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The Maternal Health Care Improvement Initiative: Nigeria

PATHFINDER INTERNATIONAL

Pathfinder International believes that reproductive health care is a basic human right. For more than 50 years, Pathfinder has delivered critical sexual and reproductive health care in the developing world that expands opportunities for women, men, and young people. Pathfinder provides a range of services—from contraception and maternal care to HIV prevention and AIDS care and treatment. Through innovative approaches and community participation, Pathfinder strengthens access to family planning, works to ensure the availability of safe abortion services, advocates for sound reproductive health policies, and, through all of our work, supports the rights and lives of the people we serve.

Through the support of the John D. and Catherine T. MacArthur Foundation, Pathfinder International launched the Sustainable Maternal Health Care Improvement Initiative in 2003 to address Nigeria's high maternal mortality and morbidity rates. Focusing on three communities in Nigeria, the project's approach sought to improve health system and community structures to enable sustainable change in the quality and coordination of maternal health (MH) service delivery, and to shape MH care-seeking behavior among key populations.

For seven years, the initiative worked closely with health service delivery, political, and community stakeholders in the Nigerian states of Kano, Lagos, and Borno. The project targeted specific communities in the respective states, working with the Minjibir community in Kano, the Agbowo community in Lagos, and the Gwoza community in Borno to engage stakeholders in local-level problem solving to address barriers to quality health care service delivery and behaviors related to positive MH outcomes.

Pathfinder's woman-centered community capacity building and health system strengthening approach worked to create an enabling, proactive environment wherein members of the community are engaged and involved in efforts to improve MH outcomes, and facilities are capable of delivering quality MH care. This report provides a summary of the initiative's approach, reflections on the challenges and barriers faced, and recommendations for implementers and policy makers seeking to improve MH in these regions in the future.



PHOTO: Amy Coughlin

Background and Project Overview

In 2003, Pathfinder launched the Sustainable Maternal Health Care Improvement Initiative to create a community- and health system-led response to Nigeria's maternal health profile. The project concept is rooted in Pathfinder's "three delay" framework, which targets the three primary causes of delay in accessing care: 1) delay in deciding to seek care, 2) distance to the health facility, and 3) facility-generated delays in delivering care, such as lack of trained staff and shortages of equipment. Viewed from a capacity perspective, the former are issues of community ability to understand and appropriately apply MH information to improve health outcomes. The latter, facility-generated delays in delivering care, speak to the health system's need for technical and procedural support in core areas to enable delivery of quality, timely MH care services. To address the community and health system roots of these delays, Pathfinder's Sustainable Maternal Health Care Improvement Initiative framework employs community capacity building and health system strengthening approaches (Figure 1).

Running from 2003 to 2010, the Sustainable Maternal Health Care Improvement Initiative pursued ambitious goals in each of its three phases. In Phase I (2003-2006), the project sought to establish the foundations for improved service delivery and greater community capacity through: advocacy to community and political leaders; needs assessments and training of existing facility health workers (FHW) and community health workers (CHW); launch of peer educator and male motivator programs; and outreach and training for traditional birth attendants (TBA). Phase II (2006-2009) efforts focused on maintaining and deepening the impact of these core activities. Ongoing needs assessment led to the provision of new and refresher trainings, and helped to address gaps in "soft skills" training needs such as provider-to-client and FHW-to-TBA relationships, which had impeded effective service delivery in the past. In addition, Phase II activities focused on capacity building for community ownership of the initiative, which involved holding dialogue sessions with community leaders, newly

Context

In 2008, Nigeria's maternal mortality rate was estimated at 545 maternal deaths per 100,000 live births. According to Nigeria's national Demographic and Health Survey, 36 percent of women who had a live birth in the five years preceding 2008 received no antenatal care, a figure that has remained constant since 2003. Sixty two percent of Nigerian women give birth at home, without the support of a skilled birth attendant, thus increasing their risk of mortality due to delayed identification of the need for care and distance to care. Furthermore, of the women who receive the recommended number of antenatal care visits, only three out of five are informed of pregnancy danger signs. This further compounds their risk, as few are able to identify risky pregnancies likely to require skilled care. Because a large percentage of mortality-related issues arise in the 24 hours following delivery, postpartum check-ups are particularly important. Despite this, 56.3 percent of Nigerian women receive no postnatal care. Considered together, these facts present a grave picture for women of childbearing age (National Population Commission 2009).

elected government officials, and community members to seed plans to lead MH care improvement efforts independently. Finally, Phase III activities focused on monitoring ongoing activities and providing technical assistance to facility and community stakeholders to prepare them to own and run initiative activities.

Implementation

LAYING A FOUNDATION

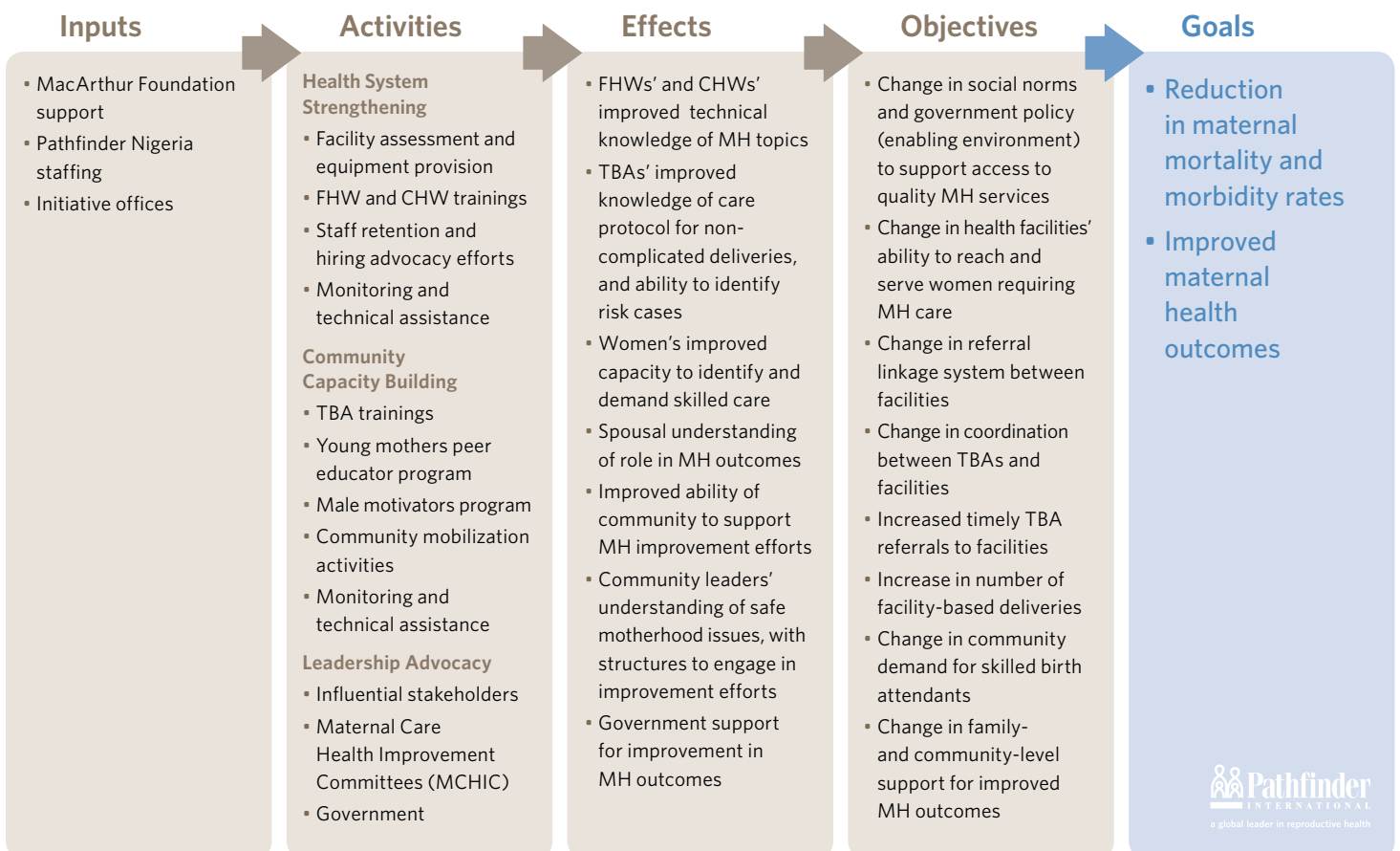
Phase I laid the building blocks for the initiative, working at the community level to generate interest in MH. To begin, the initiative reached out to informal community leaders and elected government officials, conducting advocacy events with them to raise general awareness about MH within each segment of the community. Initial advocacy events helped to identify natural leaders in each community who would go on

to receive advocacy training and serve as members of Maternal Care Health Improvement Committees (MCHICs). Composed of traditional and religious leaders, zonal facility coordinators, and informal community influencers, MCHICs serve as fixed community structures that promote community demand and use of MH care services and advocate at the political level for the mobilization of resources to improve MH service delivery.

BUILDING CAPACITY

At the facility level, the initiative began with preliminary surveys to assess the MH training needs of FHWs and CHWs in the three target areas. Assessments revealed that, although many FHW and CHW staff had received basic MH training during schooling, many had not received any technical support since and, as a result, were not equipped to address cases of complication when they presented at the facility. Drawing on

FIGURE 1: THE MATERNAL HEALTH CARE IMPROVEMENT INITIATIVE FRAMEWORK



Initiative Highlights

- **62 MCHIC members** trained in maternal health core concepts and advocacy: 20 in Gwoza; 22 in Minjibir; 20 in Agbowa.
- **30 facility health workers** re-trained in MH care service delivery.
- **60 male motivators and 60 young mother peer educators** trained in MH core concepts and behavior change communication.
- **740 FHWs, CHWs, TBAs, male motivators, peer educators, community leaders, and government representatives** trained in referral linkage systems.
- Observed **increase in community service uptake** for skilled birth attendants.
- **Established community structures** for maternal health service improvement monitoring.
- **144 supervisory MCHIC visits** to facility sites and monitoring of CHW rounds.

Pathfinder's core technical practices, curricula were adapted to enhance workers' ability and confidence to address such cases. Trainings were tailored to take into account existing limitations of respective facilities, all of which were severely under-resourced.

Because 21.6 percent of Nigerian women give birth at home with the support of TBAs, the initiative also focused on capacity building for these untrained providers who are so often communities' preferred source of guidance throughout pregnancy and delivery (National Population Commission 2009). After an informal survey of barriers existing between TBAs and health facilities, trainings were adapted to enable TBAs to provide technically sound guidance during pregnancy and care during delivery, while also defining the limits to the care they should provide. As initiative staff learned, many TBAs were hesitant to refer cases to the facility due to concern about losing the community's confidence in their abilities and about discrimination by FHWs hostile to TBAs. Thus, trainings focused on empowering TBAs to educate their communities about appropriate patient expectations for both TBAs and FHWs, aligning the two as partners rather than competitors. By identifying risky cases early and referring them to facilities, TBAs also helped efforts to increase institutional delivery rates.

Capacity building efforts also focused on community intermediaries skilled at both providing MH guidance and shaping an enabling social environment for women to access services. Influential and sympathetic male community leaders were identified for training as "male motivators," and young mothers were recruited for training as peer educators. Together, motivators and peer educators conducted one-on-one outreach efforts to community members, with motivators reaching out to spouses and fathers, and peer educators speaking with women of reproductive age. Both taught community members basic information about MH and raised awareness about the signs of risky pregnancies and labor. Through these efforts, motivators and educators focused on mitigating a key barrier to accessing timely MH care: lack of family and spousal permission to seek it.

SUSTAINING CAPACITY

Throughout Phases II and III of the initiative, monitoring FHW and CHW performance and regular TBA meetings enabled the initiative to identify persistent technical training needs and provide technical assistance accordingly. Activities ensured that nearly all program participants received secondary training to cement practice techniques and knowledge of core concepts established in Phase I. Process-oriented training needs such as data management and record keeping, patient-provider relationship development, monitoring, and referral linkage systems both between facilities and between providers and TBAs were also identified. The initiative designed intensive trainings to fit each need, helping to build stakeholders' confidence in delivering technically sound services, establishing appropriate boundaries with regard to roles and responsibilities, and strengthening relationships between key points of service provision. Though some divisions persist, trained participants were equipped with the skills to address system breakdowns directly, which built health workers' ability to own and sustain initiative efforts in the long term.

Facility-level activities in Phase III included providing critical technical assistance to introduce maternal death reviews as a core practice at each facility. Where maternal deaths had not received any routine

form of evaluation in the past, initiative staff worked closely with facility leadership to develop review systems aimed at increasing facilities' ability to identify and address provider- and system-generated errors. Once systems were developed, all facility staff were trained to apply the review processes, and leadership was assisted to monitor the new practice.

Finally, sustainability efforts led to development of an interconnected monitoring and communication model wherein CHWs, FHWs, and facilities are monitored on an ongoing basis by both the MCHICs and local government agencies. MCHICs' monitoring activities are of particular importance to the sustainability of the initiative's efforts, ensuring that communities are able to analyze and improve upon community use and facility provision of MH services in the future. MCHIC oversight also fosters positive relationships between health worker groups and the general community. This is evident when respected and influential members of the MCHICs demonstrate understanding of and support for health workers' activities, and participate in collaborative problem solving to prevent and mitigate problems outside the scope of health workers' responsibilities (e.g. spouses refusing MH care for their wives or objecting to health workers' recommendations). Local government representatives accompany MCHICs on their supervisory visits, with the result that political leaders are now engaging in problem solving as they become more familiar with the day-to-day challenges facing efforts to improve MH care.

Challenges and Lessons Learned

The Sustainable Maternal Health Care Improvement Initiative faced several challenges during its tenure. Some were unique to the initiative's organizational context, while others were the result of entrenched factors and contexts, and are thus likely to recur in future MH care improvement efforts. As Nigeria will continue to require support to meet its care delivery needs and improve its MH profile, the lessons learned by this initiative may prove valuable to future implementers in the field.

SHIFTING POLITICAL CONTEXTS

Shifts in the political landscape (national, state, and local) are an impediment to any sustained activity, and were a constant challenge to this initiative's efforts. During an 18-month period between 2007 and 2009, three different administrations came to power. Elections and re-appointments required allocation of staff resources away from service provision, as focus necessarily shifted to securing the support of new and transitioning elected officials. Disputes over election results and subsequent reformulation of government agencies also led to political stand-offs, contributing to low partner morale as facility staff and health workers were forced to go without pay for periods as long as five months. Such situations required renegotiation of agreements with key facility partners, often resulting in changes to planned initiative activities and, in some instances, strategy. For example, though scale-up had been a priority of the initiative's strategy at the outset, diffusion of efforts resulting from political turmoil rendered this plan unfeasible.

Trainings focused on empowering traditional birth attendants (TBA) to educate their communities about appropriate patient expectations for both TBAs and facility health workers (FHW), aligning the two as partners rather than competitors. By identifying risky cases early and referring them to facilities, TBAs also helped efforts to increase institutional delivery rates.

BALANCING DEMAND GENERATION WITH FLUCTUATING FACILITY CAPACITY

Political disruptions fed into challenges to service delivery and, consequently, community confidence in seeking institutional care. During political turmoil, when facility staff were unpaid or forced to scale down service provision, the initiative's demand-generation activities were, ironically, too successful. Demand outstripped the service providers' capabilities, placing great pressure on facilities and undermining the initiative's credibility. As the initiative convinced

communities to overcome biases and financial obstacles to seeking services, women—many of whom had little to no prior relationship with the health care system—found that service provision was unreliable. As these circumstances persisted, some women became less willing to support subsequent initiative goals.

Maternal Care Health Improvement Committees' (MCHIC) monitoring activities are of particular importance, ensuring that communities are able to analyze and improve upon community use and facility provision of MH services in the future. MCHIC oversight fosters positive relationships between health worker groups and the general community. Local government representatives accompany MCHICs on supervisory visits, and are now engaging in problem-solving to improve MH care.

TARGETING SYSTEMS-LEVEL CHANGE

Capacity building efforts were focused and intensive throughout the initiative, building the finer skills of initiative representatives such as peer educators and male mobilizers to execute behavior change efforts effectively, and building community structures like the MCHICs to ensure fixed channels through which community members could make their needs heard to political and health systems. However, women's and maternal health are steeped in cultural and religious sensitivities, hierarchies, and practices whose influence extends beyond individual skills building to broader systems-level change. The initiative's narrow focus on skills and service improvement was insufficient to meet the "ecological" barriers that providers and communities confront. A more detailed analysis of how the public health system interacts with community systems would have enabled the program to better appreciate and plan for these critical broader layers of influence.

SETTING STRATEGIES SUITABLE FOR EXISTING LOCAL CAPACITY

Facility assessments were conducted early in the initiative, and brought to light considerable limitations including public capacity for basic documentation, record keeping, and archiving. The initiative's strategy, established at the outset of the project, assumed a level of information availability that did not sufficiently match the reality of the three states' circumstances. In retrospect, revisions to the initiative's strategy should have been made at that point—either to substantially increase resources and staffing to enable the initiative to address this core institutional limitation, or to revise the initiative's strategy to incorporate attainable targets given this unanticipated need. Though we are confident that better records are now being kept, due in part to the initiative's monthly record keeping and data collection assistance meetings, the overall system limitations persist and continue to impede facilities' ability to monitor and solve problems independently.

Recommendations

Though varied, the obstacles that the Sustainable Maternal Health Care Improvement Initiative encountered fall into predictable categories, out of which the following recommendations emerged:

USE LOCAL INPUT TO BUILD STRATEGIES CAPABLE OF ANTICIPATING BREAKDOWNS

Program strategies and activities will inevitably be set at a project's launch, but an effective platform will include stakeholder involvement to anticipate potential breakdowns in planned program activities and allow project leadership to amend and revise program strategy to accommodate such pitfalls, once identified. Though community and facility assessments are standard practice, revision of program strategy based on the results of these assessments is a critical next step that is at times overlooked due to pre-existing government, partner, or donor agreements.

In a similar vein, for programs that seek sustained continuation of efforts beyond the life cycle of the project, capacity building efforts must also prepare the future community and facility "owners" of the

project efforts to identify and solve breakdowns that will inevitably arise in the future.

DEVELOP MONITORING SYSTEMS BEFITTING EXISTING CAPACITY

Monitoring systems are a critical element of a nimble program structure capable of detecting and responding to problems in a timely manner, ensuring that pilots reach the level of stability necessary for scale-up. Such systems require the methodical assessment of geographic, institutional, and budgetary contexts, and strategies to accommodate them. In the case of this initiative, the wide geographic distribution of community sites made continual monitoring impractical given transportation, staffing, and budgetary constraints. Pilot projects with similar constraints may be better served by working in adjacent yet distinct communities and building outward, absorbing new sites and tailoring project activities to each new community's context as they go. More careful and frequent monitoring would also address bottlenecks involving the status of personnel and facilities. Programs should also ensure an adequate and appropriate mix of staff at the facilities to counteract frequent staff turnover, better remuneration to motivate the staff, and more oversight to gauge the availability of services.

ADDRESS SYSTEMS-LEVEL CHANGE EARLY AND OFTEN

To address the larger drivers of poor MH outcomes, projects must address the larger political, religious, gender, and cultural contexts in which communities and health workers live and work. Projects must include systems-level change strategies, informed by analysis of existing community systems, health systems, and the functional relationships between the two. Inventories of community relationships, popular opinion leaders and other influential persons, existing community organizations and their activities, and detailed histories of service provision and acceptance in the community can provide a basis for alternative community action when a given health or community actor is unable to fulfill its obligations, as will inevitably occur. Having such analyses and inventories on hand will enable effective troubleshooting to navigate around problems, potentially through parallel organizations or systems.



PHOTO: Amy Coughlin

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