REPRODUCTIVE HEALTH matters

FEATURE

Using community-based research to shape the design and delivery of maternal health services in Northern Nigeria

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Abstract: *Maternal mortality ratios in northern Nigeria are among the worst in the world, over 1,000 per 100,000 live births in 2008, with a very low level and quality of maternity services. In 2009, we carried out a study of the reasons for low utilisation of antenatal and delivery care among women with recent pregnancies, and the socio-cultural beliefs and practices that influenced them. The study included a quantitative survey of 6,882 married women, 119 interviews and 95 focus group discussions with community and local government leaders, traditional birth attendants, women who had attended maternity services and health care providers. Only 26% of the women surveyed had received any antenatal care and only 13% delivered in a facility with a skilled birth attendant for their most recent pregnancy. However, those who had had at least one antenatal consultation were 7.6 times more likely to deliver with a skilled birth attendant. Most pregnant women had little or no contact with the health care system for reasons of custom, lack of perceived need, distance, lack of transport, lack of permission, cost and/or unwillingness to see a male doctor. Based on these findings, we designed and implemented an integrated package of interventions that included upgrading antenatal, delivery and emergency obstetric care; providing training, supervision and support for new midwives in primary health centres and hospitals; and providing information to the community about safe pregnancy and delivery and the use of these services.*

Keywords: antenatal care, midwifery, emergency obstetric care, maternal mortality, beliefs, norms and values, community-based programmes and interventions, northern Nigeria

Maternal health outcomes in northern Nigeria are among the worst in the world.[1,2] The maternal mortality ratio is appreciably higher than the national average,[3] with recent (2008) estimates for the north of over 1,000 per 100,000 live births, compared to below 300 per 100,000 live births for the southern region.[4]

High maternal mortality in northern Nigeria is associated with a very low level and quality of maternity services. Moreover, a decline in utilisation of maternity services in the period between the 2003 and 2008 Nigeria Demographic & Health Surveys (DHS) raised concerns: the percentage of women in the northern states of Katsina, Zamfara and Yobe who received any antenatal services for pregnancies dropped from 36.9% to 31.1% in Katsina and Zamfara and from 47.3% to 43.0% in Yobe. Similarly, the percentage of women who had skilled assistance at delivery declined from 12.0% to 8.9% in Katsina and Zamfara and from 19.8% to

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13.1% in Yobe. This was associated with deterioration in the delivery of essential health care services, particularly in that region.[5,6]

Responding to the decline in use of maternal health services, in 2008 the Maternal, Newborn and Child Health (MNCH) Programme was established by a consortium led by Health Partners International (UK), Save the Children (UK), and GRID Consulting (Nigeria), with the Nigerian State Ministries of Health and local officials of Katsina, Yobe, and Zamfara states in northern Nigeria, where there was already an ongoing programme to promote routine childhood immunisations through revitalisation of primary care services. Funded by the Norwegian Government and DFID, the programme aims to teach women basic health education and the importance of utilising health facilities for their health and that of their children, increase demand for maternal and child health services, ensure that all women know maternal danger signs, deliver with skilled birth attendants and have access to emergency care.

The Programme conducted a baseline assessment of facilities in 2008 in the three states to assess the potential capacity of hospitals in those states to provide the continuum of care for maternal, newborn, and child health and in particular to provide skilled birth attendance and essential obstetric care. The survey included all public hospitals in each state. Results showed that these states had a serious health worker shortage, and fewer people living within ten kilometres of a health centre than in the south of the country. Further, although most hospitals in principle provided the key maternal, newborn and child health services, including antenatal, intra-partum and postnatal care, family planning and under-five clinics. many hospitals were unable to provide all of these. In 2003, no northern state met the minimum standard for basic emergency obstetric services and half the primary health care facilities offering antenatal or delivery care had no midwife. In the local government areas selected for intervention, there were no midwives at primary health centres and no facilities offered basic emergency obstetric care 24 hours a day. Moreover, only two facilities offered comprehensive emergency obstetric care, and there was no functional emergency transport scheme. Under 15% of women with recent pregnancies had had any antenatal visits.[7]

Differences in health care utilisation reflect larger structural factors. Northern Nigeria is Sudano-Sahelian and dependent on subsistence agriculture. It has higher levels of poverty and lower levels of infrastructure, education and health services. The north is also strongly patriarchal, while in the south there is more participation by women in decision-making. The north is predominantly Muslim, and practices aimed at protecting women from men – including polygyny, head covering and restrictions on public interaction – serve to further restrict women's access to needed services.[8,9]

With co-funding from the UK Department for International Development and the Government of Norway, the Programme represents a strategic attempt to assist these states in reducing the high rates of maternal, newborn and child mortality through health systems changes, addressing issues of governance, human resources, access to health information, and community engagement alongside the strengthening of clinical services. This paper reports the findings of a study conducted in the first half of 2009 to provide empirical evidence on which to base these interventions, including the extent of utilisation of antenatal and delivery care among women with a pregnancy and delivery in the previous five years and associated factors, and socio-cultural beliefs and practices that influence – positively or negatively – women's access to these services.

Study population

At the 2006 census, Katsina, Yobe and Zamfara had populations of 5.8, 2.3 and 3.3 million, respectively. Among women aged 15–49 years in these states, 84% had no education compared to 63% of men, and compared to 36% of women nationwide. Only 38% were employed in the previous 12 months, compared to 59% of women nationwide. Only 33% of women were exposed at least weekly to any newspaper, radio or television, compared to 55% of the men in these states and 61% of women nationwide.[5]

Methods

The Programme selected local areas in each of the three states where integrated interventions focusing on improved emergency obstetric care services were to be implemented. Lower intensity, policy-based interventions were to be implemented in control areas of these states as well. Baseline data were collected across these areas in 2009 for comparison in studying programme impact after three years. Both quantitative and