Breakthrough ACTION

SBC Flow Chart: Nigeria MNCH+N Spotlight

February 2021

RESEARCH QUESTIONS

How might we radically improve ***maternal, newborn, and child health and nutrition*** *in northern Nigeria?*

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of Breakthrough ACTION and do not necessarily reflect the views of USAID or the United States Government.

BACKGROUND AND CHALLENGE

Catalyst

Nigeria's maternal, newborn, and child health and nutrition (MNCH+N) indicators have decreased in recent years; however, child mortality rates in Northern Nigeria remain among the highest in the world, with Nigeria accounting for 13% of global child deaths.

Challenge

The context in which MNCH+N related behaviors related behaviors are practiced and services are provided in Northern Nigeria is complex. MNCH+N health outcomes and behaviors are influenced by people's values, needs, priorities, the home environment, gender equity in decision-making, and the community's social, cultural, and religious contexts.

Objective

Breakthrough ACTION Nigeria sought to better understand the current landscape and to gain insight into the human experience of MNCH+N in three states in Northern Nigeria: Sokoto, Kebbi, and Bauchi.

METHODS

This Nigeria application of the SBC Flow Chart used the following methods:

Define

Mine Existing Knowledge

- Literature review
- Concept note

Intent

- Intent workshop held in Sokoto to define the purpose and objectives of the project
- SBC capacity strengthening with discovery team to enhance the ability to conduct human-centered discovery fieldwork

Deepen Understanding

- Discovery fieldwork consisting of 292 in-depth interviews and observations in people's homes, workplaces, health facilities, and other settings

Design & Test

Imagine

- Opportunity dialogue with partners and stakeholders to build alignment with the priorities

Refine

- Two-day imagine workshop held in Sokoto to generate ideas to address the insights and opportunities

Prototype

- Built low fidelity prototypes to bring the six ideas to life

Test

- Tested six prototypes in four states (Sokoto, Kebbi, and Bauchi) with 240-plus people
- One advanced to a full implementation stage (Albishirin Ku!)
- Three advanced to a pilot stage (Religious Teachings; Women's Empowerment Group; Community Cohesion Strengthening)
- Two were discontinued

Apply

Implement and Monitor

- Three prototypes piloted for 20 weeks. Ongoing monitoring and harvesting lessons learned for refinement and scale-up

Evaluate and Refine

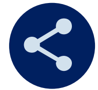
- Albishirin Ku! Monitoring audience engagement through omnibus survey and 3-2-1 platform data and adapt content for three prototypes
- Ongoing monitoring and harvesting lessons learned for refinement and scale-up

Adapt and Scale

- Albishirin Ku! Lessons learned from Season 1 applied to Seasons 2 and 3
- Expansion from Kebbi, Bauchi, and Sokoto to also Federal Capital Territory (FCT) and Ebonyi
- Three prototypes: Integrated and scaled-up into project. Ongoing monitoring and adaptation

KEY INSIGHTS

1. Religious and traditional beliefs are highly valued and strongly influence how maternal and child health is practiced.



2. Maternal and child health care is being provided by a wider community health ecosystem that combines traditional, religious, and modern practices.

3. Many women do not have the agency or ability to make decisions—or take action—concerning pregnancy, childbirth, or childcare.

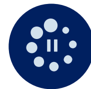
4. Preventive health care is not a priority, health seeking is often delayed, and the health facility is seen as a last resort when all else fails and the situation is critical.

5. Shyness and the need for privacy is influenced by strong religious and cultural beliefs, it inhibits learning about maternal and child health, communication, and health seeking.

6. Most babies are born at home and few women access postnatal care services. These services are often unavailable and/or of low quality in many localities.

7. Children survive infancy only to suffer from preventable diseases in early childhood.

8. Parents are aware of the need for good food but do not understand nutrition's impact on child development or how they can improve it given resource limitations.

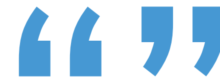


9. The use of modern contraceptive methods for child spacing is increasing but often still done in secret; preparing for pregnancy is not happening.

10. Financial or material incentives to prompt behavior change can provide short-term gains but may not link to sustainability of behaviors and may undermine the long-term financial viability of health programs.

Insight: Religious and traditional beliefs are highly valued and strongly influence how maternal and child health is practiced

Significant traditional and religious beliefs influenced MNCH+N practices in the communities visited. Beliefs are passed from generation to generation, and their practice have changed over time. Some are beneficial that can be reinforced, and some are harmful that need to change to achieve better health outcomes.



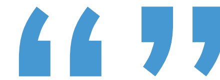
What you know can be overridden by what you believe.
Community Leader

Two days after delivery we cleansed the breast milk before feeding the baby, we had been feeding her on zamzam water.
Mother-in-law

How might the interpretation of beliefs and practices be re-imagined so that their meaning is not lost, safety is increased, and MNCH priority practices are adopted?

Insight: Many women do not have the agency or ability to make decisions—or take action—concerning pregnancy, childbirth, or child health care

Young wives and first-time mothers are least likely to have a role in decision making and are heavily influenced by their husband, parents, parents-in-law, and co-wives. Decisions about pregnancy, childbirth, and post-natal care require the input of multiple household members, and often the pregnant woman has little to no say in the final outcome.



The husband makes the decision and takes the responsibility of taking his wife to the health facility.
Traditional Birth Attendant

At times there are decisions my husband makes which I do not like, but they have to be done as he wished. Even if he is not around you have to wait for him to make decisions.
Young mother with first child

How might maternal and child health decision-making be re-imagined to reduce delays to health-seeking?

Insight: The use of modern contraceptive methods for childbirth spacing is increasing but often still done in secret; preparing for pregnancy is not happening

A range of barriers to uptake of childbirth spacing remain, including poor husband and wife communication or lack of consent from the husband. Many parents who do not correctly space their children are putting themselves, their other children, and the unborn child at greater risk of malnutrition and other issues.

I do not plan for birth; any time I get pregnant I know is from God, and I don't have any number of children I want to have, any one God gives me is fine with me.
Young mother with first child

My innermost desire is to have two children so that I will be able to care for them and also not to burden my husband.
Young mother with first child

How might we make the link between the benefits of childbirth spacing and better health outcomes for the mother and all of the children, and encourage open discussions about the use of modern contraceptives to achieve childbirth spacing?

PRIORITIZED SOLUTIONS

Religious Teachings: Advocacy Core Groups

Reduce risky practices by linking the belief with practices that support MNCH+N such as colostrum use and exclusive breastfeeding.

Women's Empowerment Groups

Building the capacity and agency for women to adopt priority MNCH+N behaviors is integral to long-term sustainable behavior change.

Community Cohesion Strengthening: Ward Development Committees

This intervention is aimed at strengthening existing community structures and demonstrate to the community how they are realizing MNCH+N outcomes.

Integrated Umbrella Campaign: Albishirin Ku!

An integrated umbrella campaign that provides an opportunity to link all interventions by reinforcing key messages on MNCH+N priority behaviors.

IMPLEMENTATION

Religious Teachings: Advocacy Core Groups

Advocacy core groups (ACG) engage with religious and traditional leaders, women in leadership roles, and other opinion leaders at the state and local government area (LGA) levels through the social and behavior change (SBC) ACG approach to garner the active support and participation of key opinion leaders on priority health and gender issues. This approach focuses dialogue among key stakeholders of key priority behaviors using the concept of *adalci*, which is a Hausa word meaning, “to provide a level playing field or ensuring fairness and justice.”

Women’s Empowerment Groups

To address gender and social issues that affect women's health-seeking behavior, women meet weekly, and priority health behaviors are embedded into the group's rules and regulations. The group also presents opportunities to intentionally highlight female leaders and service providers, including women religious leaders, female Ward Development Committees (WDCs), and health facility providers within the community who support creating an enabling environment. The economic empowerment activities are facilitated through multiple weekly contribution funds from the women (emergency health fund, social fund, and weekly contribution savings fund). Many women have started or expanded their businesses and acquired new skills while adopting priority behaviors.

Community Cohesion Strengthening: WDCs

75 WDCs have implemented innovative and practical solutions to plan, fund and implement health activities for their communities in a staged approach. The Community Health Action Resource Plan (CHARP) stages involve Stage 1: achieving quick wins and tangible outcomes in the community to build confidence and recognition of the WDCs. Stage 2 (upcoming) addressing gender issues, building financial management skills, and consolidating ownership by the community.

Expanding Stage 1 CHARP to an additional 100 wards in the existing three states and roll out in two additional states in FY21.

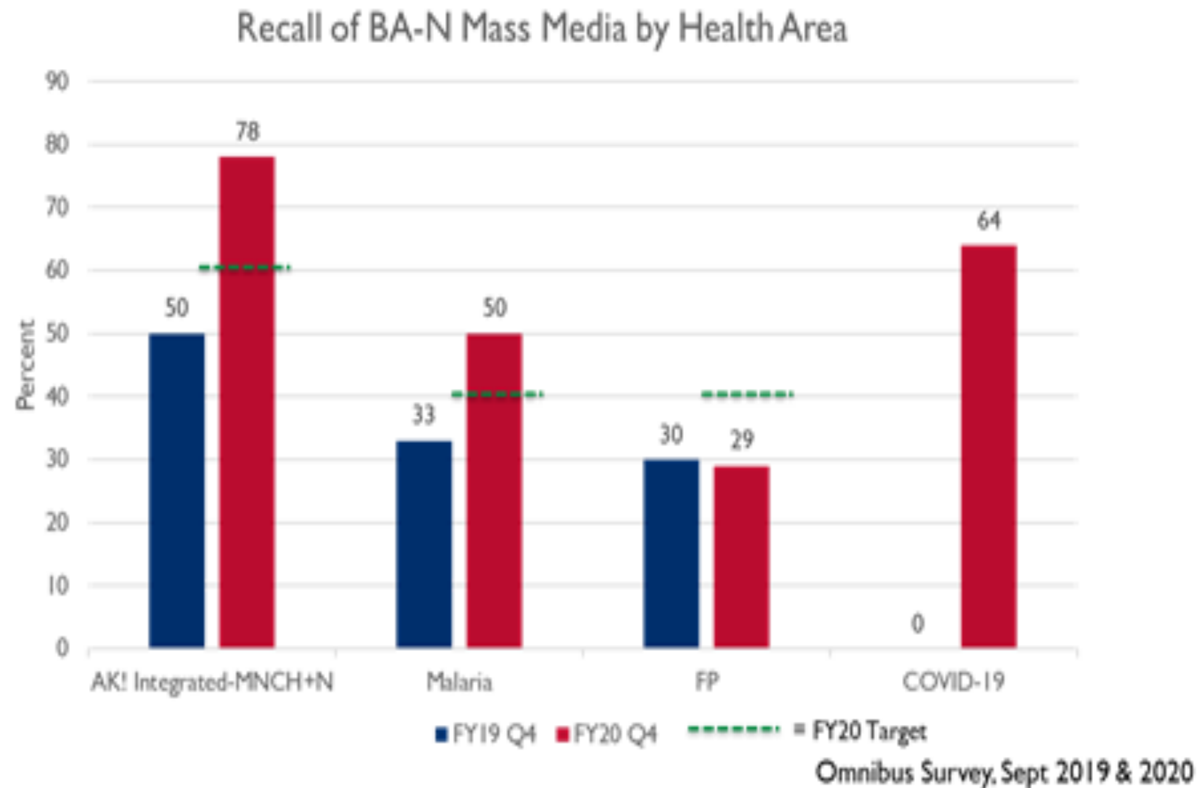
Integrated Umbrella Campaign: Albishirin Ku!

Three seasons of the Albishirin Ku! Radio program. This has been the first-of-its kind, innovative radio drama format.

One health theme each week and unfolds from a different lens each day. Episodes air three times a day every weekday in five-minute segments across 20 community and state radio stations in the three states. And on weekends, all five segments are broadcast together as a 25-minute program.

The radio drama is now complemented with an on-demand, free access episodes of the radio drama through Airtel’s Mobile 3-2-1 platform and an interactive mobile game, Kacici Kacicin. The radio drama is also being rolled out into two additional states.

MONITORING AND EVALUATION: ALBISHIRIN KU!



- Findings from an omnibus survey indicate about **50% of respondents recalled Albishirin Ku! in 2019, as compared to 78% in 2020.**
- At the end of the first two seasons, the radio drama had generated a total of **985,671** calls to 3-2-1 from **236,935** unique callers, who collectively spent **4,620,278** minutes listening to the episodes.
- Nearly **60,000** people have made a free call via the Airtel 3-2-1 network to play the Kacici Kacicin game during the first two months, spending a combined half a million minutes, guided by interactive voice response technology that allows listeners to hear a story and then make a choice on how their favorite characters should proceed.
- We attribute this high level of recall to the innovative application of the tried and true, evidence-based entertainment-education SBC approach of Albishirin Ku!

MONITORING AND EVALUATION: COMMUNITY COHESION STRENGTHENING: WDC

In FY20, WDCs:

- Raised $8,047 to implement activities including purchasing drugs and consumables for ANC, delivery kits, repairs, and facility renovations and items that enable practices of COVID-19 preventive measures: hand gloves, disinfectants, and sanitizers.
- Transported over 1,146 pregnant women for ANC and 1,127 pregnant women for facility delivery.
- Transported 132 children under five for emergency cases and 128 women for other illnesses.
- Line-list 6,693 newborns for immunization, tracked 1,418 defaulters thereby helping 4,224 newborns to receive their first dose of immunization.

Findings from BA-Nigeria Community Capacity Strengthening (CCS) CHARP Stage 1 Assessment, across the three states:

- 80% of wards had at least 35% female representation on the WDC.
- 83% of wards implemented a minimum of two CHARP activities.
- 67% of wards implemented transport for ANC and Delivery well.
- 47% of wards were able to source for funds and other resources to carryout projects and have an active bank account.

Lessons learned for expansion and Stage 2:

- Additional emphasis on women participation, most especially within the WDC. This has the potential to encourage women in the community to engage in health issues.
- Identify sustainable and innovative ways for resource mobilization to enable the WDCs to have a funding stream for their activities.
- Sustained implementation of WDC CHARPs during COVID-19 is a promising sign of sustainability.

MONITORING AND EVALUATION: WOMEN'S EMPOWERMENT GROUPS

- The Women's Empowerment Group (WEG) established during the MNCH+N human centered design pilot activities organically expanded from initial four groups to 29, with a total of 784 women enrolled in the WEGs.
- Sustained implementation of WEGs during COVID-19 is a promising sign of sustainability.
- The groups generated $1,545 from their weekly contributions and disbursed $482 to support 39 women to invest in various small-scale businesses.
- The WEG meetings are helping to increase discussions around priority behaviors as some of the women reported that they have discussed antenatal care, immunization, and other priority behaviors that they learned about in the group meetings within their households and communities.

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