An Assessment of Integration of Family Planning and Maternal, Newborn and Child Health in Kano, Nigeria

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ACCESS-FP, a five-year, USAID-sponsored global program, is an associate award under the ACCESS Program. ACCESS-FP focuses on meeting the family planning and reproductive health needs of women in the postpartum period. Interventions are designed to complement those of the ACCESS Program in the promotion and scale-up of postpartum family planning through community and clinical interventions. ACCESS-FP will reposition family planning through integration with maternal, newborn and child health programs, including the prevention of mother-to-child transmission of HIV. For more information about ACCESS-FP, please visit www.accesstohealth.org/about/assoc_fp.htm, or contact Catharine McKaig, ACCESS-FP Program Director, at cmckaig@jhpiego.net.

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# TABLE OF CONTENTS

**ABBREVIATIONS AND ACRONYMS** ........................................................................................................ iv

**ACKNOWLEDGMENTS** ......................................................................................................................... v

**EXECUTIVE SUMMARY** ...................................................................................................................... vii

**BACKGROUND AND RATIONALE** ..................................................................................................... 1
  - MNCH/FP Integration ............................................................................................................................ 1
  - ACCESS/Nigeria Program ..................................................................................................................... 2

**METHODOLOGY** .................................................................................................................................... 5
  - Assessment Objectives .......................................................................................................................... 5
  - Assessment Design, Sample and Instruments ...................................................................................... 5
  - Data Collection and Analysis ................................................................................................................ 7

**RESULTS** ............................................................................................................................................... 8
  - Policy/Management ............................................................................................................................... 8
  - Provider Level ....................................................................................................................................... 11
  - Community Level ............................................................................................................................... 14

**DISCUSSION** ......................................................................................................................................... 18
  - Comparison with Literature Findings .................................................................................................. 18
  - Barriers Identified That May Affect Use of Integrated Services ...................................................... 18
  - Identification of a Framework for Integration Programming ............................................................. 19
  - Prioritization of Elements .................................................................................................................... 19

**LIMITATIONS** ....................................................................................................................................... 20

**CONCLUSIONS** .................................................................................................................................... 21
### ABBREVIATIONS AND ACRONYMS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>Antenatal Care</td>
</tr>
<tr>
<td>CCG</td>
<td>Community Core Group</td>
</tr>
<tr>
<td>CHEW</td>
<td>Community Health Education Worker</td>
</tr>
<tr>
<td>CMT</td>
<td>Community Mobilization Team</td>
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<tr>
<td>CYP</td>
<td>Couple Years of Protection</td>
</tr>
<tr>
<td>EmONC</td>
<td>Emergency Obstetric and Newborn Care</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HTSP</td>
<td>Healthy Timing and Spacing of Pregnancy</td>
</tr>
<tr>
<td>IUCD</td>
<td>Intrauterine Contraceptive Device</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactational Amenorrhea Method</td>
</tr>
<tr>
<td>MNCH</td>
<td>Maternal, Newborn and Child Health</td>
</tr>
<tr>
<td>MNH</td>
<td>Maternal and Newborn Health</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>PAC</td>
<td>Postabortion Care</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission of HIV</td>
</tr>
<tr>
<td>PPFP</td>
<td>Postpartum Family Planning</td>
</tr>
<tr>
<td>SBM-R</td>
<td>Standards-Based Management and Recognition</td>
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</tbody>
</table>
ACKNOWLEDGMENTS

We would like to extend our gratitude to the ACCESS/Nigeria program staff and consultants who helped to conduct the assessment and/or contributed to the preparation of this report, including:

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Khadija Ibrahim, Consultant
Umma Wada, ACCESS Program Officer
Hadiza Yusuf, Consultant

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An Assessment of Integration of Family Planning and Maternal, Newborn and Child Health in Kano, Nigeria
EXECUTIVE SUMMARY

In an effort to more systematically understand mechanisms of effective maternal, newborn and child health and family planning (MNCH/FP) integration, ACCESS-FP carried out an assessment of an integrated program in Northern Nigeria. The ACCESS-FP Program supports basic maternal and newborn health care services including FP in three states, Kano, Katsina and Zamfara. Although FP services are made available to all women, a specific aspect of the program was to integrate messages and services tailored for the needs of women in their first year postpartum.

This assessment examined perceptions of policymakers, providers and community members with regard to integrated MNCH/FP services, as well as factors facilitating and negating the use of these services. The team conducted one-on-one interviews with six policymakers and eight service providers using semi-structured interview guides. The team held eight group discussions, which included a participatory methodology, with four women’s groups and four other community groups. Key findings included:

- From the point of view of providers and clients, all services were not considered equal. It was clear that perceptions of the value of different services varied. Generally, antenatal care (ANC) was the most valued by providers and community members, although for different reasons. Providers saw it as a gateway for other services, articulating the perception as the beginning of a cycle. Despite community-level education regarding risks, women continue to view ANC as a protective service that reduces risks associated with pregnancy, delivery and postpartum.

- In terms of priority MNCH services, labor and delivery was not ranked high in importance among services by either service providers or women’s groups. Only the household counselors ranked labor and delivery and ANC highly. FP was generally ranked lower or lowest by policymakers, providers and the women’s groups, with a few exceptions. Three of the eight providers rated it as the most important, citing the health and economic benefits of spacing.

- Providers and policymakers agreed with the approach of incorporating FP with routine MNCH. They attributed increases in client satisfaction and increases in service use (particularly of FP) to this systematic integration. In fact, the providers more frequently offered examples of the benefits that they see from integration. This is a finding of particular note in this conservative setting.

- Women did not appear to be daunted by the relatively complex service schedules. In every setting, they easily cited the schedules in some detail. They also noted the positive attitudes of the staff and cited barriers in terms of cost and transportation for services.

- Barriers for integrated services included the issue of staff time identified by policymakers and providers. The four women’s groups also said they preferred to have services on different days because otherwise the queues would be too long. Other barriers to services cited by respondents included cost, transportation, religion, education and clients’ husbands.
Although this study had limitations, it did demonstrate the utility of reviewing MNCH/FP integration. The tools used here will be further modified and adapted for application in other settings to improve our understanding of effective MNCH/FP integration. The findings from this assessment indicate that an approach that systematically increases MNCH/FP integration is feasible and can have a positive effect on service use, particularly FP, even in a very conservative environment.
BACKGROUND AND RATIONALE

MNCH/FP Integration
Postpartum Family Planning
The goal of the ACCESS-FP Program is to reduce unmet need for family planning (FP) among postpartum women. One of the anticipated results of the program is to maximize opportunities for incorporating FP into maternal, newborn and child health (MNCH) activities. In pursuit of this result, over the past three years, ACCESS-FP has provided technical and programmatic leadership in the area of postpartum family planning (PPFP), defined as the period through the first year postpartum, and its integration in maternal and newborn health (MNH) activities. As an associate award to the ACCESS Leader Program, ACCESS-FP has had the opportunity to work closely with MNH programs to integrate PPFP.

PPFP is a sub-set of FP, and is tailored to the needs of postpartum women, who are generally breastfeeding and often amenorrhic. Because of clients’ amenorrhea and assumed abstinence, they and providers have often misunderstood the risk of unintended pregnancy during the first postpartum year. Additionally, although the vast majority of women want to avoid another pregnancy during this time, they are not using a method of contraception to prevent it. PPFP includes specific information on fertility and contraception for the needs of those women, such as fertility return, the lactational amenorrhea method (LAM), promotion of exclusive breastfeeding, and the appropriate timing and use of contraceptive methods that are appropriate for women who are breastfeeding. In addition, PPFP information and services are designed to be delivered as part of MNCH services, including antenatal, postnatal and pre-discharge care for women delivering in facilities.

This assessment provides a unique opportunity to identify, analyze and synthesize learning from ACCESS MNH programs in which FP has been integrated.

Literature Review Findings
Literature reviews regarding MNCH and FP integration yield few lessons learned for programming. An initial literature review produced the following six key areas of documentation.

Rationale: Much of the literature has focused on making a case for integrated services\textsuperscript{1,2} with little documentation about effective strategies for implementation. The elements most generally described include the multiple missed opportunities for FP integration in MNCH services and the strong rationale for integration. Also, the rationale has to do with the similarities of the priority populations for both FP and MNCH services and the commonalities of service provision, including the clients and providers.
An Assessment of Integration of Family Planning and Maternal, Newborn and Child Health in Kano, Nigeria

Women’s perceptions of integrated services: This is one of the clearest areas of the study findings. Studies from a variety of settings indicate that women overwhelmingly want FP information and services included in key MNH services.3,4,5

Additionally, there is some evidence that integration of FP with maternal and child care services may facilitate use for women who want to use services clandestinely.6,7 While this observation is supported by anecdotal reports, the literature is limited.

Client satisfaction: Several studies have documented client satisfaction when FP is integrated in maternal health services.8

Provider time: Also commonly cited as a barrier to integration,9 there is little evidence in the literature that the lack of sufficient provider time plays a major role.10,11 On the other hand, a study in Zanzibar also found that approximately 20% of provider time is spent waiting for patients, suggesting possibilities to take on additional tasks.12

Service quality: As reflected in service provider scores on pre/post tests, there is some indication that integrated trainings, covering a variety of topics, are less effective than more focused training, covering only one technical area for conveying knowledge.5 However, there is little research on the effect of integrated training on service quality.

Negative effect: A hypothesized negative effect on services is one of the most common reasons cited for not integrating services. Of particular concern has been the integration of “controversial” interventions such as FP or HIV/AIDS with more established programs.13

ACCESS/Nigeria Program

In February 2009, in order to capture programmatic lessons learned for MNCH/FP integration, ACCESS-FP conducted an assessment to identify, analyze and synthesize learning from selected ACCESS MNH programs that have integrated FP with support from ACCESS-FP. The team carried out its first activity in Nigeria, specifically looking at activities supported by the ACCESS/Nigeria program in Kano State. This assessment is the first in a series of three anticipated assessments.

The 2007 ACCESS/Nigeria baseline data collection and analysis used in program development demonstrated very low levels of MNH service use, including FP. This baseline assessment of 396 married women 15–44 who had given birth in the past year included the following key findings.14

1. Overall, 42% of the women used antenatal care (ANC) at least once. Sixty percent said they received information on birth spacing or FP during ANC visits.

2. Twenty-two percent of the women received postpartum/postnatal care, but it varied greatly by site. Of the 22% who received postpartum/postnatal care, 40% received information about LAM, 55% received information about birth spacing and 58% said they received information...
about FP. The women most frequently discussed injectables, pills, intrauterine contraceptive devices (IUCDs) and condoms.

3. FP knowledge was low for methods other than the pill or injectables.

4. PPFP use was very low. Only five women reported choosing an FP method at the time of the survey (within one year postpartum). Two chose injectables, two were using LAM and one chose periodic abstinence.

5. Of note was the importance of others’ opinions of FP use. While women consistently cited the opinions of spouses (67%) and health workers (56%) as important, those of religious leaders (14%) seemed to be considered less important.

MNCH/FP Integration

The ACCESS/Nigeria program has the objective of increasing the use of emergency obstetric and newborn care (EmONC) services, including FP as part of the household-to-hospital continuum of care approach, for pregnant women, mothers and newborns of selected local government areas in three states, Kano, Katsina and Zamfara. The program was initiated in 2006 in Kano and Zamfara; activities in Katsina State were added in 2008.

Given that FP was considered a highly controversial activity in the Northern Nigeria region, where the program was being implemented, the program initially focused on EmONC with the intention of later addressing healthy timing and spacing of pregnancy (HTSP) and FP. FP was relabeled birth spacing.

During the first six months of program operations (January through June of 2007), the facility-level trainings carried out were related to EmONC. The first round of PPFP/FP technical update training for providers was held in July 2007. It is worthwhile to note that this technical training emphasized the integration of FP in antenatal, immediate postpartum and postnatal care. This training was then followed by clinical training in Jadelle (contraceptive implants) and intrauterine contraceptive device (IUCD) in February 2008.

The ACCESS/Nigeria program has two major areas of activities, facility-level and community-level. At the facility level, key activities have included training providers in EmONC, PPFP/FP update, implant and IUCD counseling, insertion and removal, kangaroo mother care and Standards-Based Management and Recognition (SBM-R). All trainings have been followed up by supportive supervision activities.

At the community level, the program has formed Community Core Groups (CCGs) and Community Mobilization Teams (CMTs) representing the communities in the catchment areas of the facilities. In 2007, female community household counselors were identified and trained to provide basic MNH messages at the household level for pregnant women through the first week after birth. These counselors included both community volunteers and community health education workers (CHEWs). In addition to the orientation provided by ACCESS, CHEWs have received a one-year training in health promotion as part of their CHEW training.
The community-level activities were initiated in January 2007 and while an introduction to healthy timing and spacing, return to fertility, LAM and the transition from LAM to other methods was included, it was not until March 2008 when specific PPFP messages were developed for ACCESS household counselors. However, the support materials for these messages have yet to be finalized so this aspect of the program is not yet fully operational related to PPFP.

ACCESS Annual Reports\textsuperscript{15} include more programmatic details about the program. It is noteworthy that all of the facilities visited during this assessment had experienced increases in service use, including FP. Table 1 summarizes program monitoring data for FP for the facilities visited and compares 2007 to 2008 data, and indicates significant increases in number of FP clients and method use per site.

\textbf{Table 1: Number of FP Clients and Couple Years of Protection (CYP) by Health Facility Visited}\textsuperscript{1}

<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Number of New and Old Clients</td>
<td>CYP\textsuperscript{†}</td>
</tr>
<tr>
<td>Babawa Primary Health Center</td>
<td>27</td>
<td>N/A</td>
</tr>
<tr>
<td>Dawakin Tofa General Hospital</td>
<td>22</td>
<td>N/A</td>
</tr>
<tr>
<td>Dawanau Primary Health Center</td>
<td>0</td>
<td>N/A</td>
</tr>
<tr>
<td>Gezawa General Hospital</td>
<td>55</td>
<td>N/A</td>
</tr>
<tr>
<td>Kiru Comprehensive Health Center</td>
<td>Not available</td>
<td>N/A</td>
</tr>
<tr>
<td>Murtala Muhammed Specialist Hospital</td>
<td>1,945</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>2,049</td>
<td>N/A</td>
</tr>
</tbody>
</table>

\textsuperscript{1} Data source: ACCESS Monitoring and Evaluation Tracking System.

\textsuperscript{†} CYP was not collected until the program’s inception.
METHODOLOGY

Assessment Objectives

1. To evaluate/verify findings from the literature and how they apply to MNCH/FP integration in the ongoing programs in the three countries (Afghanistan, Nigeria and Bangladesh).

2. To identify the elements of a framework for operationalizing MNCH/FP integration, guided by lessons learned.

3. To prioritize framework elements for effective programs.

Assessment Design, Sample and Instruments

The assessment employed two types of data collection methods, semi-structured interview and participatory research activities, for three types of audiences: policy influentials, health care providers and community members.

The team selected Kano for the study because of the amount of time PPFP had been implemented there and the presence of the ACCESS Program. Policy influentials and health care providers who were involved with MNCH/FP integration activities at the time of the assessment were encouraged to contribute to the interviews based on their availability. Community members include women who recently gave birth, household counselors, CMTs, CCGs and male motivators in selected ACCESS intervention areas—all of whom were invited to participate in the participatory exercises. Table 2 lists the sites visited during the assessment.
Table 2: Facilities and Communities Visited during the Assessment

<table>
<thead>
<tr>
<th>Facilities Visited</th>
<th>Communities Visited</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kano State MOH</td>
<td>Gezawa</td>
</tr>
<tr>
<td>Gezawa General Hospital</td>
<td>Babawwa</td>
</tr>
<tr>
<td>Babawa Primary Health Center</td>
<td>Dawanau</td>
</tr>
<tr>
<td>Dawakin Tofa General Hospital</td>
<td>Fagge</td>
</tr>
<tr>
<td>Dawanau Primary Health Center</td>
<td></td>
</tr>
<tr>
<td>Kiru Comprehensive Health Center</td>
<td></td>
</tr>
<tr>
<td>Murtala Muhammed Specialist Hospital</td>
<td></td>
</tr>
</tbody>
</table>

Instruments

The team developed three instruments for the assessment. A summary of each instrument is included in Table 3. ACCESS Program staff pretested all instruments and modified them accordingly prior to use. The instruments are presented in Appendices A–E.

Table 3: Summary of Instruments Used in the Assessment

<table>
<thead>
<tr>
<th>Instrument</th>
<th>Method</th>
<th>Intended Audience</th>
<th>Purposes</th>
</tr>
</thead>
</table>
| Policy interview guide | One-on-one interview | State MOH representatives, district hospital managers or other policy influentials | ■ Identify policy influentials’ familiarity with MNCH/FP integrated services.  
■ Identify policy influentials’ perceptions and factors supporting and opposing MNCH/FP integration. |
| Provider interview guide   | One-on-one interview | Nurse providers, clinical supervisors, hospital managers | ■ Identify providers’ perceptions of MNCH/FP integration in terms of importance and use.  
■ Identify providers’ familiarity with training and guidelines that include MNCH/FP integration.  
■ Identify providers’ perceptions of factors supporting and opposing MNCH/FP integration.  
■ Identify providers’ perceptions of community/family acceptance of MNCH/FP integration. |
| Community PRA guide | Group discussion | Women and relevant community members                | ■ Identify women’s current and past experience with service integration.  
■ Identify women’s expressed value of service integration.  
■ Identify barriers to integration and the role of referrals. |
Data Collection and Analysis

At the policy and facility levels, the assessment team conducted all interviews in person in English, one-on-one, and ACCESS-FP staff transcribed responses. In cases when there was a time constraint, the team used a condensed version of the interview guide. Interviewers used cards as part of the ranking exercise.

At the community level, the assessment team conducted participatory exercises with groups of 6–18 participants in Hausa. Responses were transcribed in both Hausa and English and the Hausa responses were later translated into English. The data collection team (two ACCESS-FP staff and three consultants who were fluent in Hausa and English) then reviewed and discussed the transcriptions. Cards and candies were used as part of the ranking exercise. For women’s groups, a female facilitator conducted all exercises, and no male participants were present.

ACCESS-FP staff entered all transcriptions in MS Word format and reviewed them. They examined simple groupings of recurring themes and documented frequencies of selected topics.

‡ Community groups were asked to rank various services according to importance. Each member was given three pieces of candy and was instructed to place them on the services that were most important to them. The service with the most candy was given a priority ranking of 1 (most important) and so on. Results of the rankings were then discussed and agreed upon by all members.
RESULTS

The assessment team conducted 14 interviews\(^6\) of state-level representatives from the Ministry of Health (MOH), facility managers and health providers. The team also conducted eight participatory research activities, including four groups of women, three groups of household counselors and one group of CMT/CCG members. The results from the interviews and the participatory exercises are presented here. They are grouped in three major categories—policy/management, provider and community.

**Policy/Management**

The assessment team carried out six policy-level interviews, using the somewhat shorter questionnaire. It should be noted that this group included hospital administrative secretaries as well as state-level MOH positions, representing a wide range of technical and administrative skills. Nonetheless, several themes emerged from this group. In an effort to better convey the opinions of the interviewees, quotes are provided whenever possible.

**Priority Service Rankings**

Interviewers asked respondents to rank the key services provided at facilities according to the importance (1 as the most important and 5 as the least important) for the populations they served. Table 4 summarizes the rankings, providing both the mode and the mean from four respondents. It should be noted that two respondents did not respond to this question. One refused to answer (“all are priorities, I can’t say that one is more important than another.” [P10]) and one was so new to her position that she did not feel qualified to rank. However, it should also be noted that the ranking exercises were primarily a means to stimulate discussion.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Individual Response</th>
<th>Mode</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>1 1 4 3</td>
<td>1</td>
<td>2.25</td>
</tr>
<tr>
<td>Immunization</td>
<td>2 5 2 2</td>
<td>2</td>
<td>2.75</td>
</tr>
<tr>
<td>Family Planning</td>
<td>5 4 3 4</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>3 3 5 1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>- 2 1 1</td>
<td>1</td>
<td>1.3</td>
</tr>
<tr>
<td>Postabortion Care</td>
<td>4 3 5 -</td>
<td>4</td>
<td>4.3</td>
</tr>
</tbody>
</table>

\(^6\) Some interviews were condensed (with key questions) due to interviewees’ availability.
Respondents ranked newborn care and ANC as the most important services for their populations, and noted ANC as a gateway to other services. “If a woman is happy with ANC services, she will come back for the other services in the future. For example, most people coming for immunization and spacing of children came from ANC.” (P3)

None of the respondents in this group rated FP as the most important. In fact, the group frequently ranked it the lowest along with postabortion care (PAC). Respondents tended to report the reason for the lower ranking as lack of demand. As one respondent replied, “FP is the lowest because the issue of having more children is still in the culture. Only a few are aware of child spacing. There is competition among women in the household but more are accepting the idea of spacing—then we can talk about limiting.” (P9)

This group of respondents was also careful to note that service use has increased and frequently attributed the increase to the ACCESS/Nigeria activities. “Before ACCESS, there weren’t the same services—no newborn care, immunization and women were delivering at home.” (P7)

In addition, there was a request for expansion. One respondent said, “ACCESS is doing a lot in the seven focal facilities, and a great job in facility renovation and quality ANC,” but she appealed for the program to reach other parts of Kano. She also noted that her vision is “to leave this MNCH/FP integration as a legacy in Kano.” (P10)

Barriers to Service Use

Interviewers asked respondents what they saw as major barriers to service use. This group was more likely to say religion was a barrier rather than providers or community members. They also cited education and understanding as barriers to service use.

“People need to understand more about the services. If the media can be involved, as well as "pastors" from mosques, opinion leaders, people who are implementing the services and women who have the convincing power.” (P3)

“Islam criticizes FP, and we can only talk about spacing. Spacing is a good bridge to introduce FP.... The other big issue is the level of education. People who are illiterate, these people only come to the facility when there are complications during delivery.” (P9)

The group also cited manpower and staffing issues as constraints. “There are also issues like shortage of staff, provider capacity and attrition. The recent massive transfer of staff affects delivery of services, especially in the primary health care services.” (P9)

Two respondents also noted husbands as barriers. “Some husbands don’t want to cooperate. They don’t want their wives to come for FP.” (P7)

** Interviews were conducted in English. Pastor in this case refers to an Iman.
Observations on Integration

Interviewers asked respondents to rate the MNCH/FP integration in their services on a five point scale, with 1 being the lowest and 5 the highest. The majority gave their services a “3,” most citing that it was a work in progress. “The MOH is trying to integrate FP as the services should not be stand alone. It is in the process.” (P9)

“More education for the clients will make it a 5. Before ACCESS, there weren’t these services, no newborn care, immunization and women were delivering at home.” (P7)

When asked about the effect that providing FP services could have on other services, one respondent said, “I doubt that FP will discourage people coming for MNCH visits since it is not compulsory.” (P9) Another noted, “FP must be integrated with MNCH, otherwise it will not be accepted.” (P10)

When asked about possible problems resulting from integration, one respondent noted competition between vertical programs for clients and the demonstration of the use of services. “There are conflicts between programs, especially the one supported by donors. For example, X program works in PMTCT and FP—the referrals should be two-way, but the providers at the FP unit may not refer because of the misconception, thinking providers at PMTCT receive more benefits.” (P9)

Effect of FP Use on Maternal and Child Health

Respondents were generally aware of the relationship between FP and maternal health.

Three of the six said that they saw FP as a way to prevent maternal mortality and abortion. “FP is linked with maternal mortality, as more infants are delivered, there are more risks.” (P3)

However, linkages with child health and nutrition were less well known.

Willingness to Advocate for MNCH/FP

FP advocacy was minimal at the community level. Providers are aware of the need for advocacy for MNCH/FP integration at the community level and believe this gap exists due to a lack of knowledge and education. “Advocacy is a dicey issue. To openly advocate FP, one has to be very careful. Some approaches can be used, maternal health is one. Something like accessing family planning and child planning will work.” (P9)

Policy

Two respondents spoke about a policy document for integration of maternal and child health for Kano. It is notable that these respondents were both from the state level. The other respondents, however, did not seem to be aware of the existence of this policy document.

“On the ground we want to develop a policy, then, put it into law for Kano for integrated maternal and child services to include immunization and family planning. Kano is planning on
presenting this to the National Council of Health in March—this will make Kano the first state with integrated services and give us more support from the national level.” (P9)

“For me, the greatest success is the draft integrated maternal and child health strategy.” (P10)
The respondent said that if they are able to scale it up through the strategy, it will be a success. They are trying to put it on the national agenda.

“Providers are now thinking of other services that can be provided. They no longer only think of only their services, but all the services that can be provided to a patient. It really broadens the vision of the provider.” (P9)

Provider Level
The team interviewed eight providers for the assessment. All of them were involved in providing ANC and FP services, including three who were in charge of all maternity services. The majority (six) were midwives, but respondents also included two nurses, one senior community health worker and one physician.

Priority Rankings
Interviewers asked service providers to rank key services in order of importance for the population in the surrounding area. Table 5 provides a summary of their rankings. In several cases, providers ranked two services at the same level and in others they did not identify either newborn care or PAC as services that were provided at the facility.

Table 5: Provider Service Priority Rankings (n=8)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Individual Response</th>
<th>Mode</th>
<th>Mean</th>
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<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antenatal Care</td>
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<td>1.8</td>
</tr>
<tr>
<td>Immunization</td>
<td>3 5 4 4 2 3 3 5</td>
<td>3</td>
<td>3.6</td>
</tr>
<tr>
<td>Family Planning</td>
<td>4 4 1 1 5 4 4 1</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>2 2 3 2 2 2 3 3</td>
<td>2 and 3</td>
<td>2.3</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>- - - 3 4 - - 4</td>
<td>4</td>
<td>3.6</td>
</tr>
<tr>
<td>Postabortion Care</td>
<td>2 3 - 5 6 - 4 -</td>
<td>none</td>
<td>4</td>
</tr>
</tbody>
</table>
Similar to the policy/management level respondents, the majority of the providers described ANC in the context of a gateway for other services, citing that as the reason they ranked it highly. “If they get ANC, they will get all the others. It is an opportunity to educate them on labor signs and encourage them to come to the hospital.” (P13) Another provider said, “Everything begins here. Women come for ANC, they will come for the other services.” (P1) Similarly, a third provider said, “It (ANC) is the beginning of pregnancy and childbearing. It is important because women receive counseling for other services; if they use ANC they are more likely to use other services.” (P2)

However, three of the eight providers interviewed listed FP as the most important. They cited health of the mother and children and economic benefits as reasons for this ranking.

“In my area, most women survive labor and delivery if they practice FP. With FP, maternal mortality goes down and children have better well being. “ (P4)

“FP is the most important as it entails everything—if the family is planned, deliveries benefit.” (P5)

“If a woman does FP, then she’ll have good health and take care of her children. She won’t need postabortion care…. She’ll have planned family with food, budget, prevent anemia, be physically strong—then she can decide how many children can be useful.” (P14)

Service Use Rankings
Interviewers asked four of the providers to rank services according to the levels of use by the population, while the team did not ask the other four providers this question because of time constraints.

Predictably, respondents ranked ANC as the most used service, a finding that is verified by program monitoring data. “ANC is the most popular by far, more women use it.” (P2) “For ANC, there are more women attending. It has increased with ACCESS support.” and “The number of facility deliveries is increased.” (P8)

Almost all the providers said that service use has increased (7/8). As in the citation above, many cited ANC, but several also cited FP services as having increased. “FP is more popular now as there are more clients than before.” (P4) “If the community didn’t accept FP, there would be fewer clients. There are more clients now.” (P1)

Barriers to Service Use
When discussing barriers to service use, half of the providers noted that husbands either were a barrier or had been one in the past. “Before if you suggested that woman take pills, husbands would tell you no. Now they escort their wives to FP and sign giving their permission.” (P14) In comparison to the policy/management respondents, providers were more likely to point out that the situation is changing for FP. “FP is more popular now as there are more clients now than before.” (P4) “Women are coming now for FP because of more counseling.” (P1)
The issue of having husbands’ permission for FP services was frequently mentioned by providers, despite its being expressly mentioned in the training that such permission is not necessary, according to MOH policy. It is clear that the idea of a husband’s permission continues to influence providers, particularly those who had not received FP training from the ACCESS program.

Initially, the team asked providers a question about the clandestine use of FP, asking them to estimate the percentage of use. While providers who had training did provide estimates, those who had not had training seemed confused by the question. “All clients come with permission from their husbands, we require a written note.” (P5) However, when asked if they could show the team examples of such notes, the providers were unable to do so. One provider, who had received ACCESS training, noted that even if women do not have their husbands’ permission, she would give them a method. Another noted that the number of women using FP without telling their husbands is increasing as women learn about their rights and status.

Only two providers referred to mothers-in-law as barriers in the general context of services.

Providers mentioned the theme of limited staff several times. “For FP, we really need additional staff.” (P8) Another provider noted that “clients are coming and sometimes we are very busy, so we work long hours.” (P2) On a positive note, one provider commented that she felt great about her job now. She likes to be busy and is being appreciated by her clients. The reason she cannot say it is perfect is because of the lack of staff.

Observations about MNCH/FP Integration

The six providers who provided ratings all rated integration positively (3–5), with the majority of ratings between 3 and 4. One provider noted that he felt ANC/FP were perfectly integrated and ranked it a 5, but gave PAC/FP a 3, labor and delivery/FP a 3 and FP/immunization a 2.

Four of the eight providers noted that women liked the integration of MNCH/FP.

“During ANC women may have some idea of FP in mind, but they won’t come out to ask. They are very shy. But they like it when you give them the info—they will even persuade their friends to come. They like to come to ANC more, to hear it.” (P13)

“It makes happier women. Women like to get child immunization and FP together.” (P4)
In their remarks, the providers reported no disadvantage to integration. “Difficulties from integration? There is no difficulty, it helps us a lot.” (P13) In fact, the providers more frequently offered examples of the benefits that they see from integration.

“There are benefits to including FP in MNH. Post-delivery women can start planning [to use FP], they can get pregnant again very soon. The integration is a new thing, we didn’t do it before.” (P13)

“In our setting here, most of the time they don’t come for FP. So only when we catch them in ANC or labor and delivery, we can use the opportunity to talk with them. Also, after delivery they come with their husband. For a woman to come alone without her husband is difficult.” PPFP is “the opportunity to talk to both of them together, as compared to regular FP.” (P8)

“When they are joined, there is an increase in FP; we have more clients. If it is FP alone they won’t come, but in ANC or MCH, it is very effective with other services.” (P5)

FP Benefits MNCH

The providers interviewed seemed to have a good understanding of the benefits of FP for MNCH. “If women accept it, and take two years before the next pregnancy, she will be helped. It will reduce maternal and newborn deaths.” (P8)

“Putting together services works.... When a woman is in labor and delivery, she knows the risk so it is a chance for newborn care to educate them during care. A baby takes time and needs things. After three or four months, she doesn’t want another pregnancy, doesn’t want the risk and won’t be able to take care of the child if she is pregnant.” (P5)

ACCESS Program Effect

Given that there had been a significant rotation in personnel among the facilities, only four of the eight providers interviewed had attended ACCESS-supported training. Those who had attended were all positive about the trainings.

Several of the providers also made comments about the supportive visits they had from the ACCESS staff. ACCESS job aids and posters were also present in all the facilities visited.

Community Level††

At the community level, the assessment team referred to “family planning” as “birth spacing” during the participatory exercises to avoid a potentially negative impression of FP.

†† Responses in this section reflected the group, except for individual quotes.
Utilization/Familiarity with Services

In the discussion about utilization and familiarity of services for pregnant women and breastfeeding mothers, almost all participants in the eight groups strongly expressed that they themselves or their family members were utilizing the relevant services, and they were able to indicate the nearby primary health center. In addition, participants in all four women’s groups were able to describe the schedule for relevant services at a very detailed level, for example: immunization on Thursdays, birth spacing for continuing users on Fridays, and ANC bookings on Mondays, women with one to two children on Tuesdays, three to four on Wednesdays, five children and above on Thursdays.

Importance of Services

Interviewers asked the women, household counselors and CMT/CCG groups to rank the services in order of importance. The interviewer asked each individual to place three votes for the service(s) that she or he judged to be the most important.

Household counselors and CMT/CCG members often ranked ANC and labor and delivery as most important. Household counselors see ANC as the “stepping stone to a healthy child” and this is the opportunity for women and babies to be examined. The CMT/CCG group mentioned a similar “gateway” concept. In terms of labor and delivery, household counselors and CMT/CCG members acknowledged the potential dangers and risks of complication during delivery and three out of four household counselors and CMT/CCG groups recognized the improvement of labor and delivery services at the facilities in the past two years.

While the rankings of birth spacing are not the highest, three out of four household counselors and CMT/CCG groups mentioned that child spacing resulted in a healthier mother and child. In addition, one of the household counselors’ groups said it (birth spacing) can reduce financial burden. Another household counselors’ group described the myth in the community that birth spacing would stop women from having babies in the future. They thought that this myth contributed to the low turnout for using birth spacing services. However, respondents did not mention that these views would affect MNCH/FP integration. Table 7 summarizes results of group rankings, providing both the mode and the mean from three household counselors’ and one CCG group.

Table 7: Household Counselors and CCG: Ranking (4 Group Discussions)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Group Response</th>
<th>Mode</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gezawa</td>
<td>Babawa</td>
<td>Dawanau</td>
</tr>
<tr>
<td>Antenatal Care</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Immunization</td>
<td>2</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Birth Spacing</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>3</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>
Three of the four women’s groups rated ANC as the most important by large margins. The most frequently mentioned reasons were: they had learned about nutrition, signs of complications, HIV testing, etc. during counseling sessions (3/4), and it is during ANC visits that problems are easily detected and will result in safe delivery (2/4). On the contrary, none of the women’s groups saw labor and delivery as the most important, given that they hardly experience complications; hence, they often deliver at home (3/4). Table 8 summarizes results of the group rankings, providing both the mode and the mean from four women’s groups.

One women’s group rated birth spacing as the most important. This particular group in Fagge was in an urban setting and seemed to be more exposed to the concept compared with the other three women’s groups. The main reason women cited for giving this ranking was that birth spacing improves women’s health. During our discussions with the women’s groups, we noted that they also cited some of the program messages, such as spacing, which allows one child to grow to be able to assist with care for the next one.

Table 8: Women’s Groups: Ranking (n=4 Group Discussions)

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Gezawa</th>
<th>Babawa</th>
<th>Dawanau</th>
<th>Fagge</th>
<th>Mode</th>
<th>Mean</th>
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</thead>
<tbody>
<tr>
<td>Antenatal Care</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1.2</td>
</tr>
<tr>
<td>Immunization</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2 and 3</td>
<td>2.5</td>
</tr>
<tr>
<td>Birth Spacing</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>None</td>
<td>3</td>
</tr>
<tr>
<td>Labor and Delivery</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>Postnatal Care</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>2 and 3</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Perceptions about Integration

When asked if they liked to have services provided together, the majority of respondents in three out of four women’s groups actually preferred to have the services provided separately because they did not want to experience the long queues (2/3). Of note, all four women’s group were relatively close to nearby facilities, and it was after further probing that the women agreed that having services together would benefit those who lived far from the health facilities. Similar responses were also found in the four household counselors’ and CMT/CCG groups. The only women’s group that preferred having services provided at the same time indicated the problem of their husbands not allowing them to go on constant outings.
Perceptions about Family Planning

Overall, women were very interested in FP methods and some (in Fagge) shared their positive experience in using FP. “After my second delivery, I started using birth spacing, I feel I am happier and healthier.”

Several of the questions for the women’s groups seemed conceptually difficult for them to answer. For example, they were asked: in terms of priorities, which is more important, the health of the woman or the health of the baby? Three of the four groups answered both, often illustrating the point by saying that husbands will sell belongings if necessary to pay for health care. However, with probing, the Fagge group offered more specific answers. “For the babies we will do anything possible. We are afraid to lose the babies.” “For our husbands and for our mothers-in-law, the babies are more important.”
DISCUSSION

This section is organized according to these three assessment objectives: 1) application of findings from the literature, 2) identification of an integration framework for programming, and 3) prioritization of the framework elements for effective programming.

Comparison with Literature Findings
While many of the points found in the literature were useful places to start, several do not seem to be as relevant to the Nigerian context.

There is the often repeated fear that FP can have a negative effect on MNCH services. However, in our examination of this issue, we found little basis for this observation. Both providers and women said that providing FP did not affect use of other services.

In contrast, the issue of provider time, in terms of workload, was often repeated as a concern and a limitation for services, both by providers and women.

Clearly client satisfaction was acknowledged by the providers, as they often heard that women liked the integrated services. Although providers acknowledged that their workload had increased with the number of clients, they also noted satisfaction with integrating the services.

For women, barriers to service use were more mundane and featured costs related to the services (although, in theory, services are free in Northern Nigeria) and transportation.

Women cited that queues would be too long and providers would not take the necessary time because they would be too rushed if services were integrated. In contrast, providers cited women’s understanding and education.

Barriers Identified That May Affect Use of Integrated Services
Both providers and policymakers described community attitudes and perceptions as having an important effect on service use and emphasized the need for educating communities about MNCH/FP services.

Of particular note is the general concern among providers about husbands’ attitudes, not only about FP services but also about labor and delivery.

Policymakers cited community attitudes and religion as constraints—more so than women, community members or even providers did.
Identification of a Framework for Integration Programming

Based on our understanding of the ACCESS/Nigeria program, and the aspects that were identified as valuable by the participants, the following elements appear key to effective integration.

1. Integrated provider training that facilitates service integration. Providers acknowledged a difference in services because of the ACCESS/Nigeria support. It should be noted that training and supervision particularly emphasize service integration, including FP in ANC, FP pre-discharge for women delivering in facilities and FP in postnatal care.

2. Community linkages and contextual considerations. Of particular note is the general concern among providers about husbands’ attitudes, not only about FP services but also about labor and delivery. It is clear that the context posed particular challenges in terms of services and community outreach, and was cited by the majority of respondents as an important strategy for increasing service use.

3. Support materials. Providers often drew the team’s attention to either job aids or posters provided by ACCESS. They clearly believed that these tools facilitated their work in integrating services and supporting client demand for services.

4. Integrating FP messages within MNCH services. Generally, providers noted the effect of integrating FP information with ANC on increasing the use of FP. They noted that integration provided particular opportunities for FP services, such as ANC to prepare women for FP use after delivery, and pre-discharge FP counseling as an opportunity to also counsel husbands.

Prioritization of Elements

Given that this was the first of three case studies, we cannot yet prioritize elements. When the assessment team has completed all three case studies, the findings will be compared.
LIMITATIONS

We would like to acknowledge several important limitations with regard to this assessment that may limit the applicability of the findings to other settings.

First, the sample was not intended to be representative and the selection of the sites was primarily based on feasibility of access due to the assessment team’s time limitations. While staff members in key positions were selected at the facility level, at the community level the women participants were self-selected, so they may not be representative of community attitudes as a whole. In addition, given that there was a recent rotation of staff at the facilities, some of the interviewees were relatively new in their posts.

Second, interviewer bias is also a possible factor. While the assessment team tried to minimize bias by using the questionnaire, English comprehension varied, so the team often had to restate questions and probing was fairly frequent. These adaptations may have been leading.

Third, at the facility level with providers, the team faced significant time limitations. As most of the interviews took place during the morning when services were also being provided, an effort was made to streamline interviews, and in two cases, the interviews were shortened due to time constraints.

Fourth, there were significant limitations with regard to the translation of the survey instrument, particularly at the community level. While an effort was made to make questions as concrete as possible, we did experience problems with several of the questions in the women’s group guide. These were questions that dealt with abstract concepts such as relative importance of actions.

Finally, while it is difficult to estimate, contextual factors, such as the conservative Islamic environment and the strict interpretation of the Quran, may have played a significant role in the information collected during this assessment, particularly in responses from the women.
CONCLUSIONS

There are several important lessons learned from this assessment. These include the perceived value of services, the perceived effects of incorporating FP into routine MNCH services, the complexity of the service array and the community linkages.

From the point of view of providers and clients, all services are not equal. It is clear that there are differences in the perceptions of the value of each type of service. Generally, providers and community members valued ANC the most, although for different reasons. Providers see it as a gateway for other services, articulating the perception of a cycle. Despite community-level education regarding risks, women continue to view ANC as a protective service that reduces risks associated with pregnancy, delivery and postpartum.

It was notable that service providers and the women’s groups did not rank labor and delivery highly. Only the household counselors ranked labor and delivery highly.

Providers and policymakers agreed with the approach of incorporating FP into routine MNCH. Increases in client satisfaction and increases in service use (particularly FP) were attributed to this systematic integration. This finding is of particular note in this conservative setting. The increased use of services apparently occurred without targeted interventions to create a supportive environment among religious leaders, who represent the barrier more often perceived by policymakers.

Women did not appear to be daunted by the relatively complex service schedules. In every setting, they easily cited the schedules in some detail. They also noted the positive attitudes of the staff and cited barriers in terms of cost and transportation for services.

Providers and community members cited inadequate staff time as the most persistent barrier.

While this study had limitations, it did demonstrate the utility of reviewing MNCH/FP integration. The tools used here will be further modified and adapted for application in other settings to improve our understanding of effective MNCH/FP integration.
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