schedule
- Have the complete set of vaccinations

Data generated by the community monitoring system provided further

evidence of behaviour change. Community emergency systems were well used. Just under 20,000 women with a maternal complication were supported by community emergency transport schemes between December 2009 and September 2013 (Fig 1).

**Fig 1: ETS transfers by state, Dec 2009 – Sep 2013**




Almost 20,000 women across the three states were helped by ETS drivers.

Intervention communities saved ₦39 million (UK £157,000) to support women with maternal emergencies, and just under 9,000 women (52% of reported maternal complications) were assisted by these schemes. 4,337 women, a quarter of all women reporting a maternal complication, were supported by community blood donors. Use of these schemes helped to avert many potential maternal and newborn deaths.

Hence communities were proactively identifying maternal danger signs and referring women for urgent treatment. The results contrast with the relatively low increase in knowledge of four or more maternal danger signs reported in the PRRINN-MNCH 2013 household survey (from 10% to 33%). This may have been something to do with the design of the survey: this question required enumerators to wait while respondents recalled what they had learned. Time pressures may have resulted in enumerators not doing this.

## Challenging service delivery failures

A 2013 review of the PRRINN-MNCH-supported facility health committees found that they were meeting regularly, had maintained their membership, had matured over time and were functioning across the breadth of their remit.

Despite refresher training which focused specifically on improving the quality of women's participation on the committees, the review also identified ongoing gaps in women's visibility and voice on these committees. PRRINN-MNCH will focus on how to address this in its final phase of operations.

### Box 2. Government successfully challenged by a facility health committee

In Maska community, Funtua LGA, Katsina state, there were numerous complaints by ANC clients of abuse and insults from the midwife posted to the community. The review team was informed that the midwife instructed women not to seek care from her without having a bath and wearing perfume. The FHC made several attempts to reprimand her but she remained adamant.

The FHC eventually raised the issue with the Village Head who personally led a team to the LGA Chairman to register the complaint. The erring health worker was instantly transferred and replaced by another midwife.

In some areas the committees were inviting all individuals responsible for community health – the 'Community Health Team' – to their meetings so that the different activities could be co-ordinated. The committees also challenged government about service delivery failures. In the past, many attempts to demand improvements in health services from government had fallen on deaf ears. By 2013, many of the committees were able to share advocacy efforts with positive outcomes (Box 2).

## Extent of institutionalisation

By September 2013, community interventions to improve MNCH were included in state strategic health plans and budgets, demonstrating the states' commitment to addressing demand-side MNCH barriers. At local government level, demand creation teams had accrued substantial capacity to oversee and monitor community-level MNCH activities.

Each LGA had master trainers with the capacity to oversee further expansion of the community engagement work to

new parts of the LGA. Nevertheless, as the programme drew to a close, few of the LGAs had committed funds to sustain or expand the community engagement work after the end of PRRINN-MNCH.

The experience in Katsina, Yobe and Zamfara states contrasts with Jigawa state, where PRRINN-MNCH community-level interventions had focused on RI rather than a broader safe motherhood agenda. This state had undergone a process of health sector restructuring, where the previously fragmented system had been replaced with a system that put 'primary health care under one roof' (PHCUOR). The Gunduma health system councils established to run health services in different parts of the state received regular funds for community MNCH interventions, and institutional responsibility for demand-side health activities within the councils was clear.

## Policy implications

The PRRINN-MNCH community engagement approach had many positive effects on MNCH-related knowledge and behaviour. By September 2013, there were signs that the intervention sites were on the cusp of a more substantial shift in health-seeking behaviour. The high use of community systems for maternal emergencies, the fact that these systems had been sustained for up to four years in some sites, the reports of reduced maternal and newborn mortality from communities and the increasing use of emergency transport schemes to support normal deliveries suggest that the foundations for change had been built.

By September 2013 some aspects of the community engagement approach needed more time to 'bed in'. For example, after a year, the Young Women's Support Groups had not reached the level of coverage necessary

to ensure that all under-supported young women in the community had been reached (these groups were initiated part-way through 2012). A longer implementation time frame, and a sustained emphasis on inclusion at community level, will be required to ensure complete coverage. The facility health committees also required more support so that they create space for female members to participate fully.

PRRINN-MNCH's experience to date suggests the following:

**Working at scale:** PRRINN-MNCH and its partners achieved a population coverage of 4.3 million in three states in four years – 45% of the entire population of the intervention LGAs. The size of the states means that there is some way to go to achieve state-wide coverage. The methodologies used by the programme and its partners – a community health volunteer model, a cascade training approach, and a strategy of local dissemination to neighbouring communities – are inherently 'scalable'.

**A comprehensive approach:** For MNCH behaviour to change in rural communities all demand-side barriers need to be addressed simultaneously in a comprehensive approach. Standalone interventions such as emergency transport schemes are unlikely to work effectively unless other barriers are addressed at the same time.

**Minimum package of interventions:** So that policy makers have the evidence that they need to scale up at state level, more work needs to be done to clarify and cost the minimum package of interventions needed to stimulate MNCH behaviour change. PRRINN-MNCH will be focusing on these issues during its final phase of operations.

**Institutional home for demand-side MNCH activities:** Health sector fragmentation is likely to continue to undermine efforts to place demand-side MNCH activities on a sustainable institutional footing in future. Without a shift to 'primary health care under one roof', local governments are likely to find it difficult to adequately resource and support the community MNCH response. Institutional responsibility for community-based MNCH activities needs to be clarified, adequate staff need to be in place to support these activities, and an appropriate amount of funding needs to be allocated if these activities are to be sustained over time.

## Conclusion

PRRINN-MNCH demonstrated that it is possible to devise an effective and culturally appropriate community engagement approach to address demand-side MNCH barriers in a challenging environment. Communities in the PRRINN-MNCH sites recognised the short and long-term health and other benefits to be derived from the community systems they have established and are likely to try to sustain these.

Establishing a clear institutional home for these efforts within government will be vital going forward – and will be facilitated by wider health sector restructuring efforts.

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# Adjusting health strategies

## to include women and children with least social support

*Key messages:* **Child mortality is clustered among a small proportion of women in rural communities in Northern Nigeria. Lack of individual social support is a key factor driving the skewed burden of ill health.**

1. Health programmes that ignore issues of social support may exacerbate divides among the poor and are likely to make slow progress towards achievement of maternal, newborn and child health targets.
2. A comprehensive and holistic approach to primary health care in Nigeria would place greater emphasis on social factors alongside improvements to service delivery.

## The challenge: finding evidence of clustering

Demographers have shown that in a variety of contexts child deaths tend to cluster among a few mothers (Das Gupta, 1997; Edvisson et al, 2005; Guo, 1993; Madise and Diamond, 1995; Meegama, 1980). Yet the reasons for the clustering are generally not well understood. As a result, health policy makers and programme staff lack information on how to respond appropriately.

The term 'clustering' is used to describe the skew of distribution of deaths to a particular part of a population – the skew implying that the distribution is not random.

The UK aid and Norwegian Government funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) was established to strengthen government capacity to provide quality maternal, newborn and child health (MNCH) services and to increase their use. In 2008 when the programme began, reliable evidence that clustering of mortality occurs in the northern states did not exist since the issue had not been investigated in surveys and studies.

A view that rural people were equally affected by service delivery failures and had equally poor access to health information and services was predominant among policy makers, based on a perception of generalised poverty across communities. So that health inequities could be better understood in the Northern Nigerian context, PRRINN-MNCH set out to fill the gap in the evidence base.

## The response: survey on extent of support

A child mortality clustering survey in Jigawa, Yobe and Zamfara states in 2009-10 was implemented in rural areas supported by PRRINN-MNCH and focused on communities that were uniform in their overall cultural, employment and wealth patterns. Most families had the same religion, level of education and household assets. Within each village studied, all the women who had had at least one live birth were surveyed – a total of 1,688 women.

It has long been recognised that the extent of social support and security have an enormous influence on health, and hence a variety of measures of support were examined as part of the survey. The survey looked at:

- Cognitive support (information and advice)
- Emotional support (support after quarrels, support in decisions)
- Practical support (child care, food preparation, household chores)
- Financial support (money, in-kind payments)

Survey respondents were asked about the extent to which the various types of support were given by co-wives, husbands, in-laws, their own relatives, adult children and outsiders. Women were also asked about the extent to which they felt respected by each of these groups. The appearance of the household, of the women themselves, and of their children, were assessed subjectively.

## The results: mortality clustered among least-supported women

The survey found that the burden of mortality and morbidity was indeed skewed in rural parts of Jigawa, Yobe and Zamfara. A small proportion of mothers and children suffered poor health and rarely used services. The skew happened irrespective of proximity to health facilities, poverty, level of education or household composition. The skew was very striking: 80% of child mortality was suffered by 20% of women. These women suffered multiple child deaths – an average of three deaths each (Fig 1).

THIS DOCUMENT IS ONE OF A SERIES OF TECHNICAL BRIEFS THAT DRAW ON THE ACTIVITIES, RESULTS AND LESSONS LEARNED FROM THE PRRINN-MNCH PROGRAMME

**65% of women in the survey sites had no child deaths, despite the fact that their general environment was so poor.**

If a relationship between poverty and child deaths exists, the expectation is that all women in a household will be similarly affected. To test this assumption, the survey examined whether clustering occurred within polygynous households. Clustering was indeed found to exist. In many households one of the wives suffered all (or nearly all) the child mortality, while the others had no deaths.

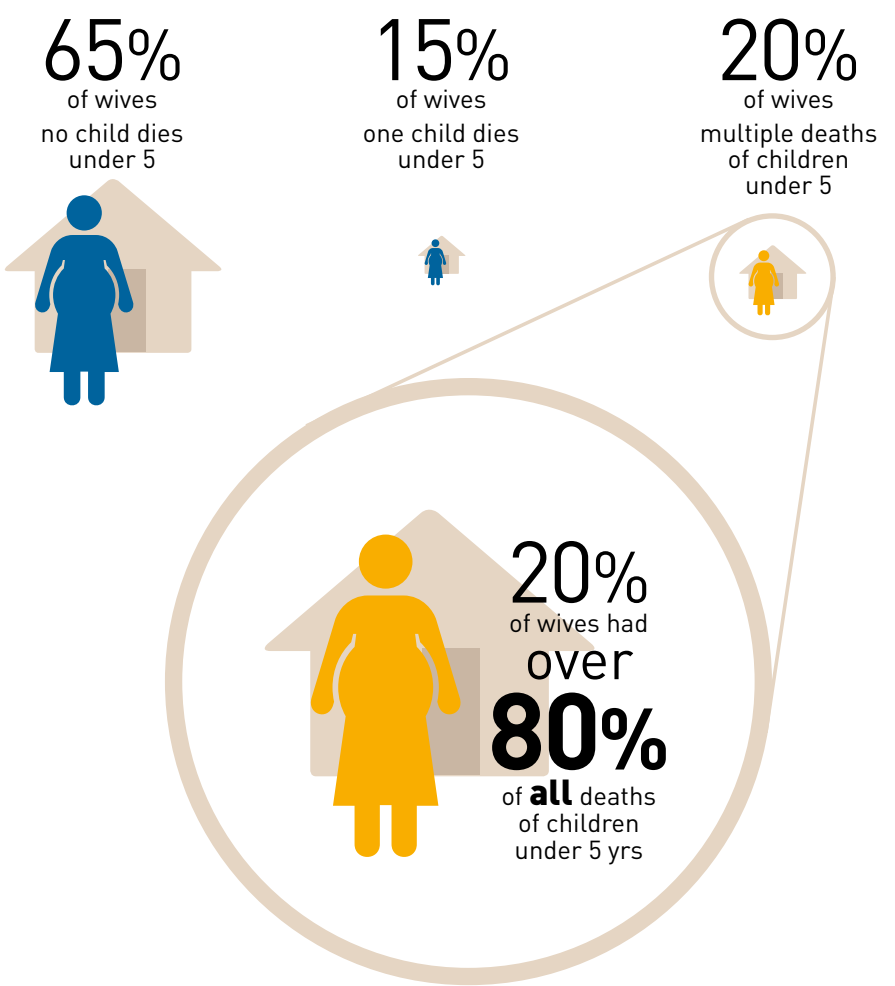
The survey also showed that within compounds of related families some of the families suffered child deaths while others did not. The clustering within compounds and polygynous families suggests that generalised socio-economic factors that affect the entire population (eg lack of education, lack of wealth, lack of resources, culture, beliefs) play a lesser role in explaining child deaths than the immediate social factors surrounding a woman.

In the survey sites, the likelihood of having any child deaths was strongly related to six factors:

- The woman rarely or never had anyone older to look after the children
- The woman had no-one to turn to for support if her children had difficulties
- The woman had no-one to turn to for support if she herself had difficulties
- The woman believed she had no or little respect from relatives, in-laws, husband or others
- The woman had almost no general support from her own relatives and in-laws
- The general appearance of the woman, the children and the household were very poor

Fig 1: Clustering survey findings

20% of women suffered 80% of child deaths.




## Implications for policy

The basic mechanisms through which social determinants impact on health are not simplistically related to poverty. Among societies that are generally poor, or which have poor access to amenities, services and opportunities, the 'moral economy' provides a very large part of the support needed to sustain life, health, functioning and security.

'Moral economy' refers to the agreements and support at community level that sustain life.

It is striking that such a large proportion of women in the study sites (65%) had no child deaths even though their general environment was so poor. The strong correlation between the appearance of the household, the woman, the children and the number of child deaths was both an indicator of lack of support and of the woman's mental health.

This is consistent with the findings of other studies that have linked mothers' mental health to child health (Ingram, 2003; Lanata, 2001; Lund, 2010).

Addressing the skewed burden of ill health in rural Northern Nigeria requires a change in primary health care strategy towards a more comprehensive and holistic approach which places greater emphasis on addressing the social factors that affect health. Practical steps taken by PRRINN-MNCH to address health inequities include:

**Supporting participatory group processes:** There is a growing body of evidence to suggest that participatory group processes can help improve both self-confidence and mental health and hence maternal and child health (Kawachi and Berkman, 2001; Campbell et al, 2004; Proust et al, 2013).

PRRINN-MNCH placed considerable emphasis on the formation of women's groups and on ensuring that the least-supported women were included in these. In many settings, the effect of group membership has proved to have a variety of positive effects for those who stay with a group. These improvements include: personal appearance and hygiene; care of self, children and family; communication with partners; improved mental health; and improved respect for others. Young women's support groups (YWSGs) in communities supported by PRRINN-MNCH are showing similar benefits.

**Training of front-line health providers:** In Europe and the USA there has been considerable emphasis recently on the training of health staff to consider the social background of people and to modify their communication and advice accordingly. This has been shown to impact positively on the self-esteem and ability of women to look after themselves and their children.

Health workers in Nigeria are not trained to take into account the social factors that affect health-seeking and decision-making or adherence to treatment. PRRINN-MNCH therefore worked with government partners to modify the training of a core group of front-line health workers – community health extension workers (CHEWs) – so that they were better able to recognise and interact with the least-supported women.

**Sensitisation of community health team:** PRRINN-MNCH developed the concept of a community health team where all those working to improve the health and well-being of the community were trained to have a strong focus on the least-supported.

**Working with religious leaders:** Religious leaders have considerable influence in rural Northern Nigeria and operate very effectively as mass communicators. PRRINN-MNCH involved religious leaders in the analysis of the clustering survey findings and worked with them to identify steps that could be taken at community level to address social exclusion and lack of support.

**Adjusting surveys:** PRRINN-MNCH ensured that any surveys that examined knowledge, attitudes and practices relating to health and health services included a methodology for analysing levels of support, social inclusion and the respect people feel they receive from others. The programme also advocated for government and other organisations to organise health-related surveys based on social factors.

*"A woman who is under-supported joined the group lately. She was always dirty together with her child. In fact she only tied a wrapper around her chest. But she has changed now, wears a dress, washes her child when coming to meetings, and participates a lot."*
*[Member of a Young Women's Support Group, Jigawa]*

**Adjustments to monitoring and supervisory processes:** Monitoring and supervisory processes for initiatives focused on increasing community demand for services were revised so that they were able to track the inclusion and level of participation of the least-supported women in group and other community processes.

**Advocacy to government:** Advocacy to government focused on the need to address social issues as part of a comprehensive and holistic approach to primary health care.

## Conclusion

Social issues at community and family level contribute to the inequities in health that result in high levels of maternal, newborn and child mortality in Nigeria. The failure to identify and address these distinctions within poor populations has important consequences and has stalled progress towards achievement of health targets.

PRRINN-MNCH has been increasing its use of social analysis since 2008 to ensure that the women and children who suffer a disproportionate burden of ill health are considered in all programme activities. Many of the practical strategies adopted by the programme can easily be replicated by government, civil society organisations and development partners.

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# Community emergency transport

## schemes for prevention of maternal mortality

*Key messages:* **Community-based emergency transport schemes (ETS) fill a crucial gap in the referral chain by transporting expectant mothers to health facilities cheaply and efficiently.**

1. The lives of thousands of women and babies have been saved in all three intervention states.
2. ETS has the potential to be scaled up nationwide under the leadership of the NURTW (National Union of Road Transport Workers).
3. Community-based ETS works best when implemented as part of a comprehensive strategy which addresses key MNCH barriers simultaneously.

## The challenge: travel is hard

Long distances to health facilities, difficult terrain and the absence of affordable transport options are major challenges for remote, rural communities in the north of Nigeria. Efforts to transfer pregnant women with complications commonly fail where transport is not available, where money cannot be found to pay for it, or where seasonal factors make the terrain impassable. Lack of security – in general or at night – adds a further challenging dimension. All these factors can result in long delays in women reaching vital health care.

Getting timely help when a maternal emergency occurs is vital. The estimated average interval between onset of an obstetric complication and death in the absence of medical intervention is just two hours in the case of a post-partum haemorrhage (bleeding after delivery), 12 hours for an antepartum haemorrhage (bleeding after 24 weeks of pregnancy and before delivery), and one day for a ruptured uterus. Hence, some modes of transport, such as oxen and carts or bicycles, may be too slow to use in addition to being uncomfortable. In too many cases, the lack of suitable transport options for women suffering a maternal complication has tragic consequences.

## The response: recruiting local drivers

In 2010, the three northern states of Katsina, Zamfara and Yobe working in partnership with UK aid and the Norwegian government funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) identified the lack of affordable rural transport options as a major cause of the high maternal and newborn mortality rates. Community-based emergency transport schemes (ETS) were established, building on previous emergency transport initiatives in the north, including a small-scale initiative in Kebbi state implemented with the support of the Prevention of Maternal Mortality Network in the 1990s, and schemes established between 2003-8 in Kano and Jigawa states with the support of the Partnership for Transforming Health Systems 1 Programme (PATHS 1).

The ETS model used a locally-available mode of transport – passenger transport vehicles driven by commercial drivers belonging to the National Union of Road Transport Workers (NURTW). The NURTW, which registered as a trade union in 1978, has a network of branch offices covering the entire country. Even remote communities in the north usually have access to cars driven by NURTW drivers; if not, cars can usually be found in neighbouring communities. It therefore made sense to work with what was already on the ground.

**Community emergency transport schemes address the weakest link in the referral chain – that of communities to health facilities.**

State and local government NURTW officials in Katsina, Yobe and Zamfara readily agreed to work in partnership with PRRINN-MNCH and proactively contributed to the design of an ETS model that suited their context. Officials from the union were trained as core trainers and cascaded the driver training down through the PRRINN-MNCH communities. Local branches of the NURTW provided supervisory support and encouragement to the drivers and special incentives – such as priority loading for ETS drivers at motor parks – were provided in some areas.

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## Box 1. How the ETS worked

Four drivers are trained in each community. This helps ensure that the ETS is operational '24/7'. Drivers are notified as soon as a maternal danger sign is recognised. The woman is carefully helped into the car and helped to sit or lie depending on what position is most comfortable. The driver leaves the community as soon as possible, taking both the woman and her carers to the nearest health facility that is equipped to deal with maternal emergencies. The drivers then wait at the facility for further instructions.

The cost of the transfer is kept to an absolute minimum with drivers encouraged to seek recompense for the cost of the fuel only. To reduce transfer delays, fuel is kept in the community at all times. Drivers are issued identification (such as T-shirts, hats, ID cards or car stickers) to assist their passage through road blocks or security check-points.

## Results: ETS saving lives

As of September 2013, community-based ETS schemes had been established in 806 intervention sites in 45 local government authorities (LGAs) in three states. These were sites that had received a comprehensive package of support from PRRINN-MNCH. As well as supporting their own communities, the volunteer community health workers and drivers were encouraged to roll out their activities to as many neighbouring communities as possible. This resulted in the inclusion of a further 1,592 communities.

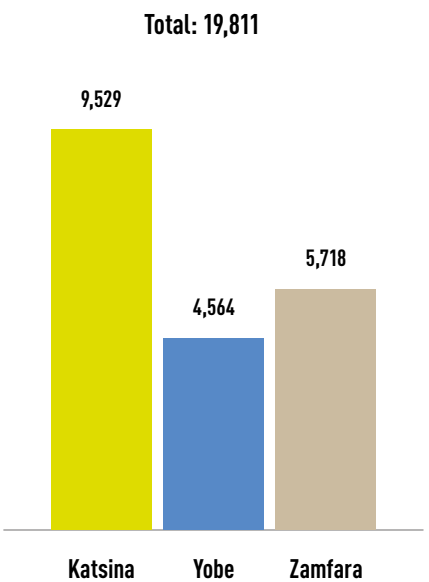
*"At certain times of the year you have to wait for the river to stop flowing before you can cross. If it is urgent to cross, you have to carry a woman on your shoulders or back. If the river is fast-flowing there are hefty men who help people cross the river. We have had three instances in 2007 and 2008 when people were swept away. Once you have crossed the river, you need to hire a car or motorbike..." (Katsina)*

Some of the new communities established their own ETS, while others used the ETS drivers in the original sites. Hence by September 2013 the population covered by ETS was an estimated 4.3 million. Approximately 3,200 ETS drivers were trained. Many of these drivers cascaded their training to other drivers in the community, increasing the pool of drivers who could be called upon.

Between December 2009 and September 2013, 19,811 pregnant women were transferred to a health facility by trained ETS drivers in Katsina, Yobe and Zamfara states (Fig 1). The majority of these transfers were for maternal complications. Hence the ETS drivers played a vital role in helping to prevent maternal and newborn deaths.

PRRINN-MNCH had exceeded its end of programme target of 5,000 ETS transfers four times over by September 2013.

**Fig 1: ETS transfers by state, Dec 2009-Sep 2013**




ETS transfers helped to save women and their babies in all three states.

ETS helped to reduce the cost of emergency transport for communities. A 2012 PRRINN-MNCH study compared costs before and after the introduction of ETS. The average reduction in the cost of transport ranged from 41% in Katsina to 70% in Zamfara.

ETS was welcomed and highly valued by rural communities, with many examples of women who had been assisted by the schemes readily shared by community members (Box 2).

The driver training included a strong emphasis on reaching and assisting socially excluded or vulnerable women. A 2012 review of the ETS found that a concern for the least-supported women was reflected in the attitudes and actions of many of the ETS drivers. In Yobe, for instance, ETS drivers assisted people from neighbouring Fulani communities, which had traditionally been marginalised.

*"Now families take their sick ones to the hospital because they have structures in the community they can rely on."*
*[Community member, Yobe]*

*"Last year, one Fulani man and his wife came here to stay during the dry season and if not for the group the woman would have been dead. The problem was prolonged labour. The family are poor with no relatives in the community. They cannot pay for the transport or medical bills. This was known to all in the community. The community volunteers supported the family.*
*The family were assisted with funds from the community savings and an ETS driver transported the woman to the health facility."*
*[Community member, Yobe]*


*"Everyone knows that ₦500 is the cost to use the ETS and that is cheap compared to other drivers that one can pay an average of ₦2,000 to." [Female community volunteer, Katsina]*

*"What we enjoy the most is for families to come to us and ask for help. We thank the Almighty for that." [ETS driver]*

## Policy implications

The ETS initiative has excellent prospects for being sustained at community level once PRRINN-MNCH withdraws. By 2013 the scheme was well-known at community level. A knowledge, attitudes and practices survey in 2013 found that 77% of respondents in Yobe, 71% in Katsina and 60% in Zamfara knew of someone who had been helped by the ETS. There was a high level of community support for the scheme, with widespread recognition of its value, its role in saving lives, and its reliability as a safety net for pregnant women:

A 2012 volunteer survey by PRRINN-MNCH found that 56% of ETS drivers were motivated primarily by a wish to "help others and save lives"; 12% primarily by religious obligation; and 19% by the training they had received. Driver drop-out rates were low and the majority of drivers stated their intention to continue their ETS activities. This bodes well for the

### Box 2. ETS beneficiaries – their stories

"In Kurnawa community, there was a time an ETS driver loaded passengers and goods and was heading to the market. His attention was called to help a woman with prolonged labour. He excused the passengers and said to them, this is his special assignment. He then offloaded the passengers. He travelled back to the community and immediately put on his Haihuwa Lafiya cap [hat for ETS drivers] and his T-shirt and rushed her to the hospital within 30-40 minutes. The woman delivered with the assistance that she got in the facility."
[Local government officer, Busari LGA, Yobe ]

"Mararіya Isa delivered at home and had a retained placenta: the husband was away from home. The chairman of the community volunteers was informed and he organised taking the woman to hospital. The chairman called an ETS driver and community volunteers accompanied the woman to Daura General Hospital. This was the first beneficiary of the ETS work."
[Village head, Yardaje, Katsina]

future sustainability of the ETS.

In July 2012, PRRINN-MNCH formalised its partnership with the NURTW by signing a memorandum of understanding. Subsequent support to the NURTW focused on ensuring that the ETS remains viable and sustainable. An ETS planning team was formed at the NURTW national head office, a signal that the NURTW was ready to assume leadership of the scheme.

An ETS driver training manual, produced with PRRINN-MNCH's support, was launched by the NURTW in November 2013 and will be used as a national training resource. A plan for building the capacity of state and local government NURTW branches was put in place with the aim of addressing weaknesses in NURTW's supervisory and monitoring role.

Improved monitoring and supervision of ETS activities at state level and below will help maintain driver motivation and will be essential for providing robust evidence of ETS performance.

With PRRINN-MNCH's support, a strategy for scaling up ETS was devised in 2013. The scale-up plans attracted funding from the federal SURE-P initiative and plans are underway to roll ETS out to eight new states plus the Federal Capital Territory.

The success and sustainability of the next phase of implementation depends to a large extent on the degree to which ETS is embedded within a wider process of community mobilisation on MNCH issues. A stand-alone transport solution may be ineffective unless other barriers are addressed simultaneously at community level.

Government recognition that ETS is a key component of a functioning health referral system will help to sustain the scheme. Recognising NURTW as an essential partner in state efforts to improve MNCH will also be important.

## Conclusion

In three PRRINN-MNCH states ETS helped to avert numerous maternal and newborn deaths. Hence the scheme is making an important contribution to state safe motherhood efforts.

A future priority, already underway in the PRRINN-MNCH-supported states, is expanding access to the ETS for all women seeking to deliver at a health facility. Institutional deliveries are unlikely to increase at the desired rate unless rural physical access barriers faced by all pregnant women are addressed.

PRRINN-MNCH

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

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# Working with volunteers

## to improve maternal, newborn and child health

*Key messages:* **Volunteering is a valuable asset, putting local knowledge, skills, dynamism, creativity and a concern for others to good use.**

1. Well designed and managed community volunteer programmes can be effective and sustainable, with benefits that extend beyond the health sector.
2. Programmes that help volunteers to address the social determinants of health complement health services and medically trained health providers. The concept of a 'community health team' is gaining traction in Northern Nigeria.
3. Finding the best ways to reward community volunteers is vital in high poverty contexts. Communal rather than individual incentives may protect the volunteer effort and provide an alternative to putting volunteers on salary.

## Context and challenge: community volunteerism faces many barriers

Volunteer health programmes are promising because they are grounded in relationships of trust, solidarity and reciprocity at community level. Nigeria has a long and impressive track record of health-related volunteers, where ordinary people willingly give their time to help others. Volunteering is a valuable asset, providing a means to put local knowledge, skills, dynamism, creativity and a concern for others to good use. But for volunteer programmes to work effectively, particularly on a large scale, they need to be well designed and carefully managed. (Ludwick et al, 2013; Bhattacharyya et al, 2001). [1,3]

The UK aid and Norwegian government-funded Programme for Reviving Routine Immunisation and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) has since 2008 supported one of the largest and longest-lasting community health volunteer initiatives in Northern Nigeria covering three states (Katsina, Yobe and Zamfara). This document describes the work of the volunteers and the impact they had in the PRRINN-MNCH states and considers whether some common concerns about volunteer programmes – high drop-out rates, high opportunity costs, and poor motivation – apply there.

At the start of the PRRINN-MNCH programme, many barriers prevented communities using MNCH services. These included:

- Lack of awareness of newborn and maternal danger signs
- Families unprepared for safe pregnancy and delivery
- Lack of information on routine immunisation services and motivation to use them
- In some places opposition to immunisation from husbands and religious leaders
- Lack of male involvement in women's health
- Deep-seated concerns about the quality of care at health facilities
- Physical and financial access barriers which delayed the response to maternal emergencies

Routine immunisation rates were low; institutional delivery rates were extremely low; and frequent failures to respond to maternal health emergencies resulted in high maternal and newborn death rates.

## The response: training volunteers to help themselves and raise community awareness

Between 2010 and 2013 PRRINN-MNCH and its government partners trained 30 community health volunteers per community in 806 intervention

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sites in 45 local government areas in Katsina, Yobe and Zamfara states. The volunteers were trained to build social approval within the community for MNCH-related behaviour change. This primarily involved:

- Raising awareness of maternal, newborn and child health and routine immunisation
- Support for the establishment of community systems to make care more accessible and affordable
- Setting up community monitoring systems so communities could track changes in their area.

The training used simple participatory methods and tools to help volunteers learn key facts and train others in an engaging way. It was supported by a structured programme of coaching and mentoring support so the volunteers could apply what they had learnt, and to help maintain their motivation. Approximately 24,000 community health volunteers were trained over three years.

The volunteers focused initially on the MNCH situation in their own communities. Participatory community discussion groups allowed ordinary people to reflect on the challenges they faced and consider what could be done to improve women's and children's health. With the help and encouragement of the volunteers, many communities went on to establish community systems to address the key barriers that they faced in accessing services. These included:

- Community emergency transport schemes
- Blood donor schemes
- Emergency savings schemes
- A system of mother's helpers

These systems enabled pregnant women with a complication to access health services without delay, so the volunteers quickly saw the positive impact of their work. Motivated by a new-found confidence that they really could make a difference, some of the volunteers went on to share what they knew with neighbouring communities, increasing the total number of intervention sites reached in Katsina, Yobe and Zamfara to 2,398.

**Communities supported by community health volunteers increased by 200% in two years at no cost to PRRINN-MNCH and its government partners.**

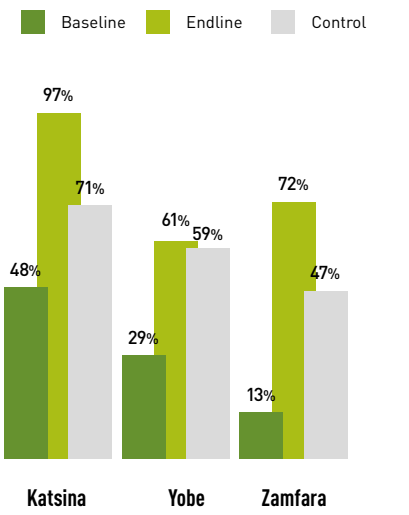
PRRINN-MNCH and its government partners also trained volunteer drivers from the National Union of Road Transport Workers (NURTW) to establish a community-based Emergency Transport Scheme (ETS). This provided 24-hour emergency transport cover at the lowest possible cost. The service was vital in a context where few alternative transport options existed for rural communities. Training of 3,200 drivers in Katsina, Yobe and Zamfara states focused on:

- The 'three delays' that prevented women from reaching care quickly: delay in seeking care; delay in reaching care; delay in receiving appropriate care at the health facility
- How the ETS worked
- Appropriate handling of pregnant women and their carers
- Communicating with health providers
- How to report on ETS activity

Once trained, these drivers went on to train other drivers in their own and neighbouring communities.

**NURTW drivers who trained as emergency drivers went on to train many additional drivers who all gave up their time to save women's lives.**

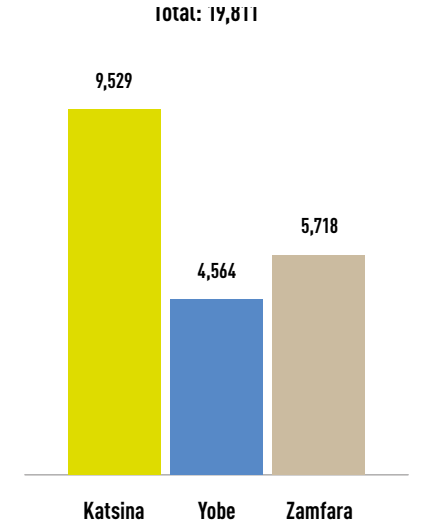
### Fig 1: Women with plan for maternal emergency (current/recent pregnancy)




*Source: PRRINN-MNCH KAP surveys (PRRINN-MNCH, 2013a)*

More women are now making plans in case they suffer a maternal emergency.

### Fig 2: ETS transfers Dec 2009 - Sep 2013




*Source: PRRINN-MNCH community monitoring system data 2013b*

The increase in transfers by volunteer drivers helped avert many potential maternal deaths.

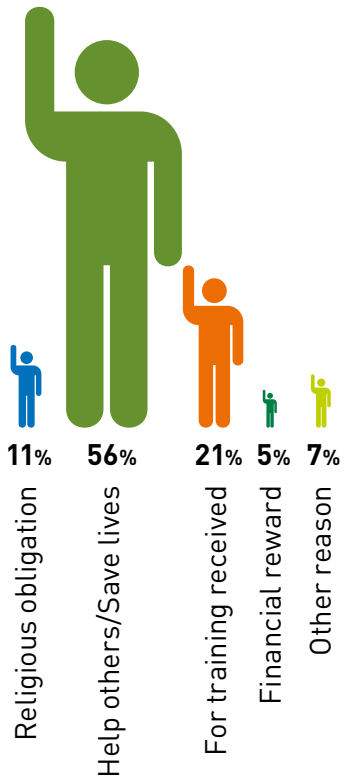
### Fig 3: Percentage of children never immunised

*Source: PRRINN-MNCH KAP surveys (PRRINN-MNCH 2013a)*

| | Baseline | Endline |
|---|---|---|
| **Katsina** | 75 | 33 |
| **Yobe** | 80 | 48 |
| **Zamfara** | 83 | 37 |

Increased skilled birth attendance rates have led to a dramatic fall in children who have never been immunised.

### Fig 4: The main motivation for volunteering




## Results: communities are better prepared for issues in pregnancy

Significant positive changes in health-seeking behaviour happened as a result of the work of community health volunteers. A knowledge, attitudes and practices (KAP) baseline survey in Katsina, Yobe and Zamfara in 2011 and followed up in 2013 (endline) found that communities were now far better prepared for a maternal emergency (Fig 1).

Between December 2009 and September 2013, 19,811 ETS transfers were recorded by the community monitoring systems in the three states. Most were women with a maternal complication. The volunteer drivers therefore helped to avert many potential maternal deaths (Fig 2).

A household survey by PRRINN-MNCH in 2013 (following a baseline survey in 2009) found that skilled birth attendance rates increased from 11% to 24% in Katsina, Yobe and Zamfara states. There were also dramatic falls in the proportion of children who had never been immunised (Fig 3).

## Implications for policy: volunteers can promote self-help within communities

Some critiques of volunteer community health worker approaches suggest they are incompatible with the drive to professionalise the health workforce. However, initial baseline assessments highlighted the many barriers that prevent women and their families using essential MNCH services – and the need for solutions that extend beyond improved service delivery.

Salaried community health worker schemes often fail to stimulate the necessary changes in MNCH social norms since they usually rely on a single trained health worker per community. Where health budgets are severely constrained, training a larger group of community health workers is usually not feasible.

**PRRINN-MNCH research found that communities with active community health volunteers and ETS drivers improved some newborn and child health indicators just as much as communities with both volunteers and community-based service delivery.**[2]

Other critiques claim it is wrong to treat community members as cheap labour that is used to fill gaps in service provision. In the PRRINN-MNCH intervention sites the community activities were designed to reignite the concept of self-help. Far from being an 'instrument' of the health system, community health volunteers focused

on building capacity and confidence so each community could devise their own strategies to address MNCH challenges. It was expected that this would lead to sustainable changes in social norms and behaviours.


**Sustaining payments to lay community health workers may not be possible for governments operating with constrained health budgets.**

Positive changes in health-seeking behaviour inspired by PRRINN-MNCH volunteers confirm that the volunteer model is both appropriate and effective. But if the approach is to be scaled up further in Nigeria, it is important to examine three key issues:

- What motivated the volunteers to work so hard in support of their communities?
- What aspects of the volunteer approach contributed to its effectiveness?
- What are the prospects for sustaining the work of the volunteers in the long-term, particularly beyond the end of an externally funded programme?

A 2012 study in Katsina, Yobe and Zamfara answered the question of motivation and gave some insights into the others (Fig 4). More than half the community health volunteers and ETS drivers were primarily motivated by a concern to help others and save lives (55% and 56% respectively).

The second most important motivating factor was the training that the volunteers received from PRRINN-MNCH and its partners at state and LGA levels (24% and 19% respectively). A further 12% of ETS drivers and 10% of community health volunteers said they were motivated by religious obligation. Very few volunteers mentioned financial incentives as their main motivation for joining the programme.

The volunteer research also looked at how much time was spent by volunteers on MNCH-related activities. Just over 65% of the community health volunteers spent two hours or less per week – many argued that they could easily fit their volunteering obligations around their other activities.

However 66% of the ETS drivers, spent two hours or more per week on voluntary work. Most of them also argued that they were fully prepared to fit their voluntary work around their other activities.

Another criticism of volunteer community health approaches is that they suffer high attrition rates and hence their effectiveness may be short-lived. But research found the opposite, with markedly low attrition rates: 1.5% in Zamfara, 0.3% in Katsina, and 14% in Yobe.

In all three cases the volunteers had been working for 2-2.5 years. The higher attrition rate in Yobe is not unexpected considering the high level of insecurity in this state which has had a devastating effect on volunteers' ability to move around their communities, and which has undermined local livelihoods.

Depending on the state, between 96% and 100% of volunteers said they intended to continue their voluntary work. This bodes well for the future sustainability of volunteer activities. It may be that an early emphasis on the voluntary nature of the work helped to sift out individuals who might have been more motivated by financial gain.

In all the states, research identified that individuals who "live from hand to mouth" – casual workers, including those who had to travel to find work – were unlikely to be able to volunteer.

**Several factors contributed to the effectiveness of the volunteer approach, including:**

**Quick, visible impact:** Community mobilisation began with a focus on safe motherhood. This is a very emotive issue and the results of community mobilisation efforts were usually visible immediately as maternal delays were addressed leading to fewer deaths of mothers and newborns. These quick impacts acted as a major stimulus for the community volunteers to continue their work.

## Voices of community volunteers in the PRRINN-MNCH states

*"I stick to the programme because of the training I received. The training has shown that I have something to share with my community; also, I am encouraged by the appreciation shown by the community. Our work has spread to neighbouring villages. Helping the community is the most important thing to me because I have seen that the community complies. They go for routine immunisation and that makes me very happy."*

*"I will work as a volunteer forever. Apart from sickness or if I travel out of the community."*

*"I will continue to be a volunteer until the end of my life."*

*"Volunteerism is good and God rewards good."*

*"Day and night, I am always willing to do my work."*

*"The training has impacted on my personal life. My children are immunised, and I educate my passengers on the importance of antenatal care, routine immunisation and the maternal danger signs."*

**For many volunteers, quick and highly visible results including lives saved were major motivating factors.**

**Strong emphasis on volunteerism:** The volunteer selection process and later, the volunteer training, placed considerable emphasis on the fact that the work was purely voluntary and that volunteers were working for the betterment of their own communities. Hence individuals motivated primarily by the prospect of financial gain were filtered out early in the process.

**Emphasis on self-help:** The approach placed significant emphasis on communities working together to identify solutions using their own energy and resources. The idea of 'self-help' was strongly promoted, encouraging communities to think of volunteering as a worthwhile and valuable activity rather than something that had been imposed from outside.

**Time-bound inputs:** Volunteers were required for a small number of hours per week and the initial period of intensive activity, when community discussion groups were rolled out across the community, was relatively short (about 12 months). Once the discussion groups had ended, subsequent volunteer activities could be flexible and not particularly time intensive. This approach differs from some other schemes where volunteers are expected to continue working at an intensive pace indefinitely.

**Mentoring and coaching support:** A system of ongoing mentoring and coaching support, intensive at first and becoming lighter over time, helped to maintain volunteer motivation. Mentoring and coaching teams helped to troubleshoot implementation problems, allowing the volunteers to avoid downturns in activity, and provided supportive feedback and encouragement. Research highlighted that volunteers considered this external support to be crucial.

**Many volunteers said that after their initial coaching, an occasional visit by external officials (local government health department or NURTW) was all that was needed to encourage them to continue.**

**Community recognition:** Communities were encouraged to recognise and reward the volunteers and ETS drivers for their efforts. Public recognition can be a major motivator, while informal recognition and respect can have the same effect. Many volunteers said the respect they received from other members of the community encouraged them to keep working.

**Mutual support:** With a large number of volunteers in every community, they could always rely on other volunteers for support and encouragement. This mutual support system is vital to the long-term sustainability of volunteer efforts, reducing reliance on external systems.

Although deeply committed to their voluntary work, many undertook these activities in a context of wide and deep poverty. They were aware that improved maternal, newborn and child health helped reduce household expenditure, and cited this as an impetus to do their work. Yet thoughts on how to sustain and support their families were never far from their minds, with some volunteers requesting further support from the programme to establish income-generation and similar activities.

For some of the ETS drivers, occasional failures to reimburse petrol costs

caused them to request support so they did not have to subsidise the scheme from their own pocket. Claims for additional (usually financial) incentives can quickly escalate when volunteers feel under-supported and under-appreciated. PRRINN-MNCH demonstrated that effective management and support of volunteers can help to manage these concerns.

In recognition of the financial hardships faced by many of the volunteers, PRRINN-MNCH is currently testing whether a social fund, which provides a group incentive in the form of a cash transfer, will help to maintain

volunteer motivation in the long-term. In contrast to the individual payments in salaried community health worker schemes, the social fund provides an incentive to a group of community health volunteers. The volunteers are encouraged to establish revolving funds or income generation activities and to use the proceeds to put the community emergency MNCH response systems on a sustainable footing.

The social fund can also provide non-monetary 'rewards' for community volunteers (eg a community celebration in support of volunteers or prizes/certification for high-achieving volunteers). The aim of the fund is to determine whether alternative methods of rewarding volunteers other than salaries have a positive impact on volunteer motivation and retention in a high poverty context.

The PRRINN-MNCH social fund pilot is at an early stage but a similar scheme implemented in Zambia as part of the UK aid-funded Mobilising Access to Maternal Health Services in Zambia Programme, had a positive effect on volunteer motivation (MAMaZ, 2013).[4] Schemes like this may provide a solution for governments that cannot afford to pay lay community health workers.

## Conclusion

PRRINN-MNCH and its government partners found that volunteer schemes work well if well designed and appropriately supported. They can generate positive changes at community level that extend beyond improvements in health, by building social capital and cohesion and by empowering individual volunteers with the capacity and confidence to apply their training in other areas of their life.

The work of community health volunteers and ETS drivers extended beyond the usual medical and health education duties of salaried community health workers and addressed the social determinants of health (the conditions in which people are born, grow, live, work and age). It is important for health policy-makers and planners to think in terms of the complementary roles that can be played by community health volunteers and salaried community-based health workers.

The concept of a 'community health team' is gaining traction in the PRRINN-MNCH states.

A key question is whether volunteer health worker schemes can be sustained beyond the end of externally funded programmes. In the PRRINN-MNCH states, supervision of facility-based front-line health workers is often irregular unless external funds are provided for fuel and other costs.

Unless state and local governments begin to budget appropriately for monitoring and supervisory support, ongoing supervision of and support for volunteer health worker schemes will be impossible.

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# Young Women's Support Groups:

## Empowering young women and improving maternal health

### The challenge: support lacking for young women

On average, women marry between 15 and 16 years old in the north of Nigeria (National Population Commission and ICF Macro, 2009) and their husbands tend to be around seven years older. Differences in age, educational attainment, employment opportunities and the size of social networks mean that many women enter marriage with fewer social, human and financial assets than their husband, which can reduce their bargaining power.

Socio-cultural norms may leave young women without access to health-related information and services. Kunya (which translates broadly as shyness) prevents free expression in the company of older women. In practical terms, this can result in lack of knowledge about the start of sexual activity and this lack of preparation can lead to the hiding of first pregnancies, which reduces demand for antenatal care, access to birth spacing advice and technologies, as well as a lack of preparedness for delivery. Restrictions on physical mobility can reduce opportunities for interaction with peers.

*Key messages:*

1. Targeted strategies are required to improve maternal, newborn and child health among young married women in the north of Nigeria.
2. In communities supported by PRRINN-MNCH, Young Women's Support Groups had positive effects on health-seeking behaviour. The benefits of these groups extended beyond health.
3. To reach the least-supported young women, a strategy of 'targeting within an age-specific target group' is essential.

In situations where young women are also deprived of social and moral support, whether from husbands, co-wives, or mothers-in-law, or worse than that, where they are bullied, abused or neglected, they can become extremely vulnerable and isolated. Under-supported women usually carry the greatest burden of ill health and mortality, with important implications for public health strategies.

**21% of young married women fell into the least-supported category in a 2012 PRRINN-MNCH survey. They were less likely to use health services, had the least confidence in looking after themselves or their children, were less likely to be involved in income generation and more likely to have poorly-supportive mothers-in-law.**

### The response: empowering young women

The UK aid and Norwegian government-funded Programme for Reviving Routine Immunisation in Northern Nigeria and Maternal, Newborn and Child Health Initiative (PRRINN-MNCH) began working in four states in the north of Nigeria in 2008. A community engagement approach was designed to address the barriers that led to poor home-based care of pregnant women and newborns, and restricted the use of health services.

Community discussion groups helped create awareness of MNCH issues and communities were supported to set up systems to tackle maternal delays. This included emergency transport schemes, blood donor schemes and emergency savings schemes. Although the approach was effective for most target groups and led to some positive changes in health-seeking behaviour, young married women were not always reached. The Young Women's Support Group (YWSG) initiative[1] was established to address this gap.

The YWSGs were based on a simple idea – that young women were likely to respond positively to information and support provided by female mentors from their own community who were only slightly older than they were. The mentors were selected from among community health volunteers who had already been trained by PRRINN-MNCH on maternal and newborn health and routine immunisation. Extra training strengthened their facilitation skills and introduced new topics.

1. With funding from the UK Department for International Development through the Girl Hub initiative.

## Box 1. Increased knowledge and changes in practices

*"A pregnant woman and a member of a YWSG in Jigawa started bleeding a few days back, which she knew was a danger sign. Without hesitation she called her husband who had given her standing permission to inform him of her situation and she was carried to the general hospital and admitted there. She was lucky that the pregnancy was not lost." Jigawa*

*"A YWSG member delivered twins in her house in Lawanti. She said she didn't used to go to antenatal care, but she now goes regularly and takes her drugs. She delivered successfully." Yobe*

The mentors helped to establish groups of 10-12 young married women who were 20 years old or below. Committing 2-3 hours a week for 20 weeks – relatively modest inputs – the mentors facilitated discussion groups on a range of topics and supported group members to translate their new knowledge into action. A focus on MNCH-related knowledge and support for accessing services formed the bedrock of the YWSG training curriculum, but the training also included modules on reproductive health and personal hygiene, nutrition and life skills.

Recognising the importance of economic empowerment to young women's personal agency and status within the household, a module on savings and financial management skills was also included. The mentors worked closely with external organisations such as religious institutions, government agencies and NGOs to link the groups to additional opportunities and resources.

**The YWSGs aimed to build young women's human, social and financial assets.**

An important part of the YWSG strategy was to 'target within the age-specific target group' (Green et al, 2012). A study implemented by PRRINN-MNCH in 2010 had found that in poorly-resourced rural communities where child deaths were common, most (80%) of the deaths occurred to a minority (20%) of women (Klouda, 2010). The deaths were associated with a lack of social support from the family.

This study had important implications for the YWSG design: it was essential to find a way to reach socially excluded or particularly vulnerable young women. Both the mentors and the members of the YWSGs were encouraged to explore who these women were, to look at the factors that contributed to their situation and to find ways to include the women in the groups.

**Substantial emphasis was placed on reaching and including the least-supported women in the community in the groups – and improving their access to MNCH services.**

Some of the first tranche of YWSGs initially failed to stick to the age criteria for membership, requiring adjustments to their membership in later months. These groups reached a much lower percentage of their target group.

The rapid rollout of the YWSGs, which took place in less than a year, was enabled by several factors:

- The previous knowledge and capacity of PRRINN-MNCH and its government partners when rapidly scaling up community engagement activities from an initial population coverage of 900,000 to 7.6 million
- The receptivity of host communities to the YWSGs due to their previous participation in MNCH-related community engagement activities
- The promotion of the YWSGs by religious leaders, who saw the groups as an important strategy to reach vulnerable and excluded young women

## Box 2. Linking YWSGs with community emergency systems

*"In Gandun Sarki community, Harira, a YWSG member, started suffering prolonged labour in the early hours of the morning. Although her husband was away, another YWSG member, Mairo, was with her. Both noticed that the labour was taking time, so Mairo quickly ran to call a community volunteer and emergency transport scheme driver. Money from the community savings scheme was used to fuel the car and the driver took her to hospital without delay. After arriving at the health facility, Harira delivered a bouncing baby boy." Katsina*

## Results: improved knowledge and access to services

### *Coverage*

By September 2013, after 12 months, PRRINN-MNCH and its government partners had trained over 4,000 mentors to work with over 2,000 YWSGs in 40 local government areas in four northern states. The groups reached over 24,000 young women. The YWSGs are estimated to have reached around 30% of the target population of young women in communities where the specified age criteria for group membership was adhered to. These were primarily communities that had come on stream later.

**The YWSGs reached 24,000 women in four states in less than a year. The YWSG model, which uses a cascade training approach, shows good potential to achieve complete coverage of target groups if implemented in a phased manner.**

### *Changes in health knowledge and practices*

The YWSG groups had a demonstrable effect on both health-related knowledge and practice. A knowledge, attitudes and practices (KAP) study in mid-2013 found that members of YWSGs were more likely than non-members to:

## Box 3. Effect of financial management skills training on YWSG members in Katsina

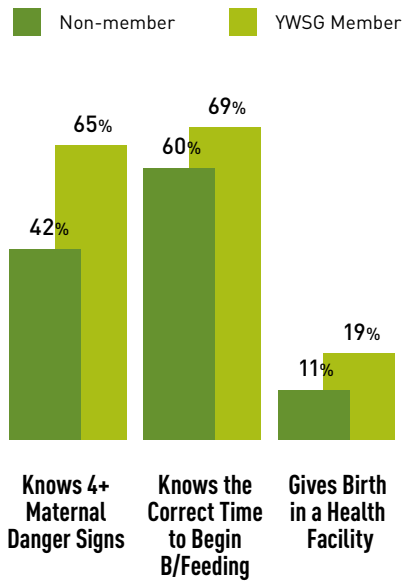
*"From the financial skills I have learnt, it helps me to start selling vegetables for which I have now a weekly income of N500-600."*

*Sahura pounded grain for other families, one of the most menial tasks. Invited by a YWSG friend, she received financial support from the group to start a business. She bought a sewing machine and a spaghetti making machine and taught her younger sisters to use them. She also gave her husband capital to establish a palm oil business and he now makes an average profit of N5,000 per month while she makes an average of N3,000.*

- Know four or more maternal danger signs
- Know when to put a newborn to the breast for the first time
- Give birth in a health facility
- Know the correct immunisation schedule
- Have vaccinated their most recent child
- Have the complete set of vaccinations

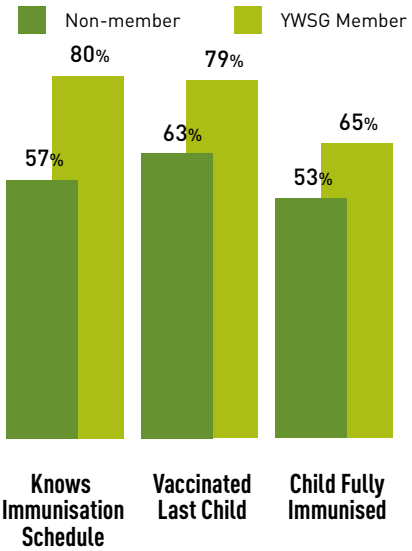
A review of the YWSG initiative in October 2013 found that many YWSG members were able to clearly articulate key health-related messages and show how they had changed their behaviour in response (Box 1).

### Fig 1: MNCH knowledge and practice




YWSG members were more likely to know about maternal health issues.

### Fig 2: Immunisation knowledge and practice




YWSG members were also likely to know more about immunisation.

### *Access to community MNCH response systems*

Monitoring data gathered from YWSG intervention sites showed that communities were beginning to work together as a 'community health team'. The October 2013 review of the YWSG initiative found that many group members had successfully activated community emergency response systems when experiencing a maternal emergency (Box 2).

### *Other benefits*

The effect of the YWSGs extended beyond health, and included improvements in economic status and women's confidence and status within the household (Box 3).

Following training in savings and financial management, the YWSGs were encouraged to establish group savings schemes – pooled funds that could be used to access health care when needed. Some of these schemes operated as revolving loan funds, where individual group members could apply for a loan to establish or expand an existing income-generating activity. In some areas, the mentors linked the YWSGs to agencies such as the Ministry of Women's Affairs, which provided skills training in income-generation activities such as tailoring or soap-making.

Members of the YWSGs also reported positive changes in their confidence and status within the household and greater capacity to resolve conflicts with husbands and other family members. Some husbands reported greater harmony at home (Box 4).

### *Increased support for the least supported*

Members of the YWSGs demonstrated increased awareness of excluded and under-supported young women in their community and willingness to support them (Box 5). Three strategies were used to support these women:

- Taking steps to include under-supported women in group activities
- Increasing their access to community emergency systems such as the emergency maternal care savings schemes or the community emergency transport schemes (ETS)
- Intervening in cases of neglect, abuse or exploitation

The October 2013 YWSG review identified positive examples of how members of the YWSGs had intervened in support of such women.

**The YWSGs place considerable emphasis on identifying young women who need support and inviting them to join the groups.**

## Implications for policy

By December 2013, the YWSG initiative had been operational for a year. At this early stage, differences in performance between groups, communities and states were evident. Future monitoring and evaluation efforts will need to establish what helps and what hinders the groups to function effectively, and

## Box 4. YWSGs Are empowering for young women

*"Before this time I could hardly talk to people. But now I can talk. This is because of the group activities. I am used to addressing members and the discussions we have in the groups have also helped me."*

*"Now if I have anything bothering me I am able to discuss it with my husband."*

*"We can now resolve conflicts among ourselves, our neighbours and even our husbands."*

*"My husband said he is happy with my participation in the group, that I don't bother him with much trouble about money any longer because I am a bit self-reliant now."*

what factors enable them to sustain their activities in the medium to long term. The fact that the PRRINN-MNCH-supported YWSGs were embedded in a wider community engagement process was vital to their acceptance by host communities.

Monitoring and evaluation data generated so far give an indication of the potential of these groups to improve MNCH and to empower young women both economically and socially. The next phase of implementation needs to focus on attaining full coverage of the target age group. This will help to ensure that the least-supported women are reached. To achieve full coverage, the number of groups in each community needs to increase from the current average of 3-4 to approximately 11. An expansion of this size is feasible: the YWSG model uses a cascade training approach which lends itself to rapid scale-up.

To ensure that all the YWSGs function effectively, they will require ongoing support from community mentors and from external coaching and mentoring teams who can help maintain group motivation, assist with problem solving and leverage external resources for the groups. These teams may comprise representatives from local government, state ministries, or in the case of Jigawa, Gunduma councils. Embedding the YWSGs into the everyday work of government agencies so that the initiative becomes part of the government-led MNCH response is a future priority.

## Conclusion

Although PRRINN-MNCH's focus was primarily on improving health-related outcomes, the YWSGs had benefits that extended beyond improvements in health. General improvements in quality of life were evident as some of the young married women developed the confidence and capacity to begin forming their own social networks and explore opportunities for self-development.

The YWSGs also demonstrated how the least-supported young women, who carry the highest burden of mortality and morbidity, can be reached. In the PRRINN-MNCH-supported communities the YWSGs now need to be scaled up to cover all young married women in the community so that the least-supported women are not missed.


**References**

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## Box 5. Evidence of increased support for least-supported young women

*"There was a woman who was interested to join a YWSG, but was afraid that she might not be accepted because she lacked decent wrappers to wear to the meetings. When the members learned of her fears, they not only offered her moral support and encouragement, but also put together N700 and gave it to her to buy a wrapper. She finally became a member of the group."*

*"A man stopped his wife, who is under-supported, from attending antenatal care. A member of the YWSG and a community volunteer visited the man and advised him on the importance of ANC and facility delivery. The man allowed his wife to go to ANC; he also joined the meetings of the community volunteers to learn about health issues."*


PRRINN-MNCH

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

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This set of Technical Briefs highlights key achievements from the PRRINN-MNCH programme in Northern Nigeria under one of four streams of work: Governance and Leadership, Health Service Delivery, Community Mobilisation, and Evidence for Decision-making.

PRRINN-MNCH worked with the federal, state and local governments, and in close consultation with local communities, to strengthen Primary Health Care services in four states, covering a population of over 19 million. PRRINN-MNCH helped each state achieve significant health-related goals, and improved the quality and availability of health services including antenatal and postnatal care, safer deliveries, care for newborns and infants, better nutrition, and routine immunization against preventable diseases.

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