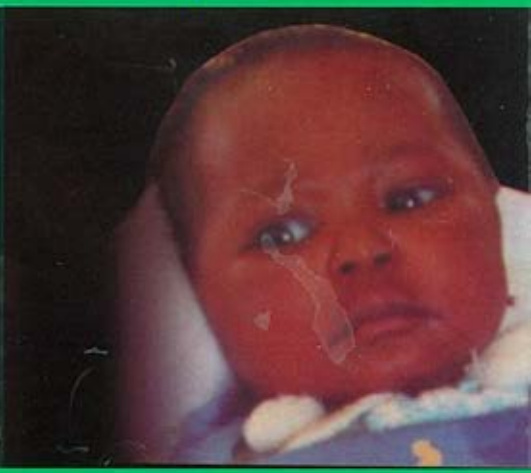
FEDERAL REPUBLIC OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY



THE MDG - DRG FUNDED MIDWIVES SERVICE SCHEME

Concept, Process and Progress

APRIL 2010

FEDERAL REPUBLIC OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

THE MDG-DRG FUNDED MIDWIVES SERVICE SCHEME

Concept, Process and Progress

APRIL 2010

THE MDG-DRG FUNDED MIDWIVES SERVICE SCHEME:

Concepts, Process and Progress

FEDERAL REPUBLIC OF NIGERIA
NATIONAL PRIMARY HEALTH CARE DEV. AGENCY

All correspondence to:

The Executive Director/CEO,
National Primary Health Care Development Agency, Abuja
Plot 681/682 Port-harcourt Crescent
Off Gimbiya Street, Garki 11
Abuja.

GSM: +234 (0)7064016670, (0)7064016671, (0)7064016672, (0)7064016674, (0)7064016670,. (0)7064016675

Email: midwivescheme@yahoo.com

Printed by: MPP. LTD. +234 (0) 803 3090 137, (0)803 318 3566, (0)805 840 0786

Table of Contents

Forward

Maternal and Child Mortality has remained very high in Nigeria despite several efforts that have been aimed at reducing the incidences, and generally improve maternal and child health. While precise figures are not available, the recent Nigeria 2008 Demographic and Health survey estimates the overall maternal mortality ratio (MMR) for Nigeria at 545/100,000 live births with wide variation across the geopolitical zones. The North East zone has the highest maternal mortality ratio - 1549/100,000 live births compared to 165/100,000 live births in the South West zone. There is also urban and rural variations in MMR, 351/100,000 live births in the urban areas compared to 828/100,000 in the rural areas.

Maternal and Child deaths are strongly linked to human capital and socio-economic development. It was the twin concerns that led the international community to put health firmly at the centre of the Millennium Development Goals (MDGs). Two of these goals are to reduce under-five and maternal mortality rates. But analysis of recent trends shows that Nigeria is making only marginal progress [Mid Point Assessment Overview, MDGs Nigeria Sept 2008] in reducing these rates and attaining the MDGs.

It is sad to note that in spite of all previous efforts, the Maternal, Newborn and Under 5 morbidity/mortality indices have shown only marginal reductions in the last five years, making the MDGs targets by 2015 clearly unachievable using current strategies alone.

In the light of the foregoing development, the Government of Nigeria (GoN) under the 2009 Federal Appropriation Act established the Midwives Service Scheme to mobilize unemployed and retired midwives for deployment to selected primary health care (PHC) facilities in rural communities in order to facilitate increase in

skilled attendance at birth and the reduction of maternal, newborn and child mortality in Nigeria. The initiative is an emergency stop gap to shortage of skilled attendance at the primary health care level.

The scheme being implemented by the National Primary Health Care Development Agency is a public sector initiative based on wide consultation, networking and consensus building among stakeholders. The hallmark of the scheme is that it is conceived as a collaborative effort between the three tiers of government based on shared roles and responsibilities formalized by signing a Memorandum of Understanding (MOU) between the Federal, State and Local Governments; supported by strategic partners such WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN etc.

Its implementation is based on the under listed eight (8) strategic and complementary components or thrusts conceived to build an effective and result oriented programme to address the maternal and child health issues from a system perspective:

1. Management and Coordination
2. Building Partnership and Consensus among key stakeholders
3. Strengthening/ Institutionalizing Community Participation,
4. Deployment of Human Resource to frontline health facilities in rural communities so as to improve the coverage by Skilled Birth Attendants,
5. PHC Support with basic equipments/commodities and supplies,
6. Capacity Building/Training of Midwives to improve Quality of Care, and
7. Monitoring, Evaluation and ICT Support component.
8. Programme Communication.

Each of the components is seen as an important strategy in the current effort at improving skilled attendance at delivery and indeed accelerating progress in the attainment of MDGs 4 and 5.

At this point of the project, 2,323 midwives have been deployed to 652 primary health care facilities in the 36 states and FCT, and trained on Life Saving Skills (LSS) and Integrated Management of Childhood Illness (IMCI). The facilities have been provided essential drugs, basic equipment/supplies including midwifery and mama kit, customized handsets, Monitoring & Evaluation (M/E) registers and forms.

This booklet has therefore been written to document the concept, the processes and actions carried out; the key result areas and achievements accomplished in the course of the implementation of the scheme.

The Midwives Service Scheme (MSS) has started a process that we hope will lead to further scale up of maternal mortality reduction efforts, generally improve maternal and child health, contribute to accelerate the pace towards achieving the health MDGs and fast track the revitalization of primary health care in Nigeria.

But more importantly, we hope the scheme will lead to a more coordinated stakeholders actions, stimulate and generate policy and programmatic actions that are critical to save the many lives at stake.

Muhas Pate

Dr Muhammad Ali Pate
Executive Director/CEO
National Primary Health Care Development Agency, Abuja.

Acknowledgement

This booklet is based on the implementation of the Midwives Service Scheme which began in Nigeria in 2009.

The implementation of the project and the remarkable success achieved has been made possible by the National Assembly and the Office of the Senior Special Assistant to the President on MDGs by the provision of funds under the MDG-Debt Relief Grant.

The project is a collaborative effort between the three tiers of government, the Federal Ministry of Health, the Nursing and Midwifery Council of Nigeria, the Schools of Midwifery, several partners such as the Society of Obstetricians and Gynaecologists of Nigeria (SOGON), Paediatrics Association of Nigeria (PAN), WHO, UNICEF, ACCESS/JEPHIGO, UNFPA, PRRINN-MCH, Pathfinder International, PPFN etc.

Several Consultations with partners/key stakeholders provided insight and helpful guidance. The National Primary Health Care Development Agency therefore expresses gratitude to all partners for their contributions and commitment. The WHO Scoping Mission on the scheme led by Drs Taiwo Oyelade and Maliqi Blertha, Profs. E. Otolorin, I. A. O. Ujah and H. Itan all of SOGON must be mentioned for their contributions, suggestions and encouragement.

Our appreciation goes to the Executive Governors of the 36 States and their Commissioners for Health and Local Government for partnering with the federal government on the project. We recognize the Governors Forum and its Director General Mr Asishana Okauru for facilitating the process. We are indeed very grateful.

The Agency is indebted to the Senior Special Assistant to the President on MDGs, Hajiya Amina Az-Zubair, the former Minister

of Health, Prof. Babatunde Osotimehim and the former Minister of State for Health, Dr Idi Hong for presiding over the birth of a scheme that was in limbo for many years. Indeed, their inspiration and guidance popularized the scheme. We are grateful to the Chairman of the Governing Board, Dr. Haliru Yahaya and Members of the Board for their support. Our immense gratitude goes to the Executive Director/CEO of the National Primary Health Care Agency, Dr Muhammad Ali Pate for his inspiring leadership style and motivation. He has been very wonderful for the high level of confidence and trust reposed in our team. This has been the success factor and the motivation that has kept the team on top of the project.

There are several individuals whose contribution and personal sacrifices are valuable. I therefore wish to specially mention and acknowledge the important role played by Prof. C. O. Akpala and Dr Labaran Ibrahim, both were past Directors of Health Systems Development, Dr P. Momah, Department of Family Health Service of the FMOH and her team, Dr Ado J.G of the OSSAP, Our Zonal Coordinators, team of Consultants and the State MSS Focal Persons, Mr Joko Ibrahim, Mrs Alheri Grace Yusuf and Ms Stella Godswill of the Nursing and Midwifery council of Nigeria.

Special recognition and gratitude goes to our colleagues, Drs E. A. Abanida, David Magwi and Olulekan. Olubajo, and Dr. O. Ogbe, the Technical Assistant to the Executive Director who worked with us on the concept paper. They were all exceptional for their suggestions, encouragement and motivation.

I would also like to gratefully acknowledge the tireless dedication and commitment of all the members of the Midwives Service Scheme Team. Special gratitude goes to the following officers: the Project Advisor, Dr Mrs Ugo Okoli for her commitment and expertise. Others include Mrs Binta Ismail (MCH Desk Officer/Training), Mrs Chito Nelson (Desk Officer, Partners/Community Development), Mrs Chinwe Ezeife (Desk

Officer Child health/Nutrition Activities) Mrs Ify Owudinjo (Desk Officer Programme Financing), Tony Amusan (Desk Officer Training), Mr Charles Ijeoma (Partners/Community Development, Supplies/Logistics), Rev. Odeka Rock (Programme Communication), Solape Folarin (Deployment Officer), Mrs Adeola Ohifeme (Allowance Officer) and Mrs Aishat Lecky (Desk Officer Resource Materials). The unprecedented success of the scheme was made possible by their team work and commitment.

We acknowledge the contribution and interest shown in the Midwives Service Scheme by other programme officers and departments of the Agency, partners and individuals too numerous to mention, the midwives for answering the call to service, the host communities and the mothers and children in the frontline.

Finally, we owe considerable debt of gratitude to the amazing and supportive Nigeria Electronic and Print Media under the coordination of our PR Unit headed by Mal. Saadu Salahudeen.

Dr M. J. Abdullahi
National Coordinator, Midwives Service Scheme
National Primary Health Care Development Agency, Abuja.

Glossary

MSS	Midwives Service Scheme
FMOH	Federal Ministry of Health
NPHCDA	National Primary Health Care Development Agency
OSSAP	Office of the Senior Special Assistant to the President
PHC	Primary Health Care
NMCN	Nursing and Midwifery Council of Nigeria
BHSS	Basic Health Services Scheme
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
M & E	Monitoring and Evaluation
LGA	Local Government Area
WHS	Ward Health System
VHS	Village Health system
CDC	Community Development Committees
VDC	Village Development Committees
CORPs	Community Resource Persons
ZTO	Zonal Technical Officer
VHW	Village Health Worker
CHEW	Community Health Extension Worker
CHO	Community Health Officer
RH	Reproductive Health
DRF	Drug Revolving Fund
NGO	Non Governmental Organisation
MCH	Maternal and Child Health
MMR	Maternal Mortality Ratio
MDG	Millennium Development Goal
IMCI	Integrated Management of Childhood Illnesses
LSS	Life Saving Skills
IMNCH	Integrated Maternal, Neonatal & Child Health Strategy
IDSR	Integrated Disease Surveliance Response

IYCF	Infant & Young Child Feeding
PMTCT	Preventive Maternal to Child Transmission of HIV
ARV	Anti Retroviral Therapy
EOC	Emergency Obstetric Care
BEOC	Basic Essential Obstetric Care
CEONC	Comprehensive Emergency Obstetric & Neonatal Care
MOU	Memorandum and Understanding
ITN	Insecticide Treatment Nets
IPT	Intermittent Preventive Treatment for Malaria
FP	Family Planning
ANC	Antenatal Clinic
IEC	Information, Education and communication
BCC	Behaviour Change communication

Executive Summary

Sufficient progress has not been made in Nigeria in her efforts to reduce maternal and child mortality over the years despite several efforts aimed at reducing the incidences, and generally improve maternal and child health. While precise figures are not available, the recent Nigeria 2008 Demographic and Health survey estimates the overall maternal mortality ratio (MMR) for Nigeria at 545/100,000 live births with wide variation across the geopolitical zones. Analysis of recent trends shows that Maternal, Newborn and Under 5 morbidity/mortality indices have shown only marginal reductions in the last five years, making the MDGs targets by 2015 clearly unachievable using current strategies. [Mid Point Assessment Overview, MDGs Nigeria Sept 2008]

The slow progress has been attributed to gaps ranging from infrastructure, access to services and human resource needs. In many health facilities across the country, there is shortage of skilled attendants and this has been reported to impact negatively on utilization of services by women. Coverage of Skilled Care, an important strategy to reduce maternal mortality is less than 40 percent while immunization coverage ranges between 32.8 – 60%. The low coverage rates translate into high rates of child and maternal mortality.

The foregoing development necessitated the Federal Government of Nigeria (FGoN) under the 2009 Appropriation Act to establish the Midwives Service Scheme (MSS). The scheme being implemented by the National Primary Health Care Development Agency is a public sector initiative based on wide consultation, networking and consensus building among stakeholders. The hallmark of the scheme is that it is conceived as a collaborative effort between the three tiers of government based on shared roles and responsibilities formalized by signing a Memorandum of Understanding (MOU) between the

Federal, State and Local Governments; supported by strategic partners such as World Health Organisation (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), Partnership for Revival of Routine Immunization in Northern Nigeria (PRRINN-MCH), Pathfinder International, ACCESS/JEPHIGO and Planned Parenthood Federation of Nigeria (PPFN) etc.

The scheme has eight (8) strategic and complementary components or thrusts conceived to build an effective and result oriented programme to address the maternal and child health issues from a system perspective and this include:

1. Management and Coordination
2. Building Partnership and Consensus among key stakeholders
3. Strengthening/ Institutionalizing Community Participation,
4. Deployment of Human Resource to frontline health facilities in rural communities so as to improve the coverage by Skilled Birth Attendants,
5. PHC Support with basic equipments/commodities and supplies,
6. Capacity Building/Training of Midwives to improve Quality of Care, and
7. Monitoring, Evaluation and ICT Support component.
8. Programme Communication.

Each of the components is seen as an important strategy in the current effort at improving skilled attendance at delivery and indeed accelerating progress in the attainment of MDGs 4 and 5.

The processes involved and the achievements accomplished so far are in the following areas:

1. Building a strong network and partnership among the critical stakeholders, ranging from the Federal, State and the Local Governments, and other strategic partners such as WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International,

ACCESS/JEPHIGO and PPFN etc.

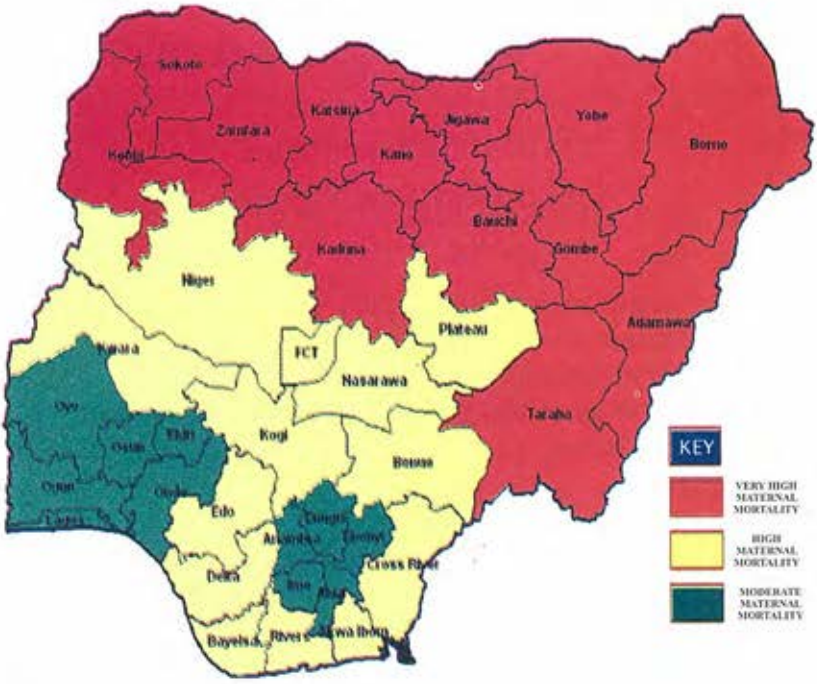
2. Deployment and call up of 2,488 midwives with about 2323 midwives retained to date in the 652 frontline facilities in rural areas.
3. Disbursement of Thirty Thousand (30,000.00) Naira monthly federal allowances to each of the eligible midwives from October 2009 to April 2010.
4. Establishment/reactivation of Ward Development Committees around all the 652 primary health care facilities to engender community involvement, participation, ownership and sustainability.
5. Conduct of Baseline Survey and capturing of information on maternal, child and neonatal health (MNCH) indicators and services in the target facilities and communities to serve as the basis for monitoring progress of the scheme towards the achievement of its objectives.
6. Training of 2,323 midwives on Life Saving Skills and Integrated Management of Childhood Illnesses in 35 selected Schools of Midwifery/Clinical sites in 35 the states and FCT.
7. Linkage of the scheme to the training institutions (Schools of Midwifery) and other MCH programmes being implemented by partners such as PRINN-MCH, Pathfinder International, UNFPA and the Ambulance Programme of the Federal Ministry of Women affairs and Social Development (FMWA/SD)
8. Strengthening the PHC system by supplying light equipment, drugs and commodities
9. Providing ICT connectivity comprising of voice, data, internet and video-conferencing services.

Chapter One

State of Maternal and Child Health in Nigeria

Nigeria is the most populous country in Africa with a population of 140 million people. Women of child bearing age constitute about 31 million while children less than five years of age constitute 28 million. Both women of child bearing age and children under five years of age therefore constitute significant percentage of the nation's population.

Maternal and Child Mortality has remained very high in Nigeria despite several efforts that have been aimed at reducing the incidences, and generally improve maternal and child health. While precise figures are not available, it is estimated that Nigeria which constitute just 1% of the world's population, accounts for 10% of the world's Maternal and under-5 Mortality rates. Annually, an estimated 52,900 Nigerian women die from pregnancy related complications, out of a total of 529,000 global maternal deaths. A woman's chance of dying from pregnancy and childbirth in Nigeria is 1in13, while it is 1 in 5000 in developed nations, and only about 40% of deliveries are attended to by skilled birth attendant. Although the recent Nigeria 2008 Demographic and Health survey estimates the overall maternal mortality ratio (MMR) for Nigeria at 545/100,000 live births, there exists wide variation across the geopolitical zones. The North East zone has the highest maternal mortality ratio - 1549/100,000 live births compared to 165/100,000 live births in the South West zone. There is also urban and rural variations in MMR, 351/100,000 live births in the urban areas compared to 828/100,000 in the rural areas.



An estimated 250,000 newborn die annually in Nigeria and the neonatal mortality rate is 48 per 1000 live births. Just as with maternal mortality the neonatal mortality rates in Nigeria have wide geographical variation, the highest rates are seen in the North-East and North West zones whilst the lowest rates are in the South East and South West zones.

Twenty three percent (23%) age 12-23 months received all recommended vaccination (one dose of BCG and Measles and three doses each of DPT and Polio). Vaccination coverage varies widely by residence and zones. Four in Ten children in urban areas are fully vaccinated compared to only Sixteen percent in rural areas. Overall Twenty Nine percent (%) of children are estimated not to have received any vaccination.

Information from the most recent Nigeria demographic and household survey (2008), shows that childhood mortality is decreasing in Nigeria. Currently 75 children per 1000 live births die before their first birthday (40 per 1000 live births before the age of one month and 35 per 1000 live births between one and twelve months). Overall, 157 children per 1000 live births or about 1 child out of 6 die before reaching age five. Infant mortality has dropped by 25% from 99 deaths per 1000 live births in 2003 and child mortality has also fallen slightly from 97 in 2003 to 88 in 2008 (2008 NDHS).

Death and ill health on large scale is a matter of concern and also a brake on national development. Maternal and Child deaths are strongly linked to human capital and socio-economic development. It was the twin concerns that led the international community to put health firmly at the centre of the Millennium Development Goals (MDGs). Two of these goals are to reduce under-five and maternal mortality rates. But analysis of recent trends shows that Nigeria is making only marginal progress [Mid Point Assessment Overview, MDGs Nigeria Sept 2008] in reducing these rates and attaining the MDGs. Even when most of the causes of these deaths are either preventable or treatable.

It is sad to note that in spite of all previous efforts, the Maternal, Newborn and Under 5 morbidity/mortality indices have shown only marginal reductions in the last five years, making the MDGs targets by 2015 clearly unachievable using current strategies alone.

In order to halt and indeed reverse this trend, and keep the national hope of achieving the Millennium Development Goals 4 and 5 on track, the Integrated Maternal Neonatal and Child Health (IMNCH) Strategies was developed. The IMNCH Strategy is a paradigm shift in our health care services, involving health resource distribution and utilization, with emphasis on continuum of health care service delivery in a cost-effective, impact-maximizing ways.

The Strategy identified three healthcare service delivery modes namely: Family/community based service; population oriented services; and clinical based individual services. Of these service delivery modes, the clinical based individual service which is mode of service that needs to be available continuously in a health facility to respond to unpredictable events such as child birth and acute illness is the focus of this initiative. The services are usually delivered by skilled health attendants in the health facility. This has been shown to be highly effective, having high impact on maternal and newborn mortality and internationally recommended, as demonstrated by the British Medical Journal, Lancet Child Survival series and the Cochrane review [Lancet Maternal Survival Sept 2006]. Therefore there is growing consensus that the reduction of maternal and newborn deaths is impossible without skilled care during pregnancy, labour and puerperium.

In Nigeria 58% of women receive some ante natal care from a skilled provider, most commonly from a nurse or midwife (30%) or a doctor (23%). Forty five percent (45%) of women have the recorded four or more ANC visits but only 16% of women had an antenatal care visit by their fourth month of pregnancy as recommended. More than 36% of women receive no antenatal care (NDHS 2008).

The importance of skilled attendant at every birth for improving maternal health has been severally highlighted in various safe motherhood conferences and technical sessions. It is held as the single most critical intervention for safe motherhood in the African region where only a few of the deliveries are assisted by a skilled attendant. Nigeria currently lacks adequate human resources for providing skilled birth attendance. In spite of this shortage the few health professionals available migrate to developed countries in search of better conditions of service which further cripples the health system. About 39% of birth in Nigeria are attended by skilled health providers (doctors, nurse/midwife) and about 35% occur in

health facilities (20% in public sector and 15% in private sector facilities) whilst 62% of birth occur at home (NDHS 2008).

Skilled care refers to the care provided to a woman and her newborn during pregnancy, childbirth and immediately after birth by an accredited and competent health care provider who has at his/her disposal, the necessary equipment, drugs and supplies and the support of functional health system including transport and referral facilities for emergency obstetric care. A skilled attendant is a health professional such as a midwife or doctor who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, child birth and the post natal period; and the identification, management and referral of complications in women and children. To increase the proportion of births that take place with skilled care, sufficient numbers of appropriately skilled health care providers backed up by an enabling health system must be deployed to areas where they are needed so as to provide first level care to all pregnant women and their children.

The overall Contraceptive Prevalence among all women in Nigeria is 15%. Most women currently using contraception use a modern method, (11%) while 5% are using traditional methods (NDHS 2008).

Maternal and neonatal mortality as we all know is now a global issue, this is considering the fact that concerned stakeholders on health are now involved in the fight to ensure universal access to improved maternal and child health. Even though the developed world has a remarkably low level of maternal mortality rate (0-11/100,000 live birth), developing nations like Nigeria has one of the worst maternal mortality data in the world.

It is worthy of note that the causes of this maternal death are largely preventable if appropriate interventions are taken towards reducing the three forms of delays in accessing health care and ensuring

skilled attendance at birth. As the deadline for achieving the Millennium Development Goals (MDGs) draw nearer, Nigerian government in partnership with key stakeholders is showing greater commitment to scale up interventions that could accelerate progress towards the attainment of MDGs 4 and 5 which is aimed at improving maternal, neonatal and child health by ensuring universal access to quality maternal health services.

Chapter Two

The Scope and Baseline Evidence: Infrastructure and Services in the Targeted Areas.

The Midwives Service Scheme (MSS) is based on a cluster model or hub and spoke arrangement in which four (4) selected primary health care facilities with capacity to provide Basic Essential Obstetric Care (BEOC) are clustered around a General Hospital with capacity to provide Comprehensive Emergency Obstetric Care (CEOC) serving as a referral facility. The scheme covers a total of 815 health facilities in the 36 States and the FCT Abuja, selected based on agreed eligibility criteria comprising of 652 Primary Health Care (PHC) facilities and 163 designated referral General Hospitals (Appendix 1). There are 163 clusters.

A comprehensive survey of all the 815 facilities was undertaken in a study conducted in January 2010. The aim of the baseline survey was to establish a comprehensive baseline data necessary for the implementation of the Midwives Service Scheme (MSS).

The specific objectives are as follows:

1. To collect baseline data on key MSS indicators

   (proportion of pregnant women receiving ANC, proportion of deliveries attended by skilled birth attendants, Maternal Mortality, Low birth weight, Neonatal Mortality, Utilisation coverage of FP services, the proportion of PHC services manned by qualified midwives, PHC facilities providing BEOC etc)

2. To determine the utilization and pattern of MNCH services, in all the MSS 652 PHCs and 163 Ghs.

3. To determine the availability and quality of MNCH services the MSS health facilities.

4. To determine the factors associated with the observed utilization pattern.

Some of the key information from the survey focusing on the core indicators (see box below) have been analysed and presented in this section..

MSS CORE INDICATORS

1. The proportion of health facilities with midwives offering 24 hours services under the Midwives Service Scheme (MSS).
2. The proportion of pregnant women receiving antenatal care 4x and above under the MSS programme.
3. The proportion of deliveries attended by skilled birth attendants in the areas covered by the MSS programme.
4. Reduction of Maternal Mortality Rate.
5. Reduction of Neonatal Mortality Rate.
6. The proportion of women using family planning services in the areas covered by the MSS programme.
7. The proportion of children fully immunized at one year in the areas covered by the MSS programme.

CHARACTERISTICS OF PRIMARY HEALTH CARE FACILITIES UNDER THE SCHEME.

Target Population:

The Midwives Service Scheme (MSS) serves an estimated 10,711,532 population in the 36 States and the Federal Capital Territory(NPCHDA MSS Baseline Assessment). The 163 clusters are distributed according to maternal mortality burden across the country. The North East (NE) and North

West (NW) zones have 6 clusters in each of their States, the North Central (NC) and South South (SS) zones have 4 clusters in each of their States and the South East (SE) and South West (SW) zones have 3 clusters in each of their States.

The population covered by the MSS programme by zone and at the National level is outlined below including estimated number of women of reproductive age annually, expected number of pregnant women in each zone annually and also estimated number of these women that may require emergency obstetric services annually.

Estimated Population Covered by the Midwives Service Scheme by Zone

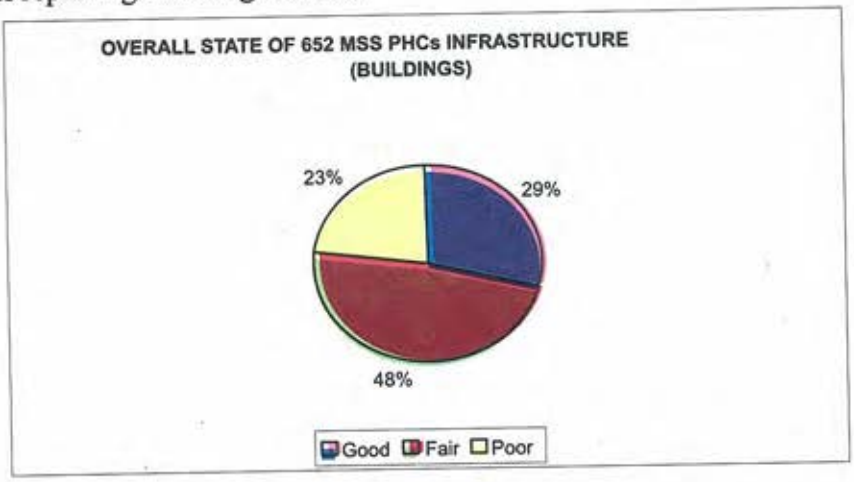
Zones	Population covered by MSS	Estimated number of women of reproductive age (15-49yrs) annual	Expected Number of Pregnant women (annual)	Estimated number of Women requiring EOC (15%) annual
NE	3,289,719	756,635	138,168	20,725
NW	4,156,042	955,890	174,554	26,183
NC	1,020,356	234,682	42,855	6,428
SS	961,836	221,222	40,397	6,060
SE	517,979	119,135	21,755	3,263
SW	765,600	176,088	32,130	4,820
National Average	10,711,532	2,463,652	449,884	67,483

N/B – National Crude Birth Rate – 42/1000, 23% of national population constitutes of women of reproductive age

State of Primary Health Care Infrastructure

Overall, 29% of the targeted PHC infrastructure under the scheme are classified as "*Good*" meaning that they do not need any repairs, 47% are classified as *"Fair"* meaning that they may need minor rehabilitation (such as replacing windows, doors or painting etc) but

are able to provide MNCH services whilst 23% of these PHCs are classified as *"Poor"* meaning that even though they provide MNCH services in areas of need they still require major rehabilitation such as repairing a leaking roof etc.

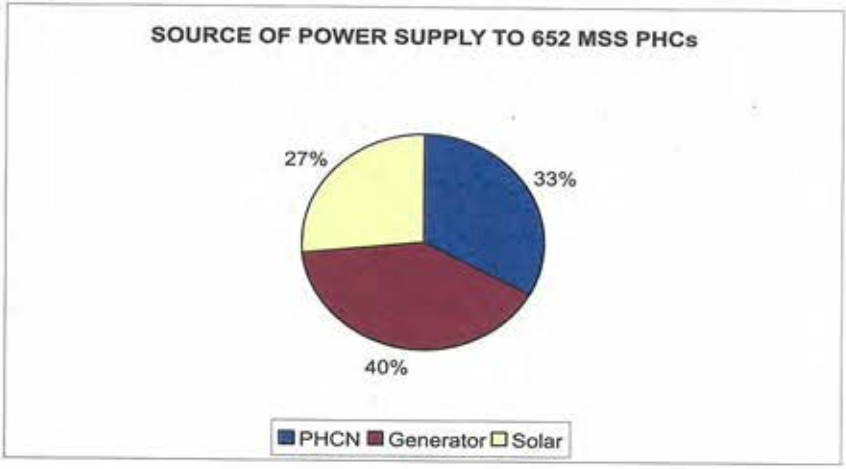


Access/Travel Time

The estimated average travelling time between the communities and the PHC facilities is 5km and between the PHCs and their designated hospitals is 23 (kms) kilometres but differs slightly in different zones.

Social Amenities

A significant proportion of the MSS PHCs are dependent on generators for power supply (40%) and 33% have PHCN power supply. However as the PHCN power supply is erratic as the rest of the country some of these PHCs are therefore also dependent on generators. Twenty seven percent (27%) of the PHCs use solar system for power supply. These PHCs are mostly in the North East, North West and North central zones.



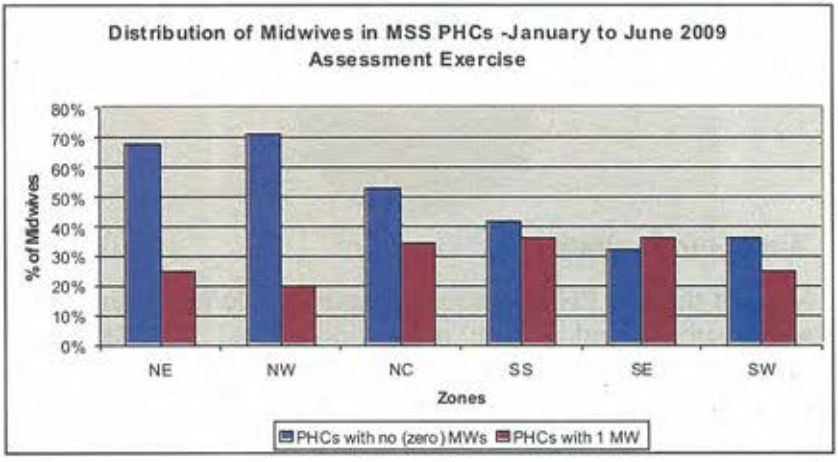
Water and Sanitation

Most of the 652 PHCs are reliant on borehole/hand pump for their water supply and a high proportion (26%), are dependent on rainwater for their water supply and sanitation system. A large proportion of PHCs use the water closet latrine (59%) and Pit latrine (35%).

Zones	Open Well (%)	Borehole Hand pump (%)	Piped water (%)	Rainwater (%)	Pit Latrine (%)	VIP (%)	Water Closet Latrine (%)
NE	15	43	19	23	36	9	55
NW	21	39	28	12	39	8	53
NC	21	36	11	32	38	6	56
SS	30	35	2	33	23	6	71
SE	5	30	2	63	36	6	57
SW	36	26	17	21	31	2	67
NATIONAL AVERAGE	**21**	**36**	**16**	**26**	**35**	**7**	**59**

Human Resources at Designated Facilities (per-implementation status)

The chart below shows the availability and distribution of midwives in the 652 MSS PHC facilities before the deployment of MSS midwives from 2009. This data was collected in August 2009 and covered the period between January and June 2009.



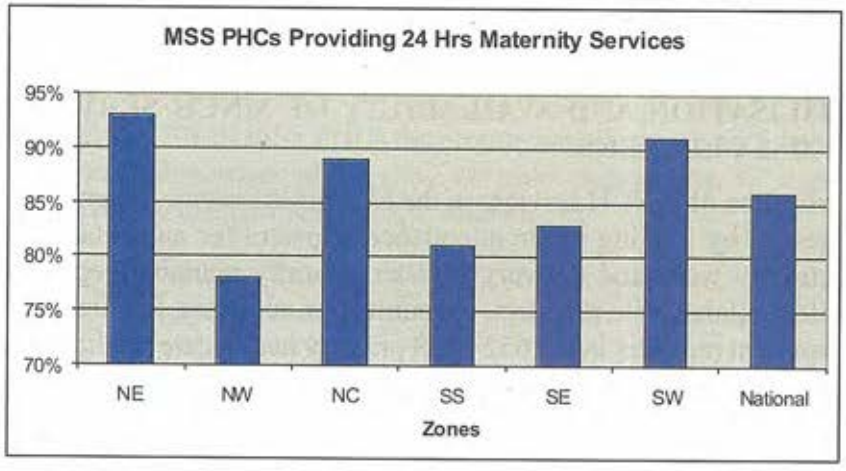
The chart shows that all the zones had a high proportion of facilities without midwives (MW) with North East and North West zones topping the list. Some facilities in the South South, South East and South West zones had at least one midwife in some facilities. Following this exercise midwives were now deployed to MSS facilities and are now able to provide 24 hour service in about 87% of the 652 MSS facilities.

PROVISION OF MATERNAL AND CHILD HEALTH SERVICES

24 hr Maternal and Child Care Services

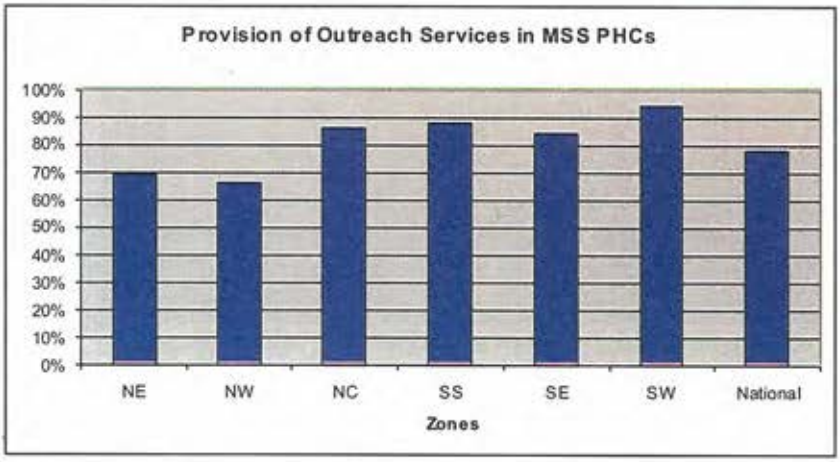
Good quality care during pregnancy, delivery and post delivery is key for the survival of both mother and child. This is also one of the Millennium Development Goals (MDG). Adequate human resources with skills for maternal care is therefore a crucial component to the achievement of this goal. The Midwives Service Scheme is designed to mobilize unemployed, newly qualified and retired midwives for deployment to selected primary health care facilities in rural communities in order to facilitate increase in the coverage of skilled birth attendants.

The table below outlines 24 hour cover for the MSS PHCs following the deployment of MSS midwives in October 2009. It indicates that overall, about 87% of MSS facilities have 24 hour cover as at January 2010. Coverage in the North West zone at 78% appears to be the lowest whilst coverage in PHCs in the North East at 94% appears to be the highest when compared to other zones.



Provision of Outreach Services

At the primary health care level maternal health care services are provided both at the facility and community level. The community outreach services involves advocacy to sensitize members of the community about the benefits of maternal and child care services. This supports uptake of MNCH services at the facility level. Overall 78% of the 652 facilities provide outreach services with this ranging from 65% to 92% in the six zones.



UTILISATION AND AVAILABILTY OF MNCH SERVICES IN MSS CLUSTERS

Utilisation of MNCH services in the Midwives Service Scheme was assessed by looking at the attendance registers for antenatal care, maternity ward and delivery registers, family planning registers, child welfare clinic registers, immunization registers, inpatient and outpatient registers in the 652 MSS primary health care facilities for July to December 2009 period.

Antenatal Care Services – Information from July to December 2009

Antenatal care (ANC) for pregnant women is important to monitor the pregnancy and reduce the morbidity and mortality risks for the mother and child during pregnancy and delivery.

On average 96.9% of the 652 MSS PHCs provide Antenatal Care services. This is expected as it is one of the criteria given to States and LGAs for selecting PHCs to participate in the Midwives Service Scheme. The table below shows that in the six month period of data collection, North East zone PHCs had 36% new ANC visits and North West zone PHCs had 46% new ANC visits as a proportion of the total antenatal visits in each zone. In the North East zone 42% of attendances were due to 4 visits.

In the North Central and South South zones with the same number of clusters, the new ANC visits make up 55% and 18% respectively whilst ANC 4 visits and above were 29% and 33% respectively as a proportion of total antenatal visits in the zones.

In the South East and South West zones with the same number of clusters, the ANC new visits were recorded as 35% and 18% respectively and ANC 4 visits and above were recorded as 43% and 44% respectively as a proportion of total antenatal visits in the zones.

On average, for all MSS PHCs the proportion of new ANC visits was 38% and proportion of 4 ANC or more visits was 39% as a proportion of the national average attendances.

Antenatal Care Services – Information from July to December 2009

Antenatal care (ANC) for pregnant women is important to monitor the pregnancy and reduce the morbidity and mortality risks for the mother and child during pregnancy and delivery.

On average 96.9% of the 652 MSS PHCs provide Antenatal Care services. This is expected as it is one of the criteria given to States and LGAs for selecting PHCs to participate in the Midwives Service Scheme. The table below shows that in the six month period of data collection, North East zone PHCs had 36% new ANC visits and North West zone PHCs had 46% new ANC visits as a proportion of the total antenatal visits in each zone. In the North East zone 42% of attendances were due to 4 visits.

In the North Central and South South zones with the same number of clusters, the new ANC visits make up 55% and 18% respectively whilst ANC 4 visits and above were 29% and 33% respectively as a proportion of total antenatal visits in the zones.

In the South East and South West zones with the same number of clusters, the ANC new visits were recorded as 35% and 18% respectively and ANC 4 visits and above were recorded as 43% and 44% respectively as a proportion of total antenatal visits in the zones.

On average, for all MSS PHCs the proportion of new ANC visits was 38% and proportion of 4 ANC or more visits was 39% as a proportion of the national average attendances.

Zones	Number of MSS PHCs in each State (Zone)	Total ANC Visits No (%)	New Antenatal Care Visits No (% of total ANC visits)	ANC Attendance 4 + Visits No (% of total ANC visits)	Women Receiving 2+ Doses of TT No (% of total ANC visits)
NE	24 (144)	64,472 (100%)	23,554 (36%)	27,101 (42%)	19,203 (30%)
NW	24 (168)	106,130 (100%)	48,425 (46%)	39492 (37%)	31,315 (30%)
NC	16 (112)	14,540 (100%)	8,016 (55%)	4,285 (29%)	6,529 (45%)
SS	16 (96)	20,502 (100%)	3,774 (18%)	6,675 (33%)	10,656 (52%)
SE	12 (60)	10,856 (100%)	3,802 (35%)	4,721 (43%)	3,066 (28%)
SW	12 (72)	23,986 (100)	4,340 (18%)	10,575 (44%)	12,324 (51%)
NATIONAL AVERAGE	**652**	**240,485 (100%)**	**91,911 (38%)**	**92,849 (39%)**	**83,093 (35%)**

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus, a major cause of neonatal death in most developing countries.

The table above details the number and proportion of women receiving two or more doses of tetanus toxoid during ANC visits whilst the table below shows women of reproductive age receiving family planning services by zone and overall. On average 35% of women received 2 more doses of tetanus toxoid in MSS facilities whilst women receiving family planning services ranged from 8% to 31% across the six zones.

Zones	No of MSS PHCs in each State (Zone)	Women aged 15-49yrs Receiving FP Services No (%)
NE	24 (144)	4,196 (17%)
NW	24 (168)	6,367 (25%)
NC	16 (112)	2,572 (10%)
SS	16 (96)	2,006 (8%)
SE	12 (60)	7,743 (31%)
SW	12 (72)	2,206 (9%)
NATIONAL AVERAGE	**652**	**25,090 (100%)**

Delivery Care Services – Information from July to December 2009

Women having access to proper medical attention and a clean environment during delivery can reduce the risk of complications and infections that may result in the death of the mother and /or the baby. The overall average number of deliveries by at the MSS health care facilities between July and December 2009 were 27,977. Of this, 11,725 deliveries were recorded from MSS PHCs in the North West zone, 8,900 in North Central zone, and 1,863 the North East, 1,561 1,596 and 2,332 South East, South South and South West zones respectively.

Zones	No of MSS PHCs in each State (Zone)	Total no of Deliveries at MSS Health Facilities	Number of Maternal Deaths Recorded in MSS Facilities No (%)
NE	24 (144)	11,725 (100%)	84 (1%)
NW	24 (168)	8,900 (100%)	79 (1%)
NC	16 (112)	1,863 (100%)	27 (1.4%)
SS	16 (96)	1,596 (100%)	14 (1%)
SE	12 (60)	1,561 (100%)	5 (0.1%)
SW	12 (72)	2,332 (100%)	11 (0.5%)
NATIONAL AVERAGE	**652**	**27,977 (100%)**	**220 (1%)**

N/B- All information is for the period of July to December 2009

Maternal mortality ratio (MMR) is the annual number of maternal deaths due to pregnancy, child birth and puerperal conditions per 100,000 live births. The available data on maternal mortality ratio in the literature points to wider variations and dependant on source, place and method of data collection. However the 2008 Nigeria Demographic and Health survey estimates maternal mortality ratio at 545 deaths per 100,000 live births. This varies between zones with North East and North West zones recording mortality ratios

above 1000 per 100,000 live births compared to South West and South East zones recording estimates of 165/100,000 live births.

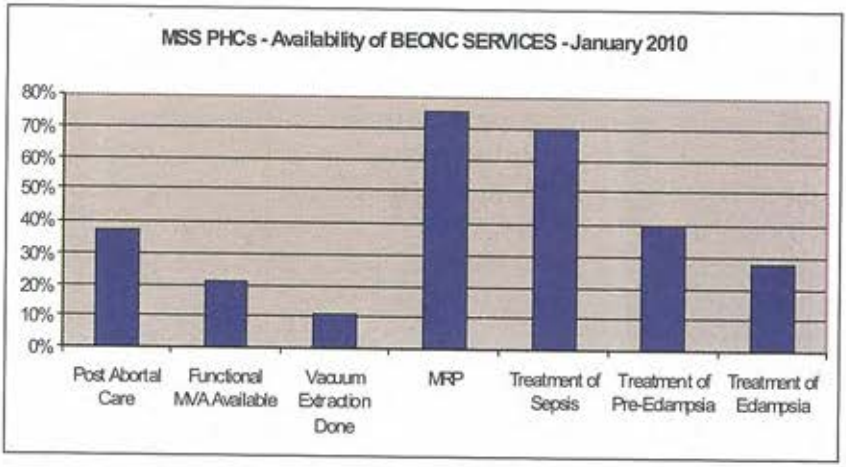
The overall average number of deaths in all MSS facilities was 220 making one percent of the total number of deliveries for that period. The data collection period (July to December 2009) covered some months before the Midwives were posted to the MSS facilities in October 2009.

Availability of Basic Emergency Obstetric & Neonatal Care Functions (BEONC) in MSS Facilities by Zone

Basic Essential Obstetric Care (BEOC) facilities should be able to provide the following:

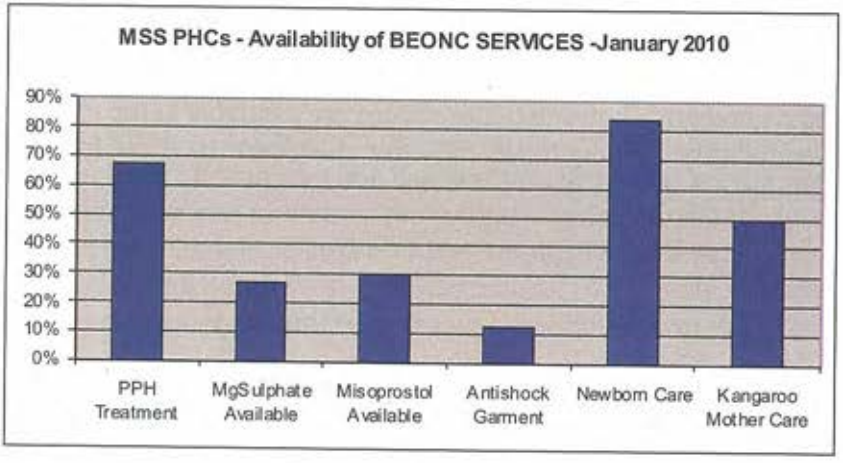
- Injectable antibiotics to treat sepsis
- Injectable oxytocin
- Manual vacuum aspiration (MVA)
- Manual removal of placenta (MRP)
- Vacuum extraction
- Treatment of post partum haemorrhage
- Post abortal care.

Of the 652 MSS PHC facilities an average of 72% provided manual removal of placenta services and 70% of them were able to treat sepsis with the drugs available. However only about 10% did vacuum extraction and 20% were able to do manual vacuum aspiration.



Other aspects of BEOC include the use of magnesium sulphate, misoprostol and anti shock garments and the indication from the baseline survey is that the proportion of MSS PHCs providing this at the moment is quite low.

Provision of new born care and kangaroo care in MSS facilities were also assessed and the chart below indicates that an average of 84% of MSS facilities provide aspects of newborn care whilst just about 50% provide kangaroo mother care for newborns.



Child Care Services – Uptake of Immunization in MSS Facilities

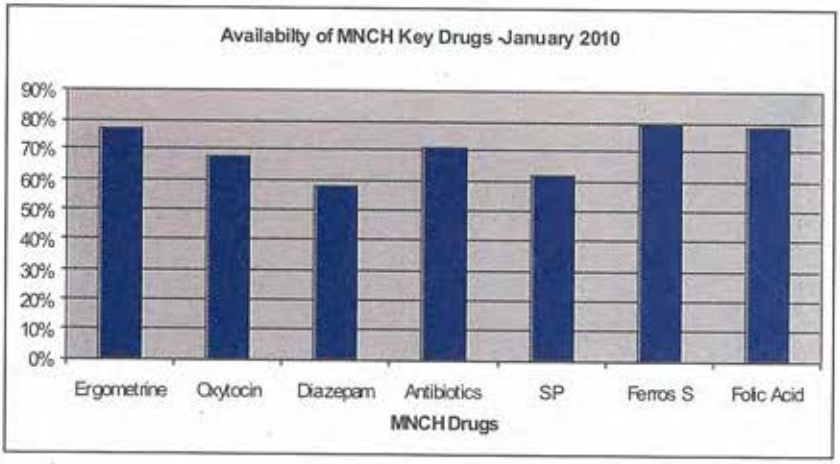
The table below indicates the proportion of children getting DPT1 and 3 and measles immunization from the MSS facilities within a six months period. It generally shows a low uptake of immunizations at the MSS facilities and reflects national coverage from other surveys.

	NE	NW	NC	SS	SE	SW	National Average
DPT -1	24122 (23%)	24170 (23%)	8977 (9%)	18038 (17%)	13249 (13%)	15276 (15%)	103832 (100%)
DPT-3	19765 (23%)	19564 (22%)	6907 (8%)	16824 (19%)	10014 (11%)	14491 (17%)	87565 (100%)
Measles	19767 (25%)	16645 (21%)	7318 (9%)	15185 (19%)	7031 (9%)	12179 (16%)	78125 (100%)

N/B – Information between July to December 2009

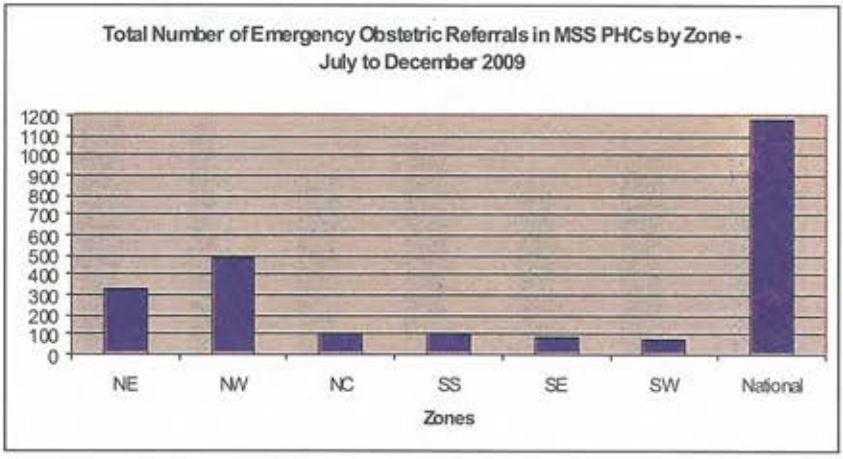
Availability of Drugs for MNCH Services in MSS Facilities

The drugs detailed in the charts below are essential for the provision of basic essential emergency obstetric care and antenatal care services. The chart below outlines the availability of these essential drugs for MNCH in the 652 MSS primary health care facilities. Information reflects data collected for July to December 2009 period and generally shows that these drugs are available at the PHCs with availability ranging from 57% for diazepam to 80% for ferrous sulphate.



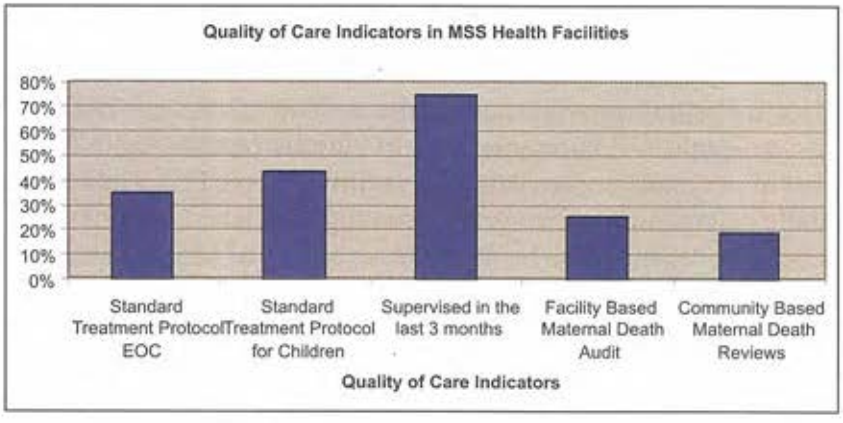
Referral System for Emergency Cases

A functional referral system is essential to improve access to Emergency Obstetric Care services for women with life threatening obstetric complications, particularly in rural areas that are likely to be very remote. Several factors such as distance to the hospital providing comprehensive emergency obstetric care, availability and cost of transport, the road condition etc have an impact on a functional referral system. The chart below shows that about 1200 emergency obstetric cases were referred from PHCs to General hospitals in a six month period from the 652 MSS PHCs. North West and North East zones with the highest number of clusters had the highest referrals. This may be due to various reasons i.e. a high number of pregnant women using the facilities, some PHCs inability to handle emergencies or women presenting very late. Low referrals from other zones may also be due to less number of MSS clusters in the South East and South West with less number of pregnant women using the services or the ability to manage emergencies at the PHC level.



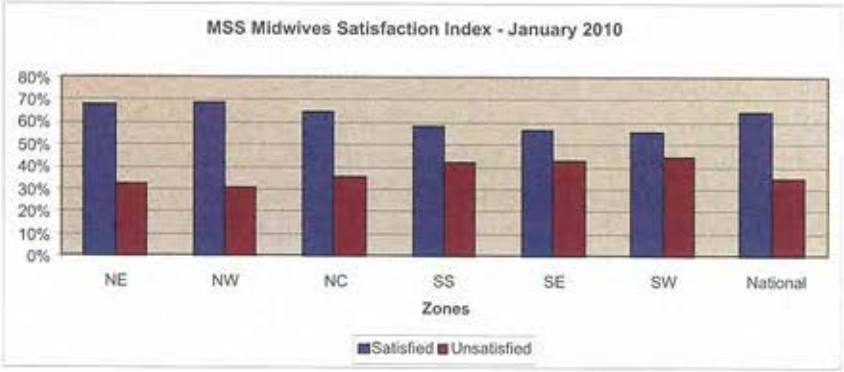
Quality of Care of Maternity Services in MSS Facilities

The availability and use of standard protocols for MNCH, institutionalising supervision and maternal audits indicate the quality of services provided. The chart below indicates that supervision takes place in about 70% of the MSS facilities whilst maternal death audits and availability of standard protocols still has room for improvement.

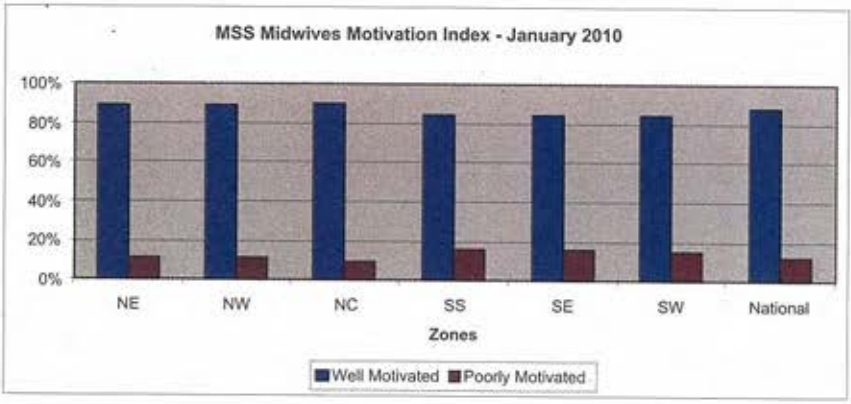


MSS Midwives Motivation and Satisfaction with the Midwives Service Scheme

The MSS midwives were asked a number of questions relating to their salary, accommodation, relationship with the community they work in, relationship with other staff in the PHC team, safety and security, the physical condition of health facility and training opportunities to assess their satisfaction with the Midwives Service Scheme. The Chart below indicates that on average, Midwives in the North East, North West and North Central zones had a higher proportion of midwives that were satisfied with the scheme (60-70%) compared to midwives from South South, South East and South West where those satisfied were below 60%. Their could be various reasons behind this, ranging from better provision of accommodation and other monetary incentives for the midwives in the Northern zones than in the Southern zones.



The motivation of the midwives, were assessed by asking questions around happiness with working with the facility and the scheme, satisfaction with the opportunities they have with the scheme etc. The chart below shows that on average, over 80% of Midwives were well motivated to work in the scheme.



Every Care has been taken to ensure the accuracy of the data presented in this section. However, data are consistently being updated. If current data is required it may be necessary to consult original sources.original sources

Chapter Three

THE CONCEPT OF THE MIDWIVES SERVICE SCHEME

Nigeria is a large and diverse country and under a federal system comprising of a federal government, 36 states and the Federal Capital and 774 Local Government Areas (LGAs). The responsibility for health services is divided between these three administrative levels. The Federal Government is responsible for tertiary health services, state governments are responsible for secondary services and the local governments are responsible for primary health care services. The health responsibilities are tied to funding flows from the Federation Account, which are shared between levels of government according to an allocation formula (Federal 56%, States 26% and LGAs 16%). However these resources are not sectorally earmarked and the states and LGAs are not required to provide budget and expenditure reports to the federal government. The result is poor coordination and integration between primary and secondary care. This development is mirrored by a weak health system, widely varying patterns of maternal and child health outcomes and slow progress towards the attainment of MDGS 4 and 5.

Over the years, several initiatives and instruments have been introduced to reduce morbidity and mortality among mothers and children. These include Safe Motherhood/Making Pregnancy Safer, Integrated Management of Childhood Illness (IMCI) Strategy, Integrated Maternal Newborn and Child Health Strategy (IMNCHs), Integrated Disease Surveillance and Response (IDSR),

Intense capacity building for health workers and Community Resource Persons (CORPs), and Accelerated Child Survival and Development Strategic Frame Work and Plan of action (2005- 2009) to guide implementation of child and maternal survival intervention by government at all levels.

Despite these interventions, gaps still exist. These gaps range from infrastructure, access to services and human resource needs. In many health facilities across the country, there is shortage of skilled attendants and this has been reported to impact negatively on utilization of services by women. Coverage of Skilled Care, an important strategy to reduce maternal mortality is less than 40 percent and immunization coverage ranges between 32.8 – 60%. The low coverage rates translate into high rates of child and maternal mortality. The low coverage of Skilled Attendant at Birth at the primary health care level have been attributed to unwillingness on the part of the LGA administrations to employ and deploy sufficient number of midwives citing high overhead cost.

It is in the light of the foregoing development that the Federal Government of Nigeria (FGoN) under the 2009 Federal Appropriation Act established the Midwives Service Scheme (MSS). The responsibility for the implementation was assigned to the National Primary Health Care Development Agency (NPHCDA), a parastatal of the Federal Ministry of Health.

The scheme sought to mobilize unemployed and retired midwives for deployment to selected primary health care (PHC) facilities in rural communities in order to facilitate increase in skilled attendance at birth and the reduction of maternal, newborn and child mortality in Nigeria. It is a collaborative effort amongst the three tiers of government based on Memorandum of Understanding signed between the Federal and State Governments and identified strategic partners such WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN etc.

The initiative is an emergency stop gap to shortage of skilled attendance at our primary health care system.

The scheme has eight (8) strategic and complementary components or thrusts conceived to build an effective and result oriented programme to address the maternal and child health issues from a system perspective and this include:

1. Management and Coordination
2. Building Partnership and Consensus among key stakeholders
3. Strengthening/ Institutionalizing Community Participation,
4. Deployment of Human Resource to frontline health facilities in rural communities so as to improve the coverage by Skilled Birth Attendants,
5. PHC Support with basic equipments/commodities and supplies,
6. Capacity Building/Training of Midwives to improve Quality of Care, and
7. Monitoring, Evaluation and ICT Support component.
8. Programme Communication.

Each of the components is seen as an important strategy in the current effort at improving skilled attendance at delivery and indeed accelerating progress in the attainment of MDGs 4 and 5.

GOAL AND OBJECTIVES

Goal

To contribute to the reduction of maternal, newborn and child morbidity and mortality in Nigeria.

The Core Objectives

The Midwives Service Scheme has set the following objectives:

1. To increase the proportion of primary health care facilities manned by qualified midwives offering 24hrs service by 80% in the MSS target area by Dec. 2015.
2. To ensure that all the midwives recruited under MSS are trained on LSS and IMCI by Dec 2010.
3. To increase the proportion of primary health care facilities providing essential/emergency obstetric care (BEOC) in the MSS target area by 60% by Dec. 2015.
4. To increase the proportion of pregnant women receiving antenatal care in the MSS target area from 60% to 80% Dec. 2015.
5. To increase the proportion of deliveries attended to by Skilled Birth Attendants in the MSS target area from 36.3% to 72.6% Dec. 2015.
6. To Increase contraceptive (Family Planning) uptake in the MSS target area from 13% to 50% by 2015.
7. To reduce Maternal, Newborn and Child Mortality by 60% in the MSS target area by 2015.

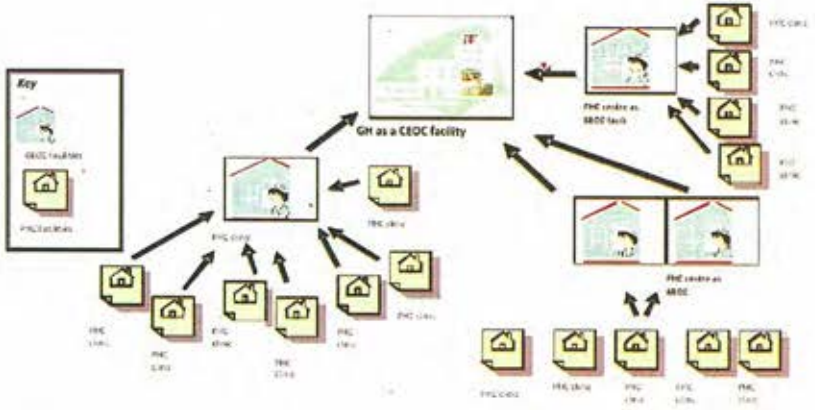
PROGRAMME DESCRIPTION

Cluster Model

In order to facilitate the establishment of an effective 2 way referral linkage between primary and secondary health care facilities under the project, cluster model approach has been adopted. The cluster model involve the selection of four (4) primary health care facilities and clustering them around a general hospital in a Local Government. Under the scheme, a total of 815 health facilities

comprising of 652 primary health care facilities and 163 General Hospitals were selected based on agreed eligibility criteria, and grouped into 163 clusters. A total of 2,488 midwives were mobilized and enlisted into the scheme. Each of the primary health care facilities had 4 midwives deployed to ensure 24 hrs provision of maternal and child health care services and access to skilled attendance at births at all time so as to facilitate reduction in maternal, newborn and child morbidity and mortality.

THE MIDWIVES SERVICE SCHEME CLUSTER MODEL



Allocation of the clusters

The country was divided into three mortality zones i.e. Very High Mortality or VHM (North East and North West), High Mortality or HM (North Central and South South) and Moderate Mortality or MM (South East and South West), and allocation of the clusters to the states was based on this. Very High Mortality zones comprising 13 states (Bauchi, Gombe, Borno, Adamawa, Yobe, Taraba, Kano, Kaduna, Katsina, Zamfara, Sokoto, Kebbi and Jigawa) all in North East and North West were allocated 50% of the clusters (or 6

clusters per state). The High Mortality zones comprising 13 states (FCT, Kwara, Kogi, Niger, Nassarawa, Benue, Plateau, Edo, Delta, Rivers, Cross Rivers, Bayelsa and A/Ibom) all in North Central and South South were allocated 30% of the clusters (3 clusters per state), while Moderate Mortality zones (South East and South West) comprising 11 states (Abia, Enugu, Ebonyi, Anambra, Imo, Lagos, Oyo, Ogun, Ondo, Osun and Ekiti were allocated 20% of the clusters (3 clusters per state).

Selection of Health Facilities

Selection of both the General Hospitals and Primary Health Care facilities for implementation of the scheme was based on agreed eligibility criteria. Only the facilities that fulfil the under listed criteria were enlisted into the programme.

A. Criteria for Selection of General Hospital

1. Basic/Essential services including ANC, Delivery, Postnatal care, FP etc
2. Comprehensive Emergency obstetrics care
3. PMTCT
4. Operating theatre
5. Functioning blood bank
6. Generator plan
7. At least 12 bed spaces in the maternity.
8. Administer antibiotics
9. Ability to administer intravenous fluids including normal saline
10. Capacity to treat pre-eclampsia

B. Criteria for Selection of Primary Health Care facility

1. Hard-to-Reach area or underserved population
2. Facility shall be located in an area with a population of 10,000 to 30,000 people,
3. Availability of potable water or alternative portable water supply
4. Willingness of State/LGA to support programme (It may be necessary to sign M. O. U).
5. Facility should be willing to offer 24 hour service
6. Client flow: at least 120 birth/year [subject to review]
7. Facility shall be type 3 [primary health care centre] with enough space for selected services (see services)
8. Availability of Medical officer, Nurse, Midwives, Laboratory/Pharmacy Technician CHO or CHEW at the facility.
9. Minimum equipment must be on ground including BP apparatus, weighing scale, equipment for MP, PCV, urine/stool tests
10. Basic MNCH service shall be available in the facility [ANC, Delivery, Post natal, FP, Immunization etc]
11. Willingness of benefiting States and LGAs to support the programme was seen as a crucial factor for the success of the scheme and states were required to improve facilities at the general hospitals to provide Comprehensive Essential/Emergency Obstetric Care, adequate monitoring and supervision of the programme.

A Primary Health Care Facility to which four Midwives are deployed.

A General Hospital around which a Cluster is Built

Operational Modalities for the Midwives

In each target area, referral network is well spelt out, where each PHC is linked to a General Hospital with capacity to offer

Comprehensive Emergency Obstetric Care for referral of emergency cases.

Presence of four (4) midwives at each of the selected health facilities would guarantee 24 hours service, running 3 shifts and 24 hours service. The midwives offer Integrated Maternal Newborn and Child Health (IMNCH) services comprising ante natal, delivery, post natal services, family planning, immunisation and nutrition services etc (*See Chapter ?*.....) both at the facility level and also through community outreaches. This is to offer a continuum of care in a cost effective and impact maximizing ways, thus reducing missed opportunities in the spirit of IMNCH Strategy.

The midwives also serve as change agents in the target communities mobilizing the people for health action including health education and promotion of women and child health care and home visits.

Each target community has Community Development Committees (ward or village) with membership drawn across interest group, and meeting monthly discuss health and other developmental issues and provide support to the midwives. The midwives in turn brief the community on their work within the month; challenges faced and address any concerns of the community.

This process is expected to enable the communities build ownership, ensure value appreciation of the role of the midwives and reinforce community demand. The LGA Councillor from the ward would be encouraged to attend these meetings. These meetings would be expected to precede the meeting of the ward or village development committees and /also serve as a platform for community mobilisation and health education.

All midwives working within a cluster meet monthly at the referral general hospital and submit a joint written report on a monthly basis to the LGA PHC department/ LGA Chairperson. The report would be discussed and acted on, and submitted to the State RH Focal

Person through the supervising NPHCDA MSS Focal Person). State Report compiled by both the RH Coordinator/ZTOs) covering all the MSS target LGAs in the state would be submitted to the State Director of PHC/Honourable Commissioner for Health. Copies of the Report are expected to be forwarded to the Zonal Office and MSS National Secretariat through the MSS Focal Persons.

The Reports is part of comprehensive MCH/PHC report to be developed at all levels and would be given 'front page' in order to underscore its importance and serve as advocacy to drive the process.

The Roles and Responsibilities of Midwives

Under the scheme, the midwives are responsible for the provision of effective care for women during normal pregnancy, labour, childbirth and the postnatal period including provision of effective care of the newborn child.

Maternal and Child Health (MCH) Functions

1. Ensures that all pregnant women are identified and have access to antenatal services.
2. Conducting health education on the importance of ante-natal care and on the danger signs of pregnancy.
3. Provision of pre-pregnancy advice and health, including nutrition education.
4. Providing family planning information and services.
5. Assisting women to successfully initiate breastfeeding within 30 minutes of delivery and continue to sustain breastfeeding.
6. Ensures that mothers come for postnatal visit.
7. Carrying out growth monitoring and promotion of children's

health in the community.

8. Promotion of infant and child health including participation in the NPI and management of childhood malaria.
9. Works with team members to ensure appropriate link between clinic staff and community based service providers.

Clinical Functions

1. Management of complications due to miscarriages and/or unsafe abortions.
2. Giving appropriate doses of tetanus toxoid, IPT and other routine drugs to pregnant women.
3. Recognizing women in labour.
4. Managing labour, treating complications and making appropriate and prompt referrals where necessary.
5. Provision of appropriate emergency obstetric care for all women who develop complications during childbirth.
6. Referral of mother and baby for interventions beyond personal technical competence or not possible in the particular setting.
7. Follow up of women for continuum of care and tracking defaulters where necessary.
8. Provision of syndromic management of Sexually Transmitted Illnesses.
9. Provision of HIV counselling and testing.
10. Management of common childhood illnesses.

Outreach/Community Health Functions

1. Carries out advocacy activities for promoting maternal and newborn health in the community.

2. Educating community members on the importance of antenatal care and the need to seek care promptly.
3. Identifying pregnant women in the community and providing antenatal care.
4. Works with other members of the PHC team to educate the community on danger signs of pregnancy.
5. Mentoring health workers and Community Resource Persons (CORPs) on midwifery skills.
6. Ensure that eligible children in the community are immunized.

Administrative Functions

1. Participate in regular staff meetings for feedback of ongoing activities.
2. Together with other staff of the facility, liaise with the CDC to support and maintain all equipment provided to the facility and ensure the drugs and consumables allotted to the health facilities are well managed.
3. Maintain appropriate logistics for drugs and consumables to avoid stock outs.
4. Ensure records of activities of the health facility are kept using all relevant books and forms provided.
5. Ensure that all relevant data collected on PHC Health Management Information System are collated, analyzed and information used for decision making.
6. Ensuring that monitoring and evaluation data are returned promptly.
7. Participate in monthly briefing of the Community Development Committee of their activities and challenges.

8. Participate in continuing education for PHC team and community.
9. Carries out all assigned administrative, including supervisory functions.
10. Receives supervision and mentoring from designated officials.
11. Participates in all statutory meetings and training related to the MSS.
12. Effectively documents all required information and provide statutory reports as at when due.

Chapter Four

MATERNAL, NEWBORN AND CHILD SERVICE DELIVERY BASED ON THE IMNCH STRATEGY

Midpoint of the MDG targets, Nigeria **Maternal, Infant and Under-five mortality rates have** shown marginal reduction in the last five years. At the present trend, the country is unlikely to achieve the Maternal and Child Health related MDGs by 2015. These include:

- Three Quarter (¾) reduction of maternal mortality ratio from 1000 in 1990 to 250 per 100,000 live births in 2015.
- Two Third (2/3) reduction of under five deaths from 230 per 1,000 live births in 1990 to 77 by 2015).

Wide regional disparities exist in health indicators with North-East and North-West having the worst figures. The national health system continues to witness low coverage of high impact interventions of MNCH.

Major Causes of Maternal deaths include Haemorrhage 23%, Infections 17%, Toxaemia/ Eclampsia11%, Unsafe Abortion 11%, Obstructed Labour 11%, Malaria 11% and Anaemia 11%. Less than 20% of facilities deliver Emergency Obstetric Care (EOC) services and only 36% of deliveries are attended by skilled personnel. About 60% of pregnant women have any ante natal care, while just 40% take one dose of tetanus toxoid.

The major causes of deaths in children under five are Malaria 24%, Pneumonia 20%, Diarrhoea 16%, Measles 6% and HIV 5% with malnutrition being the underlying cause in more than 50% of these

deaths. In addition to this, the rates of underweight and wasting are unacceptably high in Nigeria, particularly among very young children (< 3 years) (DHS 2003). Newborn deaths account for 26% of under five deaths, about 74% of these occur in the 1st week of life mainly due to pregnancy and delivery related complications (Prematurely /Low Birth Weight, Infections, Birth Asphyxia). This evidence reflects the close relationship between maternal and child health and therefore the need for this integration. Wide regional variations also exist in child health with North-East and North-West having the highest number of neonatal deaths.

Key determinants of Maternal, Newborn and Childhood Mortality
Maternal Mortality

Access in its various dimensions, is a critical determinant of maternal mortality. These dimensions include physical access (distance of 5km to PHC services or one EmOC centre per 500,000 population), cost, cultural factors and access to information etc.

Financial access: Poverty has significant implications for health and development and poor people generally have poorer health status. Poorer women experience higher morbidity and mortality compared to those of higher socio-economic status. The incidence of poverty is higher in the rural areas, where maternal mortality rate is also higher.

Physical access: Distance to a health facility is the second most important reason for not accessing health care services in Nigeria (NDHS2003). There was a six fold difference in the magnitude of this problem between the lowest quintile and the highest quintile.

Only 13.9% of estimated annual deliveries for the twelve states studied took place in health facilities.

Access to emergency obstetrics services has been shown to be clearly linked with maternal mortality situation as approximately 15 % of pregnant women may develop life threatening conditions that would need such services for effective intervention. The availability

and accessibility of EmOC services, thus, deserve particular focus in the review of maternal mortality situation.

Socio-cultural factors: A number of socio-cultural beliefs and practices in Nigeria limit the ability of women to take autonomous decisions about their own lives, including decision to seek appropriate health care. The decision-making power often lies with the husband or their male relatives, and studies have shown that many women have lost their lives in pregnancy-related conditions while awaiting decision to be taken by such gatekeepers.

Access to information: Access to mass media is also important for acquiring information and knowledge on maternal health issues. The proportion of women that have no access to any mass media was about two to three times that of men in the rural and urban areas respectively. This is likely to affect their knowledge and use of health facilities in pregnancy and delivery, and consequently maternal morbidity and mortality occurrence. In addition, other channels of communication including interpersonal communication are important in passing on key health messages to the community.

What is Integrated Maternal, Newborn and Child Health strategy?

- Integrated Maternal, Newborn and Child health strategy is a package that addresses the six conditions responsible for over 90% of maternal deaths i.e. haemorrhage, infection, obstructed labour, hypertension, Malaria and anaemia and the most common conditions responsible for over 90% of under five mortality (Neonatal conditions such as prematurity, sepsis and birth asphyxia, pneumonia, malaria, diarrhoeal disease, measles as well as the underlying malnutrition and more recently, HIV/AIDS while including neonatal conditions such as prematurity, sepsis and birth asphyxia,.
- IMNCH strategy recognises that high quality laboratory services

are essential for diagnosis and patient management and for assessing progress against targets.

- The integration of MNCH services involves the reorganization and reorientation of health systems to ensure the delivery of a set of essential interventions as part of the continuum of care for women, newborns and children.
- A focus on the continuum of care replaces competing calls for mother newborn or child, with a focus on high coverage of integrated evidence-based intervention packages.
- Sustained investment and systematically phased scaling up of essential MNCH interventions will save most maternal, newborn and child lives. If essential interventions reach 99% of women and babies, up to 72% of newborn deaths could be averted.

Vision, Mission and Goals of IMNCH strategy

Vision

- A Nigeria where pregnancy and delivery do not pose threat to the lives of mothers and newborns, and where children are healthy and able to grow and develop to their full potential, thereby contributing to the nation's socio-economic development.

Mission

- To deliver integrated high impact and cost effective maternal, newborn and child health interventions at population coverage to achieve MDGs 4 and 5 and contribute to a reduction of disease burden.

The **overall objective** of the strategy is to reduce Maternal, Newborn and Child morbidity and mortality in line with MDGs 4 and 5.

Its specific objectives are to:

- Improve access to good quality health services
- Ensure adequate provision of medical and laboratory supplies, drugs, bundled vaccines, RH commodities ITNs and provision and maintenance of basic equipment.
- Strengthen individual, family and community capacity to take necessary MNCH actions at home and to seek appropriate health care
- Improve capacity for organisation and management of MNCH services
- Establish a financing mechanism that ensures adequate funding, affordability, equity, and efficient use of funds from the various sources.
- Strengthen monitoring and evaluation systems, including quality assured laboratory services, to report on progress towards achieving the maternal and child health MDGs.
- Establish and sustain partnerships to support implementation of IMNCH strategy.

Justification for Integrated Maternal Newborn and Child Health Strategy

- The relationship between the health and well being of the mother and child is that of an inseparable dyad. It is increasingly recognized that conditions during pregnancy and in and around delivery period is a major determining factor of outcomes of pregnancy and child survival.
- Evidences have shown that similar conditions contribute to both maternal and newborn mortality. Globally countries with the highest maternal deaths are also those with the highest neonatal deaths. Of the 136 million babies born every year

worldwide, 3.2 million are still-born, and 4 million die in the 1st month of life, 98% of who live in low and middle income countries.

- Most newborn deaths in Nigeria as described earlier occur within the first week of life, reflecting the intimate link of newborn survival to the quality of maternal care. More than 44% of such deaths occur between days 0 and 1 reflecting that supervised delivery and linked newborn care may dramatically reduce mortality rates of mother and child. Maternal deaths, still births and newborn deaths are strongly linked in terms of time and place of death and delay in access to care.
- Also, lifetime issues, malnutrition, HIV/AIDS, malaria, poverty and urban rural factors contribute significantly to deaths of mothers and their children. Although mother and child outcomes are associated across the whole life cycle, the most radical effects of maternal mortality on child are in the pregnancy and neonatal period.

High Impact Interventions

1. Focused Antenatal Care

Pregnancy outcomes and newborn and child health are dependent on quality antenatal care (ANC). The strategy take into consideration the need to increase ANC uptake and access, particularly in the rural areas and areas that are largely constrained by socio-cultural and gender-based factors. The goals of focused antenatal care are to promote maternal and newborn health and survival through early detection and treatment of problems and complications, prevention of complications and diseases.

Ante-Natal Care in Session

2. Intrapartum Care

Quality of care and conditions during delivery is a major determining factor of the outcome of pregnancies. A significant proportion of neonatal morbidity and mortality have been linked to the level of intrapartum care received by women. Priority interventions for effective intrapartum care include, monitoring progress of labour with partograph; active management of 3rd stage of labour and postpartum care of mother; delivery of intrapartum ARVs for PMTCT, providing supportive care and pain relief; newborn resuscitation; immediate postpartum and postnatal care of the newborn baby (e.g. thermal protection, cord care, early initiation of exclusive breastfeeding within one hour; management of sepsis) and follow up monitoring and assessment of maternal and newborn well being to prevent, detect and manage complication and to deliver postnatal ARVs for PMTCT as well as cotrimoxazole preventive treatment for HIV infected mothers and HIV exposed infants.

3. Emergency Obstetric and Newborn Care:

Major causes of maternal mortality are preventable and are such that could be easily managed where emergency obstetric services offered by skilled attendants are available in an enabled environment.

4. Routine Postnatal C

A significant proportion
around the time of bir.
interventions for morbidi.
immediate postpartum perioo
support of early initiation and e.
and assessment of maternal and .
complications (breathing, infec.
malformation, jaundice) and deliv.
PMTCT as well as cotrimoxazole pr.
infected mothers and HIV exposed and in.

nd feeding practices
rticularly twice-a-
e-a-year de-
ons to be
deliv.
basic RH services
ments and Advocacy

Other areas of focus are vitamin A supp. n the post partum period, infection prevention and ol, rooming-in, information and counselling on home care, identification and management of low birth weight, hygiene, advice on danger signs,

emergency preparedness and follow-up. Immunization according to the national guidelines, promotion of sleeping under ITN, cord and eye care and administration of Vitamin K also improves child survival.

5. Repositioning Family Planning/Child Spacing

Despite the availability of safe and affordable technologies, many women in Nigeria still die from pregnancy related causes. Most deaths are due to short birth intervals, unsafe abortions and inadequate obstetric care. Family planning could reduce maternal mortality by 20% or more and Infants are twice as likely to survive if the previous birth interval is at least 2 years. West African countries have resolved to reposition family planning to accelerate reduction of maternal and neonatal mortality bearing in mind that family planning is a key pillar for attaining safe motherhood. Repositioning Family planning entails recognising missed opportunities for integrating FP, re-introducing FP in on-going and

4. Routine Postnatal Care

A significant proportion of maternal and neonatal mortality occur around the time of birth and following 48 hours. Priority interventions for morbidity and mortality reduction during immediate postpartum period include, promotion, protection and support of early initiation and exclusive breastfeeding, monitoring and assessment of maternal and newborn wellbeing and to detect complications (breathing, infections, preterm birth, injury, malformation, jaundice) and delivery of postnatal ARVs for PMTCT as well as cotrimoxazole preventive treatment for HIV infected mothers and HIV exposed and infected infants.

Other areas of focus are vitamin A supplementation in the post partum period, infection prevention and control, rooming-in, information and counselling on home care, identification and management of low birth weight, hygiene, advice on danger signs,

emergency preparedness and follow-up. Immunization according to the national guidelines, promotion of sleeping under ITN, cord and eye care and administration of Vitamin K also improves child survival.

5. Repositioning Family Planning/Child Spacing

Despite the availability of safe and affordable technologies, many women in Nigeria still die from pregnancy related causes. Most deaths are due to short birth intervals, unsafe abortions and inadequate obstetric care. Family planning could reduce maternal mortality by 20% or more and Infants are twice as likely to survive if the previous birth interval is at least 2 years. West African countries have resolved to reposition family planning to accelerate reduction of maternal and neonatal mortality bearing in mind that family planning is a key pillar for attaining safe motherhood. Repositioning Family planning entails recognising missed opportunities for integrating FP, re-introducing FP in on-going and

basic RH services, maximising all opportunities for addressing men's and women's FP needs. Priority interventions include Advocacy at IFC and policy levels, Improving access- expanding delivery points and NHIS coverage to include FP services and commodities. Others include strengthening capacity- pre/in-service training, CBDs, provision of equipments, strengthening community participation- building consensus among key stakeholders, religious leaders and men, addressing FP needs of vulnerable populations-young people, displace persons, refugees, war/conflict situation, operational Research – service barriers. And ensuring commodity security, sustainable financing, male involvement etc.

1. **Newborn care**

   Taking into consideration the life-course approach and continuum of care, neonatal interventions that need to be scaledup will include i) access to skilled care during pregnancy, childbirth and the immediate postnatal period at community and facility levels; ii) capacity building of professional and non-professional staff for optimal newborn care practices including newborn resuscitation, early and exclusive breastfeeding, warmth, hygienic cord and skin care; and postnatal PMTCT interventions including cotrimoxazole preventive treatment iii) timely and appropriate care-seeking for infections and care of low birth-weight infants. The Making Pregnancy Safer initiative through Integrated Management of Pregnancy and Childbirth (IMPAC) offers opportunities for addressing early newborn health. The Integrated Management of Childhood Illness (IMCI) will also be expanded to include newborn in the first 7 days of life and early detection and management of HIV.

2. **Infant and Young Child Feeding (IYCF): including micronutrient supplementation and de-worming**

   Exclusive breastfeeding for the first 6 months of life, including early breastfeeding with colostrums, as well as timely and

appropriate complementary food and feeding practices including adequate micronutrient intake (particularly twice-a-year vitamin A, iron, iodine and zinc) and twice-a-year de-worming for children ≥ 12 months are the key interventions to be scaled up.

3. **Micronutrient deficiency control for women of child bearing age and prevention of low birth weight**

This calls for micronutrient supplementation (iron and folic acid, vitamin A including in post partum, and iodine), food fortification programs (iron and folic acid, vitamin A), de-worming (throughout the life cycle but only during 2nd and 3rd trimesters of pregnancy for pregnant women) and malaria control (ITNs and IPT). Food distribution should target women that are in need.

4. **Prevention of malaria using insecticide treated nets (ITNs) and Intermittent Preventive Treatment of malaria (IPT)**

Use of insecticide treated nets for both under-fives and pregnant mothers, and intermittent preventive treatment of malaria during pregnancy in areas where malaria is endemic are priority interventions for reducing low birth-weight and child morbidity and mortality. Mechanisms to ensure universal access to ITNs include free or subsidized ITN distribution on a regular basis or through campaigns. ITN and IPT should be integrated with Expanded Programme on Immunization (EPI), ANC and IMCI activities to increase coverage rapidly.

5. **Immunization Plus**

Provision of tetanus toxoid to pregnant women in antenatal clinics, and childhood immunizations including new vaccines (Hib, HepB), at community and facility levels through outreach and fixed services will be promoted, and integration of EPI with other child survival interventions such as Vitamin A,

mebendazole for de-worming, and ITNs distributions are proven ways of improving access to and coverage of services. The Reach Every Ward (REW) strategy will be promoted to deliver "immunization plus" and other schedulable population oriented services to hard to reach children.

6. Prevention of Mother-to-Child Transmission of HIV (PMTCT)

Prevention of HIV transmission from mothers to their children involve interventions such as a number of interventions including HIV testing and counselling, ARV prophylaxis and treatment, counselling on infant feeding options, family planning and primary prevention of HIV infection in the mothers integrated to ANC services, nutrition programs, IMCI and other RH services and Voluntary Counselling Tests (VCT) and Sexually Transmitted Infections (STI) services.

7. Management of common childhood illnesses and care of HIV exposed or infected children

The interventions include oral rehydration therapy, zinc supplementation with management of diarrhoea, effective and appropriate antibiotic treatment for pneumonia, dysentery and neonatal infections, and prompt and effective treatment of malaria at health facility and community levels. Cotrimoxazole preventive treatment for HIV exposed and HIV infected children and ARVs for infected children with advanced HIV disease are key to improved survival. Integrated management of childhood illnesses (IMCI) provides an approach for addressing these common illnesses in an integrated manner.

8. Water, Sanitation and Hygiene

Improved household water, sanitation and promotion of key hygiene behaviour changes will be critical to complement and strengthen the essential package. Water, sanitation and hygiene

(WASH) components of the package will include at scale up campaigns for the promotion of hand washing with soap. These campaigns will target mothers and primary care givers and will aim toward the presence of a hand washing place in the home where water and soap are readily available. To maximise the benefits of exclusive breastfeeding, the promotion of low cost water quality treatment at house hold level will be important to ensure that young children (6-12 months) in receipt of complementary feeding do so with safe water and that the risks of contamination are reduced for U5's.

9. Prevention and management of child malnutrition

More specifically, two essential packages of services need to be put in place: 1) prevention of malnutrition in early childhood through the promotion of improved child feeding, care giving, and care seeking practices at the facility, family and community levels; and 2) care for children with acute malnutrition at facility-based care for children with severe acute under nutrition and medical complications

Organisation of Maternal, Newborn and Child Health Services

Local government level

The women, their families/households and their communities, all have an important role to play in ensuring the health of the woman, the newborn and the child, both in terms of self-care in the home and in seeking and accessing skilled care, especially when complications arise. The key elements of self-care in the home for the pregnant woman, the newborn and the child are addressed through promotion of key household practices which include:

- Timely decision making related to care seeking for the mother, newborn and the child.
- Maternal and Infant diet and nutrition including complementary feeding;

- personal hygiene and healthy lifestyle, including planning for pregnancies to ensure wanted pregnancy;
- Birth preparedness and complication readiness;
- Taking child to complete full immunization and growth monitoring;
- Essential newborn care (general hygiene, clean cord and eye care, keeping the baby warm) as well as promotion of early and exclusive breast-feeding.
- Use of ITNs in the prevention of malaria in pregnant mothers and under five children

Primary health care level

The primary health care level is usually the first level of contact between women and children and the health care system (private or public). At this level, it is important that skilled care is provided. Primary health care must be able to deliver the essential package of MNCH services in full, which includes:

- Focused antenatal care including family planning, prevention of mother to child transmission of HIV, and early disease detection and treatment.
- Early detection and timely referral with minimal first- line management of women and newborns with pregnancy-related complications.
- Normal delivery including use of partograph and active management of third stage of labour.
- Care for mother and newborn in the postnatal period (warmth, cleanliness, resuscitation, and prevention and management of sepsis.
- Early initiation of exclusive breastfeeding.

- Continued breastfeeding with timely complementary feeding.
- Full immunization and growth monitoring.
- Integrated Management of Childhood Illnesses.

At Primary Health Care level, some facilities should be equipped to offer basic emergency obstetric and neonatal and child care. These facilities should have at least 4-5 midwives with life saving skills and equipped to offer parenteral antibiotics, sedatives, oxytocin and manual removal of placenta and products of conception 24 hours daily. These are the first level of referral for the other PHC facilities within LGA. Every LGA must have at least one health facility equipped to provide a comprehensive emergency obstetric and newborn care.

At the Secondary Care, it is estimated that approximately 15% of all pregnant women, will require access to specialized medical services for diagnosis and treatment of an underlying health problem or pregnancy and childbirth related complications. These women must be referred to a secondary level health facility that offers comprehensive essential obstetric and newborn care with the necessary drugs, equipment and skilled staff to manage such complications. Services provided at this level include:

- Surgical procedures including Caesarean section.
- In the absence of electric supply, appropriate technology to use solar / kerosene fridges for blood storage.
- Safe blood transfusion.
- Assisted vaginal delivery.

The secondary facilities should also be equipped to provide comprehensive management of childhood illness including paediatric emergency care. States would need to invest in improving secondary health facilities.

At the National level, Federal Agencies under the FMOH such as the new National Hospital Agency and the National Primary Health Care Development Agency would scale up their stewardship role to improve service coverage and quality. Secondary and tertiary facilities would be supported by these agencies to meet the criteria for Comprehensive Emergency Obstetric and Neonatal Care (CEONC) facilities. In addition to their stewardship role these agencies should ensure that each LGA has a comprehensive health centre. These agencies would also work with professional associations and state counterparts to improve shortage of skilled attendants and bridge skills gaps. The National Primary Health Care Fund when operational will play a critical role in stimulating increased investment in MNCH.

Chapter Five

MIDWIVES SERVICE SCHEME: PROGRAMME IMPLEMENTATION PROCESSES

The implementation process has been guided by the eight (8) strategic and complementary components or thrusts conceived to address the maternal and child health issues from a system perspective, and this include: Management and Coordination, Building Partnership and Consensus among key stakeholders, Strengthening/Institutionalizing Community Participation, Deployment of Human Resource to primary health care facilities in rural communities so as to improve the coverage by Skilled Birth Attendants, PHC Support with basic equipments/commodities and supplies, Capacity Building/Training of Midwives to improve Quality of Care, a Monitoring, Evaluation/applied ICT Support component and Programme Communication.

MANAGEMENT AND COORDINATION

Technical Working Group (TWG)

A high level Technical Working Group (TWG) was constituted and chaired by the Honourable Minister of Health, Prof. Babatunde Osotimehin. The committee comprises of key players involved in Maternal Mortality Reduction efforts in Nigeria, and include programme managers drawn from the Office of the Senior Special Assistant to the President on MDGs, Federal Ministry of Health, National Primary Health Care Development Agency, Nursing and Midwifery Council of Nigeria, National Health Insurance Scheme and Development Partners such as UNICEF, WHO, UNFPA, ACCESS/JEPEIGO, PARTHFINDER, PRRINN/MNCH, PPFN etc; and meets periodically to receive update, review progress and advice accordingly.

The key responsibility of the forum is to provide Strategic Direction, Support and Guidance for the smooth implementation of the scheme.

In addition to the above, a broader Stakeholders Forum on Maternal Health is in the process of being institutionalized to facilitate regular consultation with key stakeholders and engender wider public support for maternal mortality reduction efforts.

The Secretariat

The secretariat of the scheme is birthed at the National Primary Health Care Development Agency. It is responsible for the day to day management of the scheme through the National Coordinator and a team of Technical Officers. The MSS team operates in work streams built around thematic areas. The National Coordinator reports to the Executive Director through the Director of Health Systems Development.

The scheme also enjoys the services of a Project Advisor and 6 Zonal consultants charged with providing technical support to all aspects of the scheme. State Focal Persons were identified from among the Agency's Zonal Technical Officers (ZTOs) whose work schedule is

The Midwives Service Scheme Team

at state level for the 36 States and FCT. They are charged with the responsibility of coordinating the scheme's activities in their state's of primary assignment. They also serve as the contact persons for the midwives in the scheme.

PARTNERSHIP AND CONSENSUS BUILDING

The Midwives Service Scheme is a public sector initiative based on wide consultation, networking and consensus building among stakeholders. The hallmark of the scheme is that it is conceived as a collaborative effort between the three tiers of government based on shared roles and responsibilities formalized by signing a Memorandum of Understanding (MOU) between the Federal, State and Local Governments; supported by strategic partners such WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN etc.

The Roles and Responsibilities

Under the scheme, the Roles and Responsibilities of each of the partners are clearly outlined as follows:

The Federal Government.

1. Pay stipend of 30,000/month to the midwives for one year in the first instance.
2. Provide midwifery kits for each of the selected primary health care facilities and the midwives.
3. Provide mama kits, Personal Health Record Booklet, basic MCH equipment, drugs, Registers and Monitoring tools
4. Conduct Refresher trainings on Life Saving Skills and Integrated Management of Childhood Illnesses.
5. Provide Technical and Administrative support to the states and LGAs on the implementation of the scheme

6. Support the states/LGAs in the Supervision, Monitoring and Evaluation of the scheme
7. Provide Health Insurance for all the deployed midwives

The State Government.

1. Approve and support the use of selected General Hospitals as referral facilities for the PHCs where midwives have been posted
2. Provide full complement of human resource to General Hospitals selected as referral facilities
3. Provide and replenish essential drugs and supplies to the General Hospitals.
4. Direct through Ministries of Local Governments/Chieftaincy Affairs that all LGAs provide at least N10,000.00 supplementary allowances for midwives
5. Direct through Ministries of Local Governments/Chieftaincy Affairs that all the selected LGAs provide decent accommodation for midwives.
6. Direct through Ministries of Local Governments/Chieftaincy Affairs that all the selected LGAs routinely provide and replenish essential drugs and supplies.
7. Approve the use of Schools of Midwifery as sites for training of midwives and collaborate with NPHCDA in the trainings
8. Provide Mentoring and monthly supportive supervision
9. Provide transport logistics for effective linkage between beneficiary facility and a referral facility

The Local Government.

1. Sign **Memorandum of Understanding** between the NPHCDA and the LGA

2. Provide supplementary/rural posting allowance
3. Provide accommodation for midwives
4. Designate LGA RH/MCH programme officer as focal person for the project and provide necessary logistics.
5. Be responsible for training and kitting of Community Resource Persons [CORPs].
6. Provide Security and Logistics for Commodities.
7. Be required to provide monthly supportive supervision.
8. Support the Ward Development Committees in the discharge of its duties under the scheme.

The Partners

The scheme enjoys the support of several partners in Nigeria.

The partners are expected to explore area of collaboration and support in their focal/operational areas and align their programmes to the scheme. This is already happening.

STREGTHENING COMMUNITY PARTICIPATION & OWNERSHIP

Primary Health Care requires a Social Development Strategy to ensure community participation and ownership in its implementation. To ensure establishment of a good managerial process, formation and reactivation of Community Development Committees is often undertaken using the Participatory Learning and Action (PLA) approach. PLA tools are used to ensure that representative committees are formed at each level to oversee the implementation of primary health care activities.

Participatory Learning and Action is a participatory method of getting people to take active part in issues that affect their development (social and health). It is a social development strategy

PLA Setting: Constitution of Ward Development Committee/Training on Roles and Responsibility in Session

that adopts some set of tools to enable the people themselves identify their own needs, problems and find appropriate solutions to them as well as lead them into forming an umbrella organization (committee) that is a true representation of the entire people to serve as a front for the community. The process involves information gathering, acquiring knowledge and skills necessary for exercising full control over their resources and environment.

In recognition of the role of the communities in the successful implementation of the scheme, the Agency adopted a PLA approach to establish/reactivate Ward Development Committees (WDC) around all the 652 primary health care facilities to engender community involvement, participation, ownership and sustainability.

The Village Development Committee/Community Development Committee

Composition

The Village Development Committee/Community Development Committee consist of:

1. A respectable person elected by committee members as chairman.
2. An elected literate member of village/community shall serve as secretary
3. Representative of religious groups
4. Representative of women's groups/associations
5. Representative of occupational/professional groups
6. Representative of NGOs
7. Representative of youths
8. Representative of traditional healers
9. Representative of patent medicine stores owners

A trusted member of the Committee is elected to serve as Treasurer. A woman should hold one of the executive posts on the VDC. The VDC should also decide on quorum (the number of people that must be present before a formal meeting can be held) and the number within the quorum who must be women.

Roles and responsibilities of the VDC/CDC

1. Identify health and health related needs in the village/community
2. Plan for the health and welfare of the community
3. Identify available resources (human and material) within the community and allocate as appropriate to programmes
4. Supervise the implementation of work plans
5. Monitor and evaluate the progress and impacts of the implementation of health activities
6. Mobilize and stimulate active community involvement in the implementation of developed health plans

7. Determine exemptions for drugs payment and deferment; but provide funds for the exemptions/deferments
8. Determine the pricing of drugs to allow for financing of other PHC activities. Supervise all account books, (monies at hand should be deposited in a bank within 24 hours or74 hours at weekends)
9. Supervise and monitor quantity of drug supply
10. Selection of appropriate persons within the community to be trained as Village Health Workers (VHWs/TBA) for PHC, AIDS/STI and other programmes
11. Supervise the activities of the Village Health Workers and Traditional Birth Attendants; including review of monthly record of work
12. Remunerate in cash or kind, the Village Health Worker for his work in the community.
13. Agree with the Village Health Worker the number of hours he/she should work-per day
14. Establish a village health post, where there is none already
15. Ensure that VHW TBA kits are stocked to top-up level for drugs
16. Liaise with other officials living in the village to provide health care and other development activities
17. Provide necessary support to VHW for the provision of health care services
18. Forward local health community plan to ward level.

Operational Guidelines

In following the above terms of reference, the committee shall:

1. Meet once every month
2. Record minutes of meetings

3. Minutes of meetings shall be signed by the Chairman and Secretary after adoption at subsequent meetings
4. Comply with the quorum set for starting meetings
5. The Treasurer should record and keep all monies
6. The Treasurer should record all expenditures
7. Where there is a Bank Account, signatories wi 11 be The Chairman and Treasurer, and if necessary the Secretary
8. Send minutes of meetings to Ward Development Committee.

The Ward Development Committee

At the ward level, a PHC Committee is set up.

COMPOSITION

Composition of the Ward Development Committee (WDC) is as follows:

1. Ward Head or Autonomous Clan head (Chairman), but where no such person exists, the most respectable village head or any other person so elected may serve as Committee Chairman. In such a case, the election of a Chairman should be left entirely in the hands of Committee members.
2. The WDC consists of representatives from each VDC/CDC in the village/ community
3. The Chairman shall be elected by members
4. The Secretary of the committee be elected by the member
5. The Ward Community Development Officer, if available
6. The committee can, where necessary, co-opt members of health related sector such as secondary/primary school head master, Agricultural Extension Workers, PHCN, Water Works staff, NOOs at least 20% of membership will be women and they should be given effective post

7. Head of facilities in the area.

ROLES AND RESPONSIBILITIES OF WDC

The Ward Development Committee is to:

1. Identify health and social needs and plan for them;
2. Supervise the implementation of developed work plans
3. Identify local human and material resources to meet these needs
4. Forward all health/community development plans (village, facility and ward levels) to LOA;
5. Mobilize and stimulate active involvement of prominent and other local people in the planning, implementation, and evaluation of health projects

- Take active role in the supervision and monitoring of the ward Drug Revolving Fund/B.I.

6. Raise funds for community programmes when necessary at village, facilities and ward levels
7. Provide feedback to the rest of the community on how funds raised were disbursed
8. Liaise with government and other voluntary agencies in finding solutions to health, social and other related problems in the wards
9. Supervise the activities of the VHWs/TBAs, CHEWS
10. Monitor activities at both the health facilities and village/community levels
11. Oversee the functioning of the Health facilities in the Ward
12. Provide necessary support to VHWs/TBAs
13. Ensure that a Bank account is opened with a reliable bank. The signatories are as recommended by the NPHCDA on the ward health services document

14. Monitoring equipment and inventory on monthly interval
15. Ensure the proper functioning of the Health Facility using a maintenance plan.

OPERATIONAL GUIDELINES

The committee shall:

1. Meet monthly
2. Record minutes of meetings
3. Recommend that minutes of meetings be signed by the Chairman and Secretary after approval at the next meeting
4. Monitor drug revolving fund at the ward/facility levels
5. Ensure that NHMIS forms are correctly filled and submitted on time
6. Give feedback of data collected at LGA PHC Management Committee meetings.
7. Comply with the quorum set for starting the meeting
8. Authorize Treasurer to record and keep all monies
9. Authorize Treasurer to spend money only after approval by committee
10. Instruct the Treasurer to record all expenditure
11. Chose where applicable, the ward referral center to serve as the meeting venue and secretariat of the Ward Development committee
12. Advise, where there is a Bank Account, signatories will be the Committee Chairman and Treasurer, and if necessary the Secretary
13. Send minutes of meetings to Local Government PHC Management Committee.

DEPLOYMENT OF MIDWIVES TO PRIMARY HEALTH CARE FACILITIES

In order to ensure that only certified and fit midwives are enrolled into the scheme, interested midwives went through a process of expression of interest in response to adverts placed in the national dailies calling for enlistment of eligible candidates, short listing of eligible candidates and screening by the Agency.

The screening exercise was carried out at the six zonal offices of the National Primary Health Care Development Agency in the six zones of the country by a technical committee comprising of key stakeholders including the Nursing and Midwifery Council of Nigeria (NMCN). At the end of the screening exercise, two thousand four hundred and eighty eight (2488) successful midwives were deployed to 652 designated primary health care facilities under the scheme.

Before the assumption of duty in the various facilities of assignment, Two Thousand Four Hundred and Eighty Eight (2,488) successful midwives went through an orientation exercise conducted in the six geopolitical zones of deployment, to acquaint them with the concept of the scheme, their roles/responsibilities toward the successful implementation of the scheme and the concept / principles of primary health care.

The midwives also went through a call up exercise during which the Agency officially handed them over to the states of deployment.

Midwives at Orientation Session

CAPACITY BUILDING FOR QUALITY CARE

The scheme provided for capacity building to enhance quality of services to be provided by the midwives. In furtherance of this, a training framework was developed for the scheme and consisted of the training timeline, course content, logistics, training locations and trainers for the Life Saving Skills (LSS) and Integrated Management of Childhood Illness (IMCI). The training was competency based and aimed at improving the skills and proficiency of the midwives in the provision of quality maternal and child health services. Thirty Seven (37) Schools of Midwifery/Clinical sites in 36 States and FCT were identified including four LSS trainers and five IMCI trainers selected from a data base compiled by the Federal Ministry of Health and Partners. The training was institution based, using the schools of midwifery in the 36 states and FCT. The training was coordinated in partnership with the principals of Schools of Midwifery and the MSS focal persons at the State level. The class size varied from 24 to 32 and midwives were trained in 2 or 3 streams depending on the State/Zone. In addition, the Agency provided training aids/equipment such as Laptops, multimedia projectors, flip chart stands, anti-shock garments and other training materials in support of identified training/clinical sites.

Flag off of the Training on LSS/IMCI by the former Minster of Health, Prof. Babatunde Osotimehin

STRENGTHENING THE PHC SYSTEM

Recognizing that only a functional PHC system could guarantee effective service delivery, the Agency identified strengthening of the PHC system as a key component of the scheme. In order to achieve

Provision of Midwifery Kits and other Supplies under the Scheme

Commodities in a Zonal Store awaiting distribution

this, basic equipment, drugs and supplies such as BP apparatus, stethoscopes, weighing scales, midwifery kits; mama kits, essential drugs and consumables, facility/community registers, service guidelines, job aids and protocols were procured and distributed to the 652 facilities using the Agency's vaccine logistics system.

APPLIED ICT SUPPORT, MONITORING AND EVALUATION FRAMEWORK

The ICT Strategy

The Agency identified ICT connectivity and application of GSM technology as a potential strategy that could enhance the effective implementation and management of the Midwives Service Scheme. Under the scheme, Galaxy Backbone was commissioned to lead mhealth development in Nigeria. The NPHCDA-Galaxy initiative involved connecting the Agency's headquarters, the 6 zonal offices at Bauchi, Benin, Enugu, Ibadan, Minna and Kano, the Central Store at Airport road, Abuja and 40 clusters comprising of 160 primary health care facilities and 40 General Hospitals to ICT facilities to establish a system that could facilitate voice and data transmission, internet and video conferencing and also provide interface with mobile technology.

The ICT connectivity is facilitating provision of dedicated Voice

ICT Support in one of the Facilities

Communication System to connect the midwives and other health workers to NPHCDA support centres at the headquarters and the zonal offices, timely transmission of service statistics and hoisting of such on the Agency's website, dissemination of technical checklists, guidance/protocols, notes and reminders and notification of complications and referral from first to second level provider etc.

The second aspect of the ICT strategy is the Mobile – Application Data Exchange System (MADEX). It involves the use of mobile phones by the facility in charge to collect key MNCH information reflecting the MSS core indicators. This information is forwarded by text directly to a server in the operations room at the NPHCDA headquarters. In addition the process also monitors the availability of midwives at the PHCs and the stock level of some commodities such as mama kits on a monthly basis.

The Monitoring and Evaluation Framework

The Agency articulated a Monitoring and Evaluation framework for the scheme. The framework provides details of the Midwives Service Scheme Core objectives and the indicators and milestones to monitor progress towards the achievement of the set objectives for the MSS. It also outlines the roles and responsibilities of staff at different levels of the health care system in collecting, monitoring and dissemination of the information on activities of the Midwives Service Scheme. The tools to be used for collection of information are based on National Health Management Information System (NHMIS) from Federal Ministry of Health (FMOH).

It provides for a Baseline Survey aimed at establishing a baseline of key maternal and child health indicators as well as utilization of these services as well as infrastructure, equipment and human resources to support these services at selected PHCs and referral General Hospitals. These key maternal and child health indicators are linked to the MSS objectives and therefore used to measure progress against the objectives.

Four questionnaires were used for the Midwives Service Scheme baseline survey. They are the Primary Health Care (PHC) services questionnaire, the General hospital services questionnaire, the Exit Interview questionnaires for PHC users and the house hold questionnaire targeted at women of reproductive age (15-49 yrs) with an experience of pregnancy.

These questionnaires were adapted to reflect the population and maternal and child health (MCH) issues relevant to Nigeria at a series of workshops with various stakeholders including Federal Ministry of Health, other government Agencies and non-governmental organisations. The WHO and World Bank provided a lot of advice and input to the development of the questionnaires.

The survey has been completed and the report is being finalized.

Operational Vehicles procured for Mentoring/Supportive Supervision and M/E

PROGRAMME COMMUNICATION.

In recognition of the critical role of communication in the implementation of health programmes in general, programme

communication was identified as a component of the scheme. Two perspectives were identified in the design of programme communication for the scheme. One targeted at the political leaders/decision makers where aspects of the communication programme serves to as advocacy tool and provide strong visibility amongst the funding partners (Federal government, state government and international partners). The second aspect is targeted at the clients: the pregnant women, families and the communities to create awareness on key household practices, birth preparedness, danger signs and encourage/persuade pregnant women, families and communities to use skilled attendants during pregnancy and delivery.

Some aspects of the communication plan include the following:

Radio: preparing impactful jingles on key radio stations such as BBC Hausa Service, Radio Nigeria, Wazobia, BBC Nigeria.

Billboards: 37 billboards nationwide located at strategic high traffic and high visibility areas such as airports, entrance of large markets or popular road intersection or near key water sources.

Community Outreach: Supporting the Ward Development Committees on community advocacy outreach in all of the 652 wards linked t o the MSS health facilities.

Health centre branding: Branding the PHCs with MSS messaging and signage so that clients are sensitized about MCH services and the presence of the midwives in the centre, and the MSS brand is a recognisable feature across the country.

Posters: Production of posters to be used at MSS facilities and also distributed to women and their families in the community. The posters cover the following issues; Birth Preparadness, Complications of Pregnancy, Seven steps in Pregnancy and Childbirth etc.

Roller Coaster Banner and the Newsletter for Programme Communication

Chapter Six

KEY RESULT AREAS AND ACHIEVEMENTS PARTNERSHIP AND CONSENSUS BUILDING

Broad Support

Under the scheme, the Agency has succeeded in building strong network and partnership from the inception. It is gratifying to note that all the critical stakeholders are on board, ranging from the Federal, State and the Local Governments. Others include strategic partners such as WHO, UNICEF, UNFPA, PRRINN-MCH, Pathfinder International, ACCESS/JEPHIGO and PPFN etc.

At a Stakeholders Forum on the Midwives Service Scheme

Consensus on Facilities/Criteria among Key Stakeholders

The 36 States and Federal Capital Territory recommended the 652 facilities designated for the implementation of the scheme based on agreed eligibility criteria. The list of facilities were ratified at a stakeholders meeting held in July 2009 in Kaduna State. At the meeting were the Honourable Minister of Health, the Chief Executive of the NPHCDA, the Office of the Senior Special Assistant on MDGS, the Registrar of Nursing and Midwifery Council of Nigeria, State Commissioners of Health, Commissioners for Local Government and Chieftaincy Affairs, State and LGA Primary Health Care Coordinators, Development Partners, Officers from the Federal Ministry of Health and National Primary Health Care Development Agency.

The outcomes of the meeting were:

1. Ratification of the final list of the facilities recommended for the implementation of the scheme.
2. Agreement that the recommended facilities be subjected to a rapid appraisal/assessment with those that do not meet the criteria to be substituted.
3. Agreement on the contents of the draft MOU.

Official Launching

The First Lady, Hajiya Turai Yar'adua officially launched the scheme on the 12th October 2009. In attendance were wives of some State Governors, the Honourable Minister of State for Health, Chairmen NASS Committees on Health and MDGs, Chairmen of the NPHCDA, NMCN Governing Boards and members of the NPHCDA Governing Board.

Official Flag Off by the First Lady, Hajia Turai Yar'adua

Signing of the Memorandum of Understanding

The scheme was conceived as a collaborative effort between the three tiers of government based on shared roles and responsibilities formalized by signing a Memorandum of Understanding (MOU) between the Federal, State and Local Governments. Two set of the Memorandum of Understanding (MOU) were designed to be signed by the Honourable Minister of Health and the State Governors; and between the Executive Director of the National Primary Health Care Development Agency and the State Commissioners for Health/Commissioners for Local Government and Chieftaincy Affairs.

So far all the 36 States and the FCT have signed the MOU (Appendix 2).