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Advancing Family Planning for Improved Reproductive Health in Northern Nigeria:

Recommendations from 10 years of practice in the region

PATHFINDER INTERNATIONAL

For more than four decades, Pathfinder has implemented sustainable reproductive health and family planning programs in Nigeria. The Private Sector Family Planning Service Delivery Project ran from 2000-2011. This report sets forth lessons from Pathfinder's 10 years of pioneering FP/RH practice in northern Nigeria, and provides recommendations for those working in the region.

When Pathfinder International began the Private Sector Family Planning Service Delivery Project in 2000, it was one of the first to attempt revitalization of family planning (FP) and reproductive health (RH) service delivery capacity in Nigeria's northern region. With the support of the David and Lucile Packard Foundation, Pathfinder has maintained a continuous presence in the region for 10 years, building the capacity of private and public health facilities to meet the need for FP and RH services, supporting local nongovernmental and community-based organizations (NGOs and CBOs) to build the quality of those services, and strengthening community systems to engage with FP and craft an enabling environment for improved RH outcomes.

Background

According to the Nigerian Demographic and Health Survey, Nigeria's maternal mortality rate is estimated at 545 deaths per 100,000 live births (National Population Commission 2008). Nationwide, the contraceptive prevalence rate for women aged 15-49 is 15 percent (UNICEF 2009), and the fertility rate is 5.6 (The World

Bank Group 2009). In the southern regions of the country, which are primarily urban and more densely populated, a majority of women receive antenatal care, deliver in health facilities, and are attended by a skilled provider during delivery. The RH profile in the more rural regions of northern Nigeria, where the majority of families in the lowest wealth quintile reside, presents a marked contrast. There, health

facility delivery rates range from 43 percent in the northeast to 31 percent in the northwest. Only 10 percent of women in the northwest deliver with the care of a skilled birth attendant, and 45 percent of girls aged 15-19 have already entered their childbearing years (National Population Commission 2008). As this data reflects, northern Nigeria has proven a challenging region for FP/RH service delivery efforts. Whereas the Nigerian government's stringent population control policies of the 1980s resulted in widespread resistance to any FP/RH throughout the country, this sentiment has largely given way in the south. Distrust has persisted in the north however, leaving the region largely closed to RH improvement efforts.

PROGRAM STRATEGY

Pathfinder's strategy to develop FP/RH service delivery capacity in northern Nigeria was built upon core tenets of health system and community system strengthening. In line with the World Health Organization's Health System

Strengthening building blocks, the project worked at the foundations of service delivery, accessing existing health facility and professional provider networks to build individual provider as well as institutional capacity to deliver quality services. Appreciating the relationship between health facilities and the social and political environments in which they work, Pathfinder worked at the community level to bolster community networks, build resources and capacity, and foster an enabling environment supportive of FP/RH services. Figure 1 presents the framework for the program's health system strengthening and community capacity building approaches.

SITE SELECTION & PARTNER COVERAGE

Running from 2000 to 2010, the Private Sector Family Planning Service Delivery Project worked in 9 states through sub-grants to 29 NGOs and CBOs. Implementing partners were selected based on results of Pathfinder's standard assessment protocol to determine program-

FIGURE 2: PROJECT SERVICE DELIVERY COVERAGE IN NORTHERN NIGERIA

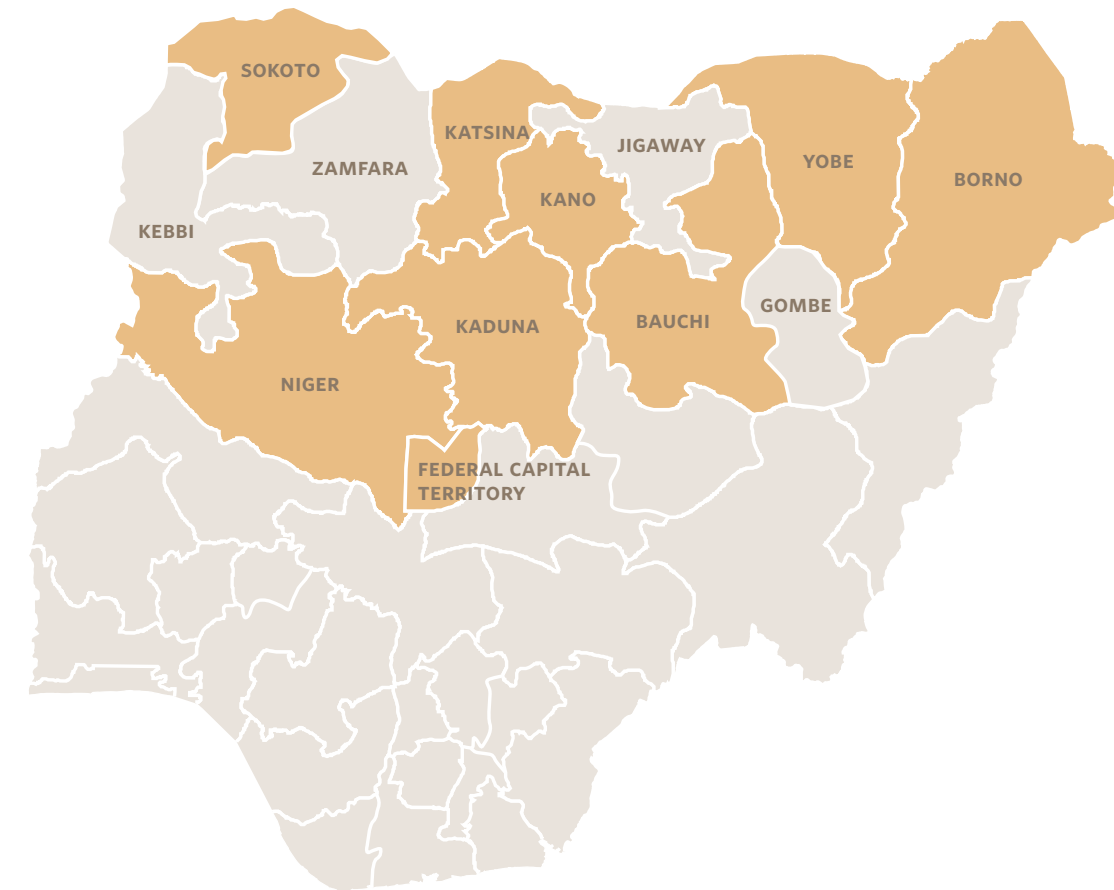
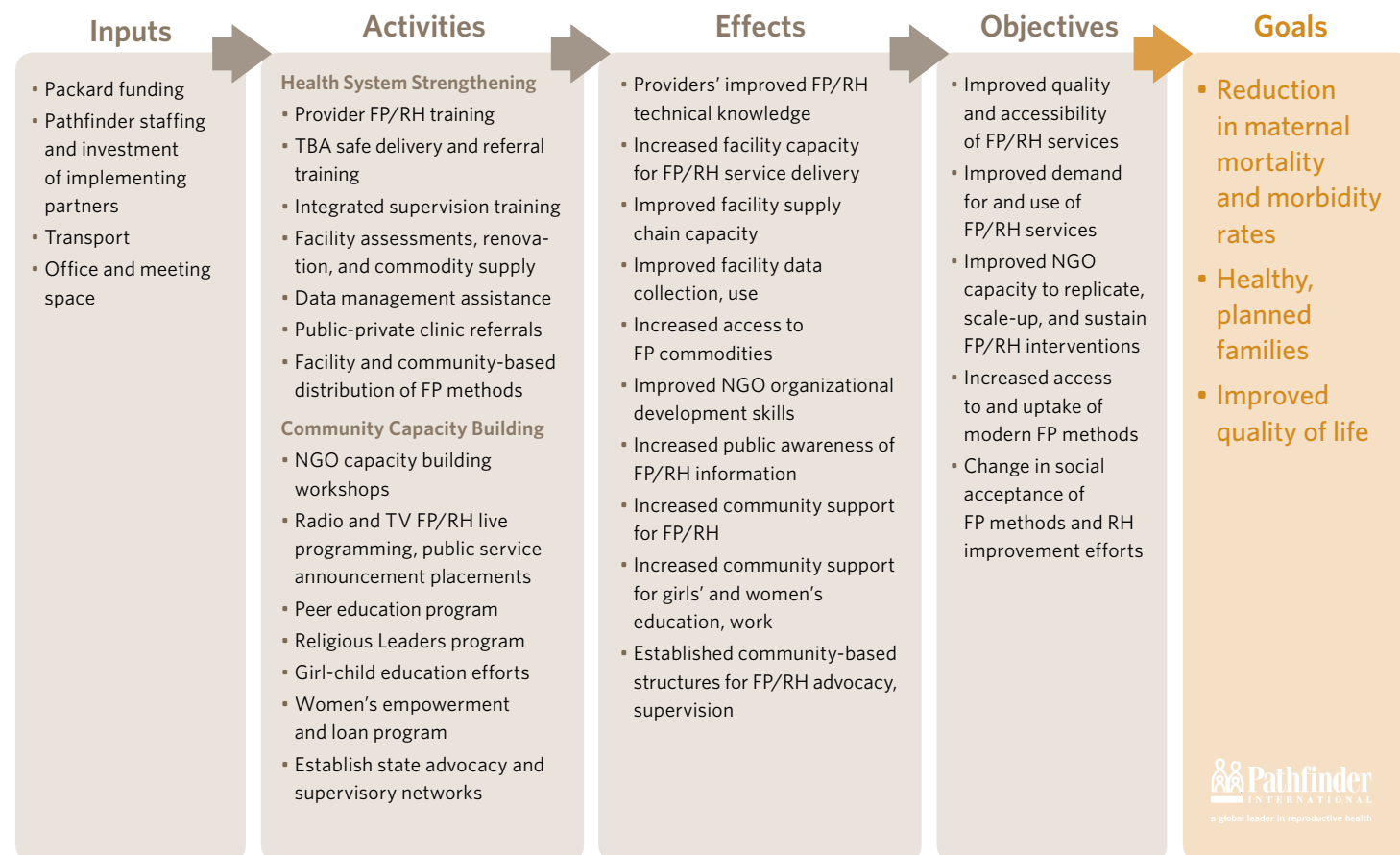


FIGURE 1: PRIVATE SECTOR FAMILY PLANNING SERVICE DELIVERY PROJECT FRAMEWORK



matic, administrative, and financial capability. Selection criteria included having offices based in at least one of the three northern regions, adequate geographic coverage in the regions in which they worked, and a history of successful management of funds.

Once selection was complete, the project and its implementing partners had established presence in 216 health facilities throughout the north—127 private clinics and, in later stages, 89 public sites. In the northwest, the program worked in Katsina (26 sites), Kaduna (52 sites), Kano (48 sites), and Sokoto (12 sites). In the northeast, programming was delivered through facilities in Bauchi (2 sites), Borno (31 sites), and Yobe (6 sites). Finally, in the north central, facilities in Niger (15 sites) and the Federal Capital Territory (24 sites) collaborated to provide improved FP/RH services.

Implementation

Phase I (2000-2003) focused on establishing relationships with implementing partner grantees, conducting trainings to address gaps in grantee skill sets, and holding community meetings to collaboratively identify FP/RH-related priorities and gain community gatekeepers' acceptance of the program. Phase II (2004-2006) built supervisory and service delivery capacity within collaborating facilities. During this time, facility renovations, commodity supply, and data management system support helped to construct the procedural and structural foundations of local organizations and their respective facilities. Phase III of the project (2007-2010) further expanded the catchment areas of intervention facility sites through establishment of satellite clinics, integration of FP/RH services into existing infant care clinics, and outreach to public facilities to bolster their FP services and establish

FIGURE 3: PHASES OF PROJECT IMPLEMENTATION

PHASE I (2000-2003)	PHASE II (2004-2006)	PHASE III (2007-2010)	PHASE IV (2009-2011)
Establishing coverage	Supervisory capacity building	Coverage expansion and quality control	Transition of 175 facilities
Community-led needs assessment	Service capacity building	Public-private linkages	Sustained community support

referral programs between public and private sites. Finally, Phase IV (2009-2011) activities focused on scaling down facility-level interventions, transitioning facilities and their NGOs and CBOs to independent operation, and focusing on sustainable community change. Program efforts drew upon information, education, and communication campaigns that had run throughout the program, bringing together the relationships established by peer educators and community and religious leaders to build community capacity to sustain support for FP and RH.

STRENGTHENING HEALTH SYSTEMS

At the provider level, Phase I organizational and facility assessments revealed the need for systematic strengthening in core FP/RH technical knowledge and management skills. Training packages were compiled according to each facility's need. Family planning core practices, contraceptive technology updates, infection prevention, and interpersonal communication and client relationship skills were prioritized across the sites. Other trainings such as those on postabortion care (PAC), syndromic management of sexually transmitted infections, and voluntary counseling and testing were provided based on facility need and client demand. To give firm ground to providers' ability to sustain application of these skills, the project focused concerted efforts on building facility capacity for supervision. Supervisors were encouraged to accompany on-the-job trainings for staff with coaching and mentoring, observing and fostering providers' use of the skills imparted during project trainings. Through ongoing bi-monthly supervisory visits, supervisors and providers collaboratively identified opportunities to strengthen any remaining gaps in knowledge or practice, improving the overall quality of services provided and patients' experience of accessing FP/RH care.

Assessments revealed that data management was a persistent challenge for intervention facilities, exacerbated by their limited technological capabilities. To aid in performance monitoring, simplistic databases were developed for site-level data collection, which providers used to compare individual performance against monthly targets. At the close of each quarter, provider data was aggregated across each site and submitted with narrative reports to the project's central office for comparison against the previous quarters' results. Finally, at the close of each year, facility sites across the north came together for annual review and comparison of performance statistics. Annual meetings provided opportunity for grantees to disseminate innovative and promising practices across partner sites, and fostered competition between sites for improved service delivery statistics. All intervention facilities' statistics were fed into the national monitoring information system on a monthly basis.

At the facility level, renovations addressed the structural limitations to quality service delivery. Private and public sites alike required substantial brick-and-mortar investment to bring dilapidated structures up to functioning standards and to supply needed equipment. Renovations included reorganization of facility floor plans to support youth-friendly service provision in line with recommendations from Pathfinder's African Youth Alliance (Youth-Friendly Sexual and Reproductive Health Services: An Assessment of Facilities 2003). Separation of waiting rooms enabled youth to seek care among their peers and with a greater degree of anonymity from adult client populations, mitigating barriers to youth uptake of FP services. More discrete service signage also helped to ensure that youth seeking FP or PAC services could do so privately. Additionally, the revised layout ensured that young

males seeking services could enter facilities separately from female community members such as maternal and child health care-seeking clients and their families.

Finally, facility- and community-based commodities distribution efforts ensured increased access to modern FP methods throughout facility catchment areas. As part of renovation efforts, all facilities received renewed stocks of long-acting and short-term methods. At the community level, distribution efforts included over 5,000 community-based distributors (CBDs) from a range of social circles. *Mai lalle* beauticians and *mai kitso* hair dressers served as CBDs among female networks. Door-to-door salesmen, known as *dillalai*, and barbers, known as *wanzami*, also distributed commodities among clients. As traditional birth attendants (TBAs) serve as the primary care givers for as many as 20 percent of Nigerian women during delivery, the program's CBD efforts included targeted outreach and training activities to engage these essential intermediaries (National Population Commission 2008). Implementing partners approached TBAs practicing in the catchment areas of local facilities and invited them to capacity building activities focused on safe delivery techniques and skills to identify signs of delivery complications early, when referral to a health facility is critical. Trainings enabled TBAs to professionalize their practice and develop as key community-based health decision influencers. Trainings were met with high demand and, as interest grew, they evolved to include communication and counseling skills related to teaching women about the healthy timing and spacing of pregnancy, and short-term contraceptives distribution.

Over the course of the program's 10 years, service delivery and commodities distribution efforts resulted in 750,347 new family planning clients receiving contraceptive methods and over 1,100,000 visits by repeat and continuing users of FP services and contraceptives. Together, these figures amount to 262,744 couple years of protection from unplanned pregnancy and an estimated 1,173 maternal deaths averted in northern Nigeria.

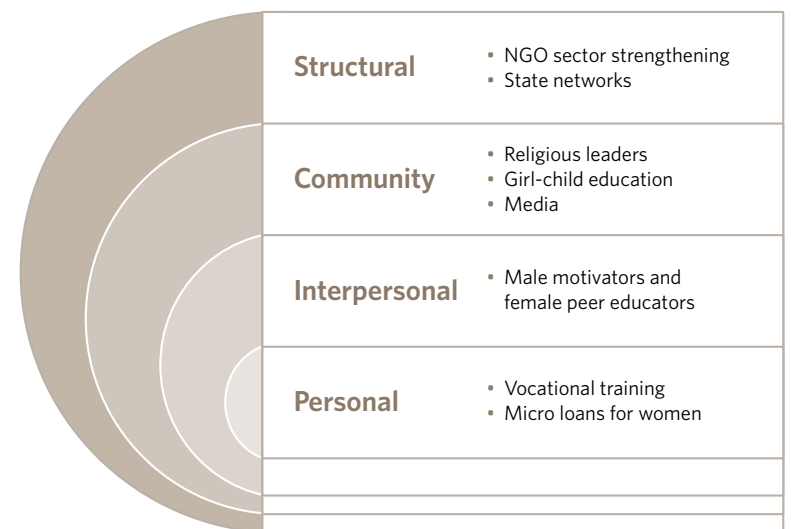
BUILDING COMMUNITY CAPACITY

Project efforts toward community capacity building also sought to address the upstream social and cultural norms driving the region's FP/RH profile.

To ensure a holistic approach, efforts targeted four levels of community systems, addressing the structural, community, interpersonal, and personal drivers of poor FP/RH outcomes.

At the structural level, the project worked to address key systemic issues underpinning community-level capacity to advocate for and sustain progress toward improved FP/RH outcomes. Knowing that the NGO sector in northern Nigeria was limited at the time of Pathfinder's entry, capacity building for partner NGOs and CBOs was a high priority. Pathfinder allocated considerable resources to building the strength of its implementing partners to develop and manage organizational and facility operations independently, recognizing them as a sustainable backbone for FP/RH improvement efforts. Using the results of Phase I organizational assessments, the Private Sector Family Planning Service Delivery Project identified core operational needs for organizational capacity building. Financial management, program planning, supervision, and monitoring and evaluation were highlighted as critical to implementing partners' sustained functioning and ability to raise needed funds. Thus, at the beginning of each program year, implementing partner staff participated in proposal development and project design trainings, as well as in workshops focused on skills building for mid-course problem solving once project implementation was underway. Throughout

FIGURE 4: SOCIAL-ECOLOGICAL APPROACH TO COMMUNITY CAPACITY BUILDING



the year, project staff conducted quarterly supervisory visits to implementing partner organizations. Project and site staff collaboratively identified needs for procedural improvements as they arose, building efficient, effective, and sustainable organizational systems. Finally, at the close of each project year, staff participated in annual project management workshops to refresh relevant topics and address any remaining needs identified over the course of the previous year. All NGO and CBO partners underwent strategic planning sessions, yielding five-year plans to sustain funding and enable progression toward staff identified short- and long-term goals. Gender mainstreaming and youth programming trainings were conducted for each partner as appropriate to its respective programmatic priorities.

“I know of one mosque where young men never came. Then one day, an imam who had been trained by the project began to preach about health and reproduction. The next week, the youth came in such numbers that they pushed the adults out of the front rows and stayed on to ask questions of the imam.”

FEMALE RELIGIOUS LEADER, KANO

At the community level, the program gave particular attention to the religious leadership networks that influence social norms in so much of the region, and to the status of girls and young women. To begin its work with religious leaders, the Private Sector Family Planning Service Delivery Project reached out to the *ulama* (Muslim legal and religious scholars) to discuss northern Nigeria’s health and social issues and reach consensus on possible solutions. Training workshops followed these meetings, providing opportunity for deeper discussion of the linkages between maternal and child health, RH, FP, and larger social and structural security issues for the region. Finally, Pathfinder organized ‘study tours’ to bring participating members of the *ulama* and imams in northern Nigeria to meet with religious and political leaders in Bangladesh. These tours enabled the project’s religious leader partners to observe and question firsthand Bangladeshi leaders’ support of FP and RH programming as related to the

teachings of Islam. New dialogue between the countries’ *ulama* and imams grew out of these meetings, which in turn fostered meaningful dialogue about the role religious leaders can play in nurturing the health and healthful decision making of their communities.

With an improved sense of common values and hopes for the region established between the *ulama* and project staff, collaborative work began to promote support for core RH and FP issues within larger religious and cultural social structures. Three publications with broad-reaching readership resulted from these efforts. *A Call to Action*, a publication produced in collaboration with religious, community, and FP/RH implementing partners, identified priority areas for FP/RH implementation in the region. This publication was later followed by *Action Guide for RH: Interventions in Northern Nigeria*, which distilled key challenges to FP/RH service delivery and provided guidance on strategic opportunities to address them. Finally, *Reproductive Health Issues in Nigeria: Islamic Perspectives* was a major product that grew out of this significant new relationship. Focusing on the intersection of FP/RH and Islamic teachings, the handbook provided in-depth analysis of FP/RH issues and recommendations for how women and men can act to improve their health and the health of their families in line with the Qur’an and other Islamic texts. The publication had significant implications for the role of religious society in northern Nigerian health improvement efforts. With the endorsement of the Nigerian Supreme Council of Islamic Affairs and the Sultan of Sokoto—a major spiritual leader for Nigerian Muslims—it had far-reaching effects not only in the north, but in the country as a whole. FP/RH trainings for 292 local imams soon followed, resulting in sermons across the region that integrated religion and RH/FP messages. Support for the handbook later grew to include a host of Muslim countries throughout the continent.

The project’s work with religious leaders also complemented its work with schools. Religious leaders involved with the project reached out to teachers at Islamic schools, garnering support to integrate FP/RH educational components into day-to-day school curricula. With the 140 school teachers working collaboratively with the project, they also proved

instrumental in identifying girls whose families had taken them out of school prior to graduation. Together, religious leaders, school teachers, and peer educators collaborated to approach girls’ families and discuss the benefits of returning their daughters to school.

At the interpersonal level, female peer educators and male motivators continued one-on-one FP/RH education efforts and conducted home visits to married couples to increase awareness about healthy timing and spacing of pregnancy. These efforts were complemented by personal-level efforts to build the capacity of women and girls to identify, demand, and engage in quality FP/RH service delivery. Vocational skills trainings increased income-earning potential among participants, thus strengthening women’s and girls’ potential for economic decision-making power in the household. Though women are less likely to work than men, they are comparatively more likely than men to be paid when they do. And, as national data suggests that women are more likely to have decision-making power over how their own earnings are spent, these efforts may improve their ability to make purchases related to health care and FP/RH needs (National Population Commission 2008). To bolster progress toward this goal, the Private Sector Family Planning Service Delivery Project gave loans to women completing vocational training to help them start small-scale businesses within their communities.

Lessons Learned: Reflecting on 10 Years of Service

WOMEN FOR WOMEN AND GIRLS

Collaboration with women and girls proved a critical approach throughout the project’s 10 years. Though the project had always intended to address girls’ and women’s lack of opportunity to stay in school and subsequent weakened income-generating capacity, the role women and girls played in driving the project itself was an unanticipated and powerful asset. Women proved articulate and powerful champions for the establishment of Islamic schools and thus the expansion of educational opportunities for both boys

and girls. For example, many female religious leaders found their own schools, and work with communities to organize the human and financial resources to establish such schools—a reflection of the strength of their community ties and influence to mobilize toward positive structural outcomes in their areas. As many women witness firsthand the role that economic insecurity plays in limiting girls’ ability to enter and finish school, they were motivated allies in efforts to return girls to school, and in promoting vocational training for the girls whom the project was not able to return to school. Though the role of women in creating opportunities for women and girls is not a new concept in health and development, the strength of this relationship should be recognized and fostered. Given how much the Private Sector Family Planning Service Delivery Project was able to accomplish once these relationships were established, far more would be possible if all efforts in the region were to tap this critical resource.

STATE NETWORKS AS A COMMUNITY-BASED MEANS TO SUSTAINED PROGRESS

Toward the end of the project’s 10-year tenure, state networks were established as a mechanism for partners to sustain the work undertaken over the course of the project. Composed of 20 teams, the network is a cross-region consortium of senior service delivery personnel, religious and community leaders, women and youth groups, civil society representatives, and policy makers. Teams each received advocacy and leadership training and, together, now serve as advocacy and supervisory entities for FP/RH advancement in each state. Though these networks are still relatively new, they have already shown promising effectiveness at identifying and addressing needs for quality improvement as they arise, and at mobilizing resources to sustain progress on FP/RH objectives. State networks also act as community-based liaisons for facilities and as leaders in efforts to build an enabling policy environment for FP/RH improvement. As these networks apply and are accepted as formal advocacy entities in their respective states, Pathfinder sees the potential for such cross-sector community-owned structures to play powerful roles in project closings and transitions, ultimately helping to sustain FP/RH efforts.

Recommendations

PROGRAM PROCESSES SHOULD REFLECT COMMUNITIES AS PARTNERS

Community-participatory processes are critical to the success of FP/RH improvement efforts in northern Nigeria, particularly given the history that FP shares with government population control measures of the 1980s. Future efforts in the region will benefit from robust community participatory program design and implementation procedures, and should include meetings with community stakeholders at the outset of the program—prior to finalization of program work plans—and ongoing dialogue throughout program launch and implementation. Community-led assets and needs assessments are recommended to build a common understanding between implementing staff and community gatekeepers. Implementers should prioritize transparent program agendas as a key step to developing community partnerships and working relationships. Community involvement was critical to the program's ability to craft culturally appropriate messaging (which was in turn critical to the political and community support the program enjoyed), and to the project's ability to anticipate and respond to shifts in community need and to culturally or religiously sensitive situations.

ENGAGE RELIGIOUS LEADERS

As in many Muslim countries, religious leaders in northern Nigeria are pillars in the community and powerful voices in defining and maintaining social norms. Salient and compelling cases for RH and FP exist in Islamic teachings and the desire to provide quality care for local communities is a shared value across health

and religious leaders. Guided by its years of experience in the region, Pathfinder has adopted the practice of engaging religious leaders in dialogue to identify common health and security concerns for the region at the beginning of project efforts. Paired with collaborative agenda-setting for programmatic design and transparent policies to ensure productive ongoing working relationships, these steps are recommended as core practices for replication in future efforts to sustain FP/RH progress in the region.

DONOR FLEXIBILITY IS KEY TO SUSTAINABILITY

When the Private Sector Family Planning Service Delivery Project began its work in 2000, the full breadth of programmatic components that would prove key to sustainability was not yet known. As is the case in any learning organization, data collection and systematic use revealed the need for revisions to program design. Although the program began with funding to target private sector health facilities and their providers, as relationships with government and community stakeholders developed, the need to address public sector health system strengthening as a vehicle for sustainability became apparent and a strategy for doing so emerged. In this case and others, the Packard Foundation's characteristic flexibility enabled the project to shift and remain responsive to new information and opportunities, which ultimately proved critical to the project's ability to foster sustainable change in the region. Relationships between programs and donors will prove important in future efforts for long-term effect in FP/RH improvement, as response to changing need requires flexibility in program design.

Future efforts in the region will benefit from robust community participatory program design and implementation procedures, and should include meetings with community stakeholders at the outset of the program—prior to finalization of program work plans.

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