Overcoming low birth registration coverage and improving death registration in Nigeria

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Advanced Social Norms Course
University of Pennsylvania Program
Philadelphia, July 2013
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

The Country
Nigeria is Africa’s most populous nation. Located in West Africa, she is bordered on the West by the Republic of Benin, on the East by Cameroon, in the North by Chad and Niger, and in the South by the Atlantic Ocean. The Country occupies a land area of 923,768 square kilometres and has a population of about 162 Million (2006 Census). Nigeria operates a three-tier federal system of government comprising the Federal, State and Local Governments. There are 36 states, 774 local government areas and a Federal Capital Territory, Abuja. Six geo-political zones are recognized comprising five to seven states, namely: North Central, North East, North West, South East, South West and South South.

Children (0-17 years) in Nigeria constitute about 50% of the population and amongst these children under five population constitutes 17%.

Map of Nigeria

Background information and problem description
Efficient civil registration systems ensures provision of legal documents, establishing an individual’s identity, nationality and kinship which are proofs for accessing basic services including immunization, health care and school enrolment at the right age. Securing children’s right to a nationality will allow them to get a passport, open a bank account, and as they become adults, to obtain credit, vote and find employment. Civil Registration
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

system establishes and provides documentation of births, foetal and still births\(^1\), deaths, marriages and divorces. This write up will focus on registration of births and deaths.

Birth registration is designed to promote recognition of a child’s legal personality. Without registration, the child effectively does not exist, is invisible and is deprived of all other human rights. Birth registration is a frontline tool in combatting of early marriage, since parents and care-givers cannot inflate age to disguise child marriage and this can be linked to other harmful practices discussed during the UPenn course. Effective birth registration system with integrity is a critical tool to combat illicit and unethical practice in inter-country adoption.

In addition, child labour, including in its most exploitative forms such as servitude, sale of children and slavery, proliferate in systems where children are both unregistered and their ages are unknown. Real protection is elusive in the absence of certainty about age, be it 12, 16, 18 or anywhere in between. Thus it is trite to state that a minimum age of admission to employment is pointless, curbing FGC where it is prevalent may be impossible, dealing with child marriage and harm to the girl child may remain impossible - if proof of age does not exist. In addition most human rights/fundamental rights of children cannot be enforced in the absence of efficient Civil registration process.

Since birth registration is closely linked to death registration, it can be inferred that death registration ALSO has human rights/health and child survival rights implications. Death registration describes and explains levels, trends, and differentials in mortality rates. It helps identify emerging diseases and conditions, as well as tracking changes in the burden of disease killing children. Further, death registration contributes to socio-medical and biomedical research and enables monitoring the impact of public health programs and child hood deaths. Vital statistics derived from civil registration are the only nationally representative source of information on mortality by cause of death. The timely recording of deaths especially by cause can provide early insights into trends in disease prevalence, thus helping to design prevention or intervention strategies.

Given this extensive background, while reliable statistics and information on death registration is difficult to come by in Nigeria, the birth registration process is also faced with

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\(^1\)The definition recommended by WHO for international comparison is a baby born with no signs of life at or after 28 weeks' gestation. The majority of these deaths occur in developing countries. Two-thirds of stillbirths occur in south-east Asia and Africa and 55% occur in rural families from these areas. Stillbirths remain an invisible public health priority. Definition accessed at [www.who.int](http://www.who.int).
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

numerous challenges and coverage remains persistently low. About 58% of children born in Nigeria do not have their births registered (MICS 2011). Birth and death registration coverage of marginalized, poor and hard to reach under-five children mostly from the Northern part of Nigeria remains persistently low. This is mainly due to inadequate number of registration centres, lack of public awareness on the importance of birth registration and ingrained social cultural beliefs that impacts negatively on registering births and deaths of children.

Most women (in the north) who had still births do not see the necessity of registering a still birth, as it’s usually a period of sadness for losing a child. Closely linked with the low level of death registration/documenting of still birth data, is the situation of places of occurrence of births of children born in Nigeria. It is the practice that when children are born at home and the babies are still born, such are quietly buried without the death or still birth registered or recorded. The 2008 DHS reported that 62% of births took place at home and predominantly in the Northern part of Nigeria.

There is a parallel between the low level birth and death registration coverage in the North and poor health indicators. Particularly, the Northern zones have 2 times lower registration levels compared to southern zones. The disparity widens as wealth index increases and birth registration levels are 3-5 times lower for children of mothers with no education (2008 DHS). Adolescent birth rate in the country is at 89 births for 1,000 women age 15 to 19 years, while the rates in the Northwest region of the country is much higher at 170 births. Similarly, the total fertility rate is 5.7 births per woman, while the rates are much higher in the North West region of the country at 7.2 births per woman (MICS, 2011). The MICS (2011) report shows significant disparity in the infant mortality rates between the South West zone which is as low as 55 and 83 per thousand compared with the North West zone which stands at 123 and 208 per 1000 live births respectively. On early childhood education among children 36-59 months, attendance to preschool is more prevalent in South West – 83% and lowest in the North East- 12%. While only 32% of young women in the North West are literate, we have 81% in the South West.

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2 MICS 2011- Multiple Indicator Cluster Survey is a household data survey that report at the national and state level birth registration status plus comprehensive household demographic and socioeconomic information.
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

**Underlying Causes and diagnostics**
There is a correlation between the socio economic status, the level of education of mothers and the quality of care provided for the child- in the north compared with the south - be it in education, health care services or in registering the births of their children. It is clear that understanding the social norms and the dynamics that linked these together has an important role to play to create a change.

The cultural values of the people of Northern Nigeria are practically shaped by religion and the social value system can be safely called a religious value system (this is explained further in the write up). Without losing the focus on the reason for persistent low coverage of births and deaths registration, it is obvious that development rights issues for the girl-child and many adult women in the Northern part of Nigeria indicate so many disadvantages. These are born out of ingrained customs, norms and religious practices. The profile of certain communities in the Northern part of the country, features the practice of a serious gender bias that excludes most women from the entire decision making process in the home. There is a continuous disadvantage in educational access for girls and high rates of female illiteracy.

There is a heavy burden of domestic labor, extensive participation in agriculture and the informal sector, but much less so in the formal sector, especially in professional, technical and management jobs. With the practice of polygyny and permission for a man to marry up to four wives, there is a large income disparity between the men and their wives with the women having no property inheritance rights and mostly lack of capital and of collateral for access to credit. Some of these women are under strict rules and regulations controlling every aspect of their lives and mostly secluded under the practice of Purdah.

In further diagnosing the norms and religious practices perpetrating the disadvantages, we find the practice of Purdah to be a sustaining factor for these practices. Purdah for example is the strict enforcement of seclusion rules upon (typically) married Muslim women in the Northern part of Nigeria (Nicola Hugo 2012). They are expected to remain indoors, except in extreme cases such as to receive medical treatment or to attend marriages and funerals with their husbands’ permission. If women do venture out, they need to be completely covered by a hijab, and in some instances also escorted. Violating these regulations may result in accusation of promiscuity or even divorce.

Most women in purdah and others from the Northern part of Nigeria are thus socio-economically backward and are disadvantaged educationally, which impacts on their understanding of the importance of accessing health care and other basic services. Gender perspectives in Nigeria’s patrilineal and patriarchal societies also makes it difficult for
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

women, especially single mothers, to register the births or deaths of their children by themselves and thus perpetrating all kinds of inequities.

Apart from the practice of Purdah, a large cohort of women in the same Northern states of Nigeria otherwise called the -Sahelian region are also faced with a negative reality of having malnourished children. Here, poor feeding and care practices, food shortages, in combination with unsanitary living conditions, precipitated stunting of children in the North. The age cohort of children eligible to access health care services provided in CMAM sites is 06-59 months.

Within the CMAM sites/health centers, one of the determinant factor for measuring the severity of malnutrition and the appropriate health care to be provided is the age of the child. Verification and determining the precise age to ensure appropriate treatment of the child remains a challenge due to non-registration of births of most of the children. Children seen in the CMAM sites tend to belong to poor parents, living in rural areas, have limited access to health care and are not attending early childhood education. They are mostly born without the support of a health professional or midwife and the mothers have low levels of formal education. The lack of a birth certificate affects planning and denies these children access to quality education or health services, or realizing their right to legal protection as children.

The methodological and conceptual framework

It is important to state here that the practice of Purdah is clearly supporting and sustaining the attitude of most of these Northern women who are socio-economically backward, disadvantaged educationally, with poor feeding and care practices for their children and unable to register the birth and death of their children. While there is no empirical data to determine the number of women in Purdah compared with those who are not, the inference and categorization is such that they are living in the same environment, are facing the same challenges and apparently have common beliefs and social expectation. The same collective behaviors are found in these communities.

Women in Purdah/or a form of seclusion have limited socialization and cannot freely go out to make friends, except with fellow women in Purdah. Under the civil registration system, these women and their children – do not exist - as acquiring travel documents and identity cards/documents remains difficult or impossible as they are not allowed to show their faces fully. They and their children also face health challenges as they are often unable to get

\(^{3}\)Ibid.  
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

proper medical care, especially during pregnancy, and regular physical health check-ups. Marriage at an early age is common and for this reason purdah tends to interfere with the continuation of school up to tertiary level.

To create the necessary linkages, it is important to state here that the specific practice fuelling the limited knowledge base - of women not registering the birth or deaths of their children – also stem from a cultural practice based on deep rooted religious beliefs. These have developed attitudes or norm of massive ignorance, academic backwardness and being educationally disadvantaged. Here the act of non-registration can be termed a practice/custom because there is an unconditional preference inferred based on the fact that most women do not register the births of their children irrespective of what other women say, do or think. There are no sanctions meted out to women who are not or who would not register the birth/death of their children.

On the other hand, one can emphatically state that the practice of Purdah is a social norm. Here, the women are found to comply with the diagnosis that a violation of the Purdah as a way of life is meted with such sanctions from their husbands and their ‘reference network’ sees those who would not comply/conform as rebellious and disrespectful. This can be seen as a social norm from the definition that: “Social Norms are often held in place by the expectation that informal sanctions such as approval or disapproval will ensue from compliance and non-compliance with the norm”5. And that a social norm is a pattern of behavior such that individuals prefer to conform to it on the condition that they believe that most people in their relevant network: a) conform to it (empirical expectation); and b) believe that they ought to conform to it (normative expectation)6.

Purdah as a practice is a social norm and a rule of behavior such that individual women prefer to conform to it, on condition that they believe that most women in their relevant network conform to it (empirical expectation) and that most women in their relevant network believe they ought to conform it (normative expectation). It is therefore important to state that it is the social norm of seclusion and ignorance of most of these women that is sustaining and perpetrating their limited knowledge base, general backwardness and pervasive ignorance of the importance of birth/death registration and persistent low coverage.

Furthermore, the ‘script’ or factual beliefs for a lot of very rural women in Northern Nigeria whether in Purdah or not features “delivering of babies in their homes”, not accessing health care services, disadvantaged educationally and with poor socio economic status”, exposed to

6 Ibid.
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

cultural practices based on deep rooted religious beliefs - impacting negatively on the registering of births and deaths of their children and other health indicators.

There is therefore a serious need to propose a different script and a new alternative to induce a change in their social expectations and factual beliefs and (empirical expectation) of “I belief I should be subject to my husband’ or stay at home (in Purdah); “I can deliver my babies at home, I do not need to get to the hospital or health centre”; “there is no need to register the birth or death of my children”; registering the birth of my children is not important”. Their preference (normative expectation) to conform to this life style because “they believe that most women in their relevant network believe they should conform” also needs to be changed.

The social expectation therefore needs to change to ensure that both their empirical and normative expectation NO LONGER UPHOLD the social norm of seclusion, limited knowledge base, ignorance, backwardness, lack of awareness of accessing health centres and registering the birth of their children. Incidentally, birth and death registration activities predominantly take place in health centres.

Critical evaluation of the work so far

As a coordinated action to create change, the National Population Commission (NPopC) – the Commission with the mandate to register birth and deaths embarked on a pilot inclusion of birth registration in public health campaigns. This is during the twice yearly rounds of Maternal, Neonatal and Child Health Weeks (MNCHW) and the Immunization Plus Days (IPDs). The MNCHW was declared to ensure that all children 0-59 months or under-five (the same target for the birth registration focus population) are reached and vaccinated with potent OPV vaccine. A combination of vaccination and service delivery strategies was employed by the National Primary Health Care Development Agency (NPHCDA) to reduce the proportion of unimmunized children and that of infant mortality rates especially in the Northern states.

NPopC thus developed a systemic partnership with the Ministry of Health and NPHCDA – to create change and trigger the initial sets of action through integrating birth registration activities into the standard package for the public health campaigns. This is to effectively mobilize community-based structures to reach parents and care givers of the under-five population mostly unregistered and also in the Northern part of Nigeria. An efficient approach to ensure births of children 0-59 months/under-five are registered during immunization campaigns was considered.
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

Two sets of core group members were formed, starting with Health Social Mobilization group. To disrupt the script so that the negative norms be abandoned and a new one created, the social mobilization team analyzed and had a good understanding of specific of communities where the seclusion are practiced, where the majority of women give birth at home, do not access the health centres and where there was a massive ignorance and very low awareness of birth and death registration. It is important to state here that the issue of death registration was played down considerably during the MNCHW.

The social network analysis was conducted. Low level of awareness of importance of health care services, including birth registration services was identified as impediments to realising universal coverage of birth registration. This was, fuelled by the Islamic practice of Purdah, or seclusion. The communication strategy focused initially on influential MEN- in the communities, religious and traditional leaders- considered as ‘high degree nodes’. The critical role of religious and traditional leaders in development efforts was critically pursued and in a systematic manner. The traditional and religious leaders were approached and the reasons to change or abandon the norm of seclusion were discussed.

They were briefed on the essence of allowing the women to access the health care services including on birth registration. Since the traditional rulers wielded a considerable social and political influence, these used their established network of people, organization and physical infrastructure especially at the community levels including the use of town criers/to promote messages on coming out massively to attend the health centres and to register the birth of their children. They were made to shift grounds on the seclusion norm and women’s social expectation was changed, for women trooped out in their thousands to access the package of health care services available at the health centres including birth registration.

The communication strategy focused on the development and dissemination of IEC materials to sensitize and motivate parents and pregnant women to bring their children to the health centres/facilities so that they can receive key preventive health services including on birth registration. The IEC materials which included the importance of birth registration were distributed as part of the health promotion activities both to the mothers and care givers as well as community/local leaders, traditional/religious rulers and other influential persons within the local government area.

Incentives were introduced into the messages stating the importance of birth registration. Mothers were told that obtaining birth certificates will facilitate obtaining a passport to enable the children travel to Mecca – holy pilgrimage- when he grows up. Based on their religious beliefs, a muslim must go to Mecca at least once in his or life time. With the change in social expectations of the cohort of women and men, brought about by the
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

influence of the social mobilization team working with the influential in the communities, there was a shift in the norms. Entire communities were mobilized to access health care services and register the births of their children. There was a precise and empirical change in social expectations. Women were made/allowed by their husbands to access health care services and register the births of their children. Individual women changed their beliefs and registered the birth of their children, because other women in their reference networks (within the same communities) conformed to registering (empirical expectations). Further, women did register their children because most women in their relevant networks believe that they ought to conform/ought to leave their homes and enclaves and come out to register their children (normative expectations). And in the word of Gerry Mackie (2013) ‘enough people believe that enough people are changing’.

Within the same reporting time and prior to the commencement of the MNCHW, a preparatory consultation and value deliberations between the NPHCDA and NPopC was held in Kano state - Northern part of Nigeria being the second core group to trigger the integration activities. The second core group during the consultation clarified key issues and mapped out the diffusion strategy. These include logistics, roles and responsibilities of different teams- involving birth registrars, health social mobilization teams, sub-registrars and health facility personnel participating in the MNCHW activities. A systematic approach to planning and implementing key activities according to well-outlined schedules were under-taken by all parties (NPOPC and NPHCDA) including State, LGA and Ward officials. The diffusion was coordinated.

The NPHCDA through House-to-House (H-H) engagements, established Fixed Posts (FP) and use of Special Teams (ST) to ensure diffusions and out-reach to thousands of women/mothers/care givers of millions of under-five children, living in all wards and communities including remote, excluded and hard to reach areas, wards and communities in the Northern part of Nigeria.

During the MNCHW, the House to House (H-H) teams visited remote and hard-to-reach households. The Special Teams were deployed to open grounds, market places and other transit points to conduct both immunization and birth registration activities. At the Fixed Posts, the arrangement was made to place birth registrars in a conspicuous place in the designated health centers- so that everyone coming in would face birth registration. Also a Crowd Controller managed the flow of the women/care givers accessing health services (i.e. immunization and nutrition information) and drew attention to the birth registrars.

The birth registration integration into the two rounds of MNCHW in 2010 as a pilot initiative was successful, resulting in considerate improvement of birth registration coverage as follows:
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

- **334,027** births from 33 states and Federal Capital Territory registered in May/June rounds.
- **716,577** births of under-five children in 35 states and the Federal Capital Territory registered during the November/December rounds.
- Within the two rounds of MNCHW, about **1,050,604** births were registered during the 8-day duration of both rounds.

**State by State results**

**May/June Rounds**

**Nov/Dec Rounds**

The role of legal, moral and social norms in creating change.

The ‘Births and Deaths (Compulsory Registration)’ Act No.39 of 1979’ and Act 69 of 1992 provides for the establishment of the National Population Commission (NPopC) and a uniform and compulsory national system of civil registration. The Commission directs and monitors nationwide - the birth registration systems - by setting national standards and uniform registration procedures for all civil registration and vital events occurring within the country of Nigeria. In spite the legal framework, coverage remains persistently low. But with the triggering activities, persuasion of the men, religious leaders, social mobilization campaign and influences of the reference networks of women in communities, a lot was changed. The combination of bringing out the wrong effects of giving births at home and that of not accessing health care services coupled with the community’s sensitivity to the social norm, determined the women’s compliance with the
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

*legal norm* of registering their births and accessing health centres. The appeal of Social Mobilization team to the religious and traditional leaders relating the benefits of women accessing immunization, malnutrition and birth registration services (moral norm) couple with the leaders consent all combined to tackle the problems of registering births of children and improving coverage during the MNCHW.

**What did not work**

Expectations in the communities were manipulated to encourage cohorts of women to troop out to access the health care delivery and birth registration services. But the issue of death registration was not raised and the core belief of keeping women in the background, poor education status especially the social norm/core belief/deep rooted belief of Purdah was not affected. There is need for more research in social psychology to deal with the attitudes, behaviours and beliefs that perpetuates practice of purdah, unequal power relations, and educational backwardness of many women in the northern part of Nigeria, including low level awareness of the importance of registering the births and deaths of children- with all its implications for development.

**Plan of action to promote institutional shift**

With the ground work done through the health social mobilization team and the religious and traditional leaders encouraging massive participation of women, it is important to build on this foundation, since its pointing to the fact that change is possible. There is the need to facilitate dialogue and collective action in numerous communities in the Northern part of Nigeria modelling on participatory social change. A systemic communication strategy will be employed to identify areas of agreement amongst those participating to change the norms and ensure an increased demand for births and death registration. Engagement will usually be through face-to-face dialogue among community members. The long term goal will be to change the social norms and collective practices and for communities to develop community-owned sustainable solutions to the identified problems. Successful models learnt at UPenn will be employed to create change- as follows:

**Diagnostic Study**

Since the cultural values of the people of Northern Nigeria are practically shaped by religion, a core group and a pool of highly placed Muslim Clerics, Academia, Ulamas, traditional leaders, versed in Islamic Law will be contacted. These would be engaged to deliberate and come up with information from the Quran that is in favour of women and that will change the norms, core beliefs, attitudes and behaviours towards them. Social
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

expectations around healthy practices, focusing on birth and death registration including registering deaths and cause of death of children will be precisely discussed to bring out Quranic facts and messages - that registering death and the cause of death will help the living and will enable them to monitor the impact of childhood deaths. Based on the positive findings, specific messages like: “allow your girls to be educated”; “perform healthy practices”; “attend and give birth in health centres to immunize your child”; and “register the births and deaths of your child” will be developed into IEC materials.

Public Declaration
The messages will be shared with the influential religious groups and traditional leaders for their endorsement. These being the next level of target group. A public declaration day will be organized, to publicize the messages. Print and electronic media will play a big part in diffusing the messages, the implications for women and to increase demand for births and deaths registration.

Diffusion
The next level will be working with civil society networks to engage with women leaders and women groups in different communities. These would work together to identify specific collective actions that will promote the messages and ensure its outreach to very rural, remote and hard to reach communities. Market women and other women leaders will be used as vanguards to broadcast the messages from one village to another as endorsed by the influential religious and traditional leaders. The civil society groups will support women to use theatre, role plays, games and poetry to diffuse the messages.

The existing community structure - of town criers⁷ will be harnessed to transmit ON REGULAR BASIS the message and acts as Bridges from one community to another and spread the information about the new practices, messages and information as agreed during the public declaration and the dialogue process of women leaders and fathers groups.

Strengthening male dominated core groups

Fathers and prospective fathers’ groups will also be formed in different communities - made up of married and unmarried men, fathers, fathers’ in law and leaders of youth groups-mostly male. These will be galvanized to endorse and spread the message, to meet regularly to have values deliberations about changing values on girls and women, moral norms, factual beliefs and other community practices that are not in favor of women. Other discussions will focus on their involvement to change the social norms and give space for

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⁷ Town criers are local media agents who announces news and information within local settings and communities
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

the women, including accepting to register the births and deaths of their children-themselves.

Social marketing
Media engagement with identified Local Government Chairpersons, wives of the State Governors, highly placed community leaders (rich men with influence and respected) will be undertaken in order to capitalize on good practices and local commitment in promoting universal birth registration, and to stimulate cross-fertilization of ideas among community members. Visit of wives of governors will be conducted around health centres to demonstrate healthy practices and registering births and deaths of children including especially raising issues around importance of registering deaths. Visits will be publicised in the print and electronic media to draw attention to high visibility and importance of registering births and deaths of children.

Measuring change
A monitoring mechanism on change in attitudes and behaviors will be agreed and employed by both the NPopC and NPHCDA. Specific number of health centers and records of attendance/registration in each of the communities are noted as a baseline. Change in attitudes will be measured within 6 to 9 or 12 months after the specific interventions and coordinated shifts have commenced, specifically from the date of ‘Public Declaration”. Hospital records and number of births/deaths registered will be tracked and documented to measure the increase and improvements recorded. Efficient monitoring mechanism will be in place. Relevant M and E indicators will be used.

Sustainability:
Birth registrars and health workers report progress and increase in birth/death registration to the influential religious/traditional leader on consistent basis. The religious/traditional leaders also on regular basis diffuse through his community structures the progress being made. Where any drop is noticed, the same channel would be used to create further awareness and sustain the momentum.

Conclusion
The outreach/community based service delivery strategy of the MNCHW offered a unique opportunity for the birth registration of a wide cohort of under-five children in the Northern part of the country. The approach was to raise awareness on the importance of birth registration and deal with socio cultural barriers, unequal power relations and patriarchal beliefs that persistently limits mothers and care givers to register their children.

The Health Social Mobilization teams and birth registrars’ capabilities to ensure a common strategy to promote birth registration messages at the lowest/ward level, led to change in
Using a Social Norm Perspective to address low birth registration coverage and improve death registration practices in Nigeria

social behaviour, drew attention to the importance of birth registration and resultant increase in birth registration coverage during the MNCHWs and beyond. The approach will be further accelerated by successful models learnt at UPenn and these will be employed to create further change.