

# Using Traditional Birth Attendants to Increase Access to Family Planning Services in Select Communities in Northern Nigeria

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## Summary

Pathfinder International, with funding from the Packard Foundation, has implemented a three-year project in seven states of northern Nigeria aimed at increasing access to family planning services in underserved communities. Focus group discussions, in-depth interviews and records of service data were used to assess information prior to and after the project. Family planning service uptake through Traditional Birth Attendants (TBAs) increased and a majority of the TBA clients were satisfied with the services. The TBAs have been empowered and referral linkages between outreach workers, TBAs and community health facilities have been strengthened. The community-focused strategy has increased access to family planning services in the intervention communities and is likely to achieve better results if a more holistic approach is employed in implementation.

## Introduction

Pathfinder International, an international nonprofit organization with programs in more than 25 countries including Nigeria, works to provide access to quality Reproductive Health (RH) and Family Planning (FP) information and services to women, men, and adolescents throughout the developing world. Since 2000, The David and Lucile Packard Foundation has supported Pathfinder to increase access to and availability of RH/FP in Northern Nigeria through a network of private sector service providers in six target states of Kano, Kaduna, Katsina, Sokoto, Niger, Borno and the Federal Capital Territory. The project manages a network of 27 organizations operating in more than 138 sites and 5,200 community-based distributors including Traditional Birth Attendants (TBAs).

## Background

Northern Nigeria is a traditional society with a predominantly Muslim population. Religious and cultural resistance to FP is associated with a rapid population growth. The total fertility rate is about 7 children per woman (6.7 in the North West region and 7 in the North East) and the Contraceptive Prevalence Rate (CPR) is 2% (NDHS, 2003). Poor health systems in the public sector fuelled by governmental neglect aggravate the situation. The private sector meets 60% of the health care needs of the population. However, despite its great potential; most RH and FP service delivery systems do not include the private sector. The private sector includes not only the private facilities but patent medicine vendors and other community-level distributors such as traditional birth attendants. Recognizing the private sector's potential to provide RH/FP services, Pathfinder/Nigeria launched a targeted intervention in several sites to improve private capacity for delivering FP services.

<sup>1</sup> The manual on RH with Islamic Perspectives was developed by Pathfinder in collaboration with a group of Islamic scholars

<sup>2</sup> Birth Kits constitute a razor, scissors, bandages, gloves, cotton wool, anti-septic liquid and other essentials for taking deliveries.

## Description

A rapid needs assessment identified key barriers to FP uptake and community resources that could improve service utilization prior to the intervention. Evaluation data were collected through direct observations, participatory focus group discussions and in-depth interviews with selected community members. Major barriers identified were perceived religious and cultural prohibitions to the use of FP, inaccessibility of services and when available, lack of skilled personnel at facilities. Religious values and cultural norms also prevent females of reproductive age being examined by male providers. Notably, TBAs were held in high esteem in all the communities as the primary providers of antenatal and postnatal care. TBAs usually operate using unhygienic instruments, are usually illiterate, and often oversee complicated births. As part of a wider, multifaceted intervention including intense and continuous advocacy efforts to major community stakeholders, select TBAs were identified and using a manual on reproductive health with Islamic perspectives<sup>1</sup> as a guide, were trained on infection prevention, FP counseling and provision of non-prescriptive methods, the concept of healthy timing and spacing of pregnancies, and in identifying prolonged or obstructed labor. They were also linked to clinics that served as referral centers and were provided with birth kits<sup>2</sup> and a seed stock of non-prescriptive contraceptives. The TBAs also underwent training on record keeping.

After three years of project implementation, a community survey was conducted in all project communities using focus groups and in-depth interviews to assess the role of TBAs in improving service uptake. Some key successes were recorded as service uptake increased steadily over the three years of project activities, as shown in the TBAs records. The community surveys also revealed that the majority of the TBAs' clients were satisfied with the services they were provided. "They establish interpersonal relations with us, and we are happy with their services," said a woman in one of the project communities. Many of the TBAs interviewed displayed a good understanding of complications and reported that they refer clients with complications or any cases beyond their capacity to the identified referral centers. The TBAs have also been empowered with support coming from government. In one state the local government councils provide an allowance for the TBAs trained by the project. Referral linkages between outreach workers, TBAs, and community health facilities have also been strengthened. The survey revealed that a community-focused strategy has increased access to FP services in the intervention communities.

## Challenges

Though some successes were recorded, the project was not without challenges. Some of them were:

- TBAs started requesting monetary incentives from the project. The community believed the TBAs were receiving money from an internationally-funded project and were thus no longer given payments for the services they provided.
- Record keeping was a big challenge because most of the TBAs were barely literate.
- After training and provision of kits to the TBAs some of the TBAs took on activities beyond their capabilities.
- Communities appeared to prefer more elderly TBAs (less literate than the younger ones) as they are seen as more experienced and trust worthy. This led to low patronage of the younger TBAs who were mostly literate.

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## Lessons Learned

- The importance of advocacy and use of culturally and religiously-sensitive methods in community interventions cannot be over emphasized.
- The inappropriate selection of the younger TBAs by the project for training highlights the importance of involving communities in all aspects of project implementation.
- Leveraging resources could be achieved through the use of TBAs as a point of entry for other developmental interventions.

## Conclusions

FP service uptake through the TBAs increased and a majority of the TBA clients were satisfied with the services. The TBAs have been empowered and referral linkages between outreach workers, TBAs, and community health facilities have been strengthened. The community-focused strategy has increased access to FP services in the intervention communities and is likely to achieve better results if a more holistic approach with greater community involvement is employed in future implementation.

## Reference

National Population Commission (NPC) [Nigeria] and ORC Macro.2004.*Nigeria Demographic and Health Survey 2003*. Calverton, Maryland: National Population Commission and ORC Macro.

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