



The SURE-P Maternal and Child Health Project in Nigeria



Improving Access to and Take-Up of Skilled Birth Attendance



Context

Between 1990 and 2008, maternal mortality in Nigeria fell from 1,100 to 545 per 100,000 live births, and neonatal mortality from 45 to 40 per 1,000 live births. Despite this progress, 33,000 mothers and 241,000 newborns still die yearly, and an estimated 70 to 75% of these deaths are preventable. Furthermore, from 2008 to 2013, the maternal mortality ratio did not change significantly. In 2013, only 60% of pregnant women in Nigeria attended one or more antenatal visits and just 38% of childbirths took place under the supervision of a skilled birth attendant.

Did you know?

In 2013, only 38% of childbirths in Nigeria took place under supervision of a skilled birth attendant

33,000 maternal deaths occur in Nigeria each year; 75% of these are preventable

To contribute to the reduction of maternal and new-born deaths in Nigeria, the Subsidy Reinvestment and Empowerment Programme Maternal and Child Health Project (SURE-P MCH) was launched on January 1, 2012, using funds from the removal of subsidies on petroleum. SURE-P MCH consisted of an innovative combination of interventions that target both supply of and demand for maternal health services. International evidence suggests that both supply-side and demand-side factors are important influences on health service utilization.

SURE-P MCH was initially launched in 500 public primary health care facilities and their catchment areas, spread across Nigeria's 36 states and the Federal Capital Territory (FCT). This brief describes a non-experimental evaluation of the SURE-P MCH project's impact on access to skilled birth attendance (SBA) and antenatal care (ANC) within the catchment areas of these 500 facilities.

Intervention



SURE-P MCH was a large-scale project that eventually reached 1,000 primary health centers and their catchment areas spread across Nigeria's 36 states and the FCT. In each of these areas, the project implemented a package of interventions addressing the supply of and demand for maternal health services. Three key supply-side measures were included: improving primary health care facilities' infrastructure; providing adequate midwife staff for primary health care facilities; and ensuring steady supplies of drugs, consumables, and other commodities for the provision of quality maternal and child health services. Demand-side interventions consisted of communication activities to change behavior and promote maternal health services, as well as a conditional cash transfer (CCT) scheme targeting pregnant women which was implemented in a sub-set of facilities. It is important to note, however, that the analysis presented here is for SURE-P MCH's early implementation and therefore does not capture the effect of the CCT.

Impact Evaluation

Study Questions

This noni-experimental impact evaluation seeks to answer two key questions:

1. Were women living in SURE-P MCH project areas more likely to give birth with a skilled birth attendant *because of SURE-P MCH?*
2. Were pregnant women living in SURE-P MCH project areas more likely to receive antenatal care *because of SURE-P MCH?*

Outcomes of interest

1. The proportion of women receiving skilled birth attendance
2. The proportion of pregnant women receiving antenatal care

Study Methods

The analysis uses data from the 2008 and 2013 Demographic and Health Surveys (DHS) to construct baseline and endline datasets. It uses geographic data collected by the research team and the Nigeria Millennium Development Goals Information System to determine whether the DHS data points fall within areas targeted by the SURE-P MCH project. The study employs a difference-in-differences study design to compare the change in SBA and ANC in SURE-P MCH project areas to the change in SBA and ANC over the same period in areas that did not receive SURE-P MCH interventions.



Key Findings & Policy Lessons

SURE-P MCH has, in its first 9 months of implementation, been effective in improving take-up of skilled birth attendance. Mothers who live in a SURE-P MCH-supported catchment area are 12 percentage points more likely to receive skilled birth attendance than they would have been without the project. This is an important result particularly considering the lack of change in skilled birth attendance in the decade preceding the program.

Results do not show that SURE-P MCH has been effective in improving antenatal care use in the project's first 9 months. This suggests that greater emphasis is needed to overcome demand-side barriers to care-seeking. Although SURE-P MCH included a Conditional Cash Transfer program to address such demand-side barriers, its effects could not be included in this analysis.

SURE-P MCH and similar programs in the future should carefully consider their targeting approach. Though SURE-P MCH aims to target underserved areas, projects areas consistently performed better than comparison areas did even before the SURE-P MCH started. This imbalance suggests that the project is reaching only a subset of its target, and strategies to reach those even more at risk should be developed.

Routine health system monitoring systems and data on Nigeria's health care facilities need urgent improvement. This study intended to include data from these routine monitoring systems, but found up to 80% of observations were missing. Furthermore, no national health facility-level data is consistently collected. This greatly limits the understanding of the state of Nigeria's primary health infrastructure and human resources, and how they vary across different parts of the country.

Finally, the SURE-P MCH Program and the National Primary Health Care Development Agency of Nigeria are to be commended for their openness and transparency in subjecting the program to a process of rigorous impact evaluation. Future policies and programs should consider incorporating experimental impact evaluations from the outset.

Mothers living near SURE-P MCH health facilities are **12 percentage points more likely** to give birth with a skilled birth attendant present than they would have been without the program.

Antenatal care use did not improve in the first nine months of implementation. Greater emphasis on demand-side barriers to care-seeking may be needed.

SURE-P MCH and similar programs should carefully target their interventions to ensure those at highest risk are reached.

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