Using Social Accountability to Improve Maternal and Child Health in Nigeria

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Social accountability interventions employ information and generate participation to demand fairer, more effective public services. This paper analyzes a campaign run by the nongovernmental organization White Ribbon Alliance Nigeria in Niger State to increase citizen demand for quality maternal health care and government responsiveness to those demands. The campaign relied on advocacy to key health system actors, town halls to bring together citizens and policymakers, and a cadre of citizen journalists to expose poor quality health care. The analysis is based on more than 40 interviews with relevant actors in Niger State as well as a difference-in-differences analysis of health system utilization data. Although an impact of the campaign on health care utilization is not yet visible, the campaign has convinced the previously unwilling state government to engage with citizens, and anecdotal evidence suggests improvements to health care facilities in response to town halls and citizen journalist reports.

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Introduction

Nigeria has one of the highest rates of maternal mortality in the world—estimated in 2015 to be over 800 maternal deaths per 100,000 live births—and is the source of a fifth of maternal deaths globally (WHO et al. 2015). High fertility, low contraceptive use, and poor health systems are among the many reasons that maternal mortality is high in Nigeria. Global focus on maternal mortality increased following the Millennium Declaration in 2000 and the Nigerian government made a major commitment to reducing maternal mortality as part of the Saving One Million Lives initiative, launched in 2012. Combined, these forces have resulted in a large deal of attention and resources for improving maternal health in Nigeria.

Most of these resources have gone to relatively conventional efforts to improve maternal health that are common around the world, such as increasing the number of skilled birth attendants and integrating maternal, newborn, and child health programs (Izugbara, Wekesah and Adedini 2016). But there are other strategies for improving service delivery that have the potential to improve maternal health, including social accountability. Social accountability interventions "employ information and participation to demand fairer, more effective public services" (Maru 2010: 84) and are non-electoral mechanisms through which civil society aims to control state power (Smulovitz and Peruzzotti 2000). Social accountability approaches enable citizen participation in service delivery while creating the space and means for citizens to hold providers and government accountable. Common techniques include advocacy for information, budget tracking, and citizen score cards. Citizen score cards, for example, involve citizens and service providers working together to plan and prioritize the types of services provided, and then allow citizens to hold providers accountable by scoring them on how well they have provided those services (CARE Malawi 2013). Scholars have found the results of social accountability interventions on outcomes to be mixed, but a recent meta-analysis concluded that strategic approaches—those that increase the capacity for both citizen action *and* government response to those demands—do lead to improved public sector performance (Fox 2015).

The paper that follows is an analysis of one such strategic intervention, a campaign run by the nongovernmental organization (NGO) White Ribbon Alliance-Nigeria (hereafter "White Ribbon") to foster and grow citizen-led accountability for maternal, newborn, and child health in Niger State, Nigeria. The White Ribbon campaign seeks to create space for citizens to demand for quality maternal, newborn, and child health care, help set up mechanisms for citizens to hold government accountable to its commitments in the health sector, and thus ultimately increase the supply and use of quality care, improving associated health outcomes. The analysis below focuses on three of the campaign's main activities: (1) advocacy to policymakers and other key leaders; (2) facilitating town halls and community dialogues; and (3) training citizen journalists.[2]

[2] Two other areas, not discussed here, include outreach to civil society organizations and media campaigns.

Background

White Ribbon is a Nigerian NGO founded in 2009 and based in Nigeria's capital, Abuja. A member of the Global White Ribbon Alliance, an international NGO focused on maternal health, White Ribbon's mission is to "inspire and convene advocates to uphold the right of all women to be safe and healthy before, during and after childbirth."[3] With funding from the Bill and Melinda Gates Foundation via the Global Alliance, in 2016 White Ribbon began a campaign in three local government areas of Niger State, Nigeria (see Figures 1 and 2) to increase citizen-led accountability for maternal, newborn, and child health.

Located in Nigeria's north-central geopolitical zone, Niger State is considered part of "The North," a band of predominantly poor, majority Muslim states. The population is 85% rural, approximately 80% Muslim, and Shari'a law has been practiced in parts of the state since 2009 (Kunnuji et al. 2017). The state has the largest land area among Nigerian states, and has many hard-to-reach areas. There are three main ethnic groups—the Nupe, Gbagyi/Gbwari, and Hausa—and Hausa serves as a lingua franca. Almost half of the population of 5.3 million is under the age of 15, and approximately a third of the population lives below the poverty line (Bill and Melinda Gates Foundation 2017). Table 1 shows basic indicators for women and children in the state: fertility is high (6.1 children per woman), contraceptive use is low (5.6%), and almost a third of women reported no antenatal visits. The state's capital, Minna, is located about 100 miles northwest of Abuja, although the drive takes at least three hours due to bad road conditions.

Poor maternal health in the state is the result of many factors related to both limited supply of high quality care and low demand for facility-based care. The main causes of maternal death in Nigeria are hemorrhage (23% of deaths), infection (17%), unsafe abortion (11%), toxia/eclampsia (11%), obstructed labor (11%), malaria (11%), and anemia (11%) (Izugbara, Wekesah and Adedini 2016). Although data specific to Niger State are not available, the same factors likely drive deaths there. Respondents understood maternal mortality to be the result of women not seeking antenatal care and failing to deliver in facilities, in part because of cultural/religious barriers and poverty, but also because of poor quality facilities and poor quality/underpaid staff who did not treat women with respect. A review of deliveries at the state's tertiary and secondary hospitals indicated that delay in getting laboring women to health care facilities is an important proximate cause of maternal mortality.[4] The average travel time to a referral facility is 60-80 minutes (Bill and Melinda Gates Foundation 2017), and people often must pay for services that should actually be free (Daaor 2016).

Niger State has 25 local government areas (see Figure 2), which are second-level administrative units roughly equivalent to US counties. Each local government area is divided into approximately 10 wards, with a total of 274 wards in the state. The state has about 1100

[3] https://www.whiteribbonalliance.org/nigeria/

[4] Interview #28, NGO. (Details on data collection are described further below.)

health facilities, including centers, clinics, and posts.[5] One hundred of these facilities are supposed to be fully functional (doctor, nurse, lab equipment, electricity, etc.), but as of 2017, only one met the full "functioning" criteria (Bill and Melinda Gates Foundation 2017). The Gates Foundation's 2017 primary health care assessment survey found that approximately a quarter of staff were absent from post (Bill and Melinda Gates Foundation 2017) and the state's primary health care facility performance monitoring system was described in 2016 as "weak, irregular and uni-directional" (WRAN 2016, p. 39).

Decades of military dictatorship as well as high levels of corruption have left Nigerians with low expectations for government, and although a democracy, voters do not hold full ability to sanction and reward elected officials, including in Niger State. Campaigns for office are not based on what politicians have achieved, but instead on their ability to provide patronage. In addition, very few people in Niger State pay taxes, giving them little stake in monitoring how the government uses the revenue they generate.

Government commitment to primary health care has increased in Nigeria in the past five years. The 2014 National Health Act led to the creation of the national Primary Health Care Development Agency, state-level Primary Health Care Development Agencies, and the reinvigoration of the Primary Health Care Under One Roof initiative, which refers to integration of all primary health care services under one authority. The primary health care provision system is decentralized, with management authority granted to the state Primary Health Care Development Agency, which oversees implementation at the local government and ward level. Each ward should have a 20-member ward health development committee that represents the community and oversees the primary health care facilities in the ward.

While the reorganization of primary health care is supposed to be occurring nation-wide, Niger State is ahead of the curve. Niger State has the best ranking among states in the north-central zone for Primary Health Care Under One Roof (National Primary Health Care Development Agency 2015). The state launched a health plan, Niger Health 1.0, in 2016.[6] The plan outlines how to implement the National Health Act and includes a commitment to a functioning primary health care facility in each ward of the state. As a result of this plan, Niger State was selected along with only two other states (Abia and Osun) to pilot the Basic Health Care Provision Fund element of the National Health Act, with support from the World Bank and Gates Foundation.[7] The National Health Act calls for 1% of Nigeria's general revenue to be available for primary health care.[8] The funding is supposed to go directly to facilities, with half to support primary health care services (equipment, drugs) and the other half for health insurance to help reduce out-of-pocket expenditures (April 2018 WRAN monthly report). Niger Health 1.0 also led the

[5] Primary Health Care Service Delivery Model dissemination meeting 2017 (April 2017 WRAN monthly report).
[6] https://www.afro.who.int/news/minister-health-flags-8-point-health-reform-agenda-niger-state
[7] Interview #33 – Ministry of Health.
[8] Although the National Health Act was passed in 2014, this funding element was included in the budget for the first time only in June 2018.

Gates Foundation to select Niger State as a primary health care focal state (along with Kaduna) and to sign a memorandum of understanding directly with the state in 2017.

Data and Methods

The analysis below is based on both qualitative and quantitative data.

The quantitative data are administrative data on antenatal visits and facility deliveries, aggregated to the local government level.[9] Nigeria, including Niger State, is using District Health Information System (DHIS2), an open-access software platform accessible through the Web that facilitates the collection, management, and analysis of health data.[10] More than sixty countries, many in sub-Saharan Africa, are currently using DHIS2 software, with an additional almost 30 countries in pilot phase. Health Systems Delivery Foundation, a Nigerian NGO supporting health system strengthening in Niger State, shared the data. These data are, admittedly, of unknown quality, although experts in the state reported their coverage had improved over time (Int. 28).

I conducted a difference-in-differences analysis of changes in the number of antenatal visits and facility deliveries in White Ribbon's three focal local government areas (Chanchaga, Lapai, and Wushishi) relative to all other local government areas in the state. Data are quarterly from the first quarter of 2016 through the first quarter of 2018; White Ribbon's campaign began in the second quarter of 2017. There are thus nine observations for each of 25 local government areas, for a total of ~220 observations.

Qualitative data come from 42 interviews that I conducted in 2017 and 2018 in Minna, Niger State, in cooperation with White Ribbon staff. The interviews were with citizens, citizen-journalists, journalists, religious and traditional leaders, civil society organizations, the Ministry of Health, implementing NGOs, health care providers, ward health development committees, and elected officials. Each interview lasted approximately 45-60 minutes. All but two were conducted in English; the other two were conducted entirely or partially in Hausa, with translation provided during the interview. The purpose of the interviews was to gain respondents' understanding of the causes of poor maternal health in the state, the most appropriate steps for improving maternal health, and their opinions of White Ribbon's campaign. The study was approved by American University's Institutional Review Board and all respondents gave consent to participate as well as to be quoted. Information from interviews is referred to with a number and a note indicating the type of respondent.

I analyzed these data with NVivo through an iterative process, coding first for pre-determined themes (e.g., conflict between White Ribbon and the government and its resolution) and then developing new themes inductively.

[9] Thanks to Temitope Awoyemi from Health Systems Delivery Foundation for obtaining these data.
[10] https://www.dhis2.org/inaction

Analysis

Difference-in-Differences Analysis

Figure 3 shows that the number of antenatal visits increased between the first quarter of 2016 and the first quarter of 2018 by 39% in Chanchaga and 13% in Lapai, but declined by 44% in Wushishi. These changes are relative to an overall average increase of 47% in the non-focus local government areas, indicating that the focus areas did worse on average. As Figure 4 shows, facility deliveries, increased between 2016 and 2018 by 81% in Chanchaga and 56% in Lapai, but declined by 28% in Wushishi, compared to an average increase of 64% in the non-focus areas. Thus Chanchaga out-performed the state-wide average, but the other two focus areas did worse.

A statistical analysis using difference-in-differences techniques (Table 2) produced similar results, indicating that there was no effect of the "treatment" of the White Ribbon campaign in the three focus local government areas. While these findings indicate no immediate effect of the campaign on health process goals, they are tempered by the fact that the data are of unknown quality, and that trends in antenatal attendance and facility deliveries are increasing overall in the state.

Advocacy to Policymakers

White Ribbon is different from most other NGOs that work in Niger State because it does not provide services. The state government was unfamiliar with this model when White Ribbon first arrived, and was concerned about the organization's motivations, worrying they might be against government. Thus White Ribbon spent the initial year of the campaign almost exclusively on advocacy, and continued advocacy efforts in the following two years of the campaign, to key actors in the state. These included the Commissioner of Health (the head of the State Ministry of Health), the executive director of the Primary Health Care Development Agency, the first lady of the state (the governor's wife), traditional leaders, and heads of key committees in the state assembly. Ultimately, all key individuals have made statements and/or taken actions that demonstrate commitment to some form of citizen involvement in the health care provision process.

The success of White Ribbon's high-level advocacy efforts suggest the importance of persistence, patience, and a team with varied skills. White Ribbon's advocacy strategy has involved relationship building with key individuals in the Ministry of Health as well as with powerful players outside of the Ministry of Health who could support the campaign more broadly. The senior program manager and the communications officer have done much of the on-the-ground relationship building. Although originally from the South of the country, both women speak Hausa, dress carefully to be appropriate for the relatively conservative setting of Niger State, and work diligently to manage relationships with the entire cast of actors. The program manager cultivated relationships through deference, while the communications officer pressed key players for commitments to accountability. The national coordinator has also

carried out advocacy efforts, particularly to high-level individuals. If things got tense between him and those individuals, the other staff members stepped in for awhile to take over. All three White Ribbon staff members were very aware of and creative towards maintaining good relationships with people.

Although the Niger State Ministry of Health was unfamiliar with White Ribbon's approach, the context was supportive in many ways. Most people involved with primary health care see a role and need for community involvement in health, which created a natural point of entry for the campaign. In particular, the key agency within the Ministry of Health tasked with primary health care, the Primary Health Care Development Agency, has been particularly supportive of the campaign. Its executive director is a doctor originally from Niger State who had practiced medicine in the US for many years and became an early backer of the campaign.

The First Lady of Niger State, Dr. Amina Abubakar Bello, is an OB/GYN who still sees patients at the general hospital and has an NGO, the Raise Foundation, which supports maternal health. She has provided support to the campaign throughout its existence, and is on record with statements in support of accountability. Specifically, in January 2018 she stated, "To improve [maternal, newborn, and child health] service delivery we must ensure that accountability structures are in place that protect the people and also provide space for citizens to hold health providers accountable" (January 2018 WRAN monthly report). To acknowledge the importance of her and the governor's support, White Ribbon will give them an award of appreciation. White Ribbon has chosen only a few other elected officials to target—the chairman of the House Committee on Health and the House Assembly Speaker—so as to be not spread their advocacy efforts too thin. They have focused in particular on the Chairman because of his position, but also because he is a medical doctor.

The Emir of Minna, the most important traditional leader in the state, is a White Ribbon champion, in large part because of an overarching commitment to health. This support was particularly important at the beginning of the campaign, when he reached out to the Commissioner of Health in support of White Ribbon. The campaign also made a bond with a traditional leader with significant national service, but also local clout and an interest in health, by asking him join a technical working group on accountability.

Respondents described a need for persistent and continuous interaction with high-level individuals, but not always focused on advocacy. More important is to first build relationships with these individuals, so that advocacy will be taken seriously. As an elected official put it, "Most times, government doesn't respond immediately to a campaign. They need to see first if the program is serious. Persistence is key – you need to keep coming back. If you don't come back, it seems your program is not serious."[11] White Ribbon also realized that they had to educate policymakers about accountability, the same as other citizens. Advocacy has also meant managing the concerns of key individuals. Some officials have felt there isn't much they

[11] Interview #27 – elected official.

can do with people's feedback because they don't have the authority or capacity to respond to people's demands. White Ribbon's counter-argument has been that participation in town halls provides evidence that those officials can use to lobby for resources from other parts of the state and health bureaucracies.

The connections that White Ribbon has fostered have paid off. As one respondent from the Ministry of Health put it, "The power of White Ribbon convinced the government to come to the table – White Ribbon is connected." Furthermore, White Ribbon was able to capitalize on the relationships that they built first in order to bring on board those key actors who were more reticent about the campaign. White Ribbon may have also benefitted from being an organization from outside the state. One Ministry of Health official noted that it was good to have an outside organization facilitate town halls because a previous attempt at such events, initiated solely by the government, had produced only the answers the government wanted to hear and thus quickly fizzled.[12]

White Ribbon's advocacy efforts are thus best described as relationship building, which although important for any civil society campaign, were particularly so in a newly democratized context. The conversations that initiated, strengthened, and sometimes strained these relationships, allowed for the compromise that emerged over what to call "accountability."

Compromise on the naming and interpretation of "accountability"

White Ribbon's campaign goal was initially phrased as increasing "citizen-led accountability," but they have purposefully switched to using "citizen engagement" in Niger State because it raises less resistance. To many, "accountability" sounds like something having to do with finances. As a White Ribbon staff member explained, "'accountability' sounds aggressive, offensive; 'engagement' is better. White Ribbon tries to be subtle in their messaging. 'Accountability' is a bitter pill to swallow - always thinking you're talking about how much money, what it's spent on, and so forth."[13] Reflecting this interpretation, a traditional leader explained, "People hear 'accountability' and they think money, corruption (especially), and everyone wants to run – you won't get cooperation. You need to explain what is meant. Talking about citizens and government working together is the best thing to do."[14]

Messaging issues in part hampered the first year of White Ribbon's campaign. An early campaign brief reported "The concept of citizen-led accountability is quite foreign to many people, including policy makers, and most of them found the concept unfriendly and were concerned it would instigate the masses to turn against them. We had to explain the benefits of citizen-led accountability to them and assure them we were working toward a mutually-beneficial relationship for citizens and the government." In order to address this issue, White Ribbon brought people together to identify barriers. They found that the media understood

[12] Interview #16.
[13] Interview #41.
[14] Interview #35.

accountability only in terms of budgets for health and the associated release of funding. As a result, the communications officer messaged instead that citizen-led accountability is about finding solutions. She also held a meeting with policymakers to say that accountability is not about budgeting, but that maternal, newborn, and child health problems are better served when everyone comes together and talks. White Ribbon has also stressed that they want to cooperate with the state's plans to provide health, but notes that holding leaders accountable will help increase demand for health care, an outcome the health care bureaucracy desires. This multi-faceted approach has helped convince the government that the campaign benefits them.

Within its own documents, the Ministry of Health uses the term "community action for health" which refers to community ownership of and involvement with health care. This is the term that the government has come to understand as synonymous with White Ribbon's "citizen engagement." Relatedly, the Ministry of Health has also proposed changing the name of the town halls to "Lafiya" forums, an engagement platform that used to happen in Niger State in which service providers and citizens came together to discuss issues. While White Ribbon has largely accepted the substitution of "community action for health" for "citizen engagement," they worry that the Lafiya forums represent a different process that does not contain sufficient opportunity for holding leaders accountable.

There are two potential costs to the compromise that White Ribbon has struck in terms of what to call "accountability." The first is that the government has in essence agreed to a form of citizen engagement that is not actually about holding the government to account. The second, related potential cost is that if the essence of accountability is lost, the campaign could ultimately facilitate the neoliberalization of health care, passing financial and managerial responsibility for facility care, drug procurement, and other tasks to unpaid community members. In short, the line between "citizens should be involved in health so that they can pressure government" and "citizens should be involved in health as a substitute for what the government should do" is very thin.

Impacts of town halls and citizen journalists

Citizens in Niger State have indicated in numerous ways that they are willing to hold government to account for promises made regarding health care. In order to do so, however, they have needed access to government representatives. White Ribbon has provided this access by organizing town halls and community dialogues, and through training citizen journalists. Respondents within the Ministry of Health felt that services had improved in White Ribbon's focus local government areas as a result of these activities.[15]

Prior to White Ribbon's campaign, a 2015 survey demonstrated that citizens felt poorly engaged in governance and service delivery.[16] Fewer than 5% of respondents agreed that

[15] Interviews #29, #34.
[16] By UKAID/DFID - the Niger State Community Perception Survey.

government informed citizens on how it spent money or that government regularly asked people what they thought of its plans to improve services. However, 73% agreed that they could express dissatisfaction with government services in public hearings where policymakers were present. Respondents also reported willingness to express their dissatisfaction with government to the press (WRAN 2016, p. 21).

There is certainly plenty of frustration with the quality of maternal health care. Many respondents described incidents of poor care that either they or close friends/family had experienced. As one citizen journalist explained, "It doesn't take much convincing for people to demand rights – it's not as though they don't know about what they're experiencing. Some say they can't talk back at the government, but I say you can."[17] Similarly, a traditional leader reported, "People are willing to complain, but they don't know how to start because they don't know their rights."[18]

Community dialogues are primarily for the community alone (although have had lower level members of government present) while town halls bring together citizens and representatives of government. The town halls and community dialogues have been very popular among citizens as well as individuals lower in the state government hierarchy and in parallel authority structures (religious and traditional leaders) because it gives them better access to those with power. Each town hall and community dialogue produces a joint action plan. In the case of a community dialogue, the plan directs White Ribbon's advocacy efforts. A town hall action plan is put together jointly by citizens and individuals from the Primary Health Care Development Agency. The Executive Director of the Primary Health Care Development Agency then takes the plan to the Commissioner of Health, and White Ribbon follows up with the Executive Director to address whether the plan has been carried out.

Within the first three years of the campaign, White Ribbon had hosted a handful of town halls and community dialogues in each of the three target local government areas. Anecdotal evidence suggests that some improvements have followed town halls: the release of equipment to health centers from the state medical store, improved treatment by health center staff, and the deployment of new health center staff. The costs associated with community dialogues and town halls remain a challenge for sustainability. Refreshments and reimbursement for transportation costs are crucial to ensuring continued participation in community dialogues and town halls. Someone in the Ministry of Health stated bluntly that "Government is struggling to put workers in facilities – it's too much to ask government to do town halls in every community as well."[19]

Citizen journalists write stories about issues they observe with the health care system which White Ribbon then helps publish primarily in online forums. The media in Niger State are

[17] Interview #2.
[18] Interview #7.
[19] Interview #38.

largely state-owned, and do not operate from a tradition of critique. There are approximately 20 citizen journalists, four of whom are professional journalists. The professional journalists have had the greatest ability to hold the government accountable given they are better writers and can place stories in more high-profile venues, although they are generally not willing to go into the communities where many of the problems exist because of the cost and difficulties associated with travel. White Ribbon has provided travel grants to some citizen journalists in order to be able to travel to hard-to-reach areas of the state and report on issues there.

The non-professional journalists can be divided into two groups. One consists of "super-mobilizers," individuals active in their communities, desiring change, and interested in writing as well. The other group is less involved, and does not go seeking stories. Super-mobilizers "can get people [to come out]. Being a citizen journalist brings them respect, relevance, and trust. People tell [the citizen journalists] their health problems."[20] One super-mobilizer carries out a number of watch-dog activities, including visiting the homes of families with newborns in his neighborhood and asking for details about the delivery.[21]

Citizen journalists reported being personally impacted by engagement with White Ribbon. One stated, "I know my rights as a human being because of work with White Ribbon."[22] Another noted that being a citizen journalist had made him the go-to source when community members found new problems with health facilities.[23] Another citizen journalist also reported trickle-down effects of the training she had received from White Ribbon. "When we are mobilizing, I tell people to go for antenatal [care], to go the hospital for delivery. We talk to the leader of the village before mobilizing. We do community dialogue the way White Ribbon taught us. Now we teach them, and they are responding. I tell my own story."[24] But journalists have varying degrees of willingness to write; as one explained, "Some citizen journalists don't want to write reports because of the implications for them as they are working for the government indirectly in some way."[25]

The experience of community dialogues, town halls, and the citizen journalists in Niger State indicates that citizens are ready and willing to hold government to account, but that doing so has required substantial support from a civil society organization.

Conclusion

Maternal mortality remains high in Nigeria. One promising strategy for improving the quality of services and increasing their use is through the use of social accountability mechanisms, specifically supporting citizens to demand better care and facilitating their holding government

[20] Interview #42 – citizen journalist.
[21] Interview #16 – citizen journalist.
[22] Ibid.
[23] Interview #21 – citizen journalist.
[24] Interview #31 – citizen journalist.
[25] Interview #42 – citizen journalist.

to account for providing that care. White Ribbon Alliance Nigeria's campaign in Niger State presents a unique opportunity to examine the impact of these outcomes on health care utilization. Based on quantitative and qualitative analysis of the campaign, there is evidence of citizen engagement with government, which government has reciprocated, although perhaps with a different interpretation of citizens' roles in health care provision than held by White Ribbon. A difference-in-differences analysis did not show any impact of the campaign on health care utilization (antenatal visits or facility deliveries), but anecdotal evidence from interviews and review of campaign materials indicates that following town hall meetings with citizens as well as reports by citizen journalists, government made efforts to improve facilities and better staff them. These outcomes are moderate, but noteworthy several years into a campaign that marks a very different way of NGOs "doing business" in Niger State. They also lay the groundwork for the next steps of the campaign, which continues for at least the next three years.

Figure 1. States of Nigeria

Figure 2. Local Government Areas of Niger State, Including White Ribbon Focus Local Government Areas (Chanchaga, Lapai, and Wushishi)

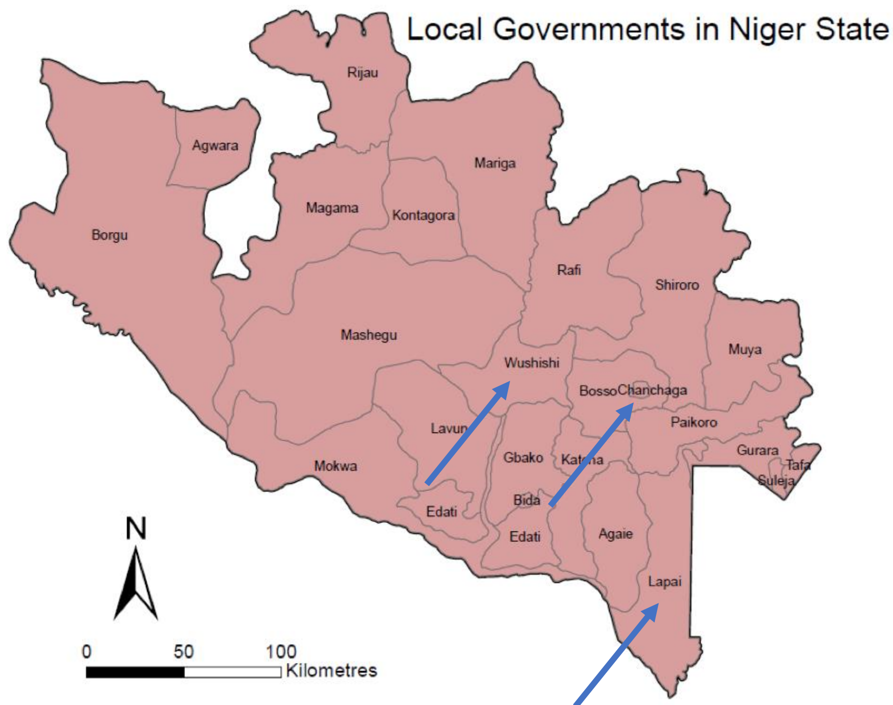

Figure 3. Change in Antenatal Attendance, White Ribbon Focus Areas vs. Non-Focus Areas, 2016-2018

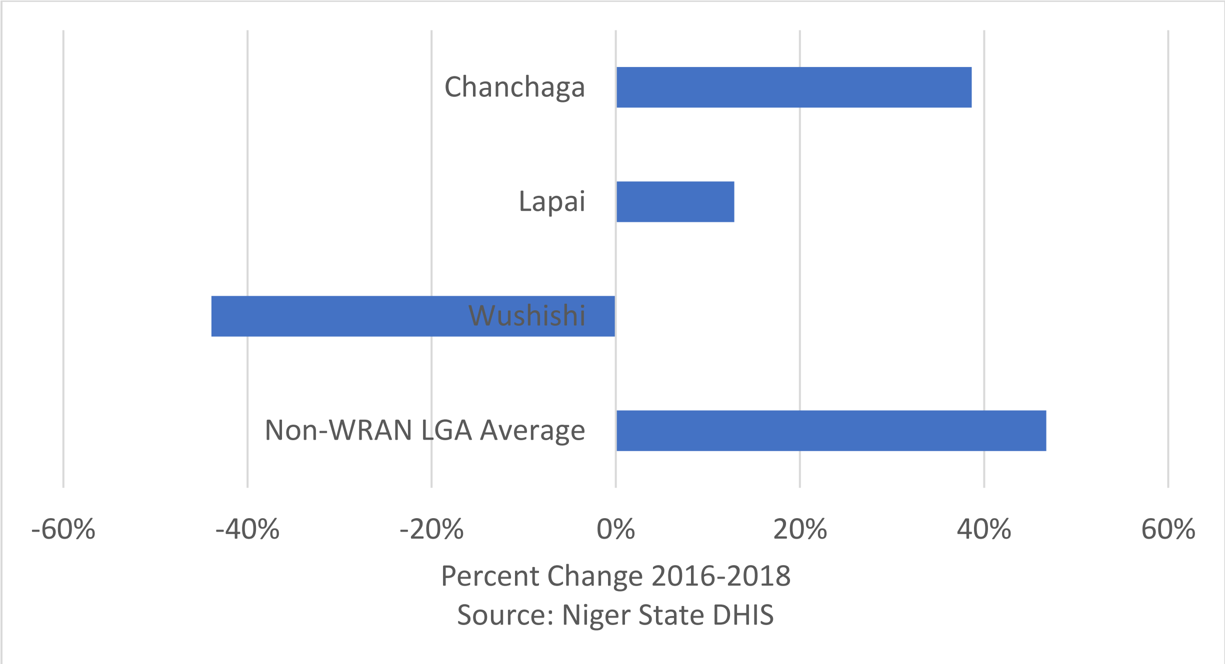

Figure 4. Change in Facility Deliveries, White Ribbon Focus Areas vs. Non-Focus Areas, 2016-2018

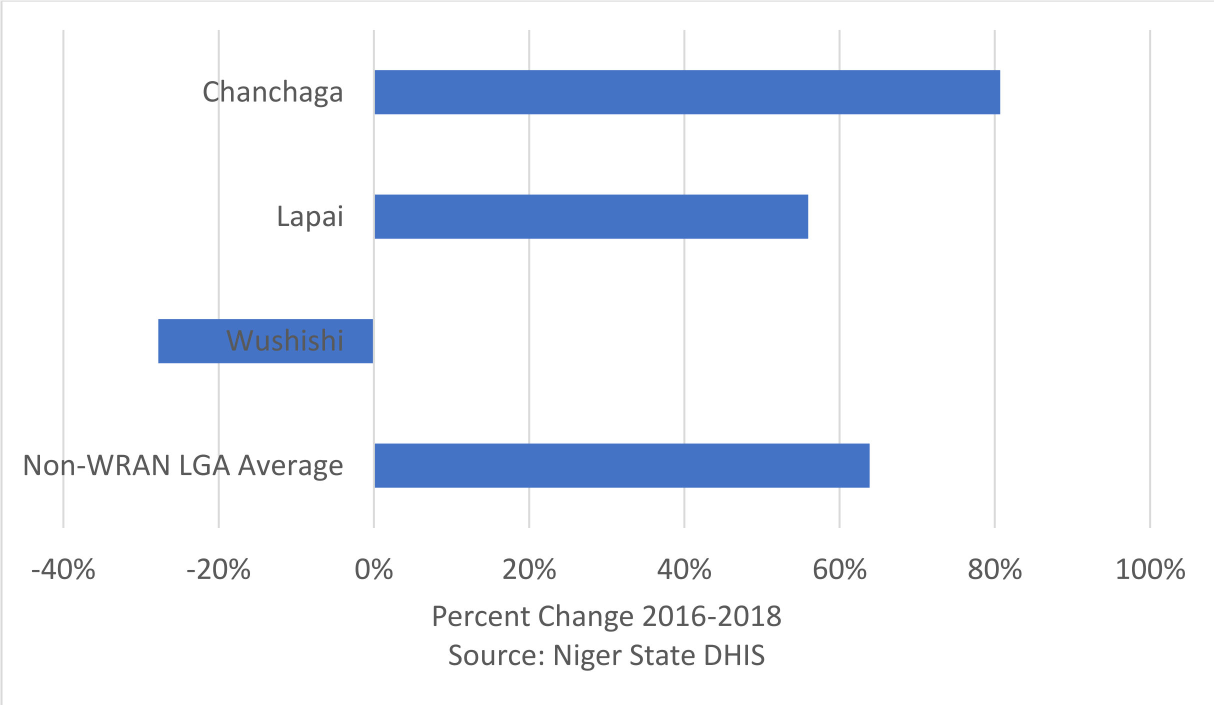

Table 1. Indicators of Women and Infants' Health and Wellbeing, 2013 Demographic and Health Survey

	Niger State	Nigeria
Women's Status		
Women literate (%)	29.2	53.1
Women who agree that wife-beating is justified (%)	50	34.7
Women in polygamous marriage (%)	31.9	32.5
Median age at first marriage (among those 20-49)	17.7	18.3
Women with no weekly exposure to media (%)	45.3	50.3
Women mainly or jointly make decisions about her health care	18.7	38.7
Fertility and Contraceptive Use		
Total fertility rate	6.1	5.5
Median age at first birth (among women 25-49)	19.8	20.2
Women 15-19 who have begun childbearing (%)	27.3	22.5
Contraceptive prevalence (modern, %)	5.6	9.8
Knowledge of contraception (%)	55.5	84.6
Unmet need for contraception (%)	24.3	16.1
Maternal Health		
HIV prevalence (%)[26]	1.2	3.4
No antenatal care (%)[27]	28.2	33.9
Took iron during last pregnancy (%)	76.8	63.4
Received Vitamin A dose within 2 months of delivering (%)	19.8	29.3
Protected against neonatal tetanus (%)	51.9	48.4
Received intermittent malarial protection during pregnancy (%)	34.5	14.6
Facility deliveries (%)[28]	25.3	35.8
Non-institutionalized births with clean delivery kit (%)[29]	97.1	48.9
Delivered by skilled provider (%)	28.6	38.1
Households with at least one insecticide-treated net (%)	49.4	49.5
Infant Health		
No postnatal checkup (%)	94.4	83.9
Children 12-23 month having received all basic vaccinations (%)	23.0	25.3
Economic Development		
Houses with improved drinking water source	48.1	60.6
Households with improved, not shared sanitation facility	16.6	30.1
Households with electricity	51.7	55.6

[26] Source: http://naca.gov.ng/nigeria-prevalence-rate/ (2012 figures)
[27] Among those receiving, only 60% from "skilled" provider
[28] Reasons for not delivering in facility – not necessary (28.8%) or too far (21.7%)
[29] This is the highest of any state in Nigeria and does not appear to be a mistake: the raw DHS data indicate that of those asked about using a "special clean delivery kit" at the last birth, only four responded that they did not or did not know.

Table 2. Results from Difference-in-Differences Analysis Predicting Antenatal Visits and Facility Deliveries, Niger State, 2016-2018

	Unstandardized Coefficients	
Variable	Antenatal Visits	Facility Deliveries
Time	567.3*	184.1**
Treated	3399.6**	1092.0***
Time x Treated	-1126.4	-47.9
Constant	3160.0***	673.1***
N	222	221
R^2	16.6%	26.5%

Note: * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$. Based on robust standard errors

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