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**Community-based Maternal and Child Nutrition and Health  
Interventions in Nigeria: A Comparative Case Study Analysis on  
Best Practices**

**Health Nutrition Population (AFTHE)  
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## ABBREVIATIONS AND ACRONYMS

ACC	Administrative Committee on Coordination
ACO	Abuja Central Office
AFTH	African Federation for Technology in Healthcare
AFTPR	Africa Public Sector Reform and Capacity Building Unit
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCG	Bacillus Calmette-Guérin
BFHI	Baby Friendly Hospital Initiative
BMI	Body Mass Index
CBO	Community-based Organization
CC	Community Coalitions
CEO	Chief Executive Officer
CHERG	Child Health Epidemiology Reference Group
CHESTRAD	Center for Health Sciences Training, Research, and Development
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CIDA	Canadian International Development Agency
COMPASS	Community Participation for Action in the Social Sector
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DfID	Department for International Development
DHS	Demographic and Health Survey
DPT	Diphtheria, Pertussis, and Tetanus
EBF	Exclusive Breastfeeding
EMC Teams	Emergency Medical Care Teams
EmOC	Emergency Obstetric Care
EmOnC	Emergency Obstetric and Newborn Care
ENHANSE	Enabling HIV/AIDS, TB, and Social Sector Environment Program
ESW	Economic Sector Work
ETS	Emergency Transport System
EU	European Union
FBFI	Food Basket Foundation International
FBO	Faith Based Organization
FEWS	Famine Early Warning System
FGN	Federal Government of Nigeria
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GINA	The Gender Informed Nutrition and Agriculture Project
GOBIFF	Growth, Oral Rehydration, Breast Immunization, and Feeding
HCHP	Hygeia Community Health Plan
HD	Health Development
HERFON	Health Reform Foundation of Nigeria

HH	Household
HIF	Health Insurance Fund
HIV	Human Immuni-efficiency Virus
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn, and Child Health
IOP	Immunization Outreach Program
IQ	Intelligence Quotient
IRIN	Integrated Regional Information Network
ITN	Insecticide-treated Net
IYCF	Infant and Young Child Feeding
IZINCG	International Zinc Nutrition Consultative Group
JCHEW	Junior Community Health Extension Worker
LAC	Latin America and Caribbean
LDC	Least Developed Country
LEEDS	Local Empowerment and Economic Development Strategy
LGA	Local Government Area
M&E	Monitoring and Evaluation
MBB	Marginal Budgeting for Bottlenecks
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal Newborn and Child Health
MND	Micro-nutrient Deficiency
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSS	Midwifery Service Scheme
NARHS	National HIV/AIDS and Reproductive Health Survey
NBS	National Bureau of Statistics
NCD	Non-communicable Disease
NCFN	National Council on Food and Nutrition
NCRSA	Newborn and Child Survival Rapid Situation Analysis
NDHS	National Demographic Health Survey
NEEDS	National Empowerment and Economic Development Strategy
NET	Network
NFCNS	Nigeria Food Consumption and Nutrition Survey
NGN	Nigerian Naira
NGO	Non-governmental Organization
NHB	National Health Bill
NHIS	National Health Insurance Scheme
NHP	National Health Policy
NIMNCH	Nigeria Integrated Maternal, Newborn Child Health
NLSS	Nigeria Living Standards Survey
NMS	National Micronutrient Survey
NPC	National Planning Commission
NPHCDA	National Primary Health Care Development Agency
OOPE	Out-of-Pocket Expenditure

OPV	Oral Polio Vaccine
ORS	Oral Rehydration Salts
PATHS	Partnership for Transforming Health Systems
PD	Positive Deviance
PHC	Primary Healthcare
PHCC	Primary Healthcare Committee
PRB	Population Reference Bureau
PREM	Poverty Reduction and Economic Management
PRRIN	Partnership for Reviving Routine Immunization in Nigeria
PPP	Public Private Partnership
PTA	Parents-Teacher Association
QIT	Quality Improvement Teams
SBA	Skilled Birth Attendance
SCN	Subcommittee on Nutrition
SEEDS	State Empowerment and Economic Development Strategy
SITAN	Situation Analysis
SOE	Statement of Expenses
SOWC	State of the World's Children
STI	Sexually-transmitted Infection
SuNMaP	Support for the National Malaria Programme
SWOT	Strength, Weakness, Opportunities, and Threats
TA	Technical Assistance
TANA	The Agriculture and Nutrition Advantage
TBA	Traditional Birth Attendant
THE	Total Health Expenditure
TOR	Terms of Reference
TT	Tetanus Toxoid
TTL	Task Team Leader
U5MR	Under-five Mortality Rate
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USD	United States Dollar
USI	Universal Salt Iodization
VAD	Vitamin A Deficiency
VPF	Virtual Poverty Fund
VVF	Vesico-vaginal Fistula
WB	World Bank
WCAR	West and Central African Region
WG	Working Group
WHO	World Health Organization

# 1. Overview

This study makes the case that: (i) despite progress on a few key indicators, Nigeria has some of the world's worst outcomes in maternal and child nutrition and health indicators with high rates of morbidity, malnutrition and mortality; (ii) the situation is particularly bad in the Northern states of Nigeria; (iii) cost-effective interventions are well known from rigorous reviews published in recent years; (iv) coverage rates on almost all these proven interventions are low in Nigeria compared to those seen in many other African countries; and (v) strategies that mobilize community engagement for better health and nutrition have the potential to dramatically improve the coverage of nutrition and health behaviors and services.

The purpose of this study is to enhance our understanding on how to effectively engage in community-based nutrition and health programs aimed to improve maternal, newborn, and child nutrition and health outcomes, particularly in Northern Nigeria. At the heart of the analysis are case studies of four projects, each of which included a community action component for improving nutrition and health outcomes. This report provides the comparative synthesis of these case studies. In so doing, it provides a normative base for designing and planning government programs that support reforms in outcome-based programming for maternal, newborn, and child nutrition and health through program support and investment lending.

Central to the report is the discussion on the roles played by various stakeholders – state and local government, NGOs, traditional and religious leaders, and communities themselves – in creating and sustaining community mobilization. The factors considered essential or useful contributors to community mobilization are analyzed. The history of government's role in Nigerian health care is discussed, as well as the current situation and future possibilities, especially at state and local level.

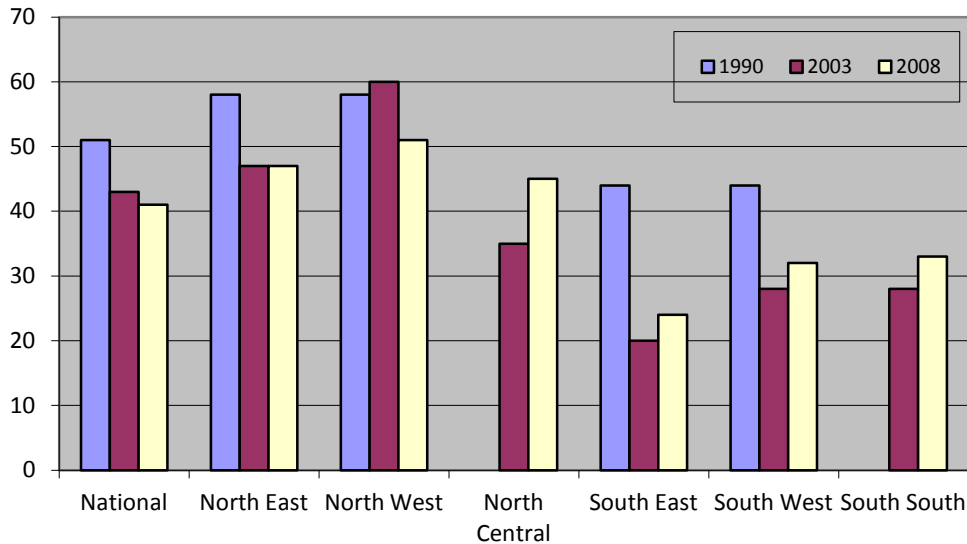
## WHY NIGERIA NEEDS COMMUNITY-BASED PROGRAMS FOR NUTRITION AND HEALTH

The nutritional status of Nigerian children is not good and has shown no improvement since 2003. The 2008 NDHS found that 41% of under-five children suffer from chronic malnutrition (stunting) and 14% from acute malnutrition (wasting), rates which are consistent with other poor countries in Sub-Saharan Africa. The proportion of children aged 6-35 months that were chronically malnourished increased from 42% in 2003 to 50% in 2008. Figure 1 shows the evolution of stunting prevalence in Nigeria by geographical zone. Although the 1990 division in four Zones is not comparable to the 2003 and 2008 division in six Zones, the message is clear:

- The Southern Zones are significantly better off than the Northern Zone;
- The Southern Zones have seen significant improvements between 1990 and 2003 while the stunting prevalence in the Northern Zones has remained stagnant;
- There have been no significant improvements in stunting rates in both the Southern and Northern Zones between 2003 and 2008;

- According to the 2008 data, the stunting prevalence in the Southern Zones is closer to Ghana (28%), Angola (29%) and Mauritania (32%) while in the Northern Zones the rates compare more with Madagascar (53%), Ethiopia (51%) and Guinea Bissau (47%).

**Figure 1: Stunting rates by Geographical Zone and by survey year**



*Source: WHO, 2011*

While significant gains in childhood and maternal mortality have been made in other developing countries in the past two to three decades, the situation of maternal and child health outcomes remain at a most depressing level in Nigeria. The estimated maternal mortality rate (MMR) ranges between 800-1,500 per 100,000 live births, with marked variation between geo-political zones – 165 in south east compared with 1, 549 in the north east and between urban and rural areas. This results in approximately a little bit more than 50,000 maternal deaths each year. For every woman who dies of maternal causes, at least six newborns die and a further four babies are stillborn. About 5.9 million babies are born every year in Nigeria, and over one million of these children die before reaching their fifth birthday, and 284,000 newborns die every year; sadly making Nigeria the world's second largest contributor to under-five mortality (U5MR) and maternal mortality ratio (MMR). Many of these deaths occur at home and are therefore unseen and uncounted in official statistics.

Most of these deaths or conditions leading to death in the mothers and in the newborns are preventable or treatable largely through proven, cost-effective preventive interventions and early care at household, community, and primary care levels such as promotion of adequate nutrition and weight gain during pregnancy, antenatal care, skilled health workers assisting at birth, access to emergency services and after delivery care for both mother and newborn, promotion of breastfeeding and infant and young child caring and feeding practices, hygiene, sanitation, case management of common illnesses at the home and community management of acute malnutrition. Yet the bulk of public spending in health goes to curative care, or around 70% in 2006-2008. As a result, coverage and quality of healthcare services in Nigeria continue to fail women and children.

Because malnutrition, morbidity and the majority of perinatal, neonatal, infant and child deaths occur in the home, there is an urgent need to identify solutions at the community level. To achieve Millennium Development Goal 1, 4 and 5 of halving child malnutrition; reducing by two thirds the under-five mortality rate; and reducing by three quarters the maternal mortality ratio between 1990 and 2015, major advances in child and maternal nutrition and health must be achieved through wide-scale implementation of cost-effective interventions in the community.

Moreover the health of the mother and newborn are intimately entwined, they must be considered together when planning strategies to improve maternal and child nutrition and health outcomes. It is important to highlight that the peak period of vulnerability for both the mother and newborn is around pregnancy and childbirth. Thus, interventions must largely focus on addressing joint outcomes. Changing health and nutrition outcomes in Nigeria will require greater emphasis on wide-scale implementation of proven, cost-effective measures to save women's lives and promote healthy child growth. Some of the biggest gains in terms of child growth and survival can be made through actions to improve infant and young child care as well as feeding practices and care of sick children at household and community level accompanied by the delivery of high impact preventive interventions such as immunization, vitamin A supplementation, de-worming, and insecticide-treated bed nets (ITN). Collaboration across all levels is essential, with development partners and target communities involved as key stakeholders in the national response to this seemingly unabating challenge.

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering 60% of health care in the country, private-public partnership is very weak.

Several cost-effective interventions for improving the health of mothers and their children have been identified by The Lancet series on Maternal, Neonatal and Child Survival, the same journal's series on Sexual and Reproductive Health and Maternal and Child Undernutrition, and WHO/UNICEF's Regional Child Survival Strategy for Asia. Despite this evidence, in Nigeria, scarce resources are often not allocated where they will have the biggest impact. For example, acute respiratory infection – the leading cause of child mortality – attracts less than 3% of donor funding globally, even though it accounts for 25% of the burden of disease. Nutrition programs also remain chronically under-funded, despite evidence from the 2008 round of the Copenhagen Consensus that five of the ten most cost-effective interventions for helping the poor are related to nutrition. Donor funding for family planning has decreased, despite its long-standing recognition as a cost-effective program.

More specifically, community and household-level interventions have highest impact, but are given lowest priority. The health system in Nigeria is set up in such a way that allocation of human, material and financial resources favors facility-based, curative care. Where community-based programs have been set up, they tend to operate on a small scale, with little support from the formal health system. The low coverage and poor performance of the health system

contribute to a high mortality rate of otherwise preventable deaths, including neonatal conditions, pneumonia, malaria, diarrhea, HIV/AIDS, measles, injuries and others.

#### PAST ATTEMPTS TOWARDS COMMUNITY-BASED NUTRITION AND HEALTH PROGRAMS

Nigeria has made various incomplete and unsuccessful attempts in the past twenty years to bring services in health and nutrition closer to the population and to create an enabling environment for community action for nutrition and health. Nigeria embraced Primary Health Care (PHC) in the mid-eighties. However, implementation beyond facility-based clinical care remains weak. Most of the reforms were poorly executed and failed to deliver on improving maternal and child nutrition and health outcomes. As a result, PHC is in a prostrate state because of poor political will, lack of accountability, gross under funding, and lack of capacity at the LGA level, which is the main implementing body.

Although national policies are broadly supportive, and the draft Health Bill holds the potential to reinvigorate primary health care services with increased funding and new mechanisms, institutional fragmentation has tended to weaken accountability relationships and hindered the effective implementation of reforms to date. For example, the proportion of PHC facilities providing immunisation services range from 0.5% in the North-West zone to 90% in the South West and South East Zones. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service. This limited coverage of basic health services, which results from poor access to information and services results in under utilisation of services. Only 58% of women receive antenatal care from a professional with coverage levels, ranging from 31% to 87%, and deliveries under the supervision of a trained birth attendant ranging from 9.8% to 81.8%. The lowest figures are from the North East and North West zones.

Similarly, nutrition, which provided the springboard for community strategies in several sub-Saharan African countries (e.g., Ghana, Senegal, Tanzania, Ethiopia) has received minimal attention from the Nigerian Government, despite widespread malnutrition in the entire country and in rural areas in particular. Nutrition has suffered from the awkward institutional location in government with responsibility for broad policy development housed in the NPC and the NCFN, public health policy development housed in the Federal Ministry of Health's underfunded Division of Nutrition; and implementation of mostly narrow vertical interventions by the NPHCDA.

Official responsibility for nutrition policy broadly considered lies with the National Planning Commission (NPC). A National Committee on Food and Nutrition (NCFN) was established in the NPC to develop the National Policy on Food and Nutrition (2002), coordinate nutrition activities across the sectors, mobilize resources for nutrition, and provide oversight on nutrition in recognition of the cross-sectoral nature of action necessary to improve nutrition. Several problems have been highlighted concerning NPC's role in coordinating nutrition activities and its commitment to nutrition and to an effective NCFN is often felt to be wanting. First, the Commission is staffed by economists and planners and only in 2002 was a nutritionist brought on as staff at NPC to be responsible for the activities of the NCFN. Secondly, there are no signs

that nutrition is privileged in the allocation of government resources by virtue of the presence of the secretariat of the NCFN in NPC. Indeed, the fact that virtually all costs for nutrition programming in Nigeria are borne by donors indicates that the NPC lacks necessary influence in this regard (Benson, 2008).

The Federal Ministry of Health has one Division dedicated to nutrition but in the past five years, there has been no budgetary allocation to the Division. Most state ministries of health have comparable nutrition units responsible for coordinating all nutrition activities in the health sector of the state. As at the Federal level, the state-level nutritionists complain of poor funding for carrying out their responsibilities. Technical activities in the public sector that are explicitly identified as being nutrition oriented are those related to PHC.

The NPHCDA is the principal institution responsible for seeing that nutritional deficiencies are directly addressed by health workers in communities across Nigeria. This work is done through programs in child growth monitoring, demonstrations of the preparation of locally adapted nutritious food and food preservation techniques, vitamin A and iron supplementation programs, and advocacy for exclusive breast-feeding.

Interest in community-based health and nutrition has increased with the adoption of the IMNCH Strategy. A new momentum for maternal and child health culminated with the adoption of the National Integrated Maternal, Newborn and Child Health (NIMNCH) Strategy by the Federal Ministry of Health and the development partners in March 2007. This strategy primarily aims at improving nutrition, maternal and child health in line with the MDGs 1, 4 and 5. It builds on and incorporates other strategies, guidelines and policies that have been functioning at various levels, e.g., the Primary Health Care strategy, the Integrated Management of Childhood Illnesses (IMCI), the Baby Friendly Hospital Initiative (BFHI), and the strategic guidelines for infant and young child feeding.

The NIMNCH Strategy organizes the interventions by three service delivery modes, i.e., the household and community-based services, the population services (e.g., vitamin A supplementation, immunization, deworming), and clinical care. Together these health care services are the most relevant for addressing the health care problems of ordinary families; they are also most crucial for addressing the MDGs that relate to health. However, little information is available about these services, in particular household and community-based services, and the systems that provide them. Most maternal and child care takes place in and around the home. However, the implementation capacity to influence these family practices has not adequately been assessed and analyzed. Moreover, there are great differences across the country in living standards, climate, health threats, quality of governance, and the patterns of state and local government (LGA) services to which people have access. So increasing understanding of what is needed to consolidate and scale up the implementation of the NIMNCH Strategy is a high priority. However, the lack of a functioning system for supporting community action has meant that the family and community mode of delivery of the strategy has so far received less attention (and funding) than the outreach and clinical care modes of delivery.

## COMPARATIVE CASE STUDIES

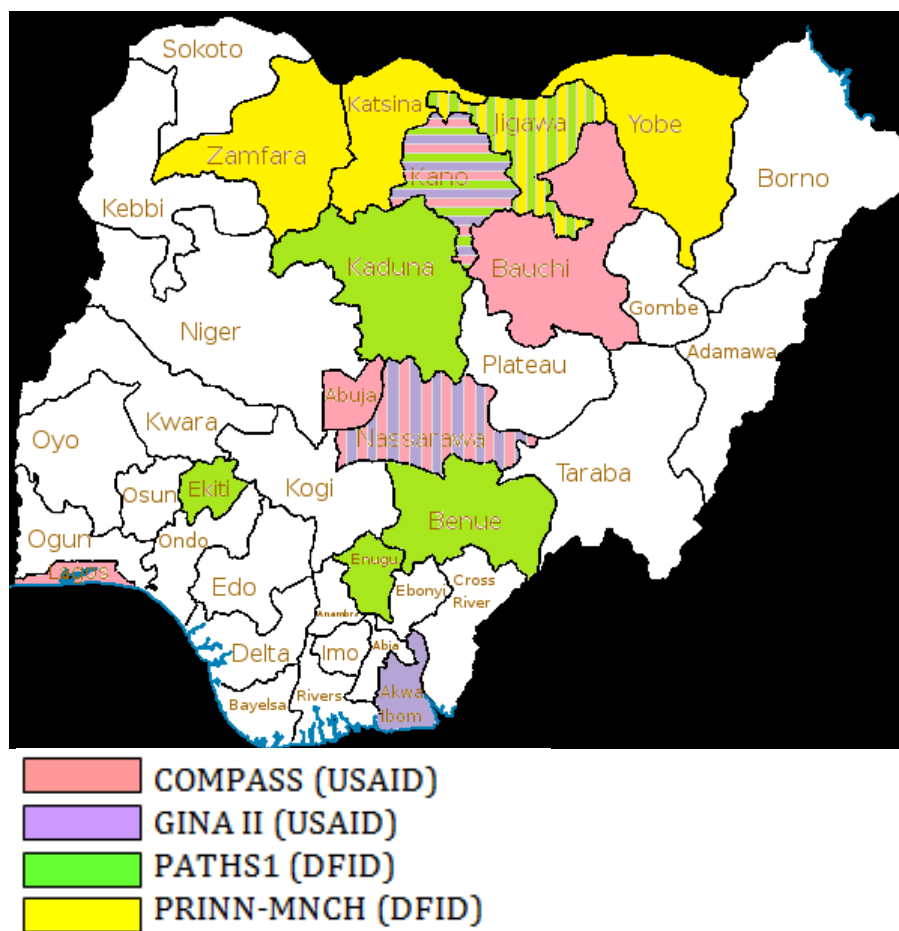
With the objective of getting a better understanding of best practices in launching and sustaining nutrition projects in Nigeria, four different projects were selected for detailed case study analysis. The cases that were chosen are the Safe Motherhood Initiative (SMI under PATHS1) in Jigawa State, COMPASS in Nasarawa and Kano States, PRRINN-MNCH in Katsina State, and GINA Phase II in Kano State.

**Table 1: Basic Project Information**

<b>Project</b>	<b>COMPASS</b>	<b>GINA II</b>	<b>PRRINN-MNCH</b>	<b>SMI/PATHS1</b>
<b>Donor</b>	USAID (USA)	USAID (USA)	DfID (UK) & Norway	DfID (UK)
<b>Main Focus Areas</b>	Basic education, child survival, family planning / reproductive health	Child survival, nutrition	Maternal health and improved obstetric care	Maternal health and improved obstetric care
<b>Intervention examples</b>	Interactive radio instruction  Pre and in-service teacher trainings  School health and nutrition (de-worming, physical examinations)  Organization of outreach events to educate communities about malaria prevention and treatment.  PD Hearth	Growth monitoring  PD Hearth, other food preparation demonstrations  Microcredit scheme  Increasing small-scale production and processing of micro-nutrient rich foods  Boreholes, water pumps	Emergency transportation scheme  Community savings scheme  Community-based information dissemination	Emergency transportation scheme  Community savings scheme  Community-based information dissemination
<b>Location</b>	Nassarawa, Kano, Lagos, Bauchi, FCT	Kano, Akwa Ibom, Nassarawa	Katsina, Zamfara, Yobe, Jigawa, Kano (management)	Jigawa, Kano, Enugu, Kaduna, Ekiti
<b>Implementation period</b>	May 2004 – April 2009 (5 years)	Jan. 2006 – Jul. 2007 (18 months)	Oct. 2006 – Dec. 2012 (6 years)	June 2002- June 2008
<b># LGAs</b>	51	3	21	6
<b>#Communities</b>	203	9	92 for MNCH	36 initial, rolled out to 90

The case studies of COMPASS, SMI/PATHS1, and PRRINN-MNCH focused on community-based initiatives within each project, and did not seek to review the totality of the projects' interventions. All projects were/are funded by bilateral donors, namely, USAID, DfID and the Norwegian Agency for Development Cooperation. SMI and PRRINN-MNCH were health oriented and targeted pregnant women, but with the intention to add more children and women health and nutrition interventions to the same community mobilization platform. COMPASS was a health and nutrition project that also integrated education components. However, for the purpose of this study, we focused mainly on the health and nutrition components. GINA in Kano State was a nutrition project with a strong focus on agriculture interventions combined with nutrition communication interventions such as growth monitoring and Positive Deviance (PD) Hearth. (Table 1).

**Figure 2: Project's location by State**



COMPASS, SMI and PRRINN-MNCH were longer-term, large-scale initiatives while GINA was a small, short duration project. PRRINN-MNCH in Katsina State had only six months of implementation, even though a similar platform had been rolled out in other states before. PRRINN-MNCH is the only project that was operative at the time of the study which allowed for direct observation of the implementation. The other three projects had already closed which made analysis of their sustainability possible. PATHS1 has subsequently been succeeded by PATHS2. Only the SMI under PATHS1 is discussed here. The projects were located in

Northern States (Kano, Katsina and Jigawa) and one of them, COMPASS, was studied in both a northern state (Kano) and a state in the North Central Zone (Nassarawa). COMPASS was the largest project, covering 51 LGAs in total, followed by PRRINN-MNCH and SMI (21 and 6, respectively). GINA had the lowest coverage, at 3 LGAs (See Figure 2).

Data collection and methods were informed by a common study framework that outlined key “dimensions” of successful community-based health and nutrition programs. The framework was developed during a one week methodology workshop organized jointly by WB consultants in Nigeria and the WB team and held in Abuja in April 2010. The framework’s dimensions included:

1. ***Using and strengthening existing community organizations*** – This dimension looked at: (i) community involvement, participation and influence in design, planning, implementation, M&E; (ii) Adaptability and flexibility of design and implementation to social, religious and environmental contexts; (iii) Degree of integration of activities, actors and resources; (iv) Ability of community members to hold project responsible for fulfilling program goals and objectives; and (v) Creation of new structures and actors and their relation to existing structures;
2. ***Extent to which project is embedded in and catalyzes policy environment and engages stakeholders*** – This dimension looked at: (i) Political and Financial stakeholder involvement and support; (ii) Extent to which stakeholders are brought together for building alliances and coalitions for change; (iii) Use of advocacy and strategic communication; and (iv) Use of existing protocols, guidelines and tools;
3. ***Cost effectiveness*** – This dimension looked at: (i) Choice of intervention, i.e., direct and proven cost-effective interventions and multisectoral nutrition and health sensitive interventions; (ii) Budget categories and cost structure; and (iii) Monitoring and evaluation of cost-effectiveness;
4. ***Financial capacity*** – This dimension looked at: (i) Funding base, i.e, single donor or multiple sources of funding including the national budget; and (ii) Resource mobilization strategy including short-term opportunistic fund raising and long-term sustainability planning; and
5. ***Management capacity*** – This dimension looked at: (i) Human resource and capacity management including technical capacity, career development, performance evaluations, team building, recruitment, training, supportive supervision, mentoring/coaching, reward system, attrition levels; (ii) Subsidiarity and decentralization of roles and responsibilities; and (iii) Financial management, including funding flow and financial arrangement.

This framework was organized into a matrix and informed each case study. In addition to the five dimensions, a number of sub-dimensions were developed to increase granularity. The complete matrix can be found in the Annex D of the main report. Three open-ended questionnaires were developed to guide the collection of data and information across each dimension for: (i) project management staff and frontline personnel; (ii) community members; and (iii) other stakeholders (e.g. LGA and State Government personnel, NGO staff). The data collection involving community members was mainly through focus group discussions or workshops. Key informants including project staff and other stakeholders were invited for

individual in-depth interviews. In addition, each case study is supported by a desk review of project documents.

## KEY FINDINGS

The case studies provided a wealth of information on best practices in community-based programming for improved nutrition and health. It also highlighted some common pitfalls and “least best” practices. What follows is: (i) a set of key findings pertaining to the organization and system development of community-based nutrition and health interventions which have important implications for the sustainability of community nutrition and health programs; followed by (ii) a set of important design-relevant findings on ways to enhance results in community-based strategies for improved nutrition and health.

### *Organization of community-based nutrition and health interventions*

- 1. Community-based services (delivered in the community and by the community) need to have a more prominent role in the delivery of basic nutrition and health services.** In the cases studied, community engagement is used mainly as a channel to increase demand for health services in facilities. Yet, community-based approaches are particularly relevant for interventions which involve behavior change at the household level such as birthing practices, neonatal care practices, infant feeding practices, and hygiene, all of which have great importance for maternal and child health and nutrition, which do not necessarily require direct support from health facilities for consumables or for technical supervision. The dire situation of many primary health care facilities and the high costs associated with: (i) their upgrading; and (ii) developing enhanced stewardship of the sector, implies that there is potentially more to gain by emphasizing community action for nutrition and health. That said, community-mobilization has the long-term potential of creating and voicing demand for good quality of services for the community members when in need.
- 2. Community-based strategies need to be part of system development.** Many initiatives are led by donors and perceived as pilot experiences. As a result, sustainability has been problematic. Project design needs to contemplate the long-term sustainability supported by government structures. This implies that government structures become actively engaged in the activities from project conception to evaluation. Moreover, given the fragmented and complex nature of the Nigerian health system, all levels of government need to be involved for an effective delivery of services at the community. The appropriate engagement of State and LGA levels is particularly crucial to improve the coverage of unmet demand for and enhance sustainability of community-based nutrition and health services.
- 3. Community-based nutrition and health programs should seek ways to more effectively use the comparative advantage of NGOs.** NGOs often represent community interests more effectively than the bureaucratic and/or vertical public sector. By virtue of being less bureaucratic, they are more flexible in the way they engage with different communities in terms of organization and cohesion, social norms and religion, infrastructure, wealth and other characteristics. Generally, NGOs also have more experience with community organization and development than the public sector. Hence, in many ways, NGOs can contribute to the

successful implementation of community-based nutrition and health programs. Yet, so far, there has been limited experience in Nigeria in developing effective public-private partnerships of this sort. In some cases, NGOs have been used as a vertical stop-gap measure without strategically anchoring their contribution in a broader approach of community mobilization and development. The resulting lack of sustainability then is often incorrectly blamed on NGOs rather the strategy (see next point).

**4. Given the inherent involvement of many actors and stakeholders in community-based programs, community-based programs should clearly define roles and responsibilities in order to avoid misunderstandings and duplication, but also to enhance coordination and accountability.** The cases provided various examples of unclearly defined roles and responsibilities undermined the efficiency of the project. The roles and responsibilities should stipulate “who does what” but also “who reports to whom”. As for institutional roles and responsibilities, the use of Memoranda of Understandings (MOU) and other contractual agreements have shown to be useful tools. Accordingly, the use of NGOs requires careful planning and consideration to ensure that their role builds on their comparative advantage and is complementary to that of other stakeholders. When properly done, using NGOs to implement community-based nutrition and health programs is as sustainable as if not more than any other strategy to reach results; it costs money, and requires training, supervision and monitoring, but most importantly, it builds capacity.

**5. Community-based nutrition and health programs should dedicate a major part of their resources on developing strong and lasting support mechanisms for community members and community (support) groups.** Community-based action for nutrition and health implies the active involvement of community members (often known as “volunteers”). These community members and community groups play a most important role in bringing about change, and therefore are essential stakeholders in community development for better nutrition and health. The identification and mobilization of local structures and resources available and capable to provide adequate support to the community mobilization efforts is a critical factor in the performance of community-based programs. The cases showed that the change process at community level quickly erodes after projects close as that puts an end to the support and guidance mechanisms.

**6. Community-based nutrition and health programs should agree on a common set of outcomes and related activities but provide space for operational flexibility at the local level in developing appropriate and effective mobilization strategies.** The case studies showed that communities generally are very flexible to accommodate different project needs. However, due to the differences in the ways communities are organized, rigid mobilization strategies generally have not worked well. By allowing more operational flexibility (without compromising on results and related activities), there will be scope for learning-by-doing, a principle that has worked well for community strategies in other countries.

**7. For community-based nutrition and health services to be scaled up, programs should decentralize the management of operational support and supervision.** As local representatives of government in charge of local development, LGA have a role to play, but also can bridge the distance between state level leadership and community action for nutrition and health, and allow for a more flexible approach to community mobilization activities that take into

account the local context and cultural norms and characteristics. However, issues of capacity need to be addressed through a gradual approach of capacity enhancing activities aimed at strengthening the implementation, coordination, monitoring and stewardship roles at the State and LGA levels..

**8. Given the political, institutional and organizational differences between individual states, community-based programs should adopt a state-by-state identification of the most appropriate lead agency for community mobilization.** By virtue of its vertical hierarchical organization, the SMOHs are not necessarily best equipped to take the lead in the mobilization and organization of community action for nutrition and health. While SMOHs have an important role to play in the guidance and supervision of the activities at community level, other institutions can complement that role in the areas of community mobilization and organization.

**9. Community-based program should follow an emerging design of gradually building the critical mass of mobilization for maternal and child nutrition and health.** Rather than starting with an all out, all-at-once approach to stakeholder mobilization and involvement, community-based programs are best served by starting with a relatively simple design in order to focus on community action and results. From there, the program can seek out the formal involvement by other stakeholders and broaden the stakeholder base around the program.

#### *Achieving results*

**10. Community-based nutrition and health programs should focus on the achievement of selected outcomes through the use of results frameworks, the inclusion of proven interventions, and the application of a results-based project design.** Programs which do not link the inputs/outputs with specific results and have broad objectives will be less effective in achieving and documenting crucial results for the MDG targets. The biggest initial gain on selected results can be made by scaling up proven cost-effective interventions which in turn will inform the program on underlying factors of ill-health, malnutrition and death and thus to additional (indirect) interventions.

**11. Programs aimed at effective community mobilization for maternal and child nutrition and health should take the time to introduce the objectives and strategies to the formal and informal authorities and stakeholders concerned.** Effective community-based nutrition and health programs depend on the involvement of formal, traditional and religious authorities, as well as community stakeholders such as men and grandmothers. Advocacy visits and community meetings are all proven strategies to inform the stakeholders and obtain their support. The case studies also showed the importance of paying due respect to the lines of authority in the sequence of sensitizing and mobilizing stakeholders at the different levels.

**12. Monitoring systems should start with and be based on community monitoring.** Community monitoring enhances community ownership of the program objectives but also provides the means to effectively link the informal, horizontal community structures with the formal, vertical public systems. The case studies showed that without good monitoring that originates at community level, the link was quickly lost and timely support became unavailable.

There is an urgent need for improved understanding of the benefits of local monitoring both among project planners and community members.

**13. Community-based programs should translate actions and interventions into visible results that communities can own and monitor.** In the case studies, safe motherhood was carried successfully by communities because they experienced (and monitored) the dramatic fall in maternal mortality. Conversely, immunization proved to be more difficult to sell at community level as it wasn't clear to communities what result was being achieved. This principle lies at the heart of growth monitoring and promotion (making growth visible to mothers and communities), Positive Deviance Hearth (using the demonstration of results in the health of children to promote the impact of good caring practices to treat and prevent malnutrition). Similarly, experiences from elsewhere in the region and beyond provide examples of the importance and ways to translate interventions into visible and "monitorable" results. Many of these experiences are in the area of child health and nutrition.

**14. Community-based programs aimed at behavior change should consider ways to combine integrated comprehensive communication approaches, e.g., individual counseling, with normative communication strategies as well as focused social marketing campaigns around key messages.** The safe motherhood initiative created very good results by saturating communities with information regarding the need to reduce delays in seeking emergency obstetric care. However, pregnant women, mothers and communities need access to more comprehensive information on the broader spectrum of issues in maternal, newborn and child health and nutrition in order to enhance healthy growth in women and children. For example, counseling during pregnancy and early childhood can effectively address information needs as they arise at individual level. Such needs cannot be taken care of by social marketing campaigns. Yet, normative communication and social marketing campaigns are very effective to raise the visibility of specific key messages.

**15. Special attention should be given to equity issues in community-based programs by ensuring the inclusion of hard-to-reach and vulnerable groups.** Vulnerable groups of women among the poor are often hard to reach and in dearest needs of the services and interventions in community-based nutrition and health programs. Strategies that have been employed to promote inclusiveness and equity include communication, community monitoring, and membership in committees and community groups. Improved mechanisms of inclusion of vulnerable households are needed which requires joined thinking of project planners and communities alike.

**16. Community-based programs for nutrition and health should systematically track and document the cost of implementing community-based nutrition and health programs.** One limitation of the study is the lack of baseline data on community-based (maternal and child health and nutrition strategies) financing in Nigeria. Based on limited information from programs in other countries, there is some reference data available as to what community-based health and nutrition programs tend to cost per mother/child per year, or per capita per year. This will improve the information basis on the cost of these programs and thereby the forecasts necessary for budget preparation.

## MOVING FORWARD

As a result of the looming end date of the MDGs, high level political support for the Integrated Maternal, Newborn and Child Health Strategy; and revamping of the Primary Health Care service delivery system, there is a real policy opportunity to build the systems necessary for sustainable community engagement for maternal and child nutrition and health. In order to seize this opportunity, the authors suggest that the states in Northern Nigeria take some bold decisions in favor of building sustainable community-based programs for maternal and child nutrition and health by 2015. The actions should comprise the following:

- Identify and convene stakeholders from all levels to: (i) disseminate the study results; and (ii) reach consensus on the need to build sustainable systems for community-based health and nutrition action as well as a road map on how to get there;
- Design strategies for community mobilization and community action for mother and child nutrition and health that:
  - i. agrees on a set of common outcomes and interventions – based on the specific health and nutrition problems of each state, the strategy should focus on evidence-based cost-effective interventions; these interventions should include at least some interventions of high perceived value to the community to enhance adoption and ownership;
  - ii. organizes communities around specific activities and interventions using a flexible mix of community implementers and community groups through participatory, consensus-building approaches to community mobilization; and
  - iii. ensures regular close and continued support to the community structures through the involvement of NGOs, LGAs and public health service providers in clearly defined responsibility arrangements for mobilization, guidance and reporting as an integral part of the Primary Health Care system;
- Pilot community service delivery in a number of LGAs with the goal to scaling up the initiative throughout the state by adopting a learning-by-doing approach to building the capacity for a flexible, decentralized and inclusive management structure;
- Re-allocate, mobilize and increase resources from LGA, state and federal health budgets for the sustainable program-wise implementation of the community-based strategies; while donor funding is attractive and useful to kick-start the process, national stakeholders should recognize the common pitfall of its time-bound nature that has caused and still causes the loss of numerous best practices in ensuring better services for nutrition and health to poor communities.

## **2. Maternal and child nutrition and health**

### **2.1 Background and context**

Nigeria, a country of over 154.7 million people (World Bank, 2009), is the most populous country in Africa, and the tenth largest country in the world. Indeed, one in every five Africans is Nigerian. Administratively, the country is organized as a federation, with a Federal Government, 36 States, the Federal Capital Territory, and 774 Local Government Areas. Abuja is the capital and the seat of the central government. As a federal system, Nigeria assigns different health responsibilities to the three levels of government. Each is largely autonomous in terms of management and financing.

Nigeria is the second largest economy in Sub-Saharan African, with an enormous income from oil in the past forty years. Yet, the country is ranked the fourteenth poorest country in the world (UNDP, 2009). According to the United Nations Development Programme (UNDP), two out of every three Nigerians live below the extreme poverty level (i.e., less than USD1.25 per day at purchasing power parity), while 84% of the population lives on less than USD2 per day (UNDP 2009). The majority of these are women living in the rural areas. It is therefore not surprising that despite a reduction in the absolute number of the poor from 80% to 52.6 %, Nigeria was ranked the 157<sup>th</sup> poorest country out of the 182 surveyed countries in 2009, with an gross national per capita income of USD930 (World Bank, 2009). Nigeria also has large income disparities, with a Gini index of 50.6 (UNDP, 2009), making equity and the responsiveness of governance to the needs of the poor a major issue needing attention in the country.

Access to quality and affordable services and other basic social amenities including safe drinking water and improved sanitation facilities is limited, and economic opportunities remain scarce for many citizens. Although the government seems to be using various reforms rigorously, weak governance has been an obstacle to improvements in public services, including health care (World Bank, 2005a). There are significant differences across the country in living standards, climate, health threats, quality of governance, and access to State and Local Government services. So, increasingly, an understanding of what is needed to consolidate and scale up cost-effective maternal and child health and nutrition interventions is a high priority.

### **2.2 Maternal and Child Mortality**

With an estimated maternal mortality ratio of 840 per 100,000 live births (WHO, 2008), Nigeria has one of the highest rates of maternal mortality in the world. In sub-Sahara Africa, only Somalia (1,200), Chad (1,200), Guinea Bissau (1,000), Liberia (990), Burundi (970) and Sierra Leone (970) have higher estimated mortality rates. Moreover, Nigeria is doing considerably worse than other large countries such as Sudan (750), the Democratic Republic of Congo (670), and Ethiopia (470). Based on the latest DHS (2008), about four maternal deaths occur in Nigeria every hour, 90 every day, and 2,800 every month, totaling about 34,000 deaths annually, with wide regional and local variation (National Population Commission and ICF Macro, 2009).

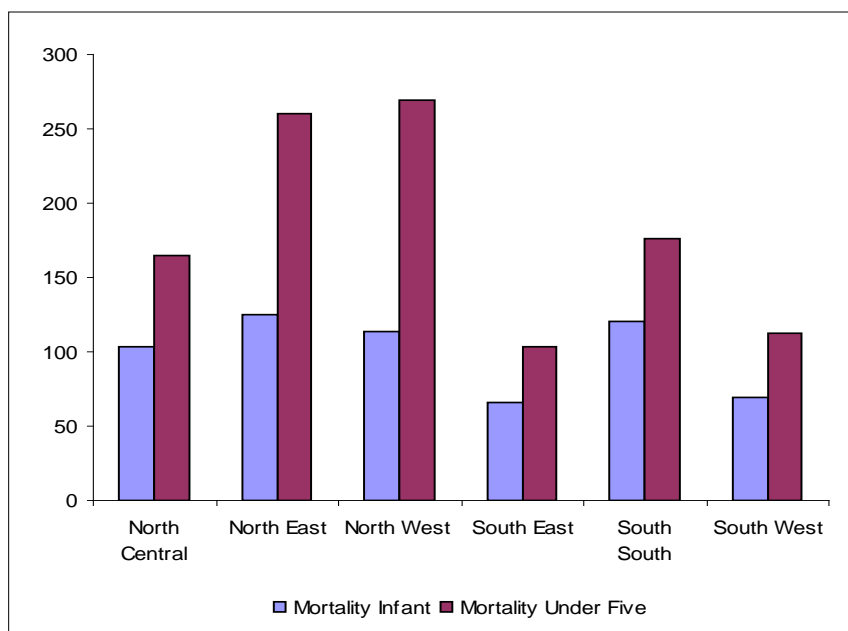
Nigeria's state of child mortality looks equally grim. The under-five mortality rate is estimated at 186 per 1,000 live births with only seven countries in sub-Sahara Africa being worse off, i.e.,

Angola (220), Chad (209), Somalia (200), Democratic Republic of Congo (199), Guinea Bissau (195), Mali (194) and Sierra Leone (194). Among the big countries in sub-Saharan Africa, only DRC has a worse scenario than Nigeria; Ethiopia and Sudan both have under-five mortality rates of 109 per 1,000 live births.

Every year about one million children die in Nigeria. Many of these children die from either preventable diseases or from diseases that can be treated at very low cost. At present, one out of every ten children dies before his or her first birthday and one out of every five before his or her fifth. Up to half of all newborn deaths are known to occur on the first day of life. Moreover, more than half of African babies who die do so at home (UNICEF, 2009a).

Not only are mortality rates high, but there is also substantial variation across geographical zones. Infants and children under five are more likely to die in the Northern region of the country than in the Southern region (Figure 2). Similarly, child mortality rates are about three times higher among children from the lowest wealth quintile and mothers with no education compared to children from the highest wealth quintile and mothers with higher education (DHS, 2008).

**Figure 2: Infant and under-five mortality rates across geopolitical zones**



Source: DHS 2008

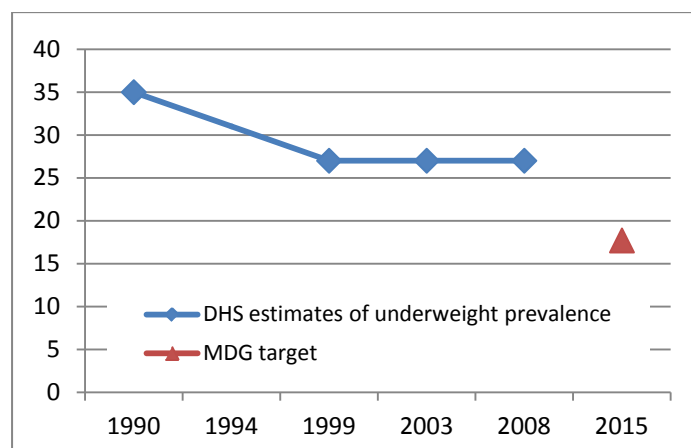
The most common causes of under-five mortality include neonatal causes (26%; i.e., asphyxia, preterm, infections), malaria (24%), pneumonia (20%), diarrhea (16%) and measles (6%). It is important to note that malnutrition is a common underlying factor in child mortality, such that between one third and one half of all child deaths are also due to malnutrition. In other words, between one third and one half of under-five deaths would not have occurred if these children would not have suffered from malnutrition (National Population Commission and ICF Macro, 2009).

## 2.3 Nutritional Status

The nutritional status in adult women is measured by their Body Mass Index (BMI) which is based on women's height and weight, and measures thinness and obesity. Two in three women have a normal BMI (DHS, 2008); 12% being thin and 22% being obese. Both conditions are associated with negative nutritional outcomes in children. Low birth weight, among other causes, is indicative of the poor nutritional status of the mothers. Although data is scarce, it is estimated that low birth weight affects 14% of newborns (UNICEF, 1990).

In children, under-nutrition is measured by stunting (shortness), wasting (thinness) and underweight. Figure 3 shows the trend in underweight prevalence in relation to the MDG target for under-nutrition.

**Figure 3: Underweight trends and MDG target**



Source: WHO, 2011

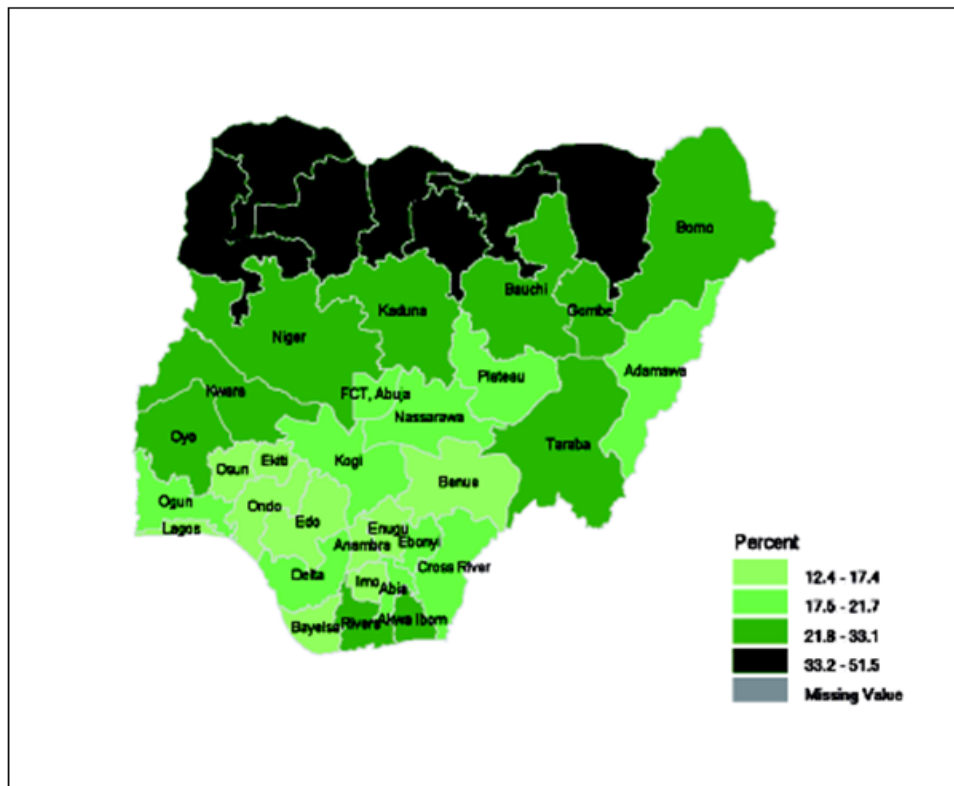
There is also wide geographical variation, with rates highest in the dry savannah areas of the Northern part of the country, and lowest in the humid forested areas of the South (Figure 4). Similarly, incidence of the problem is also higher in rural than in urban areas. Children in the North are therefore more likely to be undernourished and to suffer from the multiple and often irreversible consequences of malnutrition.

Underweight, however, can be a reflection of both stunting and wasting. The 2008 DHS found that 41% of under-five children suffer from chronic malnutrition (stunting) and 14% from acute malnutrition (wasting). The proportion of children aged 6-35 months that were chronically malnourished increased from 42% in 2003 to 50% in 2008. Figure 5 shows the evolution of stunting prevalence in Nigeria by geographical zone. Although the 1990 division in four Zones is not comparable to the 2003 and 2008 division in six Zones, the message is clear:

- The Southern Zones are significantly better off than the Northern Zone;
- The Southern Zones have seen significant improvements between 1990 and 2003 while the stunting prevalence in the Northern Zones has remained stagnant;

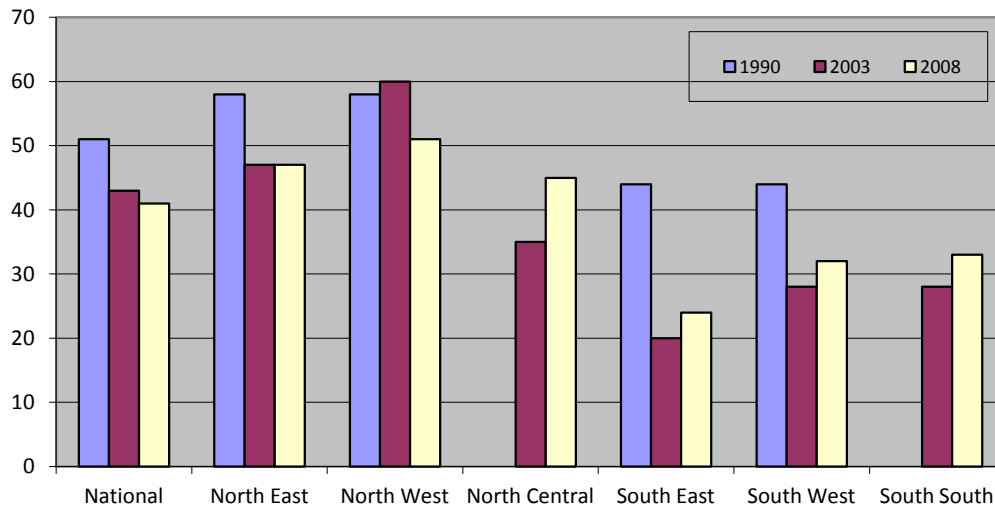
- There have been no significant improvements in stunting rates in both the Southern and Northern Zones between 2003 and 2008;
- According to the 2008 data, the stunting prevalence in the Southern Zones is closer to Ghana (28%), Angola (29%) and Mauritania (32%) while in the Northern Zones the rates compare more with Madagascar (53%), Ethiopia (51%) and Guinea Bissau (47%).

**Figure 4: Regional variation in underweight**



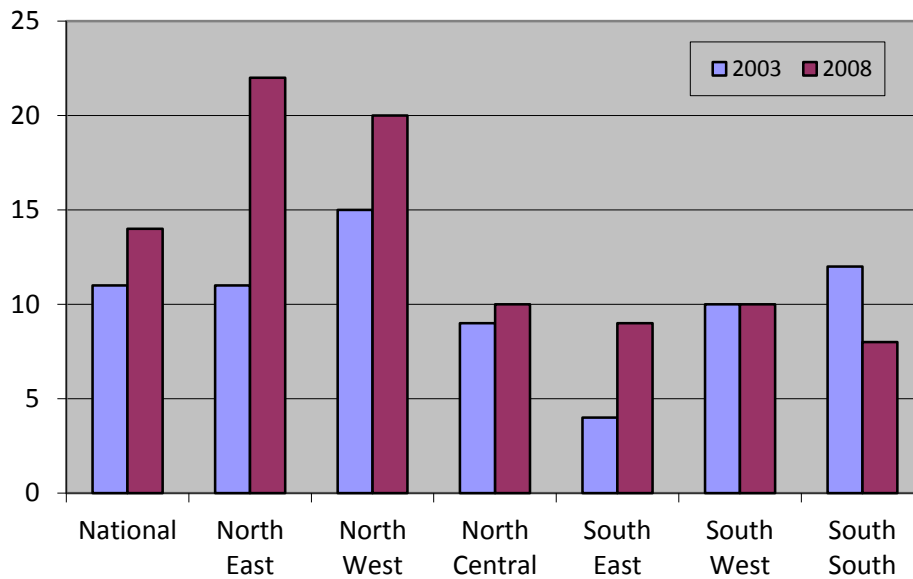
The 2008 DHS also reports that the national wasting or acute malnutrition (weight for height) rate has increased from 11% in 2003 to 14%, this increase being mainly concentrated in the two Northern Regions which have reached emergency conditions (i.e., >15%) according to WHO criteria.

**Figure 5: Stunting rates by Geographical Zone and by survey year**



*Source: WHO, 2011*

**Figure 5: Wasting rates by Geographical Zone and by survey year**



*Source: WHO, 2011*

### Micro-nutrient deficiency

Micro-nutrient deficiencies (MND) due to poor dietary intake of certain nutrients and/or inadequate absorption by the body are also widespread. The most common deficiencies are those of vitamin A, iron, iodine, foliate, and zinc. MND cuts across every sector of the country, with especially worrisome levels among women. Micronutrient deficiencies, especially during pregnancy, can harm the health of both women and children.

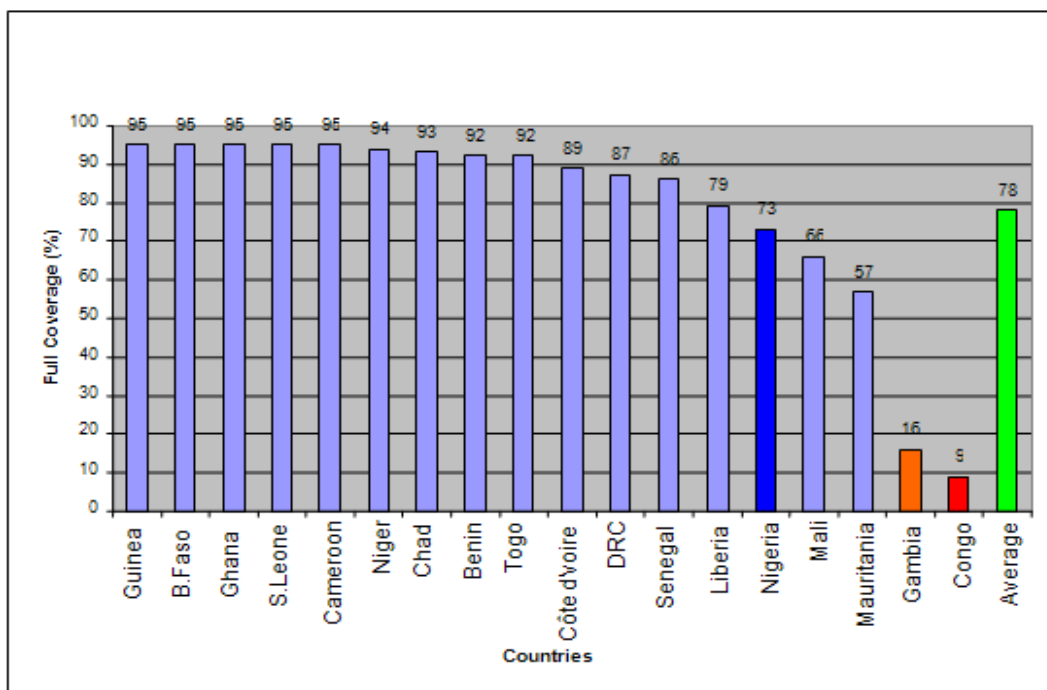
A nutritional survey found that about 10% of pregnant women had vitamin A deficiency, while 20% suffered from iron deficiency and 20% had iodine deficiency with 4% of them severely iodine deficient (Maziya-Dixon et al., 2004) . One out of every three children is vitamin A deficient. The rate of micro-nutrient deficiencies within each major zone and sector has also been highlighted in the NFCNS.

### Vitamin A deficiency

Vitamin A deficiency is considered a public health problem in Nigeria for a number of reasons; Prevalence of VAD in children under five (as measured by blood retinol level) is about 28.1%, and is about six times the global norm for public health significance of 5%. The prevalence of xerophthalmia-related cornea scars in children under five is 1%, which is about 20 times the benchmark of 0.05% prevalence that indicates a public health problem. Similarly the prevalence of night blindness in children under five is 3.7%, about four times the benchmark of 1% indicative of a public health problem. Vitamin A deficiency also increases the risk of child death due to diarrhea, measles, and malaria, and it can also cause child blindness. Systematic reviews have documented that Vitamin A supplementation in children over six months of age results in a 23% reduction in child mortality (Beaton et.al, 1993).

Over the past eight years, thanks to supplemental immunization activities, the delivery of Vitamin A capsules has improved steadily, and by 2008 more than 300 million doses had been distributed, reaching more than 70% of intended beneficiaries. Although Vitamin A coverage for Nigeria is relatively high (73%), it remains below the West African average of 78% (National Bureau of Statistics, 2007; Figure 8).

**Figure 8: Vitamin A supplementation coverage in West and Central Africa (2007)**



## **Iodine deficiency**

Iodine deficiency also constitutes a serious health problem in Nigeria, especially in areas where non-iodized salt is consumed. Iodine deficiency in the early stages of life can cause damage to the brain, leading to severe mental retardation and impaired mental functions. Serious iodine deficiency can also cause goiter among people living in iodine deficient areas. This may arise from inadequate intake of iodine or from reliance on diets containing high levels of goitrogens (e.g., cassava), which inhibit iodine utilization.

Iodine deficiency is often characterized by neurological changes, which cause permanent damage to cognitive development in children. Serious iodine deficiency during pregnancy can result in stillbirth, child brain damage, and cretinism, and it can also produce goiter. Universal Salt Iodization (USI) was institutionalized in 1993 as a strategy to control Iodine Deficiency Disorder. Since 1998, five years after the introduction of USI, 98% of households are reported to have access to iodized salt, and in 2007 Nigeria was certified as having achieved universal iodization, perhaps the only area in which Nigeria has recorded any significant achievement (Iodine Network, 2006).

## **Iron, zinc and folate deficiency**

Iron deficiency among pregnant women can result in mortality and also in premature birth and low birth weight babies. Iron deficiency is also a major cause of anemia. Iron deficiency results from insufficient absorption or excess loss of iron. Iron is depleted primarily through blood loss, including from parasitic infections such as schistosomiasis and hookworm. The National Micronutrient Survey (NMS) conducted in 1993 put the prevalence of anemia among children and women of childbearing age at 62% and 75%, respectively (Federal Ministry of Health and Social Services, 1996).

Evidence shows that zinc supplementation is one of the major interventions that can prevent diarrhea and pneumonia in children (Black, R.E. et al., 2003). Studies have shown that zinc supplementation, given in combination with oral rehydration therapy, can reduce the incidence of diarrhea in children by 27% (Brown et.al, 2009). It can also reduce the incidence of acute lower respiratory tract infections by 15%.

Deficiency in folate, especially in the woman before conception, may lead to debilitating and sometimes deadly neural tube defects, including spinal bifida, in the growing fetus. However, few women have access to this important micronutrient as it is often in short supply.

## **Underweight, overweight and chronic non-communicable diseases (NCDs)**

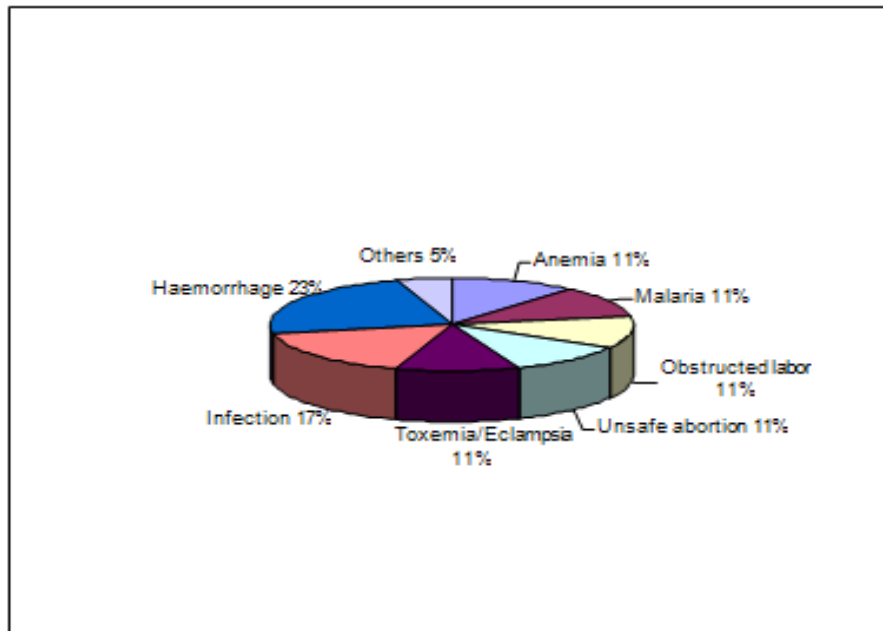
There is evidence indicating that a balanced body mass index (BMI) is important for reducing the risks of disease. Evidence in developing countries indicates that malnourished women with a BMI below 18.5 show a gradual increase in mortality rates as well as an increased risk of illness (Rotimi C. et al., 1999). The 2008 DHS indicates that 12% of women surveyed were thin, with BMI < 18.5. BMI is an index used in measuring thinness and obesity. At the same time obesity

(BMI  $\geq$  30) is known to predispose pregnant woman to non-communicable diseases such as hypertension, stroke, and diabetes mellitus, with serious consequences. One study found that, in Nigeria, 15% of women of child-bearing age were overweight and 6% were obese. Both conditions (underweight and overweight) have serious implications for the health of women and their newborns (Maziya-Dixon et al. (2004).

## 2.5 Direct causes of maternal and child mortality

Major causes of maternal mortality include post-partum hemorrhage and infection. Toxemia and obstructed labor are also risks, as are anemia and malaria, as well as unsafe abortions (Figure 9). The major causes of mortality and morbidity among children under five are communicable diseases, namely malaria, pneumonia, and diarrhea, often in association with malnutrition (Figure 10). Many of the more effective interventions for preventing or treating these illnesses as well as malnutrition and to improve maternal health can be delivered at low cost through primary health care services or through interventions that directly target communities or households.

**Figure 9: Causes of maternal mortality**

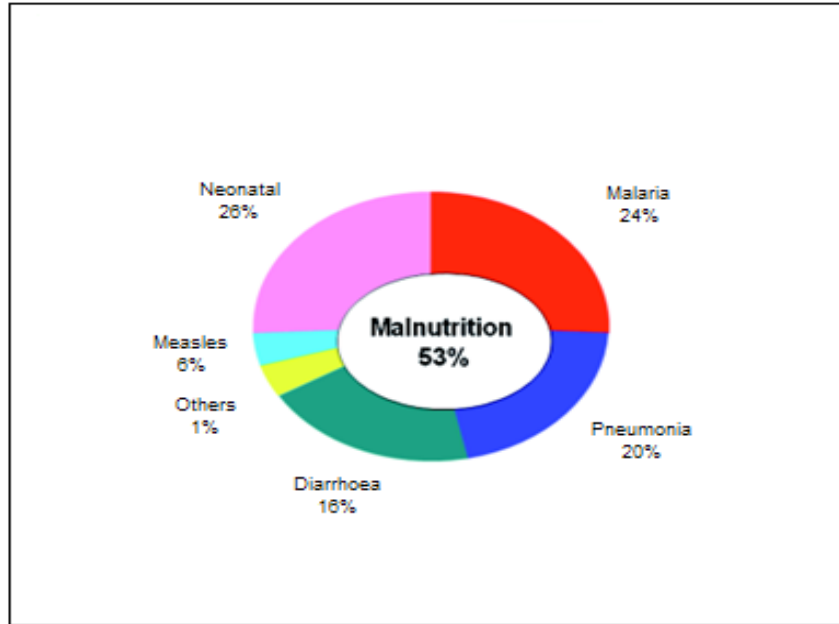


Malaria is a leading cause of death among children under five in Nigeria. Chronic recurrent malaria also contributes to anemia in children. Preventive measures, especially the use of insecticide-treated mosquito nets (ITNs) can dramatically reduce the incidence of malaria and mortality rates among children. Research has shown that the use of ITNs can reduce child deaths by 20% (WHO/UNICEF, 2003). Prompt treatment with appropriate artemisinin combination drugs can also save additional lives.

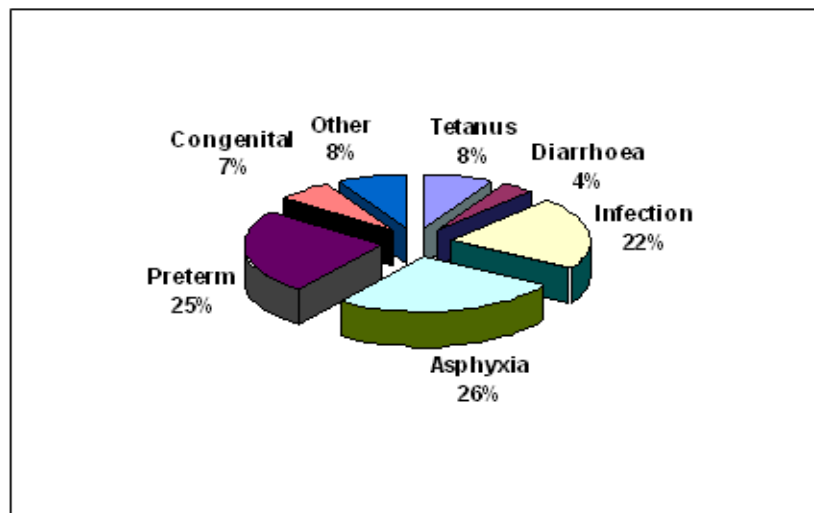
Diarrhea and pneumonia cause almost 400,000 child deaths annually in Nigeria. Diarrhea is also a major cause of child morbidity, and is both a cause and an effect of malnutrition, and can lead to linear growth retardation, causing more than 176,000 deaths among children under five in the

country. Pneumonia, the most serious acute respiratory infection (ARI), is another major cause of mortality among children, responsible for an estimated 200,000 deaths each year (Figure 10). Many of these deaths can be avoided, as both diarrhea and ARI-like malaria can be treated at low cost, yet these conditions continue to cause under-five mortality mainly due to a very low response rate at the household level and low-quality health services at the facility level.

**Figure 10: Causes of under five mortality**



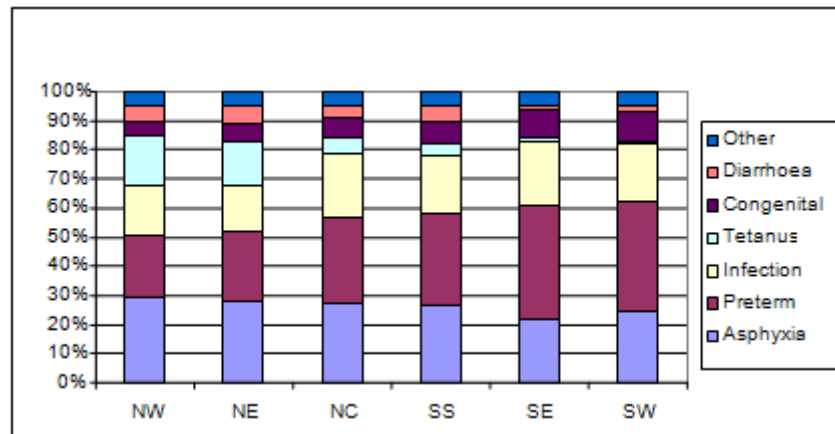
**Figure 11: Causes of newborn mortality**



Birth asphyxia or intrapartum-related neonatal deaths remain a major cause of newborn deaths and disability in Nigeria, constituting just over one quarter of all cause infant mortality (Figure 11). For each asphyxia-related newborn death, many more babies are left with permanent disabilities. Low birth weight and preterm babies also form another large number of babies who

lose their lives daily. Infections including neonatal tetanus, diarrhea, and pneumonia account for 34% of these deaths, although the distribution by cause of death varies by region (Figure 12). The World Health Organization (WHO) estimated the stillbirth rate for the year 2000 as 30 per 1,000 total births in Nigeria, amounting to an estimated 183,000 stillborn babies each year (WHO, 2000).

**Figure 12: Causes of newborn deaths by region**



Source: Save the Children, 2009

## 2.6 Underlying causes of morbidity and mortality

Many health outcomes depend on a variety of factors at the community, household, and individual levels, including water quality and sanitation, household income, and, importantly, individual health knowledge and behaviors.

### Water and sanitation environment

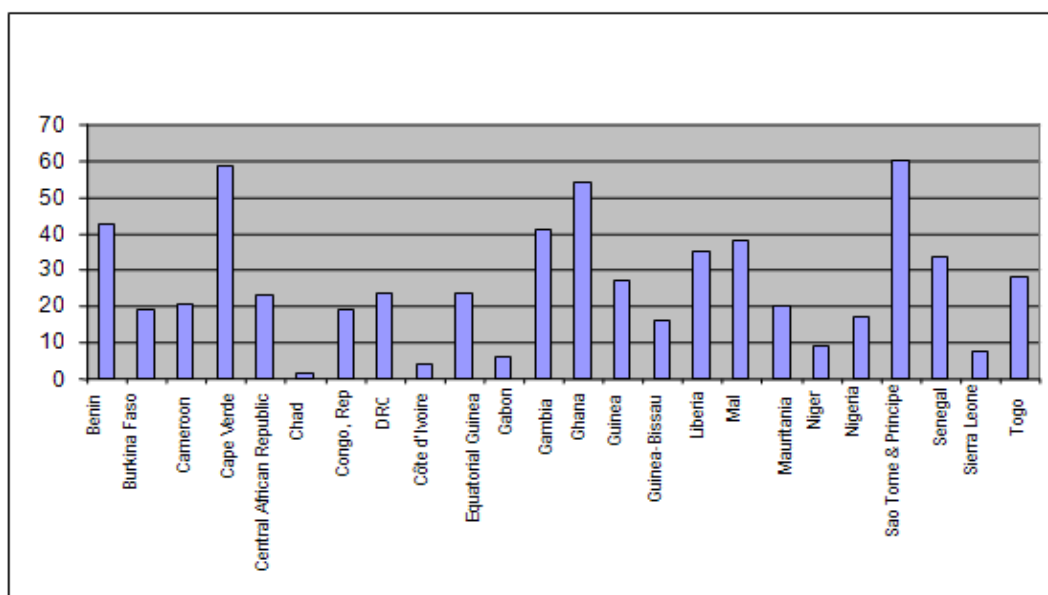
Safe drinking water is a basic necessity for good health. Unsafe drinking water can be a significant carrier of diseases such as diarrhea, cholera, typhoid, and parasitic infections. In addition to its association with the risk of disease, access to drinking water is particularly important for pregnant women and children, especially in rural areas, since both bear the traditional responsibility for carrying water, often over long distances.

The population using improved drinking water sources is defined as those who use any of the following types of supply: piped water, public tap, borehole or tube well, protected well, protected spring, or rainwater. Overall, only 49% of the Nigerian population currently has access to improved drinking water sources – 76% in urban areas and 37% in rural areas, according to the 2007 MICS preliminary report. There are North-South as well as Zone-Zone disparities with the situation in the Northern States being again considerably worse than in the South. In total, 49% of Nigerians are currently living in households using improved water and sanitation facilities. This percentage varies from 54.6% in urban areas to 15.6% in rural areas (NBS, 2007b).

## Household and community care practices

Infant and young-child-feeding practices are important determinants of the child's nutritional status, which in turn influences the risk of dying. Practically all Nigerian children (97%) are breastfed for some period of time. In Nigeria, the timeliness with which women put their infants to the breast is one of the practices in which women in the South-east and the South-west differ markedly. In the Southeast, 47% of last-born children were put to the breast within the first hour of birth, whereas in the South-west only 17% were put to the breast in the first hour (NBS, 2007a). When compared with other West African countries (Figure 13), Nigeria's exclusive breastfeeding rate is very low and 2007 MICS data show a decline in the percentage of infants exclusively breastfed to 11.7% (NBS, 2007a).

**Figure 13: Exclusive breastfeeding rate in West and Central African Region (WCAR)**



The North-central region appears to have the highest rate of exclusively breastfed babies in the country, or about 30 %, while the North-eastern and Western regions have rates as low as below 10% (NBS, 2007a). Complementary feeding has fared much better, but the critical issue is the content and quality of the feeds beyond six months. Many of the babies are often fed on gruel of low nutritional value, gradually tilting them (further) into malnutrition. Similarly, when compared with other West and Central African countries, Nigeria's coverage of exclusive breastfeeding is very low.

Preventive measures of malaria include especially the use of mosquito nets treated with insecticide (ITNs). Research has shown that the use of ITNs can reduce child deaths by 20% (WHO/UNICEF, 2003). Yet the 2007 MICS report indicates that ITN use remains very low, with only 4.1% of children under the age of five sleeping under any kind of mosquito net and 3.5% sleeping under an insecticide-treated net (NBS, 2007a). ITN-use among children under five is more prevalent in urban than rural areas (5.5% versus 2.6%). No significant improvements have been recorded, even by the 2008 DHS, which reported only 6% of children sleeping under ITNs

(National Population Commission and ICF Macro, 2009) Again, when compared with other West African countries, Nigeria fares poorly in the use of ITNs.

Diarrhea can easily be managed at home using Oral Rehydration Salts (ORS), continued breastfeeding, and increased feed and fluids. The 2003 DHS shows that only 40% of children with diarrhea were managed with ORS, home fluids, and increased fluids, whereas adequate increase fluids, continued breastfeeding, and rehydration using ORS at home can avoid 90% of diarrhea deaths (National Population Commission and ORC Macro, 2004). The 2008 DHS report reveals that the proportion of children with diarrhea who were continued on breastfeeding or received increased fluid and ORS unfortunately dropped to 25% (National Population Commission and ICF Macro, 2009).

### **Care seeking/utilization of health services**

Up to 80% of deaths in children under-five years of age occur in a home with little or no contact with health providers. Hence healthcare practices observed in the home and the community is key to the survival of these children. Indeed, indirect causes of morbidity and mortality include three types of delays that also contribute to the non-survival of pregnant women and their children. In total, 40% of delays associated with mortality in Nigeria are said to be delays in recognizing danger signs and taking the decision to seek care outside the home (Type 1); 20% are associated with difficulty of getting transport to reach a facility (Type 2); and 40% are related to delays in receiving appropriate and quality treatment at the facility (Type 3) (Okonofua et.al, 1992). This distribution indicates that reduction in mortalities is more complicated than increasing the utilization rates at formal health facilities.

Only two out of every five Nigerians with an illness or injury seek care, the poorest fifth of the population being the least likely to do so. In the 2004 NLSS report, among those reporting an illness in the two weeks before the interview, only about 60% visited a health provider and less than 50% visited a formal health provider (NBS, 2004)<sup>1</sup>. A study conducted in 2005 to identify patterns of household practices influencing safe motherhood in six states in Nigeria showed that 37.5% of pregnant women who did not attend ANC felt they were healthy and so had no need for ANC visits, while 29.2% were forbidden by their husbands, and 8.3% reported cost as the main hindrance to attendance (FMOH, 2005a).

It is important that women attend ANC at the early stages of pregnancy in order to benefit from interventions that require early or repeat visits. The 2008 DHS report revealed that, among women who receive ANC in Nigeria, only 17% make their first ANC visit during the first three months of pregnancy. Moreover; only 45% of women who had a delivery in the five years preceding the study reported visiting antenatal clinics at least four times during that pregnancy (National Population Commission and ORC Macro, 2004).

### **Distance and Quality of Services**

Distance to a health facility is the second most important reason for not accessing health care services in Nigeria. Approximately 71% of Nigerians have access to a primary healthcare (PHC)

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<sup>1</sup> Here formal refers to all health care providers except: traditional healers, TBAs, and spiritualists.

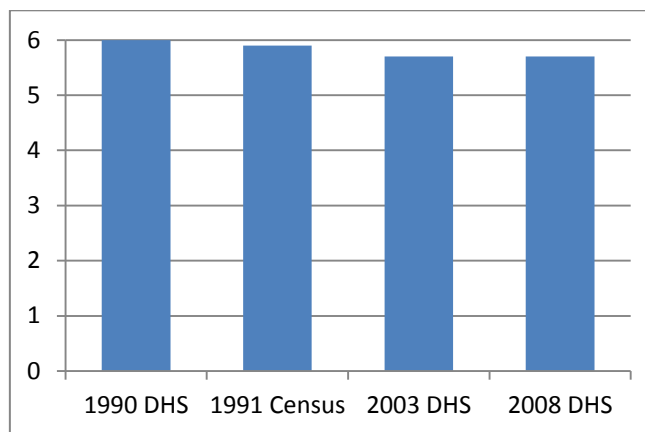
facility located within a five-kilometer radius of their homes (FMOH, 2007). However, many of these PHC centers are not functional due to frequent stock-outs and a lack of equipment, essential supplies, and qualified staff. There was a six-fold difference in the magnitude of this problem between the lowest income quintile and the highest (FMOH, 2007). The reasons for this are many, including underfunding, inappropriate location (often far from the core of the locality), and dearth of skilled personnel.

Waiting time particularly influences women's demand for health care services. A negative relationship exists between waiting time and demand for these services in both public hospitals and private clinics. Thus geographical access to healthcare services in Nigeria is significantly affected by both the time required to travel to take advantage of such facilities and the time consumers of healthcare services have to wait to use such services. The predominantly rural Northern part of the country especially lacks healthcare facilities. This explains why there is much regional disparity in the availability of social services since health services tend to be concentrated in the more affluent areas of the Southern part of the country.

### Family planning services

The importance of family planning in reducing maternal mortality cannot be over-emphasized. Surveys have shown that as many as 50% of pregnancies in Nigeria are unplanned and 25% are unwanted, and complications resulting from unsafe abortions are responsible for a substantial proportion of deaths (National Bureau of Statistics, 2007). The level of contraception (13%) is often closely related to the provision of counseling services regarding contraceptive methods (National Bureau of Statistics, 2007). If the existing demand for family planning services were met, this could reduce maternal deaths in developing countries including Nigeria by 20% or more.

**Figure 14: Trends in fertility rates**

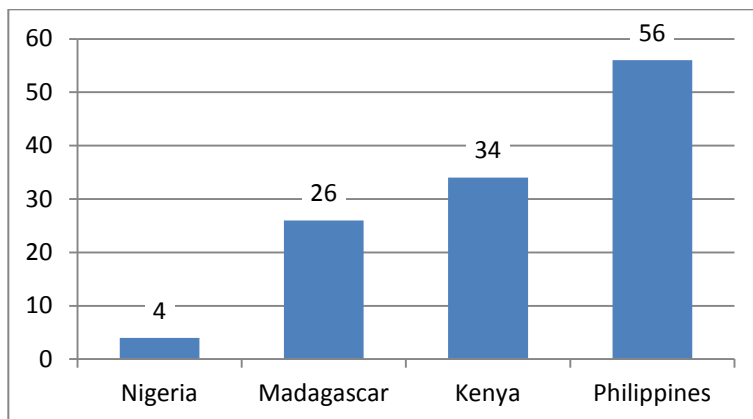


*Source: DHS, 2008*

Fertility rates also remain high (Figure 14), with the level of unsafe abortions and unwanted pregnancies on the increase (Bankole et.al, 2006). One of the most important indicators of fertility and the ability of women to adopt modern contraceptive methods is the desire to limit family size. The Population Reference Bureau (PRB), in its 2006 World Data Sheet, reported

that the lowest percentage of women with two living children who did not want more children were Nigerian (Figure 15; Population Reference Bureau, 2006).

**Figure 15: Percentage of married women with two living children who do not want more**

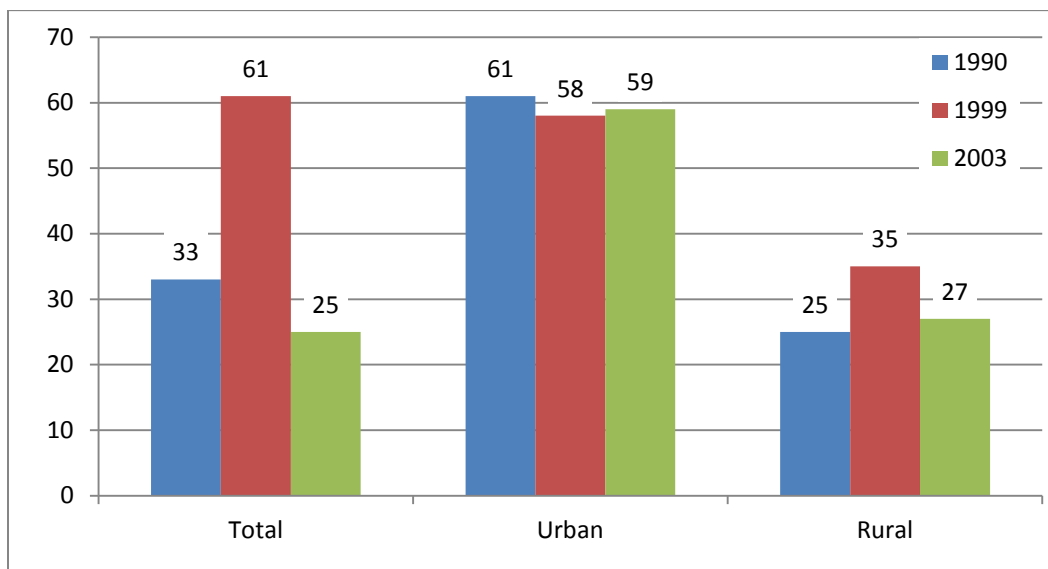


Source: PRB, 2006

### Skilled assistance during delivery

The place of delivery and type of assistance received during delivery is crucial to maternal survival. The level of assistance a woman receives during childbirth is therefore a strong determinant of the overall outcome for her and her newborn. The presence of a skilled attendant during birth is imperative and is now recognized globally as a critical step in maternal mortality reduction. The term “skilled attendant” refers exclusively to caregivers with midwifery skills, which include the capacity to initiate the management of complications and obstetric and newborn emergencies.

**Figure 16: Urban and rural variation in skilled birth attendance service utilization**



Source: ORC Macro, 2007; MEASURE DHS STATcompiler, <http://www.measuredhs.com>, October 8, 2007

Apart from improving the chances of survival of the woman, the presence of skilled attendants also ensures improved survival rates and the health of the newborn. In Nigeria, according to the 2003 DHS report, 66% of deliveries occurred at home, with only 32.6% taking place in health facilities, a number that increases only slightly (35%) in the 2008 preliminary DHS report. In total, 36% of births were assisted by skilled birth attendants as reported by the DHS 2003, with only a slight improvement (39%) as reported by the 2008 DHS (National Population Commission and ORC Macro, 2004; National Population Commission and ICF Macro, 2009). At sub regional level, the increasing utilization of skilled birth attendants over the years has been reported across zones, particularly in the South-east and South-west of the country.

It is a given that teenagers are more likely to experience complications in childbirth. It is thus important that they be attended by trained personnel and that they deliver in healthcare facilities. However, only 24% of teenage mothers are assisted by doctors, nurses, or midwives and only 21.6% deliver in health facilities.

### **Emergency obstetric care**

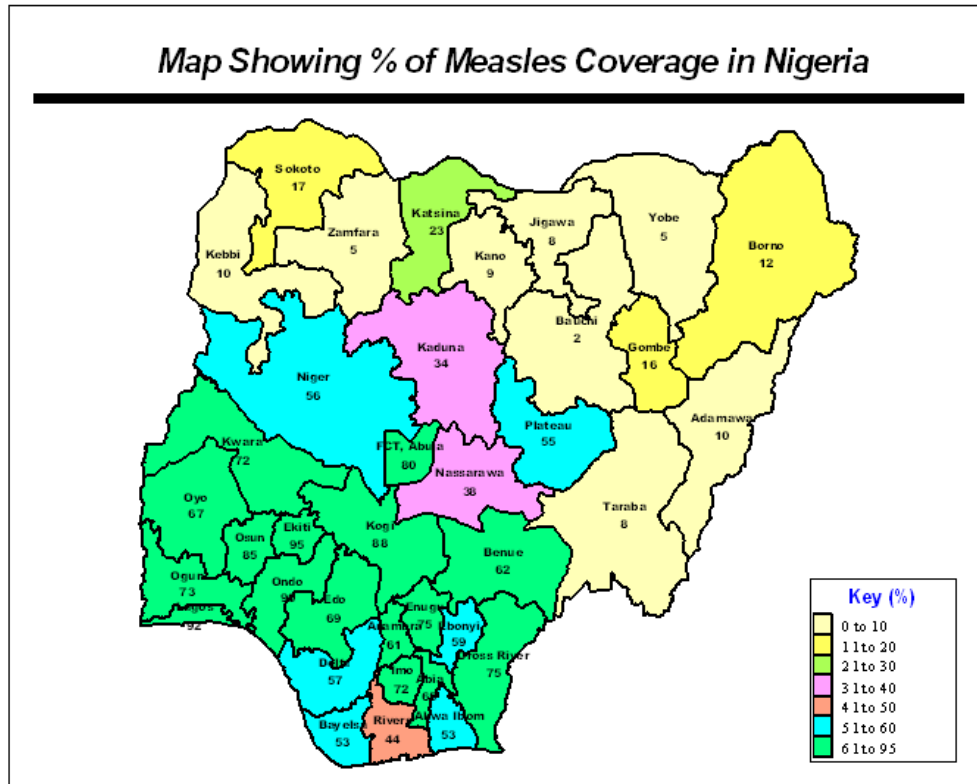
Access to emergency obstetric services has been shown to be closely linked with maternal mortality as approximately 15% of pregnant women will develop life-threatening conditions that would need such services for effective intervention. Services for emergency care must therefore be available and accessible in order to prevent maternal and/or neonatal deaths and disabilities. Specific critical services, or signal functions, should be included in the effective treatment of obstetric and newborn complications and to provide a basis for training, assessing, and equipping Emergency Obstetric Care (EmOC) services. Although neonatal resuscitation has been incorporated as an additional signal function for both basic and comprehensive Emergency Obstetric and Newborn Care (EmOnC), this service is not reflected in the policies of many African countries. The Nigerian Basic EmOnC standard includes two additional signal functions in the guideline: 24-hour service coverage, and a minimum of four midwives per facility. The availability and accessibility of EmOnC services thus deserve particular emphasis in the review of the maternal and new born mortality situation.

### **Immunization services**

Immunizing children involves delivering the complete number of doses of each vaccine in a timely, safe, and effective way. To complete the course of the most often recommended vaccines (BCG, DPT, OPV, and measles), a child needs to make five contacts with a health worker before his or her first birthday. It therefore requires that immunization services be accessible and safe and utilized by families. Low immunization coverage rates have resulted in outbreaks of otherwise preventable diseases. Among vaccine-preventable diseases, measles is a major cause of morbidity and mortality in children. In the year 2001, Nigeria reported a total of 168,107 measles cases, and in the following year, 42,007 cases (WHO, 2003). For the year 2005, more than 500 deaths from measles were reported. These numbers are nonetheless an underestimation as they only include cases that were reported to the health system. Similarly, there were outbreaks of diphtheria and pertussis in the year 2002, and neonatal tetanus continues to be one of the main causes of infant mortality in the country. These last three diseases can be prevented

by DPT immunization of the child, and neonatal tetanus also by two doses of Tetanus Toxoid (TT) immunization for the pregnant woman. While many countries in Africa have succeeded in eliminating tetanus, TT coverage in Nigeria remains very low because of the belief, particularly in the North, that TT is a family planning commodity.

**Figure 17: Regional variation in measles immunization coverage**



Immunization coverage shows wide regional disparities in Nigeria. For example, variation in measles immunization coverage ranges from up to 95% in areas of the South to as low as 0% in the South and West (Figure 17). Nigeria is also one of the four countries left in the world where the wild polio virus remains endemic. It is the only such country in Africa despite the fact that it is not in a war or conflict situation. In sum, there are some regions in Nigeria where many children receive no vaccinations. As evidenced by the measles example, 41% of children between 12-23 months of age in the North-west receive no vaccinations. These gaps in coverage have led to a very low national average: Overall, the percentage of fully immunized children aged 0-12 months in Nigeria is 11% (National Bureau of Statistics, 2007).

### 2.7 Gender inequality/disparity

Being intertwined with low levels of education, the process of household decision-making in regard to health presents another determinant that contributes to maternal newborn and under-five mortality. Control of finances and decision-making authority often lies with the husband or other male relatives. Studies have shown that “many women have lost their lives and those of their babies in pregnancy-related conditions, while awaiting a decision to seek care by such

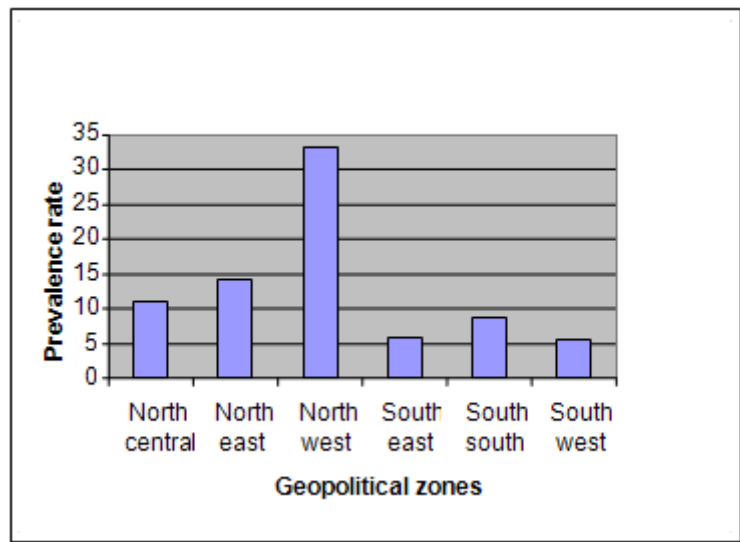
gatekeepers” (FMOH, 2007). Constraints placed on women’s movements outside the home sometimes limit their access to health facilities. This contributes to low levels of antenatal attendance, low rates of birth in health facilities, low attendance at postnatal services, poor newborn immunization, inadequate child care practices, and poor healthcare-seeking behavior. This is especially true in the Northern parts of the country. Gender disparity exists in almost every sphere of life in Nigeria, to the disadvantage of women.

**Age at marriage/child marriage**

According to UNICEF, in 2005, the median age at marriage for Nigeria was 17, with some regional variation. In Kebbi State, the average age is about 11, though marriage involving children as young as ten remains common. The same study shows that 43% of Nigerian women marry by the age of 18 (UNICEF, 2005). Early marriage is more common among rural dwellers than among urban residents (UNFPA, 2004). Per Figure 18, it is also more common in the North than the South. Prevalence is highest in the North-west (33%), followed by the North-east (14%), North-central (11%), South-south (9%), South-east (6%) and South-west (5%) (MICS, 2007).

Low age at marriage is contrary to international standards, while the extremely low age in some regions is particularly worrisome given the implications for the child. Consequences of child marriage include limited lifespan, poor health (especially the onset of obstetric fistula), infections, infertility, limited social support, and high child and maternal morbidity and mortality. Child marriage exposes children to sexually-transmitted infections (STI), HIV/AIDS, the denial of employable skills, and the perpetuation of poverty.

**Figure 18: Regional child marriage profile**



*Source: Early marriage Profile, MICS, 2007*

Maternal mortality among children under 16 has been found to be six times higher than for young women aged 20-24 (UNICEF, 2001). Children who are married too young to older spouses have limited capacity to negotiate sex, contraception, and child bearing (UNICEF, 2001). The children are, in effect, enslaved. Child marriage is a violation of all health and human

rights provisions. Both the prevalence of this practice and insensitivity to it in Nigeria suggest a need to increase understanding of its risks. This need is of particular import now, as many of the ill effects of child marriage pose a threat to a majority of the Millennium Development Goals (MDGs), each of which is eloquently canvassed through NEEDS, SEEDS, and LEEDS, as well as the 7-Point Agenda and Nigeria Vision 2020 of the new administration.

Child marriage occurs most often where poverty rates are high; parents view the practice as a “way out” for both the child and the family as a whole. Culture, tradition, religion, inappropriate understanding, and non-awareness of the rights of the child are other factors associated with child marriage. Fortunately, Sections 21 and 22 of the Nigeria Child Rights Act of 2003 forbids child marriage or the betrothal of a child (UNICEF, 2007). These texts complement steps taken by some States that have passed laws against withdrawing children from school for marriage. However, even where laws have been passed, they are often not enforced.

## **2.8 Progress towards the MDGs**

A review of the progress made toward the achievement of the MDGs indicates that Nigeria is off track and unlikely to meet the MDGs to which the country signed and committed in 2000 (Table 3). Nigeria’s health system is weak if measured by the outcome indicators. Ironically, by far the weakest part is the community health system, without which Nigeria stands little chance of reaching the MDGs. Currently, community outreach activities such as health education and the promotion of home-based treatments are largely absent throughout the country, although there are trained village health workers remaining in place from efforts dating back to the early 1990's. And although information and education campaigns can improve basic household hygienic behaviors such as hand-washing, breastfeeding, and nutritional practices –all of which have a proven impact on health outcomes - one-off training and communication campaigns are not sufficient, particularly when provision of drugs and other inputs are required.

Community based delivery platforms are essential to changing the indicators and must accompany information and education campaigns as well as improvements in PHC infrastructure. This is because a number of high-impact preventive interventions depend on community and household knowledge and behavior as well as on the availability and affordability of the necessary material inputs. These include insecticide-treated nets and family planning. In addition to preventative interventions which are actually contingent on community and household behavior, there are also many curative interventions whose efficacy is maximized when implemented at community/ household level. Management and treatment of diarrheal diseases (typically via ORT) is a prime example. Community and household provision of malaria and pneumonia treatment are also examples, particularly in the context of weak and poorly utilized health services, and given policy backing.

Simply put, revitalization of the PHC system and community-based health and nutrition strategies should go hand in hand. While the former is obviously integral in terms of inputs and trained personnel, the latter is equally essential, both in terms of preventative actions and in terms of provision of immediate emergency care where PHC infrastructure is weak or non-existent. Nigeria *can* move towards achieving MDGs 4 and 5, but only if communities and households are directly supported and empowered to improve their own health.

**Table 3: Progress toward achievement of MDGs 4 and 5**

<b>Status of MDGs on Health in Nigeria (2008)</b>				
<b>Targets</b>	<ul style="list-style-type: none"> <li>• Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate</li> <li>• Reduce maternal mortality ratio by three-quarters between 1990 and 2015</li> <li>• Reduce by half, between 1990 and 2015, malnutrition rates</li> </ul>			
<b>Indicators</b>	<b>2003</b>	<b>2008</b>	<b>Target (2015)</b>	<b>Progress</b>
• Neonatal mortality (per 1,000 live births)	48	40	16	Insignificant improvement
• Under five mortality rate (per 1,000 live births)	200	157	77	Slight improvement but still off track
• Proportion of one-year old children immunized against measles	62%	41%	79%	Off track
• Maternal mortality ratio				
• Proportion of births attended to by skilled birth attendants	800	No data	250	Limited data still
	35%	39%	79%	Insignificant change

*Source: NDHS 2003, 2008; MICS 2007*

## 2.9 Conclusions

There is a clear need for urgent steps to be taken by Northern State governments to improve health for people in those parts of the country. This chapter has described regional differences in health outcomes and health service availability and utilization that should inform policy and programs. It is clear that data and health information from national studies should be disaggregated to States so that government at this level is (1) made aware of the critical situation faced by people in the Northern region and (2) challenged to make the necessary improvements, namely devoting greater resources to healthcare. These improvements should center around improved input provision for and community-based delivery of proven maternal and child health interventions.

With sustained political commitment matched by significantly increased resource allocation for community-based nutrition and health, Nigeria can make significant progress in improving nutrition and health outcomes. Although progress may be insufficient to meet MDG Goals 4 and 5 by 2015, it will indisputably reduce unnecessary morbidity and mortality among pregnant women, babies, and children under five, now and for decades to come.

### 3. Interventions, solutions and the relevance of community mobilization

#### 3.1 Global evidence for interventions and strategies

Maternal, newborn and child health and nutrition is now at the forefront of the global development agenda because more than 10 million mothers and their offspring (including unborn offspring in their third trimester of gestation) are still dying from readily preventable or treatable conditions in spite of the fact that effective, simple, and low-cost interventions exist as evidenced in a series of global reviews (Jamison et al., 2006; Jones et.al, 2003; Darmstadt et al., 2003; Bhutta et.al, 2008). A list of cost-effective interventions discussed in these reviews is presented in Table 4. Most of these interventions require or would benefit from community involvement. The evidence regarding the effectiveness of community-based health and nutrition programs in reducing mortality and malnutrition is now growing rapidly (Freeman et al, 2009; Perry et.al, 2009; Hill et.al, 2004; Alderman et al., 2009; USAID, 2006).

Despite this evidence, scarce resources are often not allocated where they will have the biggest impact. For example, acute respiratory infection – the leading cause of child mortality – attracts less than 3% of donor funding globally, even though it accounts for 25% of the burden of disease. Nutrition programs also remain chronically under-funded, despite evidence from the 2008 round of the Copenhagen Consensus that five of the ten most cost-effective interventions for helping the poor are related to nutrition. Donor funding for family planning has decreased, despite its long-standing recognition as a cost-effective program.

**Table 4: Cost-effective interventions that affect maternal, newborn and child nutrition and health outcomes**

Intervention	Prevention (P) / Treatment (T)	Enhanced effectiveness through community involvement
<b>Preconception and antenatal</b>		
Antenatal iron and folic acid supplementation (1,3,4)	P	√
Maternal calcium supplementation (1,3, 4)	P	√
Maternal iodine through iodization of salt (4)		√
Maternal supplements of multiple micronutrients (4)	P	√
Tetanus toxoid immunization for women (1,2,3)	P	√
Maternal anthelmintic treatment (1,4)	P	√
Intermittent preventive treatment of malaria during pregnancy (IPTp) in malaria-endemic areas (1,3)	P	√
Detection and treatment of syphilis in pregnant women in areas of high prevalence (1,3)	P / T	√
Promotion of HIV testing in pregnant women and prevention of mother-to-child transmission (PMTCT)	P	√

of HIV infection (1,3)

### **Intrapartum**

Promotion of clean deliveries, especially where most births occur at home and hygiene is poor (1,2,3)	P	√
Antibiotics for premature rupture of membranes (1,2,3)	T	
Corticosteroids for preterm labour (1,3)	P	
Delayed umbilical cord clamping (4)		√

### **Postpartum**

Newborn resuscitation (1,2,3)	T	
Newborn temperature management (1,2,3)	P	√
Antibiotics for sepsis (1,3)	T	√
Intermittent preventive treatment of malaria during infancy (IPTi) in malaria-endemic areas (1,2,4)	P	√
Promotion of breastfeeding immediately after birth, exclusive breastfeeding during the first 6 months of life (1,2,3,4)	P	√
Provision family planning services and promotion of promotion of fertility behavior change (number and spacing) (1)	P	√
Promotion of continued breastfeeding up to at least 24 months and appropriate complementary feeding beginning at 6 months of age (1,2,4)	P	√
Child Immunization (measles, Hemophilus Influenza Type b) (1,2)	P	√
Provision of supplemental vitamin A (supplements and food fortification) to children 6-59 months of age and to post-partum mothers (1,2,4)	P	√
Promotion of hygiene (including hand washing), safe water, and sanitation (1,2,4)	P	√
Provision of preventive zinc supplements to all children 6-59 months of age (1,2,4)	P	√
Universal salt iodization (1,4)	P	√
Community-based treatment of childhood pneumonia (1,2,3)	T	√
Promotion of oral rehydration therapy (ORT) and zinc supplementation for children with diarrhea (1,3)	T	√
Community-based management of acute malnutrition (4)	T	√
Insecticide-treated bed nets (ITNs) in malaria-endemic areas (1,2)	P	√
Indoor residual spraying in malaria-endemic areas (1,2)	P	√
Community-based treatment of malaria (1,2)	T	√

- 
1. *Jamison et.al, 2006.*
  2. *Jones et.al, 2003.*
  3. *Darmstadt et.al, 2005.*
  4. *Bhutta et.al, 2008.*

There are marked differences of coverage of these proven interventions in high-mortality settings. In fact, the only two interventions that consistently show high coverage are immunization and vitamin A supplementation (UNICEF, 2009a). All other interventions have moderate to low levels of coverage. There is particular need to strengthen the coverage of interventions that address behavior change in the home (such as exclusive breastfeeding, appropriate complimentary feeding) and interventions that provide community-based case management of childhood illnesses (Cleason et.al, 2000).

As a result, only 16 of the 68 countries in which 97% of the world's child deaths occur are on track to reach the MDG target of reducing the mortality of under-five year old children by two-thirds between 1990 and 2015; just three are in sub-Sahara Africa (UNICEF, 2009b). As for the MDG target of reducing underweight malnutrition in under-five year old children by half between 1990 and 2015, 63 countries out of 117 are on track; however only five of them are in sub-Sahara Africa (UNICEF, 2009b). Similarly, of the 87 countries with an MMR  $\geq 100$  in 1990, 10 countries are considered to be on track to improving maternal health, only two of those ten are in sub-Sahara Africa (WHO et.al, 2010). Unfortunately, health systems are weakest where the needs are greatest.

To accelerate progress in reducing maternal and child malnutrition and mortality, there have been calls for more direct funding for maternal and child health programs (UNICEF, 2009a; Denny et.al, 2008), health systems strengthening (Reich et.al, 2009), integration of key interventions via a continuum of care (Bhutta et al.,2008; Ekman et.al, 2008), and stronger community participation (Rosato et al.,2008). However, funding for overseas development assistance has heavily concentrated on HIV/AIDS and on technical assistance (WHO, 2008). The importance of community-based health and nutrition has not been emphasized. Attention remains focused primarily on technical interventions and not on the strategies and support systems necessary to achieve high levels of coverage of interventions and to make them effective in routine conditions.

However, with the MDG deadline nearing fast, there is a growing recognition that strengthening community-based interventions (i.e., programs that reach beyond the walls of health care facilities) has potential to accelerate progress in reaching the MDGs in health in high-mortality settings (Rosato et.al, 2008; Bryce et al., 2005). Community-based health and nutrition programs are programs that happen outside the health facilities and in the communities. They broadly include three types of interventions: (i) behavior change communication; (ii) social mobilization and community involvement for planning and management of activities and delivery of services; and (iii) provision of health care in the community, including preventive services (e.g., immunizations) or curative services (e.g., community-based treatment of diarrheah or pneumonia). Several interventions involve the promotion of individual behaviors and do not necessarily require direct support from health facilities for consumables or for technical supervision but rather involve behavior change communication. Other interventions can be provided

intermittently in each community as an outreach activity by relatively low-paid level workers e.g., immunization, vitamin A supplementation). Others require professional care from trained providers with commodities readily available to treat (e.g., diagnosis and treatment of childhood pneumonia, management of severe acute malnutrition).

Well-functioning local health facilities are important as the point of referral for patients with severe or uncommon illnesses that cannot be satisfactorily managed at the community level, and as a source of supplies. They can also serve as a base of operations for field supervisors who provide ongoing motivation, training and supervision of community health workers (Freeman et al., 2009). However, in almost all high-mortality, low-resource settings, even peripherally located PHC facilities such as health posts and dispensaries are not readily accessible to a large portion of the population. It is becoming increasingly evident that community-based and/or community-directed health and nutrition programs have already made, and continue to make valuable contributions in decreasing maternal and child malnutrition and mortality and improving maternal and child health and nutrition outcomes globally (Freeman et al, 2009; Perry et al, 2009; Hill et.al, 2004; The CDI Study Group, 2010).

Obviously, community-based health and nutrition programs cannot incorporate all the listed interventions in Table 1 at the same time. Countries will have to decide based on epidemiological, political and socio-cultural criteria which interventions to focus on. Community-based health and nutrition programs have the most impact when health systems are weak and malnutrition and mortality rates are high. Thus, the potential contribution of community-based health and nutrition programs is contextual and may well vary among interventions (Perry et al., 2009).

A number of approaches appear to be common and/or important to most community-based health and nutrition programs. Community-based health and nutrition programs often involve community-based workers to implement many interventions or organize activities to reach those who need them. Experience has shown that an effective system must exist for the selection and training of and support to community-based workers. An important strategy by community workers involves group meetings and the formation of support groups. Secondly, it is important that community-based health and nutrition programs maintain contact with all the homes and mothers to identify pregnant women and young children, to provide services in the home when possible, and to identify those in need of services that cannot be provided in the home. Maintaining a register of vital events, including births and deaths, and a register of all families facilitates tracking of children to ensure that all are reached with selected program services. Finally, community-based approaches are particularly relevant for interventions which involve behavior change at the household level such as birthing practices, neonatal care practices, infant feeding practices, and hygiene, all of which have great importance for maternal and child health and nutrition (Ismail et.al, 2003; Mason et.al, 2006). Many of these behaviors are based on ingrained cultural beliefs and practices, and health systems have been notoriously ineffective in changing them.

Community-based programs *can* work usefully, bringing steady progress. However, whether they do, depends on myriad factors relating to the context. Three different concerns are (a) factors affecting widespread initiation of community health and nutrition programs with

adequate coverage, intensity, and content; (b) factors that lead to sustainability; and (c) factors that allow activities to be effective in improving health and nutrition. There seems to be some convergence on around \$5 to \$10 per head (beneficiary) per year being a workable, common level of expenditure in community nutrition programs (Mason et al, 2006). In some countries however, including Senegal, where the program currently reaches close to half of the national child population, the average cost per child per year is less than \$5 (World Bank, 2007). However, the cost per child per year varies by area and tends to be higher in (peri-) urban settings and in sparsely populated and inaccessible areas. Recent reviews have highlighted a number of important conditions that seem to underpin the success of community-based health and nutrition approaches (Ismail et.al, 2003; Mason et al, 2006; World Bank, 2005b):

**A strong, supportive policy environment** is crucial to the success and sustainability of community-based health nutrition programs. This has to go beyond the existence of a national nutrition policy, or the fact that the government is signatory to international declarations and codes. Rather, what is needed is a national commitment to improving health and nutrition as an integral part of the development process. Commitment itself must be backed up by significant financial support from the national budget. Examples of programs that have benefited from strong political support are the Philippines' LAKASS program, Sri Lanka's Samurधि program, Brazil's Child Pastorate program, Mexico's PROGRESA and Thailand's national poverty alleviation program (Bryce et al., 2005). International agencies and donors can help to create awareness of the need to address health and nutritional issues by supporting high-visibility and high-impact programs, such as in Madagascar (SEECALINE) and Senegal (Programme de Renforcement de la Nutrition).

**Partnerships with institutions outside the government sector** can make valuable contributions to program achievements and sustainability. In the past, NGOs (generally international NGOs) had a tendency to run their own development programs, often with little involvement of national expertise, employing local staff but mostly not in high positions. This situation has changed in recent years. NGOs have become increasingly involved with their country's development efforts. Public sector partnerships with national NGOs are gaining in popularity, and in many cases their involvement constitutes a contribution to sustainability much as the involvement of a government ministry would. In the Bangladesh and Senegal programs, for example, large NGOs are contracted to manage the program, with the collaboration of the Local and central Government.

**Effective, respected and socially inclusive organization at the community level** seems to have been a key feature of the success in launching, expanding, and sustaining community-based health and nutrition programs (Jamison et.al, 2006). Communities that have ownership of a project or program are more likely to sustain outcomes. This implies providing inclusive community groups with knowledge, control, and authority over decisions and resources throughout all phases from program inception (World Bank, 2005b). In other words, communities must become a resource for health programs, not simply a target. Successful promotion of changes in family and community practices, now increasingly recognized to be important for further improvements in maternal and child nutrition and health, requires strong community involvement in the planning, implementation and monitoring of community activities (Freeman et al., 2009). Support to community health and nutrition is as much about facilitating

flows of information among all groups in a community as it is about facilitating flows of funds (World Bank, 2005b).

**Decentralized management and program flexibility** are two conditions that are closely linked with effective community participation. Program flexibility is often difficult because of bureaucratic procedures in the public system and because of donor-imposed limitations. In addition, developing strong community participation and building trust between the communities and the formal public sector takes time and funding periods of 4-5 years are not sufficient to build strong community based health and nutrition activities (Perry et al., 2009; World Bank, 2005b). A national nutrition program, such as that of Thailand, has no time frame. Instead, the program is subjected to a re-evaluation and “renewal” every five years through a national food and nutrition plan. It should (indeed must) set targets and goals and time frames for achieving these, and flexibility is needed to accommodate changes in social, cultural and economic conditions and a changing profile of nutrition (Ismail et.al, 2003).

### **3.2 Policies and programs relevant to community-based health and nutrition in Nigeria**

This section provides a brief overview of major policies relevant to community based service delivery and key features of the institutional framework in which they are implemented. Nigeria has made various attempts in the past twenty years to bring services in health and nutrition closer to the population and to create an enabling environment for community action for nutrition and health. The primary health care (PHC) initiative, which was to form the bedrock for community service delivery and empowerment, has been beset by a series of challenges, leaving significant aspects largely unaddressed.

#### **Institutional Framework for Primary Health Care**

Following Nigeria’s endorsement of the Alma Ata Declaration of 1978, Nigeria formally adopted PHC in 1986. It was initially funded and managed by the Federal Government, and rolled out in 50 model LGAs across the country. The National Health Policy (NHP), enacted in 1988, was the first comprehensive national health policy. It adopted PHC as the central strategy underpinning the overall health system, and allowed for the expansion of PHC to all 774 LGAs in the country. A minimum health care package, later renamed the Ward Minimum Health Care Package, was subsequently developed to accelerate attainment of health for all, although implementation remains inconsistent.

Reflecting Nigeria’s Federal government structure, the NHP outlined roles and functions for the 3 tiers of government: Federal, State, and LGA. It also allowed for the subsequent (1992) establishment of the National Primary Health Care Development Agency (NPHCDA), a Federal parastatal with the mandate to support the implementation of policies and plans. While the Federal government develops policies that are relevant across all three levels, responsibility for health service provision reflects the three-tier structure.

- The Federal Ministry of Health formulates national health policies, issues guidelines on implementation of national health programs, coordinates, monitors and evaluates health policies and strategies throughout the country and provides technical support to the States

and LGAs in implementation. It also directly manages the provision of tertiary and specialized health services.

- The functions of the State Ministries of Health (SMOHs) are essentially State level policy guidance, secondary hospital care and supporting LGAs to provide primary health care. They have a key role in training and supervision.
- Local Government is responsible for the delivery of primary health care services, with technical support from the States, the Federal Ministry of Health, and the NPHCDA.

In practice, the delineation of roles and responsibilities both within and between the three tiers of government has proven problematic. The public health sector is highly fragmented with many different agents responsible for aspects of the same service. This has weakened responsibility and accountability relationships, and resulted in inadequate and inequitable health financing, a maldistributed and poorly motivated health workforce, poor infrastructure, inadequate utilization of the private sector, the neglect of community action for nutrition and health, and a Ministry that is not structured to provide the needed leadership and stewardship of the health sector (Health Reform Foundation of Nigeria; 2006; Federal Ministry of Health, 2004). It is not merely a question of decentralization of authority to peripheral tiers of government. Within the same tier there is also duplication and overlap of responsibility.

An important manifestation of this situation is that most PHC services are managed through vertical programs. Healthcare continues to be delivered according to a model that concentrates on diseases, technology, and specialist care, with inadequate investment in prevention. Community-based interventions have been under-prioritized and under-resourced. Implementation is characterized by uncoordinated community-based interventions by time-bound projects funded by donors (see Chapter 4).

Each LGA is responsible for delivering PHC services through the PHC Department headed by a PHC Co-ordinator. However, LGA PHC Departments are weak, understaffed, under-funded and poorly managed. They have limited capacity and frequently fail to provide even the most basic PHC services. This lack of organisational capacity is a major challenge.

Human resources are a significant constraint. In the early 1990s, training was initiated for a cadre of community health extension workers (CHEWS) to staff PHC facilities and to work in communities providing counseling on household and community care practices and linking communities to the health facility serving them. In theory, CHEWs are intended to work 80 % in the community and 20 % in the facility. In reality – due in large part to the dearth of nurse midwives and community health officers at PHC facilities - CHEWS have become largely facility-based, subsequently paying less attention to their primary preventive and promotional activities in the community. Overall, PHC has been reduced to underfunded and underperforming facility-based clinical care and better funded and better performing selective vertical outreach programs, leaving community engagement largely unaddressed.

Addressing organisational and technical capacity at LGA level alone will be insufficient. A major constraint is the disconnect between the primary and secondary health systems and

between the various institutions involved in health provision and supervision. At State level, a wide range of actors are involved in health, including the State Governor, SMOH, the State and Local Government Civil Service Commissions, State Ministry of Local Government (SMOLG), the Local Government Inspectorate and the NPHCDA. LGAs, including PHC services, are 'supervised' by the SMOLG, not by the SMOH. There is no line of authority between the SMOH Director of PHC and the LGAs' PHC Coordinators. Because roles and functions are blurred, there is a degree of competition and duplication, and little collaboration. In some states the NPHCDA has also bypassed state institutions and worked directly with LGAs.

Historically there has been little effective health planning and budgeting at either State or LGA level outside of specific programs. Information systems do not function effectively and there is little use of evidence to inform planning. In the absence of data, there is little understanding of the scale of PHC needs in LGAs, or the extent to which these needs are unmet. Whilst LGAs do produce overall annual budgets, there is little realistic analysis or prioritisation of activities. Consequently, budgets are unrelated to planned activities, priorities or past experience. There is no systematic monitoring of budget performance. The allocation of LGA funds to PHC is dependent on personal relationships and is generally very opaque, and there is little systematic service planning at facility level.

Incentives for better budget planning and execution are hampered by the lack of control LGAs have over their own budgets. Federal Government allocates discreet budgets for each State and each LGA. Funds are transferred to the State, held in a Joint Account, and accounted for by the Governor. Funds meant for LGAs are supposed to be transferred from the Joint Account into LGA bank accounts, and accounted for by LGA Chairmen. In practice LGAs rarely receive all the funds intended with control over cash releases retained at the State level. States vary across LGAs and time frames as to the proportional amounts that are actually disbursed. There are few if any transparent accounting processes which would allow scrutiny of this transfer system.

Once fund disbursement takes place, the LGA Chairman has enormous latitude in allocating resources across sectors. Therefore, at the LGA level, obtaining the LGA PHC Director's commitment is insufficient. LGA civil servants have very little control over financial resources, even if they are committed to the implementation of the program.

Notwithstanding these challenges, different levels of governments in Nigeria offer varied strengths and weaknesses for the delivery of PHC services including community-based services and interventions. LGAs are responsible for the delivery of PHC services, and therefore make for potential partners in a community-based health and nutrition service delivery scheme. LGAs are an essential piece of an efficient community health and nutrition service delivery, and an actor that needs to be brought on board. The challenge is to create the right combination of incentives and capacity building to improve their performance.

The institutional environment also points to the importance of securing agreement at State levels beyond the State Ministry of Health (i.e. Ministry of Local Government, Ministry of Finance, the Governor, the Local Government Service Commission, and potentially advisors or other power brokers within the State). The State Governor's and LGA Chairmen's personal commitment to PHC is critical for success. Without such commitment the "one-line budget" can undermine

PHC, leaving the State Health Commissioner or LGA PHC Coordinator unable to implement basic activities, such as supervision, delivery of supplies or collection of reports, and community based interventions.

The Federal level is seldom engaged directly in the community-based health and nutrition initiatives. The main role of the Federal government is to provide policy and technical support, although it has played stronger implementation roles in vertical programming such as HIV/AIDS and immunization.

### **The Case of Nutrition**

Despite widespread malnutrition in the entire country and in rural areas in particular, (where little change has occurred since 1990) nutrition has received minimal attention from the Nigerian government. So far the only focus has been on food fortification, led by the Federal Ministry of Industry (Standards Organization of Nigeria) in conjunction with the Federal Ministry of Health (National Agency for Food, Drug Administration & Control) with mandatory standards for the fortification of: (i) wheat flour, sugar and vegetable oil with vitamin A since 2002; (ii) wheat flour with iron; and (iii) salt with iodine since 1993. Nigeria is the first and only country in sub-Saharan Africa to be certified as universal salt iodization compliant in 2005. However, other initiatives in public health nutrition, in particular community nutrition, have been negligible. Much of what has happened and is currently going on is due to efforts by development agencies.

In Nigeria, official responsibility for nutrition policy broadly considered lies with the National Planning Commission (NPC). A National Committee on Food and Nutrition (NCFN) was established in the NPC to develop the National Policy on Food and Nutrition (2002), coordinate nutrition activities across the sectors, and mobilize resources for nutrition. NPC was selected to have oversight on nutrition in recognition of the cross-sectoral nature of action necessary to improve nutrition. Moreover, given its central role in government planning and budgeting, it was hoped that the NPC would mobilize financial resources for nutrition activities. Several problems have been highlighted concerning NPC's role in coordinating nutrition activities. First, NPC has neither a comparative advantage nor any special expertise in nutrition. Consequently, its commitment to nutrition and to an effective NCFN is often felt to be wanting. The Commission is staffed by economists and planners and only in 2002 was a nutritionist brought on as staff at NPC to be responsible for the activities of the NCFN. Secondly, there are no signs that nutrition is privileged in the allocation of government resources by virtue of the presence of the secretariat of the NCFN in NPC. Indeed, the fact that virtually all costs for nutrition programming in Nigeria are borne by donors indicates that the NPC lacks necessary influence in this regard (Benson, 2008).

The Federal Ministry of Health has one Division dedicated to nutrition but in the past five years, there has been no budgetary allocation to the Division. Most state ministries of health have comparable nutrition units responsible for coordinating all nutrition activities in the health sector of the state. As at the Federal level, the state-level nutritionists complain of poor funding for carrying out their responsibilities. Technical activities in the public sector that are explicitly identified as being nutrition oriented are those related to PHC. The NPHCDA is the principal institution responsible for seeing that nutritional deficiencies are directly addressed by health

workers in communities across Nigeria. This work is done through programs in child growth monitoring, demonstrations of the preparation of locally adapted nutritious food and food preservation techniques, vitamin A and iron supplementation programs, and advocacy for exclusive breast-feeding.

A 2002 World Bank study of five LGAs in 12 States with active nutrition programs found deficiencies in the quality of nutritional interventions at the PHC level. Only 40% of sampled health workers had been trained in breastfeeding promotion, 29% in growth monitoring, and 28% in vitamin A supplementation. About 20% of the workers had access to nutritional protocols or guidelines. Community-based nutrition intervention was low and none of the health workers was aware of any community outreach services in health or on nutrition provided by the health facility. Only 4% of the sampled health workers claimed to be aware of any donor support project in their health facility (World Bank, 2002).

### **Key Policies Supportive of Primary Health Care**

**The Revised National Health Policy** was revised in 2004 to reflect trends in the national health situation and to contribute to the development of a comprehensive health sector reform program. The revised NHP promotes the right of individuals and communities to participate in the planning and implementation of health care, particularly PHC. It states that the health system will need to develop the ability of communities to participate, and tasks Governments with developing appropriate mechanisms by which communities can be involved in planning and implementation of health services. The emphasis on community participation is couched in terms of promoting community self-reliance and maximising resources. The revised NHP outlines the various tiers of the health system where communities can participate, notably LGA level and below, and includes the establishment of Ward and Village Health Committees linked to the Local Government Health Authority.

**The National Policy on Public Private Partnership for Health in Nigeria (2005)** builds on the policy thrust of the revised NHP to increase the role of the private sector in service delivery. Opportunities for PPP in health promotion and advocacy are identified around:

- Raising awareness about health consumer rights
- Contracting NGOs for community mobilisation and outreach
- Using mass media to disseminate health facts and promote information exchange and dialogue.
- Promoting quality recognition.

Partnerships to promote efficiency and accountability are also foreseen. The policy stipulates that implementation of PPP will aim to continue or accelerate efforts to improve equity and suggests a number of measures to guard against PPP increasing inequity. In terms of financial management, the policy states that increased budget allocations will be needed for exemption and deferral funds, as well as allocations for not-for-profit organisations providing essential services, working in underserved areas, and supporting community mobilization. The latter point reiterates the Government's recognition and commitment to funding community mobilisation for health. Private not-for profit partners are, among other responsibilities, given the role of encouraging community participation in service delivery, advocacy for PPP, community

monitoring, and participating in planning, administration and ownership of health and other social programmes.

**The National Health Promotion Policy (2006)** articulates the importance of consumer rights and health, and lines up with current international thinking on the social determinants of health. The policy outlines the transformations required of the health system to move from a health education to a health promotion approach. It details an organisational structure for oversight of health promotion at various levels of government that is multi-sectoral.

**The National Human Resources for Health Policy (2006)** embeds the Human Resources for Health (HRH) policy within the health sector reform process. It identifies the critical challenges faced by HRH in Nigeria, including:

- Poor and uneven distribution of skilled staff, the shortages in the north and oversupply in the south, as well as the concentration of staff in urban areas;
- Low level and discrepancies in salaries between professionals working at different levels and in different states;
- Discrimination against non-indigene staff in some states;
- Cultural preferences that impact on the acceptability of health workers; and
- Lack of motivation, high attrition rates, and inefficient HRH systems.

The policy builds on and supports the National Health Promotion Policy and attempts to strengthen rewards and career paths of health promotion specialists. It emphasizes the institutionalisation of community mobilisation and involvement and proposes a number of strategies to support this including:

- Redistribution of staff, including redeployment of CHEWS back into community;
- Development of career paths to allow community health workers to remain in primary care services;
- Strengthening community mobilisation and advocacy training in the training of frontline workers;
- Inclusion of advocacy, community involvement and sensitisation training in the training of health managers;
- In-service training of all health workers in community advocacy; and
- Establishment of State units to provide technical support to health workers in the design, packaging and delivery of “socio-culturally relevant health education and health promotion messages in communities.”

**The Integrated Maternal, Newborn and Child Health Strategy (IMNCH)** was developed in 2007 to address poor maternal, newborn, and child nutrition and health outcomes, enhance equity in service delivery, and to work towards universal coverage of the recommended interventions. The IMNCH Strategy consists of a three-phase implementation plan, with the package of evidence-based interventions organized into three service delivery modes: (i) family and community-based interventions; (ii) population-oriented outreach schedulable interventions; and (iii) individual-oriented clinical care interventions.

Together these health care services are the most relevant for addressing household health care problems and for addressing the health MDGs. Although the community component of IMCI

which focuses on household and community practices, is key to improving the health and nutrition of children under-five years and is currently being implemented, national rollout has been limited and the capacity to influence care practices has not been adequately assessed and analyzed. Because no readily available system for supporting community action for health and nutrition exists, the family and community mode of delivery of the strategy has received less attention to date than the outreach and clinical care mode of delivery.

Attempts to integrate State and LGA responsibilities under a ‘district’ or zonal system are underway in several states, each with its own model of reorganization. Jigawa, for example, started this process in 2007 and the resulting *Gunduma* system is now thoroughly into its implementation. Other states that have started the process are: Kaduna, Enugu, Yobe, Bauchi and Zamfara. The NPHCDA has adopted this consolidated approach, termed “**Primary Health Care under one Roof**”. The main elements of this approach are:

- **Integration** of all PHC services delivered by one authority – at a minimum consisting of health education and promotion, MCH/FP, immunization, disease control, essential drugs, nutrition and treatment of common ailments.
- A **single management body** with adequate capacity that has **control over services and resources** (especially human and financial). As this is implemented this will require repositioning of existing bodies.
- **Decentralized authority, responsibility and accountability** with an appropriate “span of control” at all levels. Roles and responsibilities of the different levels will need to be clearly defined.
- Principle of “three ones” (**one management, one plan and one M&E system**).
- An **integrated supportive supervisory** system managed from a single source.
- An **effective referral system** between/across the different levels of care.
- Enabling **legislation and concomitant regulations** (inclusive of the key elements).

The NPHCDA Board has approved the policy and guidelines and a memo to the National Health Council is in process. These new developments are encouraging for enhanced community action for nutrition and health outcomes.

With the growing evidence regarding the effectiveness of community-based health and nutrition programs in reducing mortality and malnutrition, various donor agencies have already been or are working with different states to support innovative approaches to community-based health and nutrition service delivery as community empowerment programs (USAID through the COMPASS project), as part of service delivery programs (The World Bank with the Malaria Control Booster Project to which a Community Health Systems Strengthening for Malaria Control component has been added), or as part of general health systems strengthening support (DfID through the PATHS projects).

### **A new National Health Bill underway**

Along with the revised NHP policy in 2004, a new National Health Bill (NHB) was drafted in 2004. After several revisions, the NHB is nearing passage in the National Assembly. It seeks to clarify some of the responsibilities between different levels of government, improve the

coordination of the sector, and earmark more resources for PHC. Once enacted, it will codify the 3 tier structure of the health system initially articulated by the 1988 National Health Policy. It also makes progress in defining health consumer entitlements against which accountability can be claimed.

Importantly, the NHB aims to enhance financing of investment and recurrent costs for primary health care through the creation of a National Primary Health Care Development Fund. The fund is to receive 2% of the national budget, and will be managed by the NPHCDA (45%), the National Health Insurance Agency (50%), and the Federal Ministry of Health (5%). The funds managed by the NPHCDA are to be disbursed through State Primary Health Care Boards (also new under the NHB) for distribution to local government health authorities. The disbursements require counterpart funding from States and LGAs, thus leveraging more funds from other levels of government. This is an innovation for Nigeria and is modelled upon the successful use of conditional matching fiscal transfers in other Federal countries. The National Primary Health Care Development Fund would dramatically increase the availability of domestic financing for PHC and help ensure a minimum package of care available at PHC level for all Nigerians. It will also help to integrate health services at State and LGA levels.

Notwithstanding the improvements, the NHB still retains some ambiguity in terms of the division of responsibilities between various institutions (e.g., the State Primary Health Care Board and Local Government) and will not definitively resolve the full range of problems driving institutional fragmentation.

The NHB specifies no particular prototype for the delivery of primary health care services by local governments and secondary health services by the states. This lacuna leaves each state the latitude to develop laws with respect to the establishment of its State Primary Health Care Board and in fact could be presumed to impose an obligation on each state to develop policy and legislation reflecting the primary health care delivery configuration best suited to the state, including obligations of the Board responsible for disbursing funds. While state legislation would necessarily have to comply with Federal policies and legislation, each state is in a position to consider and codify its requirements (McKenzie et.al, 2010).

### **3.3 Conclusions**

Maternal, newborn and child health and nutrition is now at the forefront of the global development agenda because more than 10 million mothers and children under five are still dying from readily preventable or treatable conditions in spite of the fact that effective, simple, and low-cost interventions exist as evidenced in a series of global reviews. Most of these interventions require or would benefit from community involvement. The evidence regarding the effectiveness of community-based health and nutrition programs in reducing mortality and malnutrition is now growing rapidly. There are marked differences of coverage of these proven interventions in high-mortality settings. In fact, the only two interventions that consistently show high coverage are immunization and vitamin A supplementation. All other interventions have moderate to low levels of coverage. With the MDG deadline nearing fast, there is a growing recognition that strengthening community-based interventions (i.e., programs that reach beyond

the walls of health care facilities) has the potential to accelerate progress in reaching the MDGs in health in high-mortality settings.

Recent reviews have highlighted a number of important conditions that seem to underpin the success of community-based health and nutrition approaches:

- A strong, supportive policy environment is crucial to the success and sustainability of community-based health nutrition program;
- Partnerships with institutions outside the government sector can make valuable contributions to program achievements and sustainability;
- Effective, respected and socially inclusive organization at the community level are a key feature of the success in launching, expanding, and sustaining community-based health and nutrition programs; and
- Decentralized management and program flexibility are two conditions that are closely linked with effective community participation.

Whilst proven cost-effective interventions for the reduction of maternal and child malnutrition and mortality are known, Nigeria has a dismal record when it comes to bringing these interventions to the levels of communities and households. Nigeria embraced PHC in the mid-eighties. However, implementation beyond facility-based clinical care remains weak. Most of the reforms were poorly executed and failed to deliver on improving maternal and child nutrition and health outcomes. Although national policies are broadly supportive, and the draft Health Bill holds the potential to reinvigorate primary health care services with increased funding and new mechanisms, institutional fragmentation has tended to weaken accountability relationships and hindered the effective implementation of reforms to date.

Nutrition has suffered from the awkward institutional location in government with responsibility for broad policy development housed in the NPC and the NCFN, public health policy development housed in the Federal Ministry of Health's underfunded Division of Nutrition; and implementation of mostly narrow vertical interventions by the NPHCDA.

Interest in community-based health and nutrition has increased with the adoption of the IMNCH Strategy. However, the lack of a functioning system for supporting community action has meant that the family and community mode of delivery of the strategy has so far received less attention (and funding) than the outreach and clinical care modes of delivery.

## 4. Panorama of Community Health and Nutrition Projects in Nigeria

There is ample evidence from past assessments that the Non-Governmental Organizations (NGO) and Community-Based Organizations (CBO) have been active when and where government services have been lacking or are weak (World Bank, 1996, PATHS, 2008, Abegunde, 2009). As far back as in 1996, it was estimated that together they provide around 40 percent of the formal health care services used by the poor in Nigeria (World Bank 1996). The indications are that this percentage has increased since then. For example, the Christian Health Association of Nigeria's (CHAN) network of health facilities (3,500 in total across the country) are said to represent 40% of the total formal private sector (World Bank, 2005a). Hence, the government could rely more on non-governmental and community groups for the provision of health-related services (e.g., nutrition, child health, maternal welfare, immunizations, HIV/AIDs) (WHO, 2008). A study on the role of NGOs in Nigeria in 2005 found that CBOs are essential in organizing poor people, taking collective action, fighting for their rights, and representing the interests of their members in dialogue with NGOs and government (Uwhejevwe-Togbolo, 2005). NGOs, on the other hand, are better at facilitating the supply of inputs into the management process, mediating between people and the wider political and government institutions, networking and information dissemination. The strength of NGOs, particularly those operating at the field level, is their ability to form close linkages to local communities, and to engender community ownership and participation in development efforts.

In practice, many seem to work independently, and government-civil society relationships are fragile (PATHS, 2008). NGO activities are often limited due to funding challenges and institutional and other capacity constraints. Civil Society Organizations (CSO) often lack important skills in management and accounting. PATHS found in Kaduna State that a structured means of engaging civil society in the delivery of health services had not been successfully secured by either the State or Local Governments (PATHS, 2008). Systematic programs should therefore be developed to strengthen CSOs, giving them access to training and financial resources which can be retained under their own control. If progress is formally monitored, CSOs offer an important possibility for development. Innovative partnerships could be developed between LGAs, CSOs and local leaders. The capacity of LGAs should be raised through training, financial strengthening; and the promotion of more effective and balanced relationships with State and Federal levels.

The following sections describe recent and ongoing experiences in Nigeria with household and community-based or community-directed programming for health in Nigeria. Primary data collection involved the application of a semi-structured tool, to document the typology of agencies involved in community based action for health and nutrition (Annex B). This agency listing tool obtained information to map agencies and organizations active in community based health and nutrition programs in Nigeria, and obtain detailed information on the projects implemented by these agencies. The form was self applied and provided identifier information on the agency; the total number of projects in the focal area of health, nutrition, health and nutrition as well as integrated projects between 2003 and 2008; and the agency's listing of community nutrition and health projects by the following:

- Type of Agency
- Geographical Focus of the project

- Type of Project
- Project activities
- Stakeholder Involved
- Community Health Workforce Engaged
- Funding Source
- Status

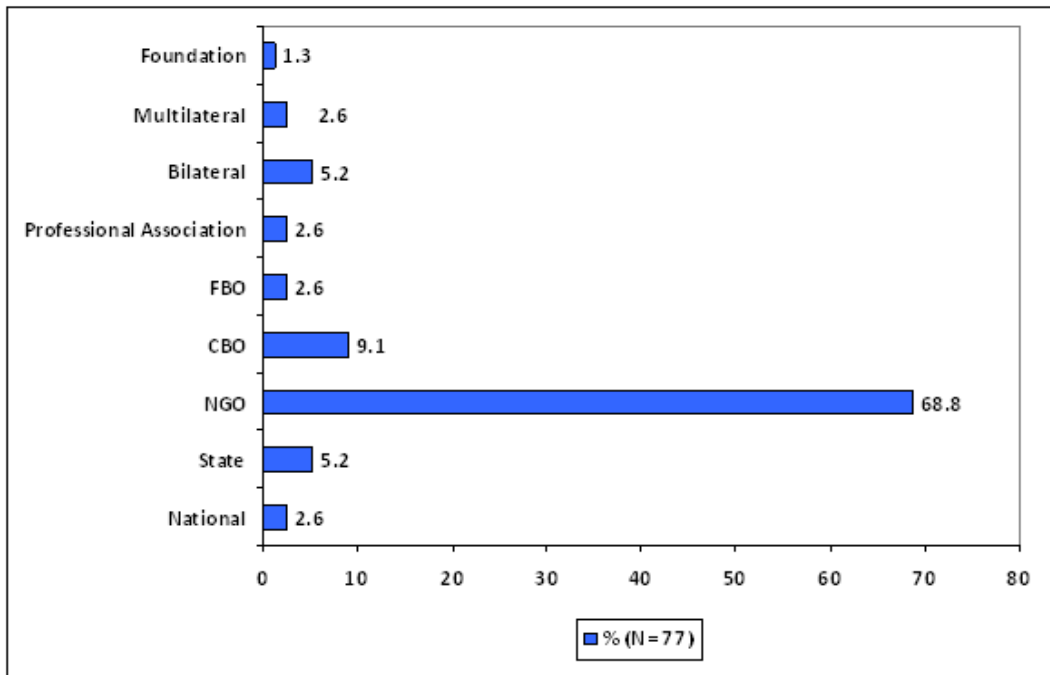
The participation of nongovernmental, community and faith based organizations was invited and expanded using news paper placements strategically placed in journals and on days where target agencies and organizations could be reached. Forms were also distributed to Local Government PHC Committees (LGA-PHCC) and the major national programmes through the network of the NPHCDA, Federal Ministry of Health, and other members of the working group and primary contacts of the consultant's base organizations. Although a web based application process was designed for the study, its application was limited. The completion process was supported when required by trained research assistants and the sub study consultants. Telephone interviews were conducted with selected agencies.

The analysis is principally descriptive, involving a cross-sectional analysis of self-reports from agencies involved in health, nutrition, and integrated community-based projects in Nigeria. This is on account of the limited number of records covering a total of 77 agencies and 286 projects between 2003 and 2008. This listing is far from exhaustive, all the more so as the 2010 edition the Directory of Development Organizations in Nigeria reports 63,350 organizations, including civil society organizations. The Nigeria Network of NGOs, a more focused list of development NGOs has a membership of close to 900 organizations. This underscores the recognition that the information and data presented in this report is but a starting point for structured and strategic reporting and management of community-based and community-oriented actions for health and nutrition in Nigeria

Figure 19 presents the distribution of reporting agencies by agency type. More than two-thirds (69%) of reporting agencies were NGOs. Note this sub-study makes no distinction between national and international nongovernmental organizations. This was followed by reports from CBOs (9.1%), followed by State and bilateral agencies (5.2%). Although CBOs are ubiquitous, it is impossible to quantify them as only a tiny fraction will formally register. The average number of years since establishment was nine for NGOs, and ten for development partners. This suggests that, although NGOs are active players in community action for health and nutrition in Nigeria, their participation in this work is more recent.

As for the projects (n=286), 70% were development projects and 30% were (operational) research projects. Also 70% were implemented by NGOs, 14% by state agencies, and 9% by federal agencies. The low percentage (less than 1%) by CBOs may indicate that there is limited capacity among CBOs to provide the level of detail and information required in the project listing forms. Health had pride of place with 71% of all reported projects, with both nutrition and combined health and nutrition projects distant second (13%) and third (12%), respectively. Only 4% of the listed projects were integrated projects.

**Figure 19: Distribution of responding agencies by type**



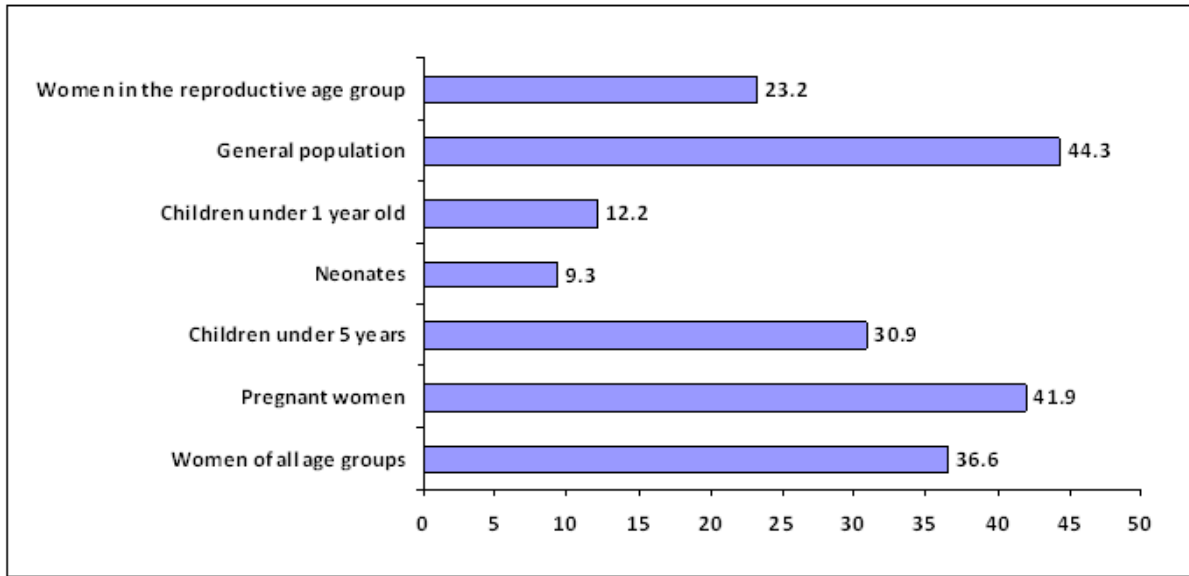
On account of the variability in project duration, Table 5 presents median duration of the projects by type of agency. Federal, State, multilateral, and bilateral projects largely last longer than 36 months while NGO projects are considerably shorter. This observation might suggest that NGOs, though the most active at all operational levels of community action for health and nutrition, are inadequately supported and financed.

**Table 5: Duration (months) of project by type of agency**

Type of Agency	Duration of Project in months	
	Median	N
Federal	84	23
State	84	38
NGO	23	177
Multilateral	60	26
Bilateral	63	2

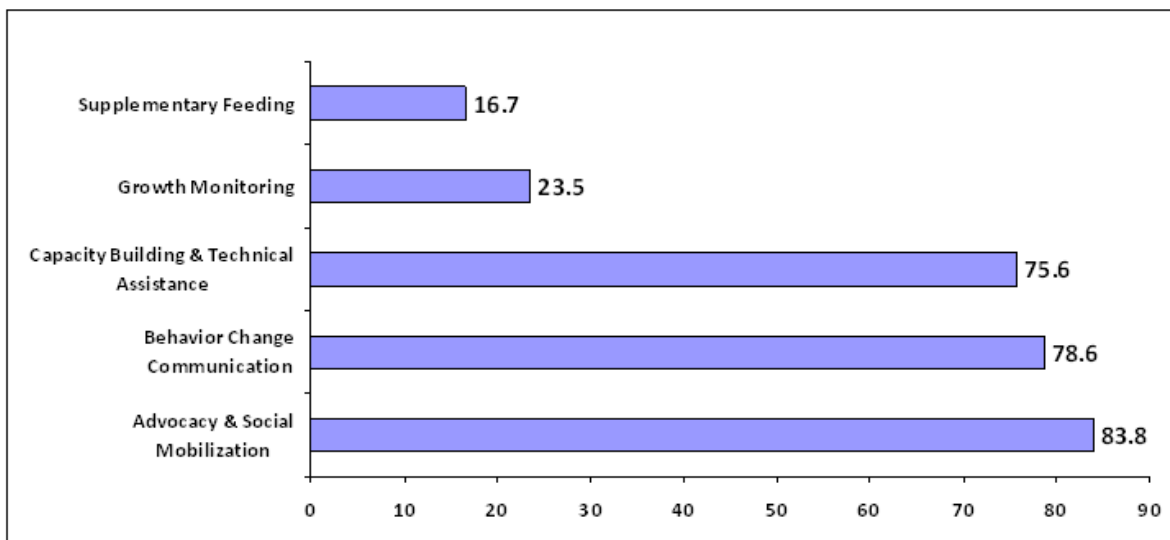
The highest number of target groups reported by the projects consists of general population (44%) (Figure 20). However, women and in particular women of reproductive age or specifically pregnant women are most often engaged in the projects. Children under five (31%) are more commonly targeted than neonates (9%) and infants (12%).

**Figure 20: Percentage of projects by target group categories**



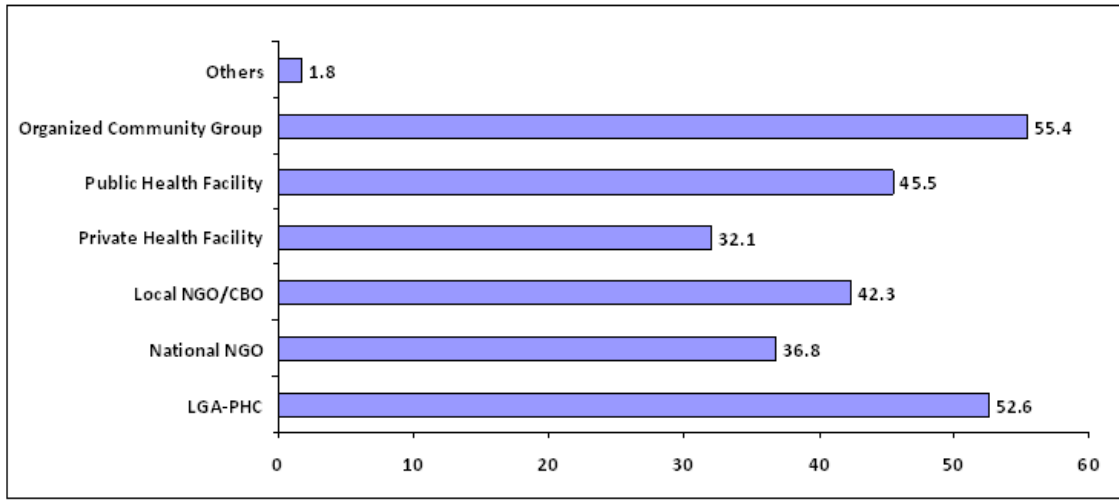
Advocacy and social mobilization (84%), closely followed by behavior change communication (79%) and capacity building and technical assistance (76%) are the most frequently reported activities (Figure 21). It is worth noting that specific nutritional activities such as supplementary feeding (17 %) and growth monitoring (24 %) did not figure often among these projects.

**Figure 21: Percentage of projects by project activities**



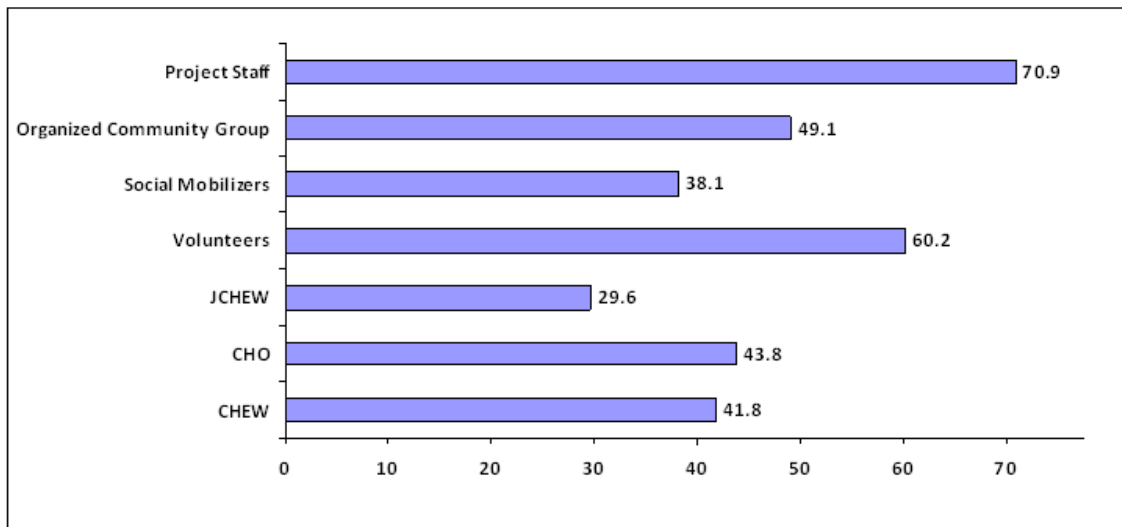
Organized community groups (55%) and LGAs (53%) were frequently reported stakeholders (Figure 22). These are closely followed by public health facilities (46%), which might also be primary care facilities operated at LGA-PHC level or other providers at the local level. Local NGO/CBO groups were also stakeholders. It is interesting to note that as many as 32% of the projects were engaging private health facilities.

**Figure 22: Percentage of projects by stakeholder groups**



The largest type of community human resources employed are project-based staff (71%) (Figure 23). Community volunteers (60%) and organized community groups (49%) are also reported. In combination, it would appear that these latter two groups are employed in larger numbers than are project-based staff. The effectiveness of capacity building efforts targeted at these voluntary groups is an important project activity to look into. In addition, the management of monitoring and evaluation (M&E) data by community groups and volunteers needs to be explored to ensure the cycle of collecting and providing feed-back to all involved agents. Various cadres working with community workforces linked to public sector services were also reported as employed community human resources. It will also be important to investigate delivery and supervisory linkages between this workforce and project-based staff on the one hand and with community-level organized groups and /or volunteers on the other.

**Figure 23: Percentage of projects by type of community human resources employed**



## 5. Four Case Studies on Community Nutrition and Health

### 5.1 Case study selection and methodology

With the objective of getting a better understanding of best practices in launching and sustaining nutrition projects in Nigeria, four different projects were selected for detailed analysis. Data collection and methods were informed by a common study framework that outlined key “dimensions” of successful community-based health and nutrition programs. The framework was developed during a one week methodology workshop organized jointly by WB consultants in Nigeria and the WB team and held in Abuja in April 2010. The framework’s dimensions are as follows:

1. Using and strengthening existing community organizations
2. Policy alignment and influence (extent to which project is embedded in and catalyzes policy environment and engages stakeholders)
3. Cost effectiveness
4. Financial capacity
5. Management capacity

This framework was organized into a matrix and informed each case study. In addition to the four dimensions, a number of sub-dimensions were developed to increase granularity. The complete matrix can be found in Annex D. Three open-ended questionnaires were developed to guide the collection of data and information across each dimension for: (i) project management staff and frontline personnel; (ii) community members; and (iii) other stakeholders (e.g. LGA and State Government personnel, NGO staff). The data collection involving community members was mainly through focus group discussions or workshops. Key informants including project staff and other stakeholders were invited for individual in-depth interviews. In addition, each case study is supported by a desk review of project documents.

Four cases were selected for this study, based on the following criteria:

- Availability of project documents and information (all cases)
- Use of internationally known cost-effective interventions aimed at women and children (at least 2 case studies)
- Effective implementation strategies based on results achieved (at least 2 case studies)
- Geographic location (at least one in the Northern region)
- Coverage of at least three LGAs (at least 1 case)
- Involvement of multiple types of actors, e.g. different levels of government, civil society, community members, PHC facilities, community health workers (at least 1 case)
- High level of community engagement (at least 1 case)
- Duration of the project (at least 1 year)

Cases were selected using the project database compiled under one of the commissioned papers coupled with interviews with project staff that worked on them. The interviews were conducted to confirm that cases fit the criteria, and to probe their potential to contribute valuable lessons for

the design and implementation of community-based nutrition and health for women and children in Nigeria.

**Table 6: Basic Project Information**

<b>Project</b>	<b>COMPASS</b>	<b>GINA II</b>	<b>PRRINN-MNCH</b>	<b>SMI/PATHS1</b>
<b>Donor</b>	USAID (USA)	USAID (USA)	DfID (UK) & Norway	DfID (UK)
<b>Main Focus Areas</b>	Basic education, child survival, family planning / reproductive health	Child survival, nutrition	Maternal health and improved obstetric care	Maternal health and improved obstetric care
<b>Intervention examples</b>	Interactive radio instruction  Pre and in-service teacher trainings  School health and nutrition (de-worming, physical examinations)  Organization of outreach events to educate communities about malaria prevention and treatment.  PD Hearth	Growth monitoring  PD Hearth, other food preparation demonstrations  Microcredit scheme  Increasing small-scale production and processing of micro-nutrient rich foods  Boreholes, water pumps	Emergency transportation scheme  Community savings scheme  Community-based information dissemination	Emergency transportation scheme  Community savings scheme  Community-based information dissemination
<b>Location</b>	Nassarawa, Kano, Lagos, Bauchi, FCT	Kano, Akwa Ibom, Nassarawa	Katsina, Zamfara, Yobe, Jigawa, Kano (management)	Jigawa, Kano, Enugu, Kaduna, Ekiti
<b>Implementation period</b>	May 2004 – April 2009 (5 years)	Jan. 2006 – Jul. 2007 (18 months)	Oct. 2006 – Dec. 2012 (6 years)	June 2002- June 2008
<b># LGAs</b>	51	3	21	6
<b>#Communities</b>	203	9	92 for MNCH	36 initial, rolled out to 90

The cases that were chosen are the Safe Motherhood Initiative (SMI under PATHS1) in Jigawa State, COMPASS in Nasarawa and Kano States, PRRINN-MNCH in Katsina State, and GINA Phase II in Kano State. The case studies of COMPASS, SMI/PATHS1, and PRRINN-MNCH focused on community-based initiatives within each project, and did not seek to review the totality of the projects' interventions. All projects were/are funded by bilateral donors, namely, USAID, DfID and the Norwegian Agency for Development Cooperation. SMI and PRRINN-

MNCH were health oriented and targeted pregnant women, but with the intention to add more children and women health and nutrition interventions to the same community mobilization platform. COMPASS was a health and nutrition project that also integrated education components. However, for the purpose of this study, we focused mainly on the health and nutrition components. GINA in Kano State was a nutrition project with a strong focus on agriculture interventions combined with nutrition communication interventions such as growth monitoring and Positive Deviance (PD) Hearth. (Table 6).

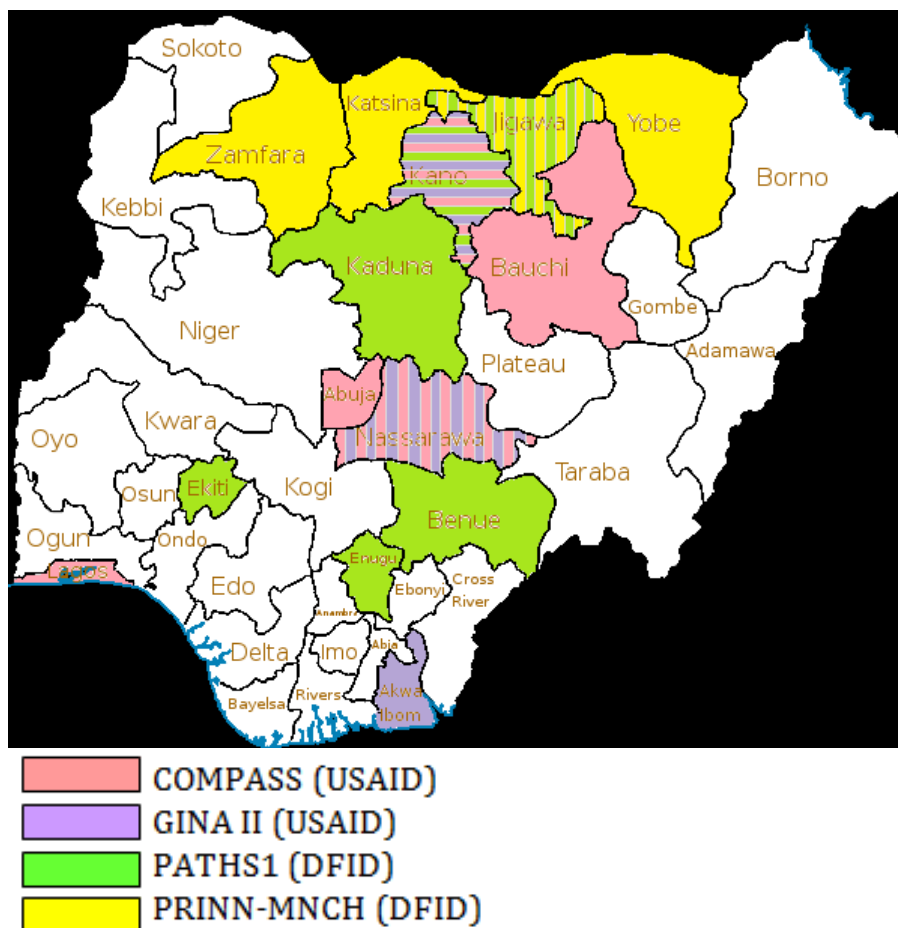
COMPASS, SMI and PRRINN-MNCH were longer-term, large-scale initiatives while GINA was a small, short duration project. PRRINN-MNCH in Katsina State had only six months of implementation, even though a similar platform had been rolled out in other states before. PRRINN-MNCH is the only project that was operative at the time of the study which allowed for direct observation of the implementation. The other three projects had already closed which made analysis of their sustainability possible. PATHS1 has subsequently been succeeded by PATHS2. Only the SMI under PATHS1 is discussed here.

The projects were located in Northern States (Kano, Katsina and Jigawa) and one of them, COMPASS, was studied in both a northern state (Kano) and a state in the North Central Zone (Nassarawa). COMPASS was the largest project, covering 51 LGAs in total, followed by PRRINN-MNCH and SMI (21 and 6, respectively). GINA had the lowest coverage, at 3 LGAs (See Figure 24).

Three out of four projects implemented internationally-known cost-effective interventions for children and women's health. GINA was the only one that used interventions that are not internationally recognized for being cost-effective in reducing malnutrition. All the projects had a high level of community engagement and involved multiple actors (LGAs, states, NGOs, communities, etc). Overall project results (including those for states not covered by the case studies) are briefly outlined below. More detail on individual projects regarding results, chain of command, coverage, area of intervention, and community mobilization strategies can be found in Annex D.

COMPASS saw modest gains in education - e.g. an increase of 1 to 3 percent in test scores over a one-year period for most grades (EDUCAN, 2007) - and significant gains in health outcomes, including a dramatic increase in the use of basic primary care interventions over the course of the project (The Mitchell Group, 2008). In addition, in some villages, the community mobilization strategy used by COMPASS is considered to have contributed significantly to empowering communities to advocate for improved health and education services, and to have raised significant funds. In 2008 alone, COMPASS-supported communities leveraged about \$3.6 million from individual member contributions, community donations, and funds raised from advocacy efforts with LGAs. However, the overall long term impact of COMPASS is considered minimal. Resources appear to have been spread too thin and government involvement appears to have been too limited to develop the critical mass of capacity sustainability requires That said, COMPASS is unique in its focus on training the community to advocate for itself at state and LG level. In this sense, there was a 'demand led governance'/social accountability element in COMPASS not found in the other projects.

**Figure 24: Coverage by State**



GINA’s End of Project evaluation cited completion of baseline surveys in all three states, volunteer training in growth monitoring and Positive Deviance/Hearth methods in three states, and production and distribution of locally appropriate information and education materials for counseling, presumably in all three states. (Tanamly MD, Downer G, Chikodere D, 2008). Underweight among under fives decreased by 18.7 percent in Nasawara, However this indicator - which was considered the project’s primary outcome indicator - actually increased in Akwa Ibom and Kano between baseline and endline (by 8.7 and 3.6 percents, respectively.) The end-of-project report also cites a few nominal achievements in the area of liaising between the project and public sector, but overall, GINA does not appear to have achieved its objective of building linkages between the project and state and/or local government. Although GINA may have experienced some success during its lifecycle, it was too short-lived, small and grant-oriented to have made any sustainable progress towards its objectives.

According to the Final Review of PATHS1, there has been a steady decline in maternal mortality since the program’s inception in 2002. In addition, service utilization increased between 2005 and 2007 (PATHS Final Review). There is some evidence that improvements along these lines made in Jigawa can be attributed (in part) to the SMI’s community mobilization and behaviour change strategies. For example, an end line survey on “Knowledge, Attitudes and Practices” conducted in February 2008 showed significant improvements from a baseline survey conducted

in June 2007. Findings indicated progress across a range of subjects related to obstetric emergency. It is worth noting that the PATHS1 Final Review mentioned the SMI as “a notable innovation” which was “demonstrating significant change in attitude and behavior of women and men, service providers and community leaders, although on a fairly small scale.” The Review concluded that there was potential for scale-up (PATHS Final Review, 2008). Despite these successes, the overall long-term impact of the PATHS1 SMI is unclear. After PATHS1 ended, the participation of NGOs in supervision, monitoring and evaluation could not be sustained due to lack of funds. In addition, ambiguity regarding the roles of relevant ministries as well as exclusion of the LGAs in the SMI’s design and execution almost certainly reduced potential sustainability. These factors and others may have contributed to the decline in service utilization reported in Jigawa (and other states) after PATHS1 closed out in 2008.

As PRRINN-MNCH is quite young and still extant, it is not possible to present a comprehensive picture of its results. However, thus far, the program has made progress in a range of areas, including immunization rates, M&E, development of a “data culture” in the States, partnering with stakeholders, government accountability, and community based action. Although DFID’s 2010 Annual Review (PRINN-MNCH Annual Review, 2010) notes that it is too soon to look at MNCH indicators and that no new surveys have taken place since the baseline survey done in 2009, anecdotal evidence indicates that MNCH covered communities have reported a decline in maternal deaths (interviews with Dan Heij community, 2010). And within the context of this Report, the program’s strong emphasis on governance and its ingenious “cascade and saturation” approach to community mobilization are especially noteworthy (see Annexes C and E). That said, while government commitment to the program has become evident in some states, there is no guarantee that this commitment will be sustained. As noted by the Annual Review, the program remains high risk as long as governance and institutional issues persist.

## **5.2. Actual and potential purpose of community mobilization**

Three out of the four projects used community engagement for very specific purposes. SMI, PRRINN-MNCH, and COMPASS used community mobilization primarily as a method of organizing demand for facility-based services. They did thus not emphasize mobilization as a way of increasing community-based health and nutrition activities even though some projects had planned to do so. COMPASS, and to a lesser extent SMI, evolved during the course of implementation to incorporate social accountability objectives through supporting community members to voice concerns and articulate demands on facility staff and higher level decision makers. PRRINN-MNCH has introduced a similar approach, although it is not part of the case study presented here.

SMI and PRRINN-MNCH were set up as demand creation for emergency maternal care at health facilities by reducing two of the three delays of maternal mortality: delay in the decision to seek care and delay in reaching care. Hence the projects communicated the danger signs of an emergency situation in pregnancy and promoted rapid evacuation to the hospital. In the case of COMPASS - though some project components were community-based activities (breast feeding promotion, community-based management of acute malnutrition through behavior change called Positive Deviance (PD) Hearth, malaria prevention) - other aspects of the project were facility-based (renovation of facilities, set up of Quality Improvement Teams (QIT) and increased use of

ante-natal and reproductive health services. The latter was given priority in the overall project which for example was reflected in the choice of only having facility-based indicators. That could have contributed to a bias in favouring the facility-based outcomes as well as incentives to pay more attention to those services. Also, much effort was put into the creation of Community Coalitions and their training to advocate for better government delivered services. Finally, the community-based components, such as PD Hearth, were given limited attention and funding in the project, and could not be sustained, even though women in the communities reportedly had expressed great interest in their continuation.

In the case of COMPASS several shortcomings worked against a proper implementation of nutrition related components, such as PD Hearth: ( i) the lack of nutritionists on the implementation team and reliance on the reproductive health specialist for all nutrition and reproductive health issues; (ii) lack of sufficient funding for nutrition activities as opposed to other activities in the project; and (iii) insufficient time and resources dedicated to the training and supervision of this activity which deteriorated the quality of the activities.

GINA provides a very different perspective on community-based projects, as a nutrition project that combined improvements of the agriculture production with growth monitoring and counselling of mothers. Furthermore GINA took the approach of delegating the responsibilities of selection, implementation and monitoring of interventions to the communities themselves. Two committees were created for this purpose: the Project Implementation Committees (PICs) and the community-based Monitoring and Evaluation Committee (MECs) which were both comprised of community members. Community members volunteered for most activities, including: i) increase of food production, using inputs and techniques provided by the project; ii) construction of bore holes and provision of pumps; iii) micro-credit; iv) improvement of food processing techniques with inputs provided by project; and v) nutrition education and growth promotion and monitoring. Thus, GINA was set up not only as a community-based, but also community-driven project despite the decision to set up new organizations.

Unfortunately, the short term nature of the project (18 months) resulted in some limitations for analyzing its full impact. A project evaluation found uneven results in which two of the three States covered reported an increase in malnutrition rates while the third State reported large gains.<sup>2</sup> The evaluation did not include results on the component-specific activities involving food production, boreholes and communication for behavioural change. Impact evaluations of large-scale community-based nutrition programs with a growth monitoring component in other parts of Africa have indicated that they are highly effective in the reduction of malnutrition (Galasso et.al, 2009; Alderman et al., 2009) which is encouraging for future projects in Nigeria. Community mobilization in GINA was however reported as successful in that communities organized themselves and participated fully in the implementation of the projects. Mothers were ready to learn and adapt to new changes and men were reportedly supportive.

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<sup>2</sup> Reduction in percentage of underweight children between baseline and end of GINA II was as follows: Akwa Ibom (-8.7%), Nasarawa (18.7%) and Kano (-3.6%).

### **5.3 Government engagement in community-based health and nutrition initiatives**

The four cases show that the donor-supported implementing agencies have been experimenting with alternative ways of engaging different levels of government. Most of the projects have engaged at least one specific level of government (and/or civil society). At times, projects have missed the opportunities to: i) weave the engagement of different levels in such a way that it takes advantage of what each level of government can offer, especially in the context of Nigeria in which fragmentation in roles and responsibilities requires the active involvement of State and LGA Governments, with guidance and support from Federal level; and ii) support governments in developing their own systems for delivery of community services. Each case study provides support for strategies that can be used to attain engagement and illustrate some of the challenges still remaining especially in regards to sustainability (for detailed descriptions of government engagement in each of the four cases see Annex E).

In all cases studied, we observed that in order to engage government authorities successfully, it is important to follow the government structure and the chain of command: starting with the State government and appropriate agencies at that level; and LGA Chairman and other LGA officials as appropriate to the specific project. Before accessing communities and after government authorities have been engaged, traditional and religious authorities need to be brought on board. In Northern Nigeria, the Emirs are important authorities that need to be addressed. Community selection may also need to balance technical and ‘political’ considerations, such as coverage in different areas of the State and emirates to ensure high level political buy-in at the outset. Traditional and religious leaders are especially important in projects that require behavior change.

Commitment of staff and office space are easier to attain from LGA authorities, but financial commitment was harder. In part this is due to the lack of reliability on the funds that are transferred by the State, and therefore a State commitment needs to be ensured. However, PRRINN-MNCH has found that MOUs with clear monitoring frameworks at the State and LGA levels can help in ensuring both output delivery and financial commitments. Motivation of LGA public officers can be elicited simply by participating in a meaningful project at the community level. Given that absenteeism is quite high, public officers found these opportunities not taxing and quite rewarding. Projects usually provide transportation allowances, as these are not provided by LGAs and are necessary to perform their tasks. Therefore, tapping on these underutilized human resources proved to be a good strategy.

The use of statistics and advocacy and communication strategies are effective in eliciting the engagement of different levels of government. This strategy has been used by GINA and PATHS1-SMI quite successfully.

### **5.4 Using NGOs to bypass LGAs**

LGAs have an important role in providing primary education and PHC. Whereas the federal government coordinates the tertiary and university teaching hospitals, and the state governments manage the various general hospitals, it is the LGAs (via their statutory allocations channeled

through the State Joint Account) that are tasked with maintaining the PHC clinics and dispensaries that are the ostensible backbone of the Nigerian healthcare system.

Allegations of corruption at the LGA level are widespread in Nigeria. Although government corruption and the misappropriation of public funds have certainly not been limited to the LGA level, LGA-specific corruption has been partially implicated in the poor state of PHC in Nigeria, since PHC facilities are often understaffed, undersupplied, and ill maintained. Because of this, many international donors have chosen to circumvent local government in rolling out aid projects in Nigeria, preferring instead to work with local NGOs.

COMPASS and PATHS1-SMI relied primarily on NGOs with experience in the field to conduct their community mobilization activities. These NGOs were either partners or sub-contractors and were paid to raise awareness of the project in the communities and to organize them to perform well. They became an indispensable link between the state level project and the state level government on the one hand, and the community where the project was implemented on the other.

While understandable from a donor short-term perspective, the choice to avoid LGAs perpetuates a vicious circle of distrust and subsequent lack of capacity in delivering services. As long as LGAs are not considered valid implementation partners, they are denied the opportunity to prove themselves. In addition, they are denied the opportunity to gain experience and capacity that might tempt future donors to involve them in projects.

Using NGOs as implementing partners has high returns in the short term. NGOs are paid to deliver, and have to deliver to get paid. Additionally, NGOs specialize in community mobilization and have experience regarding community entry points.

However, once a project closes, NGO activities typically cease. Transportation and other costs often prove prohibitive. Moreover, even when logistics are not a problem, the prospect of continuing without reimbursement may reduce incentives to the point that activities stop or are curtailed. For both COMPASS and PATHS1-SMI, NGOs stopped their activities after the projects closed, severing the link between state and communities and reducing the long-term impact of the project.

By partnering primarily with local government PRRINN-MNCH has gone against the trend of relying on NGOs for implementation. In so doing, the project has dealt with several challenges, most notably inadequate capacity and accountability. Working with LGAs also poses problems in terms of political turnover. PRRINN-MNCH has had to cope with a succession of both elected appointees and technical staff, many of whom have required cultivation regarding participation in the project.

These challenges are offset by the fact that the LGA approach has far greater long-term potential than does using NGOs. Given their constitutional responsibilities, and the fact that they are a conduit through which state funds are disbursed at local level, LGAs are, in many ways, the appropriate choice for projects undertaking long-term community engagement and service delivery activities. Per PRRINN MNCH's Social Development Advisor:

*“We know the local governments are not perfect, yet we know there is no alternative. NGOs cannot replace the LGAs. The NGOs are only available when the money is there. When the money is gone, they are gone too. The government is spending a lot of money for the LGA community development, social development, and health promotion officers. These people collect their salaries every month, and it doesn’t make sense to pay an NGO to do the work the government is supposed to do.” (PRRINN-MNCH Case Study)*

Although a sustainability assessment of PRINN-MNCH is difficult, (out of the four projects, it is the only one that is still extant) a number of intermediate outcomes bode well. These include the LGA’s partial funding of both PRRINN and MNCH communities and project roll outs in Katsina.

It is possible that implementation does not have to be framed as an “LGA versus NGO” conundrum. One option, which has yet to be tried but which holds potential in theory, is a Public Private Partnership (PPP). For example, local governments would retain their data collection and monitoring obligations, but would contract out the project’s community mobilization component to state and local NGOs. This approach would enable the project to use the NGOs’ comparative advantage in working with communities without reducing the onus of responsibility placed on LGAs. Additionally, it increases the chances of extending the NGOs’ participation beyond the life of the project, as financing for community engagement activities could be incorporated into the budget of the LGA.

Although COMPASS relied primarily on NGOs for implementation, a fledgling version of the PPP strategy can be seen in this project’s approach. COMPASS worked to build skills for data collection, financial planning, budgeting and community partnerships at LGA level in an effort to, *inter alia*, increase the likelihood of local government collaborating with NGOs in expanding coverage to non-COMPASS areas. However, the degree to which this exercise was successful is unclear.

One risk which may have affected COMPASS and which would challenge any PPP strategy is as follows: Contracting out necessitates greater capacity than most LGAs currently have. As in the “LGA only” approach, projects would still have to work with local governments (and State-level PHC departments in the MoLG and MOH) to raise their awareness regarding activities to be undertaken by NGOs, and build their capacities for budget design. In addition, this approach might require training both the LGAs and NGOs in public-private partnerships.

## **5.5 Role of traditional and religious leaders**

Northern Nigerian society is a formal hierarchy shaped by two distinct political systems. The first is the modern, post-colonial government of the Federal Republic. The second is the traditional political structure inherited from the Fulani conquests of the nineteenth century. Although the post-colonial, official chain of command goes from the Federal level to the State level to the Local level, traditional and religious rulers – Chiefs, Emirs, Sultans, Sarkis, Sardaunas, village heads and imams – have retained considerable power and prestige. Some of

this power is institutionalized. For example, Emirs play an advisory role to elected representatives. Much of Nigerian society, however, is driven by the informal influence these leaders exert over the population at large.

In general, LGA officers are respected by community leaders. Cooperation is presumably motivated largely by the fact that funds are released by the States to LGAs, which are empowered to disburse those funds among communities under their jurisdiction. Despite this situation, the official government, especially at the local level, is often discretely criticized for its lack of both accountability and competence in maintaining good primary public services. Misappropriation of funds is frequent and does not go unnoticed by the population. Traditional authorities hold important gatekeeper roles, and many retain the respect of the population. All four projects recognized that gaining the support of these traditional leaders was essential to gaining access to targeted communities. In each case, traditional and religious leaders were approached during the initial phase of mobilization.

In COMPASS, volunteers approached Emirs and Chiefs and urged them to publically encourage women to seek health care. In one instance, the deputy chairman of Keffi's QIT cited the aid provided by the Emir in advocating to community members who had been defaulting on their children's immunization schedules.

In GINA, the support and agreement of traditional leaders was solicited via delivery of a letter originating at state level. These letters provided proof of the project's legitimacy at state and LG level. They were delivered in person by the LGA chairman during a meeting between GINA team members and traditional councils. Although traditional authorities were not admitted in the PICs or MECs, they were made guarantors of the microcredit loans provided by the project.

In PATHS1-SMI, Imams were included among the community volunteers to facilitate the discussions. They also made use of the Friday prayer to relay information regarding the SMI.

At the beginning of each community mobilization campaign in PRRINN-MNCH, traditional leaders were approached by project personnel and an LGA officer. The request was made to gather the community for an introductory forum during which the project would be explained. Throughout the project cycle, traditional leaders were asked or volunteered to make use of their religious or political authority to give more weight to the PRRINN-MNCH advocacy campaign. For example, traditional leaders were often essential to convincing husbands to provide "standing permission" for their wives to leave the house in case of obstetric emergency. In some villages, traditional authorities made the "executive decision" that any woman facing an emergency would be driven to a health facility with or without the consent of her husband.

Official chains of government also play a role in gaining access to communities. During the project's early stages, PRRINN-MNCH's Community Engagement Officer systematically visited each LGA to solicit its participation. The officer explained that PRRINN-MNCH had the choice to use either NGOs or LGAs to lead the community mobilization component of the project, and that, despite the fact that many projects were opting for NGOs given the bad reputation of the LGAs, PRRINN-MNCH was willing to give them a chance. Further, it was pointed out that, as representatives of the Nigerian Government, the LGAs were the appropriate organization to

involve, and it would be inappropriate to bypass them. This strategy typically gained the commitment of the LGA Chairman. In so doing, support from LGA staff was implicated. Gaining support from traditional leaders was also facilitated, given the ties between LGA officers and community leaders (see above).

In addition to traditional leaders and official government, civil society organizations are also important to gaining access to communities. These CSOs are usually experienced in mobilizing communities around specific social development goals (e.g. education, health, gender equality). They typically have extensive field experience and a deep understanding of the problems encountered by communities. Civil society organizations can be essential to bridging the gap between communities and higher levels of authority. For example, the Federation of Muslim Women's Association in Nigeria (FOMWAN) was used by COMPASS and PATHS1-SMI. FOMWAN is considered an expert in gender-sensitive social development at the community level. It was founded in 1985, is currently operative in every Nigerian state, and benefits from a large network of local associations.

### **5.6 Role of (voluntary) community members**

Use of community members (e.g., “volunteerism”) was central to all of the projects' community engagement strategies. The discussion below looks at similarities and differences between the projects in terms of scope, incentives and sustainability.

In GINA, three separate volunteer groups were involved in the process of community mobilization. First, in each community, a volunteer “congress” ranked interventions according to perceived community needs. Second, PICs were responsible for the actual implementation process, including subcontracting and other types of financial management. And third, MECs were in charge of supervising implementation and conducting informal “external audit” of the PIC's activities. The scope of community members in GINA was thus quite wide, ranging from design to implementation to monitoring; community members were involved at every stage of the project. Moreover, this balance of responsibilities may have contributed to the project's ability to maintain its financial integrity.

The role of community members in COMPASS was primarily via the Community Coalitions. Community Coalitions were local level task forces which typically included representatives from pre-existing community associations (e.g. women's groups, PTAs, youth associations, farmers associations). Members were recruited from these groups and, collectively, were meant to represent all stakeholders within the community. In addition to the CCs, community members were recruited to participate in Quality Improvement Teams (QITs), this committee was designed to increase collaboration between service providers and clients.

For both PATHS1-SMI and PRRINN-MNCH, the group in charge of the activities at the community level is composed of thirty or thirty-one Community Volunteers led by four Lead Community Volunteers. Here, the volunteers' main function was to sensitize community members to the dangers relating to obstetric emergency and to mobilize the community into taking preventative action. Here, as in COMPASS, it did not appear that communities were

involved in choosing which activities would take place. Rather, through introductory discussions, the project managed to gain community support for a predetermined menu of activities.

The outcomes measured in these projects are, on average, an improvement over GINA's, implying that involvement of communities in the design stage might not be necessary as long as the mobilization technique facilitates appropriation of the project.

There are two philosophies concerning compensation of community members who take an active part in the project: They can either receive a stipend or not. For the former, the concern is that remuneration introduces bias. Once payment is introduced, the continuity of the work is contingent upon continuity of the payment. Once a project closes, payments cease and so does the work. Another concern is the change of loyalty away from the community to the payment provider, thereby reducing the scope of community ownership.

For the latter, "volunteer fatigue" and subsequent attrition are the primary risks. Not reimbursing volunteers with a stipend or in some other fashion increases the opportunity cost of community service, sometimes prohibitively. By working for the public good, volunteers forego time which could have been allocated towards generating revenues or other activities for themselves and their families. For example, while PRRINN-MNCH has been implemented in less than a year, there are already reports of "volunteer fatigue":

*"Many volunteers have mentioned that they felt bad about being the only ones to really work toward improving health and to contribute to the saving schemes. The free rider dilemma is definitely a concern for the sustainability of the project."*  
(PRINN-MNCH Case Study)

To some degree, fatigue may be offset by communities' recognition and appreciation of what the volunteers are doing. In COMPASS, CC members appeared to value the fact that they were gaining competence and knowledge via their activities, and were satisfied with the unpaid condition of their job. Similarly, the GINA case study reports that recognition within the community and increased influence were important non-monetary incentives for members of the PICs and MECs. The same was true in PRRINN-MNCH:

*"After a few months, and a few lives saved, the volunteers gained respect and appreciation even from the most reluctant people (impact on their self esteem). Volunteers mentioned that they were called "doctors" in their villages, and that when they were accompanying pregnant women to the Out Patient Department, the staff members called them by their name and showed them respect, which made them feel proud. Many thought of their work as useful, and definitely not a waste of time. They were proud of being able to help their mothers and sisters, and they often put forward that what they do is a moral and religious duty (fisabililah)." (PRINN-MNCH Case Study)*

In addition to respect, this excerpt addresses the moral import of volunteer work. In all four projects, the strongest incentive driving volunteer work appears to have been good will.

Interviewees repeatedly explained that the work they were doing was for the sake of God and their fellow community members.

If remuneration is to be provided, the challenge of providing the right incentive becomes a problem in itself. For example, the COMPASS case study reported complaints from volunteer data collectors who considered the incentives “limited” and “not reflecting the reality of the challenge of their task”. In PATHS1-SMI, provision of a transportation stipend and refreshments seemed sufficient to maintain participation during the project. However once it closed and provisions were curtailed, attrition increased. In addition to the unsustainability of remuneration after projects close, stipends and other types of reimbursement may also backfire while the project is still extant. In PRRINN-MNCH, there were reports of suspicion among community members who saw the provision of travel and meal stipends as indicative of volunteer “salaries”.

### **5.7 Approaches for behavior change communication**

The most common approach used in COMPASS and GINA is the use of a trained community worker who organizes and conducts communication activities aimed at a specific target group, e.g., mothers of under-five year old children. The communication activities vary from group-based education to individual counselling and the topics addressed included varied pre-defined behavior priorities for maternal and child nutrition and health. The community worker is provided with communication tools to assist with the broad range of messages. The advantage of counselling is that messages are selected according to individual needs. The community worker, who can advise on a broad range of topics regarding maternal and child health, becomes a resource person for the community.

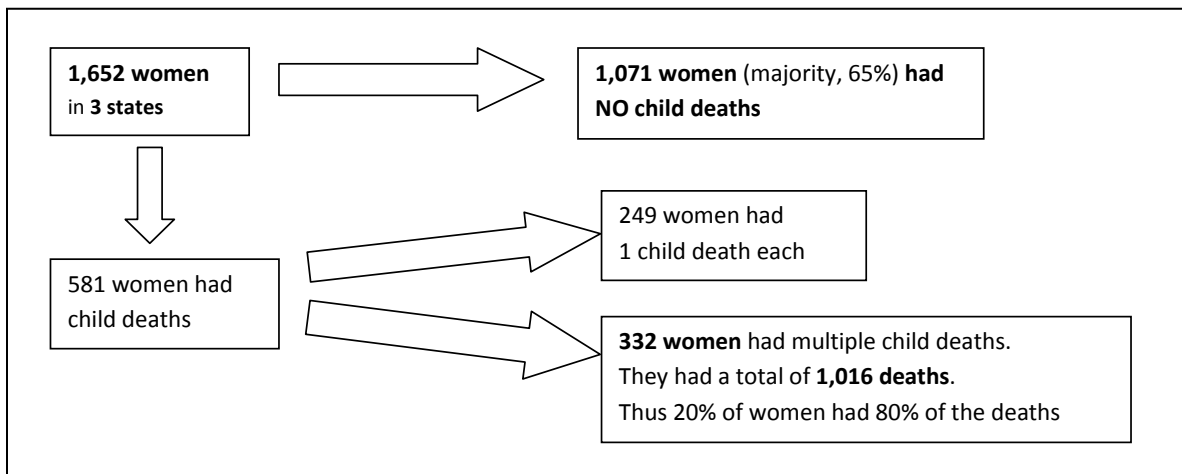
PATHS1-SMI, later followed by PRINN-MNCH, used a normative change approach referred to as the saturation technique. This approach to behavior change is based on the premise that it is difficult for an individual to change her habits if they conflict with mainstream cultural norms. The strategy thus aims at building social approval via a communal atmosphere of change. Through group discussions and with support from the traditional authorities, the entire community is asked to transform their views at the same time. As a critical mass of support builds in favor of the proposed change, it becomes difficult and stigmatizing for an individual to resist changing his or her behavior (for a description of the technique’s logistics see Annex F).

Translating interventions into visible results for the communities is also important to ensure and sustain engagement of volunteers. Immunization activities, for example, appear to have been met with less enthusiasm than those oriented around reducing maternal mortality which the communities monitored in community registers. Interventions which lead to dramatic results (i.e. saving a woman’s life) are capable to mobilize community engagement, upon which further interventions can be built. PD Hearth uses a similar approach by demonstrating the effect of good caring practices on malnourished children who respond rapidly by becoming more active and socially responsive. Growth monitoring and promotion is another effort to translate the intervention into visible and monitorable results, namely the growth curve of the child. Turning immunization into an intervention with visible results is more challenging but complete vaccination and community coverage are two ways of making the intervention monitorable for the community

## 5.8 Inclusiveness of vulnerable groups

Ensuring the participation of vulnerable groups, especially women with low-income and women who are marginalized by their families or the community, is essential to any project aimed at changing health and nutrition indicators. In addition to the moral imperative, the fact is that both mortality rates and malnutrition are often highest in these demographics. A DfID survey from May 2010 provides a good illustration of this from PRRINN-MNCH: In Jigawa, Zamfara and Yobe states, women who reported very little support (moral, financial, logistical) from their own families, in-laws and spouses were 2.26 times more likely to face multiple child deaths (Kloda, 2010). Moreover, 80 percent of deaths under five occurred among children of the 20 percent of mothers surveyed. These women were reported to have had minimal or no support networks and to be living in poor conditions. These findings underline the importance of inclusiveness as a consideration in community based health and nutrition projects (Figure 25).

**Figure 25: The clustering survey in Jigawa, Yobe and Zamfara**



Source: Kloda, 2010

It is unclear to what degree the poorest demographics were targeted by the projects' community recruitment processes. It is possible that the strong community-mobilization component of all four projects may have been insufficiently addressed these dynamics, as the most vulnerable individuals in a community often live on its periphery and may not be included in activities. Moreover, the opportunity cost of many of the activities (e.g. attending food preparation demonstrations like PD/Hearth) may have been too high for those with very low incomes.

Both COMPASS and PATHS1-SMI used Muslim Hausa women at the community level to facilitate understanding and cooperation. GINA had a strong gender-focus and the majority of its interventions focused on women. For instance, cassava grinders and peanut shelling equipment were introduced as labor saving devices. PRRINN-MNCH included an equity oriented line-item<sup>3</sup> in its budget for community engagement and is also considering additional

<sup>3</sup> "Promote mainstreaming of equity and social inclusion" (£84,572 out of £788,787)

measures to target vulnerable women, as it has become clear that they are not being reached through normal mechanisms of community mobilization.

How attempts at inclusiveness played out on the ground for the three projects which have closed is unfortunately unclear. GINA's end of project evaluation notes that, "Nigeria adopted a community development approach to GINA and aspects of gender were overshadowed by strong cultural and religious beliefs" (Tanamly, Downer & Chikodere, 2008). This quote addresses an issue of particular importance in Northern Nigeria and one that is closely related to targeting and inclusion issues: In Hausa culture, women are highly dependent on their husbands and public meetings are often segregated by gender.<sup>4</sup>

A challenge faced by all four projects was how to include women in the community support groups and community meetings while at the same time respecting cultural norms regarding gender segregation. Women were in the minority in all four projects' committees and volunteer groups, despite the fact that they were targeted as the primary beneficiaries of the vast majority of interventions, and despite the fact that in some cases, the project included clear gender ratio requirements. The projects chose to include a minority of women to start promoting gender equality without threatening the traditions and challenging the men's authority too much.

On the one hand, this could be seen as an inclusiveness failure and on the other hand, male involvement in health and nutrition activities is important in Northern Nigeria given the fact that men are more politically powerful than women and thus integral to instigating changes in action and attitude.

*"Because of the type of our community, most of the work is carried out by men. This is because, when you talk to women, they will tell you that their husbands will not allow them. This makes male involvement a key strategy in communities where women are substantially restricted in decision making and participation in development activities." (COMPASS Case Study)*

Furthermore, it is possible that the only reason *any* women were included in volunteer groups and community meetings was due to the stipulations of the project. From this perspective, the unequal gender ratios were progressive.

Working within existing cultural norms may also be essential to gaining the support of traditional and religious authorities. As mentioned above, the COMPASS case study also reports on an Emir who loaned a COMPASS volunteer team "his men" to speak with community members regarding the importance of regular facility visits and immunization schedules. There is thus a trade-off between increasing the number of women in the committees/volunteer groups and receiving support from traditional and religious authorities as well as the community at large.

## 5.9 Adaptability

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<sup>4</sup> The Fulani do not appear to have been explicitly targeted in any of the programs and were most likely not fully included in community engagement activities. However, the feasibility of including this nomadic group, which may live adjacent to Hausa communities for only part of the year, is questionable.

Adaptability refers to the project's flexibility in response to exogenous factors as well as the degree to which flexibility is included in the project's design. For example, in regards to exogenous factors, Northern Nigeria is predominantly Hausa or Fulani (Muslim); other areas of the country are more ethnically diverse and predominantly Christian.

An equally (or perhaps more) important consideration might be the degree to which projects are able to adjust to and take advantage of the range of political environments which exist in Nigeria. For example, the use of the SMWA by PATHS1-SMI in Jigawa was not replicated by the project in other states, largely because the capacity and commitment of SMWAs (or other line ministries) in other states were not as strong. In these states, PATHS1-SMI relied primarily on NGOs to manage demand-side activities.

In regards to design, all four projects' content, structure and feedback mechanisms were set from the beginning and did not leave much room for flexibility. For example, both PATHS1-SMI and PRRINN-MNCH had/have strict requirements regarding the number of volunteers recruited for the EMC teams and Community Volunteers (thirty-one and thirty, respectively). These requirements were not adjustable, regardless of the size of the community in question. In addition, all the projects except GINA had a set menu of interventions which were implemented regardless of context.

Standardization in design can make comparison between communities possible. It can also increase efficiency and provide a "blueprint" for implementation. However, one issue that arises is the degree to which the benefits of such a "blueprint" compare with the costs of inflexibility. Does the imposition of a rigid project framework compromise sustainability? Is a tightly controlled project unlikely to be fully owned at ground level, with negative implications for sustainability? Some answers to these questions can be provided by looking at how all four projects approached adaptability in design.

In perhaps the one clear example of flexibility in design, GINA communities were given the responsibility of choosing interventions in addition to those deemed "compulsory" by the project. Eight out of the nine communities included boreholes among these chosen interventions. Although GINA had not initially considered boreholes as an intervention option, they were approved at state and national level and implemented. It appears that this component of the project is the one that has been best sustained after GINA's close.

However, it is uncertain that the boreholes served the project's purpose and improved nutrition indicators in any of the eight communities. Although provision of potable water is associated with reductions in malnutrition (Burger & Esrey, 1995), reductions in underweight did not occur at all in Kano, were modest in Nasarawa, and negative in Akwa Ibom (0.2, 7.9, and -3.3 percents, respectively). The boreholes were not framed as a means to reduce malnutrition which would have required additional behavior change communication. In other words, despite responding to the felt needs of the community, this intervention does not appear to have increased ownership of the nutrition objectives to sustain the other, essential aspects of GINA after the project's close. Efficacy might have been increased had instillation of the boreholes been accompanied by hygiene behavior change education.

Although the PATHS1-SMI and PRRINN-MNCH project designs can be construed as rigid, there is no evidence that community ownership of these projects was (or is) compromised. Indeed, it appears that the strict parameters of the project design are actually key to the high levels of community engagement reported for these projects. The PRINN-MNCH case study describes the situation as follows:

*“From the beginning, the project knows where it wants to go, and the project plan is a way to get the activities to come to be accepted by the community. The community itself does not get much leeway in what it implements. No matter what (specific economic or demographic conditions), there will be thirty volunteers, ten of which are women, there will be a savings group, there will be the same formatted danger signs, there will be volunteer drivers designated by the local chairman of the Union. The approach seems to work.... The community (more specifically the community volunteers, at least so far) appeared to feel a strong ownership of the project, and definitely, it seems that MNCH did an excellent job in involving the communities, facilitating their acknowledgement of the importance of emergency obstetric care and the community responsibility for the lives of the women presenting danger signs. Even if the framework seemed to us to be somewhat rigid, none of the persons we interviewed expressed the feeling that something had been imposed to them. The community arrives to the conclusion that it needs what the project offers through a smooth mobilization process facilitated by LGA team members trained by the project.” (PRINN-MNCH Case Study)*

The case study goes on to point out that, within the parameters of the project design, some flexibility does exist. Volunteers and community members organize their own saving and blood donation groups, and communities make their own rules regarding contributions to savings schemes (e.g. compulsory or not, frequency, amount) as well as allocation of funds and conditions for repayment.

Because COMPASS had a double focus on health and education, the projects’ interventions had greater breadth. As a result, the project was essentially forced to exhibit more adaptability than PRRINN-MNCH and PATHS1-SMI, both of which had (comparatively) narrowly defined objectives. For example, on the education side, self-help grants were made to improve school infrastructure and furniture. How these improvements were made was left to the discretion of the PTAs. On the health side, Community Coalitions were expected to determine which health activities would best serve the community and to submit a proposal to COMPASS. If accepted, COMPASS implemented the intervention directly. However, unlike GINA, COMPASS did stipulate that the cost of these interventions be at least partially offset by donations from the community (Mitchell Group, 2008). In addition to sector-specific activities, the advocacy work done in COMPASS was entirely community-driven. Communities were responsible for determining upon which issues to lobby local government.

The majority of interventions instigated by COMPASS appear to have faded out in Nassarawa state. Although some Community Coalitions are still reported to be functioning and some

advocacy efforts have continued, most of the actual intervention activities have stopped. These include PD Hearth food demonstrations, default tracking, and monitoring of health indicators at facility level. Community interest in schools does not appear to have been maintained. In some schools, PTAs remain active but the self-help grants have not been fully utilized. Moreover, no PTA interviewed by an independent evaluation team at the project's close had plans to carry out major initiatives to improve the schools. Rather, the focus was reported to be on ad hoc provision of supplies. Whether maintenance of facilities provided by the project is ongoing is unclear.

One reason for this may be a disconnect between the interventions and impact in both projects. COMPASS and GINA both included multiple areas of intervention which were not always easy to connect to visible results. In contrast, PATHS1-SMI and PRINN-MNCH used a log-frame for the results-driven approach for the community interventions. In so doing, they reduced project flexibility, but increased community engagement by being able to link intervention activities explicitly and quickly to reduced maternal mortality.

### **5.10 Community level monitoring**

Community level monitoring is most likely to continue as long as incentives are in place to do so. Monetary incentives are perhaps the most obvious and certainly did play a role across the projects studied. For example, COMPASS had a well-developed community monitoring system which included an innovation called “default tracking”. Default trackers were volunteers trained by COMPASS to “track” community members who fell behind on their children’s immunization schedules and facility visits. Default trackers were trained to identify the reasons for defaulting and worked to address them with the individuals in question, in an attempt to convince them to resume regular visits to the facilities. Default trackers were not supposed to be reimbursed or receive stipends for their work. In contrast, during its lifecycle, COMPASS *did* pay a token amount of three to four thousand naira per month to community volunteers participating in its Immunization Outreach Program (IOP). As most of the volunteers involved in the IOP had also volunteered for default tracking, the stipend for the former ended up serving as an informal incentive for the latter. Once the project closed and the IOP terminated, the volunteers were left with very minimal incentives to continue tracking.

*Because incentives were quite limited and did not reflect the reality of challenges data collectors face in the course of visiting facilities to collect data, the quality and regularity of data collection were challenged. For instance, while it was possible for the data collectors to visit facilities severally before obtaining the required data, provision for transport allowed for only one visit. (COMPASS Case Study)*

Another more important incentive is the use (i.e., regular review and dissemination) of the data by themselves as well as higher level authorities. This provides communities with a clear purpose for keeping records as well as creating pressure to do so. For example, the lack of sustained monitoring after PATHS1-SMI closed might be largely attributable to the fact that the SMWA did not have the capacity to aggregate and report on the data that were being collected at community level. During the project’s life cycle, NGOs had been performing this function and both the EMC Teams and the ETS drivers had been motivated, indeed, under pressure, to keep

careful track of the number of women who had received standing permission from their husbands to leave the house, the number of women transported to hospital and other details essential to monitoring the integrity of the SMI. However, once PATHS1 closed, the NGOs stopped being reimbursed for the data consolidation and, as the SMWA was unable to pick up where the NGOs had left off, the incentive to keep track of activities and achievements evaporated.

In GINA, monitoring and evaluation was built into the project via the MECs, which were responsible for monitoring all intervention activities and were reported to function well throughout the project's life cycle. Once GINA closed, most intervention activities stopped, thus removing the primary incentive for MECs to continue collecting any sort of data within the project communities.

PRINN-MNCH improved the sustainability of the system introduced by PATHS1-SMI by using LGAs and state government in place of NGOs as the party responsible for aggregation. Once a month, data logged by communities and ETS drivers are collected by LGA Demand Creation Team members who submit them to the state governments and state project agencies for aggregation. However, the basis of monitoring remains at the community level. Logbooks kept by the Community Volunteers and ETS drivers provide information on coverage, activities, the amount of money saved, names of volunteer drivers, danger signs identified, and so on. Involving both the LGAs and state governments during the project's lifecycle is expected to increase the chance of continuation of monitoring activities after its close, avoiding the bottleneck created by the SMWA in PATHS1-SMI. In addition, the dual reporting system has created a feedback loop where the results reported by the drivers are corroborated by the reports made by the EMC Teams at LGA level.

It is important to note that the strongest incentive driving community level monitoring activities across all four projects appears to have been good will. However, except for PRINN-MNCH, which is ongoing, the opportunity costs in combination with the lack of fiscal and political incentives seem to have been too high to sustain community monitoring activities after the projects closed.

### **5.11 Funding flow and financial arrangements**

Financial arrangements across projects varied, reflecting the range of stakeholder involvement in project activities. Three of the four projects necessitated some procedures to release the funds in an appropriate way to a Nigerian stakeholder. GINA placed the responsibility of contracting project workers (e.g. borehole diggers) directly on to the communities, via the PICs. COMPASS and PATHS-SMI used NGOs as sub-grantees to lead the community mobilization activities. In contrast, because it relied principally on volunteerism at the community level and on official government channels, PRINN-MNCH did not have to transfer much funding to any stakeholder and most of the expenses were taken care of by the project management at the state and national level.

The details of each project's funding flow and financial arrangements of three projects are discussed below.

## COMPASS

Pathfinder International, an American based non-governmental organization with expertise in reproductive health was awarded the lead of the implementing consortium, and was therefore responsible for its overall financial management. While project activities costs were paid by COMPASS' Abuja Central Office (ACO), staff salaries and administrative costs were paid by Pathfinder (who received the funds from USAID). Release of funds to Nigerian organizations was via the ACO which "controlled the budgeting and the allocation of all expenditures based on a work plan exercise that identifies implementation priorities". Additionally, all expenses going to the Nigerian partners had to be explicitly approved by the ACO even if they were part of the already approved budget. Slow allocation of funds by the ACO was mentioned as a challenge by many of the implementing partners (Pathfinder International, 2009; The Mitchell Group, 2008).

Initially, three categories of grants were to be awarded by COMPASS: "Micro-grants", "Community coalition grants" and "Technical assistance and equipment support", corresponding to different level of support (local and state). Nevertheless, it appears that the project decided not to award the community coalition grants, and claims that "the decision to exempt community coalitions from receiving grants from the project though challenging demonstrated that true ownership and sustainability can be attained by communities reliance on themselves to address their issues and if needed, leverage funds themselves" (Pathfinder International, 2009).

In COMPASS, the decision to work with NGOs as sub-grantees was driven by recognition of these organizations' comparative advantage in community mobilization. Sub-grantees were Nigerian state level NGOs<sup>5</sup>. To qualify as a sub-grantee, NGOs had to be registered as an official association, and had to have passed an initial assessment of managerial and operational capacity.

Funding flow for the sub-grantees was as follows: NGOs submitted estimated quarterly budgets to the COMPASS State Office which transmitted them to the national office in Abuja. After review (and approval by COMPASS' Chief of Party), the funds were released to the State office which emitted a check to the sub-grantee. To increase transparency, sub grantees were required to open a bank account exclusively dedicated to COMPASS activities into which all checks were deposited. They were also required to provide receipts for their expenses, and to submit bank statements and financial reports on a quarterly basis.

Aside from the state level NGO sub-grantees, some national NGOs were also involved as Nigerian members of the project's consortium. However, these agencies were primarily cast in consultative and advisory roles, and were not given any responsibility concerning the management of funds. The case study notes that this lack of financial independence was considered problematic and led to some tension between the Nigerian partners and the project. Perhaps as a result, FOMWAN<sup>6</sup> was eventually given some responsibility in direct implementation and was therefore allocated funding.

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<sup>5</sup> e.g. Child Rights Foundation (CDF), Center for Peace and Rural Development (CENPERD), Nasarawa Center for Women, Youth and Community Action (NAYWECA), Center for Research and Documentation (CRD)

<sup>6</sup> The Federation Of Muslim Women Associations of Nigeria (National level NGO)

## **GINA**

GINA, the other USAID-funded project, was totally grant-based. No contribution was required from communities and 100 percent of the funding came from USAID. As mentioned above, GINA communities -via the PICs - were in charge of disbursement of the funds for project activities. Payment of contractors was done in phases to ensure proper and complete execution.

After selection of projects was completed, the project evaluated the cost and schedule of the activities. Funds were then released to a bank account opened for the community from which no money could be withdrawn without the signature of two designated PIC members and GINA's State Program Officer (SPO). Before approving any withdrawal, the SPO had to check that the decision to withdraw money for a given expense had been taken in a community forum. This verification was done by reading the minutes of the meeting (which had to be signed by the persons who had attended it). Additionally, the SPO had to get the approval from GINA headquarter (which confirmed conformity with the work plan). This procedure, though burdensome, resulted in minimal misappropriation of funds.

## **PRRINN-MNCH**

As previously discussed, PRRINN-MNCH is the combination of two projects with two different funding sources (the British and the Norwegian Governments) administered by a single consortium of mostly international partners (contracted by DfID). The funders and project management are aware that sustained change will require at least a decade of support. The Norwegian funded MNCH was added in 2008. DFID has extended its funding of the PRRINN component to coincide with the close of the MNCH Component. Both are now scheduled to conclude in December 2013.

Currently, the project remains relatively centralized; 40 percent of expenses are incurred at the national level, in Kano. However, as noted in the 2010 budget plan, this statistic represents an improvement over the 2009 estimate of 67 percent (PRINN-MNCH, 2009).

Demand creation activities represent approximately 15 percent of total costs. This might be related to the fact that supply side activities are costly (e.g. refurbishment of facilities).

PRRINN-MNCH provides as little direct financial support as possible in an effort to avoid becoming indispensable. For example, the community mobilization system is almost completely financially independent. Volunteers are not paid, drivers receive an in-kind incentive from their union (priority loading), and LGA demand creation team members remain on the LGA payroll, receiving only a transportation stipend from the project.

### **5.12 Challenges of sustainability of project activities**

In addition to remuneration of volunteer community members, the case studies highlighted three additional challenges to sustainability:

**Poorly defined stakeholder roles:** If the roles of LGAs, NGOs, state agencies, CBOs and other stakeholders are not clear, the risk of redundancy increases. In PATHS1-SMI, the SMWA's purchase of 36 ambulances jeopardized involvement of the National Union of Road Transport Workers (NURTW) in the project. As the agency that was coordinating the Emergency Transport Scheme (ETS), the NURTW saw provision of the ambulances as an activity which should not have occurred under the SMWA's purview. Moreover, it was seen as undermining the efficacy of the ETS.

**Lack of continuity in monitoring activities:** For PATHS1-SMI, it appears that disruption of the monitoring chain caused by attrition of the NGOs after the project's close threatened sustainability of all the activities. As the SMWA was unable to continue monitoring each and every community on its own, volunteers had no one to report to, this led to the abandonment of book keeping and threatened sustainability of some activities.

**Community contribution:** The GINA case study pointed out that it is important that the communities contribute financially or in kind:

*“The whole idea that poor communities do not have to pay anything to participate in the Project [is] entirely wrong. The communities should have been made to pay a given percentage of the project cost so as to ensure that they see the project as their own, thereby ensuring sustainability.” (GINA Case Study)*

## **6. Recommendations and conclusions for design and scale up of community-based health and nutrition programs**

**Community-based services (delivered in the community and by the community) need to have a more prominent role in the delivery of basic nutrition and health services.** In the cases studied, community engagement is used mainly as a channel to increase demand for health services in facilities. Yet, community-based approaches are particularly relevant for interventions which involve behavior change at the household level such as birthing practices, neonatal care practices, infant feeding practices, and hygiene, all of which have great importance for maternal and child health and nutrition, which do not necessarily require direct support from health facilities for consumables or for technical supervision. The dire situation of many primary health care facilities and the high costs associated with: (i) their upgrading; and (ii) enhanced stewardship of the entire system, imply that there is potentially more to gain by emphasizing community action for nutrition and health. That said, community-mobilization has the long-term potential of creating and voicing demand for good quality of services for the community members when in need.

**Community-based programs should translate actions and interventions into visible results that communities can own and monitor.** In the case studies, safe motherhood was carried successfully by communities because they experienced (and monitored) the dramatic fall in maternal mortality. Conversely, immunization proved to be more difficult to sell at community level as it wasn't clear to communities what result was being achieved. This principle lies at the heart of growth monitoring and promotion (making growth visible to mothers and communities), PD Hearth (using the demonstration of results in the health of children to promote the impact of good caring practices to treat and prevent malnutrition). Similarly, experiences from elsewhere in the region and beyond provide examples of the importance and ways to translate interventions into visible and "monitorable" results. Many of these experiences are in the area of child health and nutrition.

**Community-based programs aimed at behavior change should consider ways to combine integrated comprehensive communication approaches, e.g., individual counseling, with normative communication strategies as well as focused social marketing campaigns around key messages.** The safe motherhood initiative saw very good results by saturating communities on the need to shorten the delays in seeking emergency obstetric care. However, pregnant women, mothers and communities need access to more comprehensive information on the broader spectrum of issues in maternal, newborn and child health and nutrition in order to enhance healthy growth in women and children. For example, counseling during pregnancy and early childhood can effectively address information needs as they arise at individual level. Such needs cannot be taken care of by social marketing campaigns. Yet, normative communication and social marketing campaigns are very effective to raise the visibility of specific key messages.

**Special attention should be given to equity issues in community-based programs by ensuring the inclusion of hard-to-reach and vulnerable groups.** Vulnerable groups of women among the poor are often hard to reach and in dearest needs of the services and interventions in community-based nutrition and health programs. Strategies that have been employed to promote inclusiveness and equity include communication, community monitoring, and membership in

committees and community groups. Improved mechanisms of inclusion of vulnerable households are needed which requires joined thinking of project planners and communities alike.

**Community-based nutrition and health programs should focus on the achievement of selected outcomes through the use of results frameworks, the inclusion of proven interventions, and the application of a results-based project design.** Programs which do not link the inputs/outputs with specific results and have broad objectives will be less effective in achieving and documenting crucial results for the MDG targets. The biggest initial gain on selected results can be made by scaling up proven cost-effective interventions which in turn will inform the program on underlying factors of ill-health, malnutrition and death and thus to additional (indirect) interventions.

**Monitoring systems should start with and be based on community monitoring.** Community monitoring enhances community ownership of the program objectives but also provides the means to effectively link the informal, horizontal community structures with the formal, vertical public systems. The case studies showed that without good monitoring that originates at community level, the link was quickly lost and timely support became unavailable. There is an urgent need for improved understanding of the benefits of local monitoring both among project planners and community members.

**Community-based nutrition and health programs should dedicate a major part of their resources on developing strong and lasting support mechanisms for community members and community (support) groups.** Community-based action for nutrition and health implies the active involvement of community members (often known as “volunteers”). These community members and community groups play a most important role in bringing about change, and therefore are essential stakeholders in community development for better nutrition and health. The identification and mobilization of local structures and resources available and capable to provide adequate support to the community mobilization efforts is a critical factor in the performance of community-based programs. The cases showed that the change process at community level quickly erodes after projects close as that puts an end to the support and guidance mechanisms.

**Community-based nutrition and health programs should agree on a common set of outcomes and related activities but provide space for operational flexibility at the local level in developing appropriate and effective mobilization strategies.** The case studies showed that communities generally are very flexible to accommodate different project needs. However, due to the differences in the ways communities are organized, rigid mobilization strategies generally have not worked well. By allowing more operational flexibility (without compromising on results and related activities), there will be scope for learning-by-doing, a principle that has worked well for community strategies in other countries.

**Community-based strategies need to take a central part in the development of health systems.** Many initiatives are led by donors and perceived as pilot experiences. As a result, sustainability has been problematic. Project design needs to contemplate the long-term sustainability supported by government structures. This implies that government structures become actively engaged in the activities from project conception to evaluation. Moreover,

given the fragmented and complex nature of the Nigerian health system, all levels of government need to be involved for an effective delivery of services at the community. The appropriate engagement of State and LGA levels is particularly crucial to improve the coverage of unmet demand for and enhance sustainability of community-based nutrition and health services. .

**For community-based nutrition and health services to be scaled up, programs should decentralize the management of operational support and supervision.** As local representatives of government in charge of local development, LGA have a role to play, but also can bridge the distance between state level leadership and community action for nutrition and health, and allow for a more flexible approach to community mobilization activities that take into account the local context and cultural norms and characteristics. However, issues of capacity need to be addressed through a gradual approach of capacity enhancing activities aimed at strengthening the implementation, coordination, monitoring and stewardship roles at the State and LGA levels...

**Given the political, institutional and organizational differences between individual states, community-based programs should adopt a state-by-state identification of the most appropriate lead agency for community mobilization.** By virtue of its vertical hierarchical organization, the SMOHs are not necessarily best equipped to take the lead in the mobilization and organization of community action for nutrition and health. While SMOHs have an important role to play in the guidance and supervision of the activities at community level, other institutions can complement that role in the areas of community mobilization and organization.

**Community-based nutrition and health programs should seek ways to more effectively use the comparative advantage of NGOs.** NGOs often represent community interests more effectively than the bureaucratic and/or vertical public sector. By virtue of being less bureaucratic, they are more flexible in the way they engage with different communities in terms of organization and cohesion, social norms and religion, infrastructure, wealth and other characteristics. Generally, NGOs also have more experience with community organization and development than the public sector. Hence, in many ways, NGOs can contribute to the successful implementation of community-based nutrition and health programs. Yet, so far, there has been limited experience in Nigeria in developing effective public-private partnerships of this sort.

**Programs aimed at effective community mobilization for maternal and child nutrition and health should take the time to introduce the objectives and strategies to the formal and informal authorities and stakeholders concerned.** Effective community-based nutrition and health programs depend on the involvement of formal, traditional and religious authorities, as well as community stakeholders such as men and grandmothers. Advocacy visits and community meetings are all proven strategies to inform the stakeholders and obtain their support. The case studies also showed the importance of paying due respect to the lines of authority in the sequence of sensitizing and mobilizing stakeholders at the different levels.

**Given the inherent involvement of many actors and stakeholders in community-based programs, community-based programs should clearly define roles and responsibilities in order to avoid misunderstandings and duplication, but also to enhance coordination and**

**accountability.** The cases provided various examples of unclearly defined roles and responsibilities undermined the efficiency of the project. The roles and responsibilities should stipulate “who does what” but also “who reports to whom”. As for institutional roles and responsibilities, the use of Memoranda of Understandings (MOU) and other contractual agreements have shown to be useful tools.

**Community-based program should follow an emerging design of gradually building the critical mass of mobilization for maternal and child nutrition and health.** Rather than starting with an all out, all-at-once approach to stakeholder mobilization and involvement, community-based programs are best served by starting with a relatively simple design in order to focus on community action and results. From there, the program can seek out the formal involvement by other stakeholders and broaden the stakeholder base around the program.

**Community-based programs for nutrition and health should systematically track and document the cost of implementing community-based nutrition and health programs.** One limitation of the study is the lack of baseline data on community-based (maternal and child health and nutrition strategies) financing in Nigeria. Based on limited information from programs in other countries, there is some reference data available as to what community-based health and nutrition programs tend to cost per mother/child per year, or per capita per year. This will improve the information basis on the cost of these programs and thereby the forecasts necessary for budget preparation.

## Annex A: Commissioned Papers

Afolabi, WA. A case study of Safe Motherhood Initiative (SMI) project by Partnership for Transforming Health Systems (PATHS) in Jigawa State, Nigeria,

Ajieroh V. A case study of best practices in the COMPASS project in Nasarawa and other states.

Akinyele IO, Dare LO. Catalogue of Community Oriented and Community Based Programming Experiences for Maternal and Child Nutrition and Health. Abuja: World Bank, 2010.

Dare LO, Akinyele IO. Landscape Analysis of Community Oriented and Community Based Programming for Maternal and Child Health Nutrition Programmes.

Darpeix P-E. Case-study #4: The PRRINN-MNCH Program in Northern Nigeria

Omonona BT. A case study of best practices in Gender Informed Nutrition and Agriculture (GINA) project in Kano State.

Williams CA. Analysis of maternal, newborn and child nutrition and health situation and policy environment.

## Annex B: Project Identification and Listing Form

### *Landscape Analysis and Community Oriented Community Based Programming for Maternal and Child Health and Nutrition Programmes:*

#### *Project Form A: Project Identification and Listing Form*

#### **Section 1: Introduction and Consent**

In March 2007, the Federal Ministry of Health adopted the National Integrated Maternal, Newborn and Child Health (NIMNCH) Strategy. This strategy primarily aims at reducing maternal, newborn and child morbidity and mortality in line with the MDGs 4 and 5. The NIMNCH Strategy organizes the interventions by three service delivery modes. However, little information is available about these services, in particular household and community-based services, and the systems that provide them. The World Bank in collaboration with government authorities and development partners is supporting a sector study to fill in the knowledge gap through a landscape analysis of existing experiences in community health and nutrition programmes. This questionnaire seeks to collect the needed information on existing ongoing or completed programmes and projects in different parts of Nigeria. Your consent in facilitating the completion of this form by the appropriate section of your organization is appreciated.

#### **Section 2: Agency Identification**

1	Name of Agency	
2	Year of Establishment	
3	Type of Agency (Please choose one option) 1 = National/Federal 2 = State 3 = LGA 4 = NGO 5 = CBO 6 = FBO 7 = Private Sector 8 = Professional Asso. 9 = Academic/Research 10 = Bilateral agency 11 = Multilateral agency 12 = Foundation /PVO 13 = Others (Specify )	
4	Geographic focus (please choose one option) 1 = National 2 = Zonal 3 = State 4 = Local Government Area (LGA)	

	5 = Community Level Outreach & Action	
5	Total number of projects in the following areas since establishment	
A	Health Projects	
B	Nutrition Projects	
C	Health and Nutrition Combined	
D	Integrated Projects	
6	Total number of projects in the following areas between 2003 – 2008	
A	Health Projects	
B	Nutrition Projects	
C	Health and Nutrition Combined	
D	Integrated Projects	



## Annex C: Case Study Project Descriptions

### **Community Participation for Actions in the Social Sector (COMPASS)**

Community Participation for Actions in the Social Sector (COMPASS) was a five-year integrated health and education service delivery project with a cross-cutting community mobilization component. It was funded by US-AID and implemented in collaboration with the Government of Nigeria. The project was launched in 2004 across four states (Bauchi, Lagos, Kano and Nasarawa) as well as the Federal Capital Territory (FCT). Headquarters were in Abuja with state offices in Lagos, Kano, Bauchi, and Nasarawa, and the FCT.

#### **Chain of Command**

COMPASS was led by a consortium of national and international partners who provided technical oversight in their areas of comparative advantage. The Federation of Muslim Women's Associations of Nigeria, for example, was essential to reaching women and girls in areas where cultural norms might otherwise have prevented access. The lead partner, Pathfinder International, was responsible for strategic planning and overall direction, including managing the grants program and provision of technical direction and support for family planning and reproductive health activities.

Other international consortium members were:

- The Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (led communications activities and the full range quality improvement interventions)
- Management Sciences for Health (MSH) (responsible for child survival and polio activities)
- Creative Associates International (led all aspects of the education component)
- The Futures Group (provided monitoring and evaluation and data for decision-making)

Local Nigerian partners were:

- Nigerian Medical Association (NMA)
- Federation of Muslim Women's Associations of Nigeria (FOMWAN)
- Civil Society Action Coalition on Education for All (CSACEFA)
- Adolescent Health Information Project (AHIP) (The Mitchell Group, 2008).

COMPASS also worked with nongovernmental organizations (NGOs) at the state level as well as community and faith based organizations at the community level.

COMPASS worked to build skills for data collection, financial planning, budgeting and community partnerships at both state and LGA level. However, state governments did not provide financial support to COMPASS other than financing the monthly costs of the radio-based intervention (see below) and provision of health personnel at the clinic. LGAs participated in training and service activities via a COMPASS/LGA Coordinator (a COMPASS staff member) and five LGA desk officers who were recruited to work with COMPASS within each LGA. Monthly stipends were provided by COMPASS to these LGA staff. (These stipends grew from N3000 to about N10, 000 over the life of the project.) Desk officers were expected to liaise with other LGA officials and authorities in responding to issues brought up by the programs "Community Coalitions" (see below). They were also involved in project monitoring via facility level data collection, and were encouraged to take

the lead in expanding the program to other communities where COMPASS' presence was limited.

**Table 7: Coverage of COMPASS Project by LGA and LGA Population**

	Lagos	Kano	FCT	Bauchi	Nasarawa	Total
<b>Number of Target LGAs</b>	14	16	6	8	7	51
<b>Population of Project LGAs</b>	6,784,160	4,000,127	1,405,201	2,072,259	660,401	12,849,889
<b>Percent of State Population in Target LGAs</b>	75	42	100	44	35	-

(Source: The Mitchell Group, 2008)

### Coverage

COMPASS was operative in 51 Local Government Areas (LGAs). Although the population represented in the targeted LGAs is about 9 percent of the total population of Nigeria, not all communities were serviced by COMPASS (Table 7). The project covered over 203 communities and targeted 1,400 schools (of which 1000 had been reached by June 2008, ten months before the project's close) and 712 primary health care facilities (of which all had been reached by June 2008) (End of Project Report, 2004).

### Areas of intervention

The project goal of COMPASS was to create an environment in which all Nigerians are involved in learning, planning and action to improve health and education in their communities. The project had four designated intermediate results:

- Improved Quality of Social Sector Services
- Strengthened Enabling Environment
- Expanded Demand for Social Sector Services; and
- Increased Access to Services, Commodities, and Materials (The Mitchell Group, 2008)

Simply put, project objectives were to increase use of health and education services through improved quality and access to services, commodities and materials; a strengthened enabling environment; and expanded community demand.

The primary education outcome appears to have been to increase achievement scores in numeracy and literacy. Increased enrolment and increased satisfaction among students and

parents regarding school services were also aims. Health outcomes were to increase immunizations, improve malaria prevention and treatment, improve micronutrient status, increase control over diarrheal diseases, and promote advocacy for birth spacing, birth preparedness, and basic obstetric care (The Mitchell Group, 2008).

Intervention activities were organized into three core areas: Basic education, child survival, and family planning/reproductive health. The project also included a polio eradication component. Listed below are some sample interventions from the three core areas:

- Interactive radio (IRI) broadcasts to improve numeracy, literacy and deliver simple health messages
- Pre and in-service teacher trainings
- Self-help grants to school PTAs to help renovate the school environment and encourage greater community involvement;
- Provision of school supplies
- School health and nutrition (de-worming, physical examinations)
- Organization of outreach events to educate communities about malaria prevention and treatment.
- Promotion of exclusive breastfeeding, appropriate complementary feeding, and Vitamin A supplementation during National Immunization Days (through the Federal Ministry of Health)
- Tracking and counseling of parents who defaulted on their children's' immunization and facility visits

### **Community Mobilization**

The community mobilization component of COMPASS centered on formation and empowerment of "Community Coalitions" (CCs). CCs were local level task forces which typically included representatives from pre-existing community associations (e.g. women's groups, parent teacher associations, youth associations, farmers associations) as well as traditional rulers and religious leaders. CCs developed action plans to address health and education problems in their communities and to promote the use of health and education services. In addition to CCs, Parent Teacher Associations (PTAs) were often designated as the primary body responsible for managing education activities, and in some cases acted as the "education CC". COMPASS provided technical assistance and mentored the CCs and PTAs in identifying strategies for implementing their action plans. Finally, Quality Improvement Teams (QITs) were established at the facility level (hospital, clinic, or school) and consisted of both service providers or teachers and community representatives working together to improve quality of services. The QITs, which essentially acted as a sub-committee within the CCs, worked with the other CC members to address quality improvement issues (End of Project Report, 2004).

### **Results**

Gains made by the project in education were slight. In 2007, COMPASS commissioned an independent contractor to assess the performance of COMPASS-assisted schools in numeracy and literacy. The study showed that there was a modest increase of about 1 to 3 percent in English and mathematics test scores over a one-year period for most grades. The study also showed that scores improved about ten percent on average from year-to-year when compared to "control schools" (EDUCAN, 2007). However, it is important to note that the study did not control for a variety of confounders and that the gains reported thus cannot be directly attributed to teacher training, IRI broadcasts or other COMPASS inputs. Enrolment

increased by approximately 2 percent overall (about 3 percent in girls) in primary schools between the 2006/7 and 2007/8 academic sessions (End of Project Report, 2004). Again, it is not clear to what degree this increase can be directly attributed to COMPASS. In addition to the very modest increases in test scores and enrolment cited above, there was little evidence that any improvements in teaching behavior were made. Learning materials and supplies were only sparsely distributed, and the self-help grants and radio broadcasts were not seen to have significantly improved the learning environment (The Mitchell Group, 2008).

Results in health were more positive. An independent interim-project evaluation written in 2008 reported that, in selected target areas, COMPASS had extended the range and quality of primary health services, increased the number of trained personnel, tailored services to target client groups and promoted active community participation that led to increased financial support of health care. The evaluation included a review of clinic service statistics in the targeted states showing a dramatic increase in the use of basic primary care interventions promoted by the health project (The Mitchell Group, 2008). These findings were corroborated by results cited in the end-of-project report. Immunization rates, contraceptive prevalence rates, number of skilled deliveries, number of women receiving antenatal care and intermittent preventative treatment for malaria were all reported to have increased. In addition, health service utilization for family planning, antenatal care, facility deliveries, and routine immunization was considerably higher in facilities supported by COMPASS than in matched, non-program supported facilities.

Where effective, the CCs are seen to have contributed significantly to mobilizing communities, empowering them to advocate for improved health and education services, and raising money. In 2008 alone, COMPASS-supported communities leveraged about \$3.6 million from individual member contributions, community donations, and funds raised from advocacy efforts with LGAs. Funds were used for a range of infrastructure improvement activities, including construction of new PHC facilities and schools, renovation of existing facilities, toilet construction, electrification, digging boreholes for water, and provision of equipment and supplies such as text books, exercise books, furniture, blood pressure cuffs, medicine, school first aid kits, radios and batteries for IRI programs. In a number of cases where COMPASS was supporting renovation of facilities but funding was limited, the CCs were able to raise matching funds to complete the job (End of Project Report, 2004).

Despite the modest gains in education and the significant gains in health and community mobilization made during the project's lifecycle, the overall long term impact of COMPASS is considered minimal. Although the LGAs participated in service and training activities supported by COMPASS, the vast majority did not attempt to replicate those activities after the project's close, nor did any State commit funds to replicate COMPASS activities (The Mitchell Group, 2008). Moreover, the extent to which CCs have remained active and effective, post-project, is unclear. In both sectors, it appears that resources were spread too thin to have developed the critical mass of local capacity sustainability requires.

COMPASS was, however, notable in that it was one of the few efforts to explicitly incorporate a substantive focus on leveraging upwards and creating avenues to take health issues and requests up to the LGA and State MOH – i.e. institutional change. In this sense, there was a 'demand led governance'/social accountability element to COMPASS which is often missing in other programmes.

## **Gender Informed Nutrition and Agriculture (GINA)**

The Gender Informed Nutrition and Agriculture (GINA) program was piloted in projects in Uganda, Mozambique and Nigeria between 2005 and 2007, and was funded primarily by USAID. It was preceded by the Agriculture and Nutrition Advantage (TANA) program, which focused on developing capacity and advocacy for nutrition and food security initiatives at multiple levels of government. Unlike TANA, GINA was exclusively community-focused. It used “linked” agriculture and nutrition interventions to improve food security and nutritional status through livelihood development, improved production practices, and direct nutrition interventions. The program was gender-sensitive and used a community based approach. In Nigeria, GINA ran for 18 months. It was launched in 2006 in 9 communities across three states: Kano, Akwa Ibom, and Nassarawa. This project description is largely based on how the second phase of GINA was implemented in Kano.

### **Chain of Command**

Unlike the other programs described in this report, GINA funds were managed and administered at community level via community-based Project Implementation Committees (PICs). Funds were dispersed from USAID to a single implementing agency and then flowed directly to communities covered by the program. In Kano during the second phase of the project, this agency was Food Basket Foundation International (FBFI). FBFI provided training to GINA’s front line staff, community extension workers, and the communities themselves.

State level Project Officers were the main signatories to the community accounts as well as the authorizing officer for disbursement of funds (Tanamly MD, Downer G, Chikodere D, 2008). Each state had its own Project Officer as well as a coordinating office and team. In Kano, three staff from the agriculture or health departments of each LGA were recruited to liaise with these teams and FBFI personnel. These LGA staff were considered community focal points and, in collaboration w/ FBFI, were responsible for coordinating GINA activities in a given community. Quarterly community roundtables were held to review GINA progress and link activities with local government area (LGA) and state actions (Tanamly MD, Downer G, Chikodere D, 2008).

There was also a Working Group which met twice or more annually to provide technical and advisory backstopping to the State Team’s coordinators. The Working Group included representatives from the Federal, State and LGA Ministries of Agriculture, Rural Development and Health, as well as academics, members of the National Planning Commission, and development partners<sup>7</sup>. Two affiliated USAID projects, LINKAGES and COMPASS, were also members.

#### *Coverage:*

GINA was executed in 3 states, 3 LGAs and nine communities in Nigeria (3 communities per LGA). A total of fifty women and twenty-three men were reported to have received training on nutrition health and agriculture technology.<sup>8</sup>

### **Areas of Intervention**

GINA’s primary objective was to reduce prevalence of underweight among children less than five years of age. The program also developed three additional objectives specific to Nigeria.

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<sup>7</sup> USAID, Micronutrient Initiative, Helen Keller International

<sup>8</sup> Tanamly, M.D., Downer, G., Chikodere, D. (2008) Evaluation of the Gender Informed Nutrition and Agriculture Project. University of Missouri.

The first was to implement nutrition and agriculture activities that had been ranked as high priority by the community, (see below for a description of how projects were chosen by the community.)The second was to develop appropriate linkages between GINA and existing donor, civil society and government-supported activities in the project LGAs. The third was to implement activities that supported the integrated nutrition and agriculture nature of the community-based projects.

The project was also guided by five principles:

- Introduction of high nutrient crops and animal source foods
- Provision of technical support to farmers to increase yields
- Provision of nutrition education to encourage improved dietary intake (in terms of diversity and quality)
- Empowerment of women through provision of knowledge and skills to (1) improve capacity for care giving and (2) increase access to resources and income generation opportunities
- Promotion of a “nutrition lens” in national development, poverty reduction and food security policies, programs and budgets.

Interventions were divided into “compulsory” and “non-compulsory”. The former were required activities in all GINA villages and were as follows:

- Growth monitoring
- Cultivation of vegetable gardens
- Food preparation demonstrations, including PD/Hearth<sup>9</sup>
- Microcredit schemes

Additional intervention activities were chosen by the communities themselves and included:

- Provision of inputs (e.g. cassava stem cuttings, improved seeds, fertilizer)
- Provision of potable and irrigation water sources (e.g. boreholes, tube wells, rainwater harvesters)
- Provision of food processing equipment (e.g. grinders, shellers, oil presses) and training on how to use them
- Animal husbandry

Although most of these activities were not gender-oriented per se, a number of them were implemented in an effort to reduce the amount of physical labor expended by women and to increase income generation in areas that are traditionally “female” (Tanamly MD, Downer G, Chikodere D, 2008). For example, the provision and use of food processing equipment reduces time spent on food preparation (for home consumption or market) and the presence of boreholes reduces (or obviates) the need to fetch water for irrigation and/or household use.

### **Community Mobilization**

As mentioned above, among the projects discussed in this report, GINA was unique in that it put communities in charge of financial management and implementation. After the project was introduced by the GINA team and traditional and religious leaders, Project Implementing

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<sup>9</sup> Positive Deviance/Hearth Programs are community-based nutrition programs for children at risk of malnutrition in developing countries. The program uses the “positive deviance” approach to identify behaviors practiced by mothers or caretakers of well-nourished children from poor families and to transfer such positive practices to others in the community with malnourished children. The “Hearth” or home is the location for the nutrition education and rehabilitation sessions.

Committees (PICs) were formed and trained by FBFI. PICs were responsible for project implementation, including dealing with problematic sub-contractors and other issues. They were registered organizations and, during the second phase of GINA, opened bank accounts to facilitate funds transfers. In addition to the PICs, Community-Based Monitoring and Evaluation Committees (CBMECs) were formed. CBMEC volunteers received training in growth monitoring, which was one of the project's compulsory activities, and were responsible for monitoring the implementation activities of the PICs.

GINA communities were also in charge of determining which interventions – above and beyond the program's designated compulsory activities - should be included in the project's operations within their community. Potential interventions were selected by a community "congress," ranked according to a system developed by FBFI, and presented in formal proposals developed by the PICs. After being vetted by FBFI, the proposals were submitted to a round table review process involving GINA staff at state and national level. Out of a total of thirty-five proposals, four activities were selected for implementation across each LGA. These activities focused exclusively on provision of agricultural inputs, borehole construction and repair, food processing, and micro credit schemes.

GINA also held training sessions for community leaders and members. Subject matter focused on methods and appropriate technology to produce nutritious crops, improving health and nutrition practices, and processing technologies that reduced labor and saved time for women.

## **Results**

Although GINA's primary objective was to reduce child malnutrition, progress was made in this indicator for only one state. Underweight actually increased in Akwa Ibom and Kano between baseline and endline (by 8.7 and 3.6 percent, respectively). It is important however, to note that these results may be partially attributable to civil unrest in those states (Tanamly MD, Downer G, Chikodere D, 2008). In Nasarawa, which has a stable political climate, underweight decreased by 18.7 percent.

Also in regards to nutrition, an end-of-project evaluation cited a number of achievements in Nigeria, including baseline surveys of the nutritional status of children under five completed in all three states, detailed food and nutrition baseline surveys carried out in two states, volunteer training in growth monitoring and Positive Deviance/Hearth methods in three states, and production and distribution of locally appropriate information and education materials for counseling (presumably in all three states) (Tanamly MD, Downer G, Chikodere D, 2008).

The end-of-project evaluation also cited achievements in the areas of improved availability of nutritious foods and a number of other subjects that are either proximally or distally related to improved nutrition outcomes.

In terms of community mobilization, the end-of-project evaluation concluded that:

- The model for selecting and implementing community activities was too time consuming and resource-intensive for such a short project
- PICs did not have the required technical proficiency to manage micro-credit loans
- Micro and capital investment projects rather than the nutrition status of children became the focus of many activities.

- The GINA time frame was too short for the type of community development needed to build capacity to manage complex interventions
- Micro-credit expertise was insufficient to effectively assist implementers and communities in the micro-credit activity (Tanamly MD, Downer G, Chikodere D, 2008).

It was also noted that the gender sensitivity aspect of GINA was largely overshadowed in Nigeria by strong cultural and religious beliefs (Tanamly MD, Downer G, Chikodere D, 2008).

A few achievements in the area of building linkages between the project and local government were cited by the evaluation. Namely the Ministry of Water Resources committing to providing one borehole per state and linkages formed between FBFI field staff and LGA district representatives. However these achievements are nominal. Generally, the project does not appear to have achieved its objective of building linkages “between GINA and existing donor, civil society and government-supported activities in the project LGAs.” That said, the end-of-project evaluation did note that GINA’s efforts to coordinate nutrition activities with additional stakeholders resulted in a national plan for Vitamin A supplementation led by the Primary Health Care Department. The report also mentioned that a specific chapter on nutrition has been included in the Government of Nigeria’s *National Economic Empowerment and Development Strategy 2008-2011* as a consequence of ongoing advocacy by GINA and other programs (Tanamly MD, Downer G, Chikodere D, 2008).

Overall, although GINA may have experienced success during the life of the project, it was too short-lived, small and grant-oriented to have made any sustainable progress towards its objectives. Although boreholes in a number of communities continue to be maintained, the vast majority of interventions have ceased due to lack of funds and motivation. Communities were given responsibility in terms of choosing and implementing interventions, but were not accountable for procuring any funding themselves. Moreover, both states’ and LGAs’ roles seem to have been marginal; the project did not appear to develop an identity beyond the activities that were implemented during its lifecycle.

### **The Safe Motherhood Initiative (SMI) under Partnerships for Transforming Health Systems (PATHS1)**

Partnerships for Transforming Health Systems (PATHS1) was a six year health sector reform program. It was funded by DFID between 2002 and 2008 and implemented in collaboration with the Government of Nigeria. The program was active in 6 States and included a number of projects focused on improving the delivery and use of effective, replicable, and affordable health services. One of these projects was the Safe Motherhood Initiative (SMI). Piloted in Jigawa (2003) and Kano (2005) states and funded by PATHS1, the SMI’s purpose was to improve service delivery to pregnant women and mobilize communities to recognize and prevent obstetric emergency.

PATHS1 was the predecessor of PRRINN-MNCH. Many of the initiatives that were used by the SMI in PATHS1 were subsequently adapted by MNCH. In addition, PATHS1 has been followed by PATHS2, and the SMI has continued to receive support and roll out in new communities under this second program. Note however that this project description is based on the SMI implemented in Jigawa during PATHS1.

### **Chain of Command**

PATHS1 was led by a consortium of national and international partners (Health and Life Sciences Partnership). The national program officer and staff were based in Abuja. State offices, managed by a team leader and program officer, supported implementation in each state (PATHS Final Review, 2008).

PATHS1 did not approach the LGAs for involvement in the SMI. Although LGAs were encouraged to participate in bi-monthly “ownership meetings” (Jigawa Safe Motherhood Report, 2004-2008), LGA involvement was not a priority for this project. Instead, PATHS1 recruited a diverse group of Nigerian NGOs to facilitate implementation activities via State Working Groups. In Jigawa these were the Gumel Youth Movement, Jigawa State People’s Congress, Popular Theatre & Health Education, and the Society for Community Health Mobilization & Awareness. These State-based NGOs were responsible for identifying and training the CBOs recruited for implementation at community level, as well as monitoring activities in later stages of the project. In addition to NGOs, PATHS1 and the SMI worked with government at State level. In Jigawa, the State Ministry of Women’s Affairs (SMWA) and the State Ministry of Health (SMOH) were both actively involved in implementing the SMI. A number of national level civil society organizations were also involved, perhaps most notably the National Union of Road Transport Workers (NURTW), which was responsible for the Emergency Transport Scheme (ETS). The ETS proved to be an invaluable component of the SMI and is discussed below.

### **Coverage**

PATHS1 initially supported thirty six SMI villages in Jigawa (Jigawa Safe Motherhood Report, 2004-2008) and targeted nineteen health facilities for supply side strengthening (PATHS-SMI Increasing Access to Emergency Care). By 2007 the project had scaled up to fifty-four villages, bringing the total number to ninety; by June 2008, one hundred and ten communities were involved in “demand side strengthening” activities (see below) (PATHS-SMI Increasing Access to Emergency Care). The project supported the training of 1,116 Community Volunteers.

Under PATHS2, the SMI has been rolled out to two hundred and eighty villages in Jigawa.

### **Areas of intervention**

The goal of the SMI was to reduce maternal mortality and its objective was to increase access to emergency obstetric care (EOC). Outputs and activities were organized around the concept of the “three delays”: Delays in seeking EOC, delays in reaching EOC and delays in receiving EOC at the facility. The first two “delays” were considered “demand side” while the third was considered “supply side”.

The main supply side output was upgrading EOC facilities. PATHS1 and the SMI took the “Cluster Approach” to this intervention area. Based on the UNICEF/WHO/UNFPA’s *Guidelines for Monitoring the Availability and Use of Obstetric Services* (UNICEF, WHO, UNFPA, 1997) PATHS1 focused on upgrading existing facilities to enable them to offer either “basic” or “comprehensive” levels of obstetric care. To meet Guidelines standards, one Comprehensive Obstetric Care (CEOC) facility and four Basic Emergency Obstetric Care (BEOC) facilities are required per “cluster” of 500,000 individuals. PATHS1 thus selected and grouped the LGAs in which the program was operative in a way that their combined populations were approximately 500,000. Existing facilities were assessed and within each cluster, facilities were selected to be upgraded to either CEOC or BEOC level. The main supply-side activity associated with the SMI was thus upgrading health facilities to meet

BEOC or CEOC standards. Deferral and exemption for drug costs, provision of free services, and advocacy for service improvements were also considered supply-side activities (PATHS-SMI Increasing Access to Emergency Care) and in some case dovetailed with other PATHS1 projects such as the Drug Revolving Fund (PATHS Final Review, 2008).

In Jigawa, supply-side activities were handled by the State Ministry of Health together with the State Ministry of Local Governments.

Demand-side outputs attempted to reduce delays in seeking and reaching EOC. In Jigawa, demand-side activities were managed by the SMWA. This approach recognized the comparative advantage held by the SMWA in behavior change communication. Demand-side outputs were as follows:

- Increased awareness among communities of the need to seek EOC
- Increased referrals of obstetric complication to facilities by community identifiers
- Reduced delay in seeking EOC through Community Emergency Loan Funds (via improved ability to pay for transport, hospital bills, other costs)
- Reduced delay in seeking EOC through improved transport
- Increased number of communities taking communal action to improve access to EOC
- Reduced financial burden faced by families who have received EOC
- Strengthened capacity of the SMWA to coordinate access increasing activities

The vast majority of activities associated with these outputs were implemented by community volunteers (CVs) and ETS drivers. Interventions included:

- Organizing community meetings where individuals were taught to memorize the “danger signs” or symptoms of obstetric emergency
- Obtaining standing permission from husbands to allow their wives to be transported to a facility in case of obstetric emergency
- Organizing collective savings schemes to cover the cost of transportation, examination and treatment
- Organizing blood donors groups to ensure a free supply of blood in case of hemorrhage
- Advocacy to gain the support of elected, traditional and religious leaders in villages and communities
- Log books tracking women transported to facilities

CVs were also responsible for linking their communities to the free Emergency Transportation Scheme (ETS). The ETS was an innovative partnership between the National Union of Road Transport Workers (NURTW) and the SMI. In Jigawa, the state branch of the NURTW provided incentives to taxi drivers to provide speedy transport of women to facilities without requiring pre-payment. The Union also supported the piloting of motorcycle ambulance trailers and mobilized and trained volunteer drivers. In addition, the NURTW collaborated with the SMWA on monitoring, as both volunteer and professional taxi drivers were required to keep track of the women transported to facilities.

It is important to note that during PATHS1 in Jigawa, the SMWA took the decision to distribute cars to SMI communities in the hopes that they could be used for emergency transport. This decision undermined the NURTW’s role in the SMI and may have contributed to the poor functioning of the ETS after the project’s close. That said, since its pilot phase in Jigawa, the ETS has spread to other states, is being utilized by PRRINN-MNCH as well as

PATHS2, and appears to have support from the NURTW's national management.

### **Community Mobilization**

Community mobilization was essential to the demand-side activities of the SMI. NGOs were deployed via the SMWA to selected communities, where traditional and religious leaders were used as an entry point for introduction of the project. After briefing the traditional rulers and members of the community on the objectives of the SMI, thirty-one volunteers, ten female and twenty-one male, were selected to serve as members of the "Emergency Maternal Care Team" (EMC) in their community. Four EMC members were then selected by the supervising NGO and local leaders to be "lead volunteers" and invited to a three-day PATHS1 training-of-trainers workshop at state/zonal level. Once back in their communities these four lead volunteers were responsible for training the remaining twenty-seven volunteers (facilitated by the supervising NGO). Once training was completed, this critical mass of CVs was responsible for training the community as a whole, as well as instigating and monitoring the demand-side activities cited above. This "cascade and saturation" approach was based on the idea that changing one's mindset is easier in a group than alone, and that information exchanged between peers may be better received than information that is disseminated hierarchically.

It has been continued under both PATHS2 and PRRINN-MNCH.

It is also important to note that even though the leadership of the SMWA was crucial in community mobilization, the SMI was not really a community-based health service delivery project, which means that they were not accountable for health outcomes.

The original design of the SMI lacked an explicit focus on voice accountability although this element evolved over time. In some communities, SMI created capacity and willingness to vocalise demands about the need for general improvements in the quality of health services. As community confidence in their ability to take action and effect change grew, attention turned to addressing other factors that were negatively affecting the health of the community. Recognising that there were issues that lay outside the capacity of the community to act on, communities were aware that they needed the support of local government. However, this awareness was underlain by a tremendous cynicism about the degree to which local government activity was guided by community priorities. Despite this cynicism, some safe motherhood communities did lobby local government for assistance, and some were effective in drawing down support (Green, 2008).

### **Results**

According to the Final Review of PATHS1, there has been a steady decline in maternal mortality since the program's inception in 2002. In addition, service utilization increased between 2005 and 2007 (PATHS Final Review). There is some evidence that improvements along these lines made in Jigawa can be attributed (in part) to the SMI's community mobilization and behaviour change strategies. For example, an end line survey on "Knowledge, Attitudes and Practices" conducted in February 2008 showed significant improvements from a baseline survey conducted in June 2007. Findings indicated progress across a range of subjects related to obstetric emergency. For example, knowledge of danger signs increased from 4 percent to approximately 80 percent, respondents who felt that obtaining standing permission for women to go to a health facility increased from approximately 26 to 90 percent, and the number of informants who discussed obstetric emergency with their spouses went from 3 to 36 percent (PATHS-SMI Increasing Access to Emergency Care). In addition, anecdotal evidence indicates that the SMI in Jigawa receive

widespread support from traditional and religious leaders, that savings funds were established in all the SMI communities, blood donors were listed in all SMI communities, trained emergency drivers were available, and that demand for safe motherhood interventions from neighbouring villages increased over the life of the project (PATHS-SMI Increasing Access to Emergency Care). Finally, it is worth noting that the PATHS1 Final Review mentioned the SMI as “a notable innovation” which was “demonstrating significant change in attitude and behavior of women and men, service providers and community leaders, although on a fairly small scale.” The Review concluded that there was potential for scale-up (PATHS Final Review, 2008).

Despite these successes, the overall long-term impact of the PATHS1 SMI is unclear. After PATHS1 ended, the participation of NGOs in supervision, monitoring and evaluation could not be sustained due to lack of funds. This in turn presumably reduced motivation to continue project activities at village and community levels. In addition, ambiguity regarding the roles and responsibilities of the NURTW and the SMWA in the ETS may have reduced this important strategy’s efficacy, and further impaired the SMI as a whole. Finally, exclusion of the LGAs in the project’s design and execution almost certainly reduced its potential sustainability. These factors and others may have contributed to the decline in service utilization reported in Jigawa (and other states) after PATHS1 closed out in 2008.

### **Programme for Reviving Routine Immunization - Maternal, Neonatal, and Child Health (PRRINN-MNCH)**

PRRINN-MNCH incorporates two projects from two funding sources which have been merged into one program. The first, Programme for Reviving Routine Immunization (PRRINN)), was a health-system strengthening project begun in 2006, focused primarily on routine immunization and funded by DFID. The second was a Maternal, Neonatal, and Child Health (MNCH) project funded by the Norwegian government (PRINN-MNCH Annual Review, 2010). Both projects were integrated into a single, comprehensive program in 2009 (PRRINN-MNCH Progress Report, 2009). However, to date, the projects are being implemented separately. The vast majority of LGAs selected for MNCH activities are not covered by PRRINN activities. (See Table 8 and text below for more discussion on this topic.) PRRINN is funded through 2013 and MNCH is funded through 2013. Both components are being implemented in three states: Katsina, Yobe, and Zamfara. A fourth State, Jigawa, is served by PRRINN but not MNCH. The program’s headquarters are in Kano State.

Many of the strategies that were used by the Safe Motherhood Initiative in PATHS1 were subsequently adapted by MNCH.

### **Chain of Command**

PRRINN-MNCH is managed by a consortium of three organizations: Health Partners International, Save the Children, and GRID Consulting Limited. Other implementing partners include both Nigerian and international agencies<sup>10</sup>.

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<sup>10</sup> PRRINN: Partnership for Appropriate technologies in Health, Johns Hopkins University Center for Communication Programs, University of Oslo (Norway), Transaid UK  
MNCH: Columbia University Mailman School of Public Health, Ahmadu Bello University (Nigeria), University of Liverpool (UK), The Health Reform Foundation of Nigeria.

PRRINN-MNCH has avoided the model of relying primarily on NGOs for implementation and instead has made a very deliberate effort to partner with local government. For example, LGA representatives are solicited early in the process for both financial and logistical support. Five to eight officers are recruited from each LGA to serve as “Demand Creation Teams” (DCT) for community mobilization. These teams work with program officers to select which communities within the LGA will be covered by the program (see below). They are also responsible for training the lead community volunteers, visiting the communities once a month, collecting statistics from communities regarding activities, attending monthly DCT meetings, and submitting a monthly report to the state PRRINN-MNCH office. LGA team members receive paid time-off to work with PRRINN-MNCH, as well as a monthly stipend from the program to cover transportation costs. As of July 2010, about half the PRRINN communities were at least partially funded by the LGAs and this fraction was about 20 percent for the MNCH communities (Adamu, Fatima, 2010).

**Table 8: Coverage of PRRINN-MNCH by State and LGA**  
(Highlighted LGAs are those covered by both PRRINN and MNCH)

	<b>Initial PRRINN</b>	<b>Initial MNCH</b>	<b>Rolling out PRRINN (operative)</b>	<b>Rolling out MNCH (planned)</b>
<b>Katsina</b>	Funtua Danja	Zango Baure Daura	Sandamu Mai’Adua Kusada Charanchi Kurfi Bakauri	Faskari Funtua Danja
<b>Yobe</b>	Fune Karasuwa	Geidam Yunusari Bursari	Bade Jakusko	Bade Jakusko Yusufari
<b>Zamfara</b>	Gummi Birnin-Magaji	Bungudu Maru	Anka	Kaura-Namoda B/Magaji
<b>Jigawa</b>	Kiyawa Hadejia		Jahun Miga Ringim Birnin kudu Gumel Kazaure	

### Coverage

In 2009, the program covered twenty-one LGAs in total. PRRINN was initially implemented in twelve and MNCH in eight. As mentioned above, there was no overlap or “double coverage” between the two. LGAs were served by PRRINN or MNCH, but not both. Currently, six additional LGAs are rolling out activities for PRRINN in Katsina. In addition, in what appears to be the first instance of “double coverage,” there are plans in Katsina to roll out MNCH activities to three LGAs, two of which are already covered by PRRINN (Table 8). At the community level, as of July 2010, PRRINN was active in one hundred and ninety-eight communities and MNCH was operative in ninety-two. Not counting roll outs, MNCH is targeting a total population of approximately 1,514,000 people across three states, and claims to have reached about 584,000 persons in the first six months of implementation.

### **Areas of intervention**

PRRINN-MNCH's overarching goal is to improve maternal and child health; its primary objectives are to increase routine immunization and reduce maternal mortality in Northern Nigeria. However, the program's actual outputs are complicated and range from strengthening governance of PHC systems to promotion of operational research to increasing demand for health services at community level. The program has developed a log frame for these outputs. Together, they are meant to provide a comprehensive response to the major challenges to PHC in Northern Nigeria.

The program's intervention activities can be organized according to demand and supply-side drivers of PHC. The supply-side interventions are aimed at instigating a fundamental shift in service delivery. Some examples are:

- Contributing to the revision of curricula for training health workers
- Provision of in-service training
- Development of a Sustainable Drug Supply System (procurement, distribution, legislation, advocacy)
- Refurbishment of health facilities
- Recruitment and retention of healthcare personnel

In addition, for MNCH specifically, the program has taken what it calls the "Cluster Approach" to improving service delivery. This intervention focuses on improving accessibility to emergency obstetric care, and is based on the UNICEF/WHO/UNFPA's *Guidelines for Monitoring the Availability and Use of Obstetric Services* (UNICEF, WHO, UNFPA, 1997): For every cluster of 500,000 individuals, one Comprehensive Obstetric Care (CEOC) facility and four Basic Emergency Obstetric Care (BEOC) facilities are required. LGAs that are targeted for the MNCH component of the program are thus selected and grouped in a way that their combined populations are approximately 500,000. Existing facilities are assessed and within each cluster, facilities are selected to be upgraded to CEOC and BEOC level. MNCH also stipulates the addition of eight PHC facilities within each cluster. Unlike the B/CEOCs, which are required to have the equipment and personnel necessary for performing technical obstetric-related operations, PHC facilities simply provide a safe environment where babies can be delivered by a skilled birth attendant.

Complementing the supply-side interventions are community-based demand-creation activities. These activities are designed to help communities raise awareness regarding how to prevent and respond to obstetric emergency as well as regarding the importance of immunization (discussed below). All of these activities are instigated by community volunteers (CVs). For example, the responsibilities of CVs in communities where MNCH is being implemented include:

- Organizing community meetings where individuals are taught to memorize the "danger signs" or symptoms of obstetric emergency
- Obtaining standing permission from husbands to allow their wives to be transported to a facility in case of obstetric emergency
- Organizing collective savings schemes to cover the cost of transportation, examination and treatment
- Organizing blood donors groups to ensure a free supply of blood in case of hemorrhage
- Linking the community to a free Emergency Transportation Scheme (ETS)

CVs were also responsible for linking their communities to the free Emergency Transportation Scheme (ETS). The ETS was an innovative partnership between the National Union of Road Transport Workers (NURTW) and various safe motherhood projects in Northern Nigeria. It was piloted in Jigawa State under the PATHS1 Safe Motherhood Initiative (see PATHS1/SMI Project Description). Through the ETS, the NURTW provided incentives to taxi drivers to provide speedy transport of women to facilities without requiring pre-payment. The Union also supported the piloting of motorcycle ambulance trailers and mobilized and trained volunteer drivers. In addition, the NURTW collaborated with the state and LGAs on monitoring, as both volunteer and professional taxi drivers were required to keep track of the women transported to facilities.

### **Community Mobilization**

Community mobilization is an essential aspect of PRRINN-MNCH. As mentioned above, LGA officers work with program officers to select which communities within a given LGA are best suited to the program. After getting approval from traditional and religious community leaders, the program is introduced to the community by the LGA officer during a Participatory Learning and Action (PLA) session. During the PLA, the issue of maternal mortality or immunization is presented, causes are analyzed and the community is urged to address the problem. Thirty volunteers (twenty men and ten women) are selected to be the on-site agents of community mobilization. Four of them are designated “lead volunteers” and invited to a one-day workshop at Local Government headquarters where they receive training from the local government officers (under the supervision of program consultants). Once back in their communities, these four lead volunteers are responsible for training the remaining twenty-six (under the supervision of the local government officer). Once training is completed, this critical mass of CVs is responsible for training the community as a whole, as well as instigating and sustaining the demand-creation activities cited above. This “cascade and saturation” approach is based on the idea that changing one’s mindset is easier in a group than alone, and that information exchanged between peers may be better received than information that is disseminated hierarchically.

### **Results**

As PRRINN-MNCH is quite young and still extant, it is not possible to present a comprehensive picture of its results. However, thus far, the program has made progress in a range of areas, including immunization rates, M&E and development of a “data culture” in the States, partnering with stakeholders, government accountability and improved performance, and community mobilization and action. DFID’s 2010 Annual Review (PRINN-MNCH Annual Review, 2010) of the program cites the following specific achievements over the past year:

- Increased transparency of funds transfer in Zamfara State (presumably from State to LGAs)
- Appreciation expressed by the state governments of Zamfara and Jigawa for capacity building elements of the program, demonstrating their willingness to participate in the process of transparent government.
- Human resource audits with fulltime HR units established within each SMOH, demonstrating progress in HR planning in all states.
- Costing of the Minimum Service Package in each state.
- Posting of 96 midwives per state through the Midwife Service Scheme
- Increasing demand for routine immunization and a programme survey indicating a doubling of routine immunization rates for the four states (albeit from a very low base)

The Annual Review notes that it is too soon to look at MNCH indicators and that no new surveys have taken place since the baseline survey done in 2009. However, anecdotal evidence indicates that MNCH covered communities have reported a decline in maternal deaths (Interviews with Dan Heij community, 2010).

In sum, PRRINN-MNCH appears to be achieving a considerable degree of success. Within the context of this Report, the program's strong emphasis on governance and its ingenious "cascade and saturation" approach to community mobilization are especially noteworthy. However, as noted by the Annual Review, the program will remain high risk as long as governance and institutional issues persist. While government commitment to the program has become evident in some states, there is no guarantee that this commitment will be sustained.

## Annex D: Case Study Matrix

Dimensions	Indicator	Source of information	Questions	Methods
<b>A. Using and strengthening existing community organizations</b>				
1. Community Involvement (participation and influence in design, planning, implementation, M&E.)	<p>a. Participatory approaches/decision making mechanisms over the project cycle.</p> <p>b. Inclusiveness (different actors at different levels)</p>	<p>Project documentation</p> <p>Project managers and supervisors</p> <p>Community members (gender, age group, social category), groups, committees, organizations</p>	<p>a. How central has participation been over the project cycle?</p> <p><u>How?</u> (Process, methods)</p> <p>What has been your role in planning, implementation, M&amp;E?</p> <p>Consequences of participation (or lack of)?</p> <p>b. Inclusiveness?</p>	<p>Desk review</p> <p>Interviews, KIIs &amp; FGDs w sources of info</p> <p>Observation (if possible)</p>
2. Adaptability and Flexibility (Adapt design, implementation to social, religious and environmental contexts)	<p>a. Different activities</p> <p>b. Different delivery mechanisms</p>	<p>Project Documents, operational Guidelines</p> <p>Project management</p> <p>Community actors</p>	<p>What activities and mechanisms are in place, <u>how and why?</u></p>	<p>Desk review</p> <p>Interviews, KIIs &amp; FGDs w sources of info</p> <p>Observation (if possible)</p>
3. Degree of integration (synergy, complementarities, around use of resources)	<p>a. Polyvalence (workers, associations, committees)</p> <p>b. Bundling of activities</p> <p>c. Common use/sharing on inputs (bicycles, community centers, other resources)</p> <p>d. Sharing of tools (communication, monitoring, training)</p>	<p>Project supervisors, managers</p> <p>Outreach personnel</p> <p>Development committees</p> <p>Community workers</p> <p>Operational</p>	<p>a. Who are the workers, committees, groups? Probe on the linkages</p> <p>Are there other groups, workers, etc. not involved? Probe on the</p>	<p>Desk review</p> <p>Interviews, KIIs &amp; FGDs w sources of info</p> <p>Observation (if possible)</p>

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
	manuals, guidelines)	guidelines, training manuals Beneficiaries	linkages  b What activities are being delivered? Do actors/committees provide other services? Probe on the linkages or lack of  c/d. Are there shared tools, equipment, vehicles, etc?	
4. Community level monitoring (extent of community members/groups/orgs involved in monitoring )	a. Level of involvement b. Inclusiveness (different stakeholders at different levels) c. Training /orientation /skills/support d. Response taken e. Strategies/Tools/Checklist used in monitoring	Project documents, training manuals Monitoring Tools /Checklist/Strategies Actors in community & project	a. Are there monitoring mechanisms at community level?  Who was involved & to what degree?  How? (Process & methods).  How frequently? (ad hoc, monthly, annual?)  b. How recruitment done? Ensured inclusion?  c. How did you acquire the monitoring skills?  d. What actions resulted in response to monitoring?	Desk review  Interviews, KIIs & FGDs w sources of info
5. Accountability (Ability of community	a. Clear assignment of roles and responsibilities	Project documents	a. Who is responsible for	Desk review

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
members to hold project responsible for fulfilling program goals and objectives )	<ul style="list-style-type: none"> <li>b. Effective complaint /response mechanisms</li> <li>c. Inclusiveness of the process (especially Gender)</li> <li>d. Transparency (accessibility of information)</li> <li>e. Conflict resolution mechanisms</li> <li>f. Rewards and sanctions</li> </ul>	<p>Project staff</p> <p>Key actors at community level (by gender, age group, social category)</p>	<p>what?</p> <p>b. Are there mechanisms in place for feedback, about performance?</p> <p>Where do you go if there are problems, dissatisfied with project?</p> <p>c. Who did complain? Inclusiveness?</p> <p>d. Info you wanted to know available</p> <p>f. If you complained, what happened?</p>	<p>Interviews, KIIs &amp; FGDs w sources of info</p>
6. New forms of organization (creation of structures and actors to complement and not substitute)	<ul style="list-style-type: none"> <li>a. Number of new structures /functions/actors</li> <li>b. Overlap with existing roles and structures</li> <li>c. Institutional Assessments in communities</li> </ul>	<p>Project documents (operational guidelines)</p> <p>Beneficiaries</p> <p>Project managers, supervisors</p> <p>Community orgs and actors (new &amp; old)</p>	<p>a/b. Tell me about the orgs/workers (trad, otherwise) you have in your community?</p> <p>Which ones already here?</p> <p>Which ones created by this project?</p> <p>Reasons for creation: process of creation</p> <p>Are the new orgs/workers complementary or in conflict with existing organization?</p> <p>Do they relate to one</p>	<p>Desk review</p> <p>Interviews, KIIs &amp; FGDs w sources of info</p>

Dimensions	Indicator	Source of information	Questions	Methods
			another? How? Need and efficacy of the new structures? Inclusiveness? c. Did they assess existing orgs/workers before creating new?	
<b>B. Policy alignment and influence (extent to which project is embedded in and catalyzes policy environment and engages stakeholders)</b>				
1. Stakeholder involvement /supports	a. Broad based awareness b. MOUs (existence and degree of implementation) c. Contributions (financial, in-kind, others) d. Political influence (traditional, state, CSO)	Project documents Stakeholders (trad, state, CSOs, universities, etc.) Project staff Community members Media	a. Are you aware of the rationale and purpose of the project? b. Ask to see the MOUs? c/d. Tell me about your involvement (roles and responsibilities) in the project What do you know about other stakeholders' involvement and contributions, political influence?	Desk reviews: (MOUs, project docs, minutes of meetings (who attended), media publications. Interviews
2. Building alliances (multi-	a. Mobilization of champions	Project documents &	a. Who are the champions,	Desk review

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
level?) & coalitions for change. (extent stakeholders are brought together for action for change).	b. Common goal/narrative	activity reports Media reports Champions Project staff Stakeholders (trad, state, CSOs, universities, etc.) Community members (local coalitions)	what are the coalitions? What do they do in the project? How were champions and coalitions they mobilized? <b>PROBE!</b> b. Was there a common goal/narrative? If so, what was it, and how created?	Interviews, KIIs sources of info
3. Advocacy/Strategic Communication (multi-level)	a. Broad based awareness b. Existence of a common narrative c. Power of a common narrative d. Spread of a common narrative e. Level of stakeholders targeted f. Inventory of communication /advocacy events g. Memorability of communication/advocacy events	Project documents & activity reports Media reports Project staff Stakeholders (trad, state, CSOs, universities, etc.) Community members (local coalitions)	a. What is known about the project How did you learn about it b. What were the main messages? c. Which of the above struck you most? In what ways did it influence your perception and behavior? d. What were the channels, messages, techniques? And Why?	Desk Review Interviews & FGDs w sources of info Review of materials, radios, videos/
4. Use of existing protocols, guidelines and tools	Compliance of program guidelines and tools with existing protocols, policies and norms.	Project documents, tools, policies, guidelines, manuals, protocols Project staff	What activities do you implement? How were activities & messages determined?	Collect existing protocols, policies & norms, guidelines & tools Desk

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
		Community members and organization members	Did you follow existing protocols, policies & norms when developing guidelines & tools? Why? Why not?	review of above Interviews
<b>C. Cost – Effectiveness</b>				
1. Choice of Intervention	Internationally recognized cost effective nutrition and health interventions	Project documents, description, literature	What guided the choices or decisions?  Why not, if didn't choose internationally recognized interventions?	Desk review  Interviews, KIIs sources of info
2. Non-internationally recognized cost-effective strategies	Existence of such a strategy	Project management	Why chose interventions of unknown cost effectiveness?	Interviews
3. Categories (overhead & cost structure)	a. Cost structure b. Cost per result (outcome) c. Percentage that goes to the community d. Ratio of fixed cost (including preparation) versus variable cost (including implementation) e. In relation to age/stage and coverage/scale /Reach/location of project f. Cost per beneficiary	Database	Cost effective?  Who delivers the activity ? At what price?	Desk review
4. Monitoring and Evaluation				
<b>D. Management Capacity</b>				
1. Human Resources (Technical capacity,	Multi-disciplinarity of actors	HR manual, personnel		Desk review

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
career development, performance eval; team building )		handbook		Interviews with project staff
1.1. Recruitment	<ul style="list-style-type: none"> <li>a. Inclusion</li> <li>b. Appropriateness (gender, education, age, skills, education requirements too high/too low</li> <li>c. Transparency</li> </ul>	<p>Project documents</p> <p>Multilevel actors (service providers, project supervisors, community members)</p>	<p>a/b/c. How was the recruitment conducted?</p> <p>Were the right people employed? Why and why not?</p> <p>Would you have recruited different persons and why?</p>	<p>Desk reviews</p> <p>Interviews, FGDs</p>
1.2. Training (Orientation)	<ul style="list-style-type: none"> <li>a. Skills assessment b4 training</li> <li>b. Differentiation and customization</li> <li>c. Graduality</li> <li>d. Frequency</li> <li>e. Methods-participative methods</li> <li>f. Inclusiveness (different stakeholders at different levels)</li> </ul>	<p>Project documents, training manuals and guides</p> <p>Trainers and supervisors</p> <p>Trainees</p>	<p>a. Whether there was skills assessment before training</p> <p>b/f. Customization -who was trained</p>	<p>Desk reviews</p> <p>Interviews, FGDs</p>
1.3. Supportive Supervision (facilitation, constructive guidance and coaching)	<ul style="list-style-type: none"> <li>a. Methods and content of supervisory support</li> <li>b. Levels of contact of supervision</li> <li>c. Frequency (supervisory visit)</li> <li>d. Reporting and Feedback system</li> <li>e. Decisions made after feedback</li> </ul>	<p>Project documents and manuals</p> <p>Interviews with service providers (Community/Facility-based)</p> <p>Project managers and supervisors</p>	<p>a. Tell me about the on the job supervisory support</p> <p>What kind of feedback support you get?</p> <p>Do you receive any coaching?</p> <p>What did you gain from it?</p> <p>What would you change in</p>	<p>Desk review of project docs</p> <p>Interviews with sources of info</p>

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
			<p>the supervision process?</p> <p>b/c. Who and how often do you receive supervisory support?</p> <p>d. What kind of reporting system?</p>	
1.4. Reward system	Incentives (monetary, non-monetary, in-kind, skill building, community recognition, increased influence, other)	<p>Project documents</p> <p>Interviews with service providers (Community/Facility-based)</p> <p>Project managers and supervisors</p>	<p>What were the incentives employed with your community workers?</p> <p>Why were these incentives chosen?</p> <p>How well did they function?</p> <p>What would you have changed?</p>	<p>Desk review of project docs</p> <p>Interviews with sources of info</p>
1.5. Level of attrition	Percentage of workers leaving the project yearly	<p>Project documents</p> <p>Interviews with service providers (Community/Facility-based)</p> <p>Project managers and supervisors</p>	<p>Tell me about attrition in the program</p> <p>What factors underlie this?</p> <p>What would you have changed to reduce attrition?</p>	<p>Desk review of project docs</p> <p>Interviews with sources of info</p>
2. Subsidiarity (actors, roles and responsibility)				
	<p>a. Proportion of funds/variable cost reaching the community level</p> <p>b. Responsibility by level</p> <p>c. Fit between workers</p>	<p>Actors (service providers, project manager, supervisors)</p> <p>Project documents</p>	<p>Who does what best at the lowest level?</p>	<p>Desk reviews</p> <p>Interviews</p>

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
	<p>and tasks</p> <p>d. Number of actors at the lower levels</p> <p>e. Diversity of actors' profiles</p> <p>f. Ratio between beneficiaries and actors and between actors and supervisors</p>			
<b>3. Financial Management</b>				
3.1. Funding flow	<p>a. Transaction cost</p> <p>b. Number of transactions</p> <p>c. Timeliness (timely release of funds and procurement-esp. at the activity level)</p> <p>d. Tracking system adequacy</p>	<p>Financial management manual, reports</p> <p>Financial manager</p> <p>Independent audit reports</p> <p>Community members and structures</p>	<p>Do you have internal audit systems?</p> <p>Any delays experienced? Why?</p>	<p>Desk reviews</p> <p>Interviews (confidential)</p>
3.2. Financial arrangement	<p>a. Transparency (oversight committees, financial mgt; dissemination of financial and procurement information.)</p> <p>b. Book keeping quality (justification &amp; vouchers)</p> <p>c. Internal and external audit</p>	<p>Financial management manual, reports</p> <p>Financial manager</p> <p>Independent audit reports</p> <p>Community members and structures</p>	<p>How satisfied are you with the financial arrangements?</p>	<p>Desk reviews</p> <p>Interviews</p>
<b>E. Financial Capacity</b>				
1. Funding Base	<p>a. Funding diversification (local, national-PRSP and varied donors).</p> <p>b. Funding gaps</p> <p>c. Absorption capacity of funds/implementability/readiness</p>	<p>Financial manager and project manager</p> <p>Donors (occasionally)</p> <p>Proposals, concept note etc.</p> <p>Relevant project</p>		<p>Desk reviews</p> <p>Interviews</p>

<b>Dimensions</b>	<b>Indicator</b>	<b>Source of information</b>	<b>Questions</b>	<b>Methods</b>
		documents, annual reports and accounts		
2. Resource Mobilization Strategy (Short term/opportunistic/long-term)	<ul style="list-style-type: none"> <li>a. Proposals and concept notes</li> <li>b. Costed strategy</li> <li>c. PRSPS</li> <li>d. Donor liaisons (scanning for new opportunities)</li> <li>e. Partnerships (PPP)</li> <li>f. Development of strategic alliances</li> </ul>			Desk reviews Interviews

## **Annex E: Case Study Experience with Engaging Government**

### **SMI in Jigawa**

The Safe Motherhood Initiative (SMI), under PATHS1 in Jigawa has been exemplary in engaging the State level in the implementation of the project. The state government has been responsible for implementation of both the demand-side and the supply-side of emergency maternal care (SMI), and has done it through the direct involvement of agencies and personnel from the State Ministry of Women's Affairs (SMWA) and the State Ministry of Health (SMH) respectively. PATHS1 provided these agencies with technical assistance, in support for the reform of their health care system.

SMI's demand-side component has been essential to addressing the socio-cultural influences associated with the delay in reaching facilities during emergencies, and has done so through intense community mobilization. NGOs and volunteers have been the main agents catalyzing community mobilization and training, under the supervision of the State government. The implicated actors will continue to use this effective platform for community mobilization for additional community interventions in health and nutrition.

Initial results from pilot communities indicate that SMI did contribute to a decline in maternal mortality. These results led the Jigawa State government to commit budget funds to the project (through line Ministries) and also led to a grant from the MDG fund at the federal level. These additional funds have allowed the government of Jigawa to expand the number of communities covered by SMI from an initial 36 communities in 2004 to 280 communities in 2010.

The commitment of the State has led to continuity of the project. However, the project is exhibiting some shortcomings due to the lack of engagement of an appropriate partner "on the ground" that is closer to the communities. SMI-Jigawa was implemented in a context where the overall PATHS1 project had invested relatively little at LGA levels, and communities have found the State hard to reach when demands arose, especially once the donor support had been discontinued. Participation of NGOs which had been a key actor during the mobilization of the communities was not sustained after the closing of the project.

The State focused their resources on scaling up but neglected the supervision and monitoring of existing communities. The discontinued support by NGOs without the mobilization of an alternative actor in the project has been a missed opportunity to keep up the efforts in the existing communities and it is leading to the disengagement of some of them.

The case of SMI in Jigawa also points to the importance of being strategically pragmatic when it comes to identifying the lead ministry for community mobilization. SMWA had taken exceptional leadership in this project and had housed a managing structure for it. It had also taken steps for getting additional funds from the national level, and it had partnered with NGOs for training and supervision of communities, although the partnership was not sustained.

PATHS' decision to work with SMWA was based on their observation that the SMH was not the best 'home' for demand led work. In Jigawa state, the SMWA proved to be better equipped for (and more interested in) this type of engagement. This argues for a high degree of flexibility during the course of implementation, and a solid understanding of the politics driving the institutional landscape. In Jigawa, for example, the State Ministry of Women

Affairs was subsequently restructured and individuals with a background in safe motherhood transferred to other the Ministries. Meanwhile, since 2007, the state has pursued reforms of their PHC delivery system along the lines of the district health system by creating “Gunduma Councils” and a Gunduma Board. The best institutional home is (probably) now the Gunduma Councils – the new Jigawa State ‘district health system’. In fact, the Gunduma Board is already part of the SMI coordinating committee that gives overall guidance to one of the most successful community-based initiatives in the State—i.e. a program for emergency maternal care

The downside of the involvement of the State is the potential of political interference, which should be factored in. The SMI project has already been the subject of reports of the use of political consideration in the selection of communities and community members of Emergency Maternal Care Team (EMC) team and trained volunteers for training-of-trainers. Some communities are refusing to work with them and they had to go through another selection process.

Given the successful engagement of the State in Jigawa, the question arises of what accounts for it, and how it could be reproduced in other states. The SMI initiative in Kano for example did not get the same level of engagement of the State government. To some extent the visibility of the safe motherhood initiative is related to DfID funding and the sheer size of PATHS, and PATHS’ showcasing of the initiative. But there were also State specific considerations; there was a clear institutional home for the initiative within the State Government, key individuals who took interest and leadership including senior female civil servants, and solid long standing working relationships between project staff and State officials. Eventual program design would benefit from state and sector specific institutional and political analysis to determine what interventions and institutional arrangements are most appropriate for the context.

### **PRRINN-MNCH in Katsina**

Drawing on the lesson of the Jigawa experience, DfID has taken a very different approach in the implementation of PRRINN-MNCH in Katsina. PRRINN-MNCH in Katsina also started with SMI as a platform for community mobilization that will be used for adding other interventions on maternal and child health, including nutrition, in the near future. In the state of Katsina, LGAs have assumed most of the responsibility for the implementation of the demand-side creation for treatment of emergency obstetric complications. LGA officials engage in community mobilization, training, supervision and monitoring from beginning to end. PRRINN-MNCH provides supportive supervision, training, funding and technical advice.

One interesting lesson from this experience relates to the motivation of LGA civil servants to engage in implementation. LGA civil servants are highly motivated to participate in the implementation of these very successful projects that can have positive impacts in the communities’ lives. The sense of fulfilment that arises from contributing to this positive outcome is enough as a motivation. A team of LGA officers were provided with paid time-off from their primary responsibilities to carry on the project in the communities. They received a small stipend for transportation costs. The same sort of arrangement was observed in COMPASS. The LGA Chairman seems very willing to offer their human resources for these projects.

LGA level work is also facilitated by LGA ‘Engagement Coordinators’ which are direct

project staff. The LGA Engagement Coordinators have proven to be important for pace of implementation and scale. This is in part a ‘lesson learned’ from the PATHS1 experience, which had no project resources working consistently at LGA level and hence immediate influence on service delivery at facility levels was less evident.

PRRINN-MNCH has incorporated more LGA involvement, but there has been significant investment at State level as well. It is too early to know if this engagement of LGA officers in community mobilization for health and nutrition will be sustainable once the project stops. At the time of the case studies, PRRINN-MNCH was the only project that was still on-going.

The LGAs have already engaged in expanding the project to other communities with their resources, which is promising in terms of sustainability. However, there are no guarantees that this will be sustained after the upcoming elections of 2011, given the tendency of high turn-over for Chairman and PHC Directors, and changes in State-level appointments which in turn influence the release of LGA allocations.

### **COMPASS in Nasarawa and Kano**

The heart of the project was community participation and ownership. The gist of the project was to get Community Coalitions to increase demand for facility-based services, increase voice and demand for better services at LGA level overall, and to engage communities in projects in health and education alongside government. LGAs were supported to respond better to these demands but they were engaged mostly to provide a policy environment for the COMPASS project and to participate in several activities on the request of project officers.

The case study showed that in Kano, for example, key government personnel found that COMPASS worked “for” the government and not “with” the government, which did not help to encourage the government to take over responsibilities once the project closed activities.

COMPASS engaged LGAs in project activities, in particular monitoring and participation in the QIT at health facilities and Parent-Teacher Associations (PTA) in schools. In fact, many community engagement activities were facilitated by LGA staff paid by the project. As members of QITs and PTAs, technical personnel of the LGAs participated in community meetings, situation assessments, project identification and monitoring implementation. Many of these activities were about renovation of health facilities, and making them more functional; as well as engaging communities to seek services in these facilities—ANC, immunizations, reproductive health, etc.

LGA engagement was more limited than in the case of PRRINN. Using the same mechanism, LGA officers worked for the project on secondment, thus receiving government salaries while performing tasks for the project. LGA officers were in charge on monitoring statistics that were recorded in health facilities and were project indicators.

The COMPASS LGA Coordinator (a fulltime COMPASS staff) oversees COMPASS project activities across communities in a given LGA. This Coordinator works with an LGA facilitation Team that he leads. The Facilitation Team comprises the Coordinator and five LGA desk officers also known as facilitators. These facilitators are full time staff members of the LGA who are designated by the LGA to work with COMPASS in that LGA. They are drawn from the departments of Primary Health Care, Education, Agriculture, Community Development and Personnel/Management. These are government employees, paid by the

government and given some monthly stipends by COMPASS to facilitate their involvement in the COMPASS project activities within the LGAs. The stipend grew from N3000 to about N10, 000 across the project life course.

The role of the five facilitators included identifying other facilitators, acting as liaison between the COMPASS project and their departments, participating in Community Coalition formation, doing follow up activities and reporting back to COMPASS through the COMPASS LGA Officer. These desk officers were also involved in project monitoring helping to collect project related-data from the facilities.

The involvement of LGA officials in the monitoring reflects some of the challenges of working with LGAs and the need to provide for appropriate capacity building. LGA officers were in charge of gathering basic statistics from health posts. However, these data was not always readily available in part because there is no culture built in the LGA on this data collection and in part because the incentives at that level are to under-report information of services rendered, as fees received need to be submitted to the State level. As LGA officers had to make recurrent visits to get this information, the stipends they got from COMPASS were insufficient.

The engagement of Ministry of Local Government at State level (SMoLG) was essential to secure participation of LGA Primary Health Care units in the project. The engagement at the State level came through the Department of Primary Health Care in the SMoLG and/or SMOH. This is a good example of the importance of engaging the different levels of government in the Nigerian context. Both state ministries need to be involved.

COMPASS also brought on board the Federal level in order to ensure that it operated within the policy framework of the Federal Ministry of Health and NPHCDA.

### **GINA in Kano**

GINA engaged different levels of government to support the project, but their role was limited to the duration of the project and there was no strategy to build capacities and commitment to continue the activities after project closing. This might be explained in part by the short duration of the project (18 months) and their small coverage (9 communities in 3 states).

At the federal level, project management participated in a previously created coalition in support of nutrition hosted by the National Planning Commission's National Committee on Food and Nutrition. It was utilized as a forum to report on project progress and gather ideas for solving problems that arose. It also served as a source of motivation for project staff. There was no reporting that GINA had influenced this Council or any policies at national level.

The different levels of government were targeted for "advocacy visits" which main role was to get their approval to roll out the project and have access to the next level of government down the line of command. So, State government authorities were targeted in the first place, followed by State line ministries (Health first and then Agriculture); then, LGA Chairman was targeted and from there access was granted to LGA departments of health, agriculture and PHC. After that, traditional authorities were visited before the project staff could access the communities. This same strategy was also used by the other projects studied.

At the State and LGA levels, food and nutrition committees were created to provide policy guidance for the project. These committees were comprised by representatives of the Ministries of Health and Agriculture respectively, with the intention to bring about the multi-sector approach that is necessary for nutrition, and it is often lacking in Nigeria. The project argued that under the aegis of the Ministry of Health, where nutrition is often housed, nutrition had been relegated and had not been given proper prominence. From the case study, however, it is unclear how these committees helped to solve this issue, and what they actually did. In fact, these committees ceased their existence at project closing.

As in the other projects, LGAs released their Health and Agriculture staff to work for the project on government payroll. They were however “focal persons” which main role was to be a liaison between the project staff and the communities. They did not seem to have had direct involvement in the project implementation.

As observed in other cases studied, financial commitments from government agencies were hard to come by. It is easier to get access to office space of personnel. For example, the Federal Ministry of Water Resources had promised to provide a water source for each of the 3 GINA LGAs in Akwa Ibom, Nasarawa and Kano, but it was never fulfilled. Another Chairman in an LGA in Akwa Ibom state promised to pay for food for the food demonstrations, but it did not happen. However, the project managed to get office space and the release of offices and officials for use of the project in Bichi LGA in Kano, and the release of a water harvesting expert from the Kano State Agricultural and Rural Development Agency (KNARDA).

## **Annex F: The Saturation technique**

The four lead community volunteers attend a one day training session at state or LG level (depending on the project). During the session, the volunteers are taught about the fundamentals of obstetric emergency and provided with a menu of interventions designed to reduce maternal mortality, namely: raising awareness regarding the dangers of obstetric emergency, getting standing permission from husbands to bring their wives to facilities, creating a savings group to pay for transport and medical expenses, starting a blood donors group, and linking the community to the Emergency Transport Scheme (ETS).

After the session, the four lead volunteers return to their community and immediately train the remaining volunteers. The final step in the process is the gathering of non-volunteer community members. At this point, the volunteers gather community members for subsequent trainings. The number of trainings that occur at this level depends on the size of the community and the number of individuals recruited per session.

The community is considered “saturated” when every member is aware of the symptoms of obstetric emergency and of the actions to take in such an event. Records are kept by volunteers regarding every individual who has “graduated” from a training session. By corroborating the number of names on record with a population estimate of the community (typically provided by a traditional leader and/or the LGA), it is possible to determine what stage of “saturation” a given community is in. Obviously, the range of issues that can be communicated by using the saturation approach is much more limited. It is similar to running a social marketing campaign on one particular key message.

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