



THE GOMBE STATE

Village Health Workers Scheme

Documentation of the Village Health Workers Scheme - Implemented by the Gombe State Primary Health Care Development Agency, Gombe State Nigeria

October 2017



Forward

The Village Health Worker (VHW) intervention in Gombe State is a timely and innovative response to the relatively high incidence of maternal, neonatal and child morbidity and mortality. The Village Health Workers Scheme is co-funded by The Bill and Melinda Gates Foundation and the Gombe State Primary Healthcare Development Agency with technical aid from the Society for Family Health while receiving active support from Pact, Evidence for Action and IDEAS.

The Maternal, Neonatal and Child Health Project in Gombe State have undergone various forms of transformation ranging from implementation through the use of Traditional Birth Attendants (with support from a state owned call center) to the use of Village Health Workers (with greater community and state involvement). This major modification from the first strategy was because the TBA strategy was unable to sustain the apparent progress being made over time and in a quality manner. It also lacked the requisite buy-in from various stakeholders for sustainability.

The goal of the Village Health Workers Scheme is to take relevant health information and services to women in their homes using trained local women who are bona fide members of the community. These women engage with the community in a language and custom they are familiar with. The fact that these women are indigenous fosters trust and encourages community members to visit the health facility regularly for their antenatal, delivery, postnatal and child health services.

This scheme is not without its own challenges such as the recruitment of appropriate volunteers and issues around attrition. Nevertheless, the project found ways of engaging the best available VHW fit for the respective intervention communities, built their capacities to create demand on health-seeking behaviors and motivate community members for health facility delivery.

This document which was developed in line with the National VHW Roadmap of the National Primary Healthcare Development Agency essentially serves to painstakingly provide the step-by-step procedure on how the VHW Scheme was conceptualized, designed, implemented and monitored in the hopes that it would be replicated by other State Governments to yield improved healthcare for mothers and children across board.

Dr. Ahmed Gana (Executive Secretary, Gombe State PHC Development Board)

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We are grateful to the Bill and Melinda Gates Foundation for co-funding this project and to the Gombe State Government through the instrumentality of the Executive Secretary, Gombe State Primary Healthcare Development Agency and the entire Agency team for taking ownership of the project and co-funding it to ensure sustainability. This is an example we hope other States Governments will emulate.

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We are also thankful to the National Primary Healthcare Development Agency officials who provided leadership and explanations on National Roadmap for Community Health Workers which was reviewed to suit the peculiarities of Gombe State.

We are especially thankful to the management of SFH as well as the other Gombe MNCH2 project team members who have supported the Project Team in working tirelessly to bring this project to fruition.

Magdalene Okolo (*Project Director, Gombe MNCH Project, Society for Family Health*)

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List of Acronyms

ANC:	Antenatal Care
BMGF:	Bill and Melinda Gates Foundation
C4C:	Champions for Change
CHEW:	Community Health Extension Workers
CHW:	Community Health Workers
CTV:	Community Transport Volunteer
DHSD:	Director, Health System Development
DPD:	Deputy Programme Director
DPRS:	Director, Planning Research and Statistics
E4A:	Evidence for Action
ES:	Executive Secretary
ETS:	Emergency Transport Scheme
FMoH:	Federal Ministry of Health
FOMWAN:	Federation of Muslim Women Organisation of Nigeria
FP:	Family Planning
GSPHCDA:	Gombe State Primary Health Care Development Agency
IDEAS:	Informed Decisions for Actions in Maternal and Newborn Health
IPC:	Interpersonal Communication
ISS:	Integrated Support Supervision
JCHEW:	Junior Community Health Extension Workers
LGAs:	Local Government Areas
LLIN:	Long Lasting Insecticidal treated Net
MCH:	Mother and Child Health
MDG:	Millennium Development Goal
MMR:	Maternal Mortality Ratio
MNCH:	Maternal, Neonatal and Child Health
MNHC:	Maternal and Neonatal Health Care
MoU:	Memorandum of Understanding
NDHS:	Nigeria Demographic and Health Survey
NGOs:	Non-Governmental Organisations
NMR:	Neonatal Mortality Rate
NPHCDA:	National Primary Healthcare Development Agency
PD:	Project Director
PHC:	Primary Health Care
PPMVs:	Proprietary Patent Medicine Vendors
PSC:	Project Steering Committee
SAQIP:	State Accountability for Quality Improvement Project
SBA:	Skilled Birth Attendant
SDG:	Sustainable Development Goal
SFH:	Society for Family Health
SMoH:	State Ministry of Health
SMS:	Short Message Service
SSV:	Supportive Supervisory Visit
SURE-P:	Subsidy Reinvestment and Empowerment Programme
TBA:	Traditional Birth Attendant
ToR:	Terms of Reference
TSS:	Training Supply and Supervision
UNICEF:	United Nations Children's Fund
VHW:	Village Health Worker
WDC:	Ward Development Committee

Executive Summary

The population of Nigeria is estimated to be 190 million (est) 2016, with an estimated population growth rate of 2.44% (est 2016), fertility rate of 5.13 children per woman (2016 est), birth rate of 37.3 births per 1000 population and death rate of 12.7 per 1000 population.

Although the quality of health services, coverage, and accessibility still produce major challenges, Nigeria has recorded a reduction in the infant mortality rate from 127 per 1,000 live births in 1990 to 71.2 per 1,000 live births in 2016 (est) and maternal mortality rate at 814 death per 100,000 live births 2015 (est). While both rates are declining, Nigeria is still falling short in achieving her health goals to the populace especially women, neonates and children. Vaccine-preventable deaths, such as pneumonia, diarrhea, and measles, account for about 40% of all deaths among children under-five in Nigeria. Other significant causes of death are malaria, neonatal causes ante and post-natal complications.

The concept of the village Health Workers scheme (VHW) in Nigeria and some other parts of the world is a community-based intervention aimed at creating a lower level cadre of health workers who can be trained quickly to deliver preventive and curative maternal, neonatal and child health care services at the household level. This cadre of health workers are called Village Health Workers (VHWs) and referred to as Community Health Workers (CHWs) in some other countries. It is a viable basic health care delivery model, particularly impactful in rural communities for the provision of preventive, diagnostic, and curative services in the community directly at household levels as a first step contact for basic health care service delivery geared towards encouraging and improving access and patronage to the more established primary health care facilities.

The overall aim and objective of this initiative is to accelerate the Government's effort to reduce maternal, neonatal and child morbidity and mortality rates both at the National and State levels through active community engagement and mobilization strategies especially in the rural areas where majority of the death cases are recorded.

The VHWs program involves the recruitment, training and equipping Village Health Workers (VHWs) within their communities to educate the local women and their key influencers to seek pre, peri and post-natal care at the nearest health facilities manned by skilled health care workers. The VHWs are also to educate the women and their family influencers on how to improve key household practices for basic health hygiene for themselves, children and neonates and how to manage and treat minor illnesses and diseases such as malaria and diarrhea in children and infants.

The Gombe State Primary Health Care Agency (GSPHCDA) responded to this clarion call in the wake of increasing maternal and neonatal deaths in the state to initiate and implement the VHWs scheme program with the financial and technical support of the Bill and Melinda Gates Foundation (BMGF) and the Society for Family Health (SFH) respectively. The (GSPHCDA) adapted extracts from the National VHW Roadmap developed by the National Primary Health Care Development Agency (NPHCDA) to design the methodology for the implementation with supportive inputs from other BMGF grantees working in the state in like of PACT, Evidence for Action and IDEAS.

This document is a compilation of the stepwise procedures and activities deployed to set up and operationalize the Village Health Workers scheme in Gombe State. It is meant to be a useful guide on

how to conceptualize, design and implement the VHW scheme for future program extension and scale up.

The whole program roll out was divided into two stages namely the **Design** and the **Implementation stages**

The major activity steps for the design stage are:

- i. Review of the National Roadmap document with relevant stakeholders
- ii. Adaptation and adoption of VHW Roadmap for Gombe State
- iii. Development of a zero draft Gombe State VHW training manual
- iv. Development of relevant training materials – curriculum and guide
- v. Review of the VHW training manual by the donor & GSPHCDA
- vi. Meeting of collaborating partners to harmonize roles
- vii. Review of the planned VHW scheme with relevant stakeholders (Alignment Meeting)

The Major activity steps deployed for the implementation are:

- i. Selection and verification of identified VHW volunteers
- ii. Procurement of work tools and supplies
- iii. Planning of the training of trainers and step down trainings
- iv. Launch and deployment of the trained VHWs

Operationalizing each of the above-mentioned steps involved series of meetings among supporting partners and stakeholders within and outside Gombe State to clarify and harmonize the stakeholders roles. Success stories, challenges, proffered solutions and lessons learnt during the different stages of the program implementation are all documented to close identified gaps and facilitate improved program implementation in future.

SECTION ONE – Introduction

The Village Health Workers scheme was initiated in Nigeria and since being implemented upon the backdrop of some persistent historical background of the National Maternal, Neonatal and Child Health indices particularly in the Northern zones of the nation.

- An overview of Maternal, Newborn and Child Health (MNCH) situation in Nigeria with attention on the North East region and Gombe State in particular,
- The National Village Health Workers Roadmap
- The Village Health Workers Scheme in Nigeria
- Overview/Profile of Gombe State
- Gombe State Primary Health Care Development Agency (GSPHCDA)
- MNCH Responses in Gombe State

1.1 Overview of Maternal, Newborn and Child Health (MNCH) Situation in Nigeria

Over the years, there has been increased attention on the issue of maternal, newborn and child health in Nigeria. The undesirable, but growing incidence of maternal and child mortality rates have attracted intense augmentation of the Government's response and intervention efforts by local and international development partners to curb the situation.

The current Nigeria Demographic and Health Survey (NDHS, 2013) records shows that the country has a neonatal mortality rate of 37 per 1000 live births; an under-5 mortality rate of 128 per 1000 live births and a maternal mortality ratio of 576 deaths per 100,000 live births. Annual deaths recorded for neonates is 260,000; under-5 - 854,000 and maternal – 40,500 respectively. This is far reached from the globally agreed 3rd Sustainable development goal (SDGs) targets to reduce the global maternal mortality ratio to less than 70 per 100,000 live births, reduce neonatal mortality to as low as 12 per 1,000 live births, under-5 mortality to at least as low as 25 per 1,000 live births and end preventable deaths of newborns and children under 5 years of age by 2030.

As stated in a publication released by UNICEF, Nigeria loses about 2,300 under-5 year olds and 145 women of childbearing age every single day, making the country the **second largest contributor to the under-5 and maternal mortality rate in the world**. The publication further reports that the deaths of newborn babies in Nigeria represent a quarter of the total number of deaths of children worldwide with majority of these deaths occurring within the first week of life, mainly due to complications during pregnancy and delivery.

Major causes of neonatal deaths have been identified as birth asphyxia, severe infection including tetanus and premature birth most of which could have been averted if the women and babies had access to timely essential and basic care interventions.

The report acknowledged the progress Nigeria has made so far in cutting down maternal, newborn and under-5 mortality rates, but stressed that the pace still remains slow as a woman's chance of dying from pregnancy and childbirth in Nigeria is still as high as 1 in 13. This demise is due to inadequate coverage, low access and quality of health care services in Nigeria with less than 20 per cent of health facilities offering emergency obstetric care and only 35 per cent of deliveries are attended by skilled birth attendants (UNICEF, 2015).

1.2 MNCH Demography of the North –East Region.

There is wide regional disparities in the maternal, newborn and child health indicators in Nigeria with the North-East and North-West geopolitical regions having the worst case incidences. In the 2013 NDHS, the North East region which house Gombe state has the worst MNCH indices amongst all regions in Nigeria with the highest maternal mortality rate of **1,549 deaths per 100,000 live births**, compared to 165 deaths per 100,000 live births in the South West region as well as the **national estimate of 576 deaths per 100,000 live births**. The region has a persistently high neonatal mortality rate (NMR). In 2013, more than 4 percent of newborns died in the first 28 days, or 43 newborns per 1,000 compared to the national level NMR of 37 in same year. This is quite far reachable from the globally agreed target of 12 per 1,000 by 2030. In addition, the under-5 child mortality rate in the North East region of Nigeria, which includes Gombe State is 160 deaths per 1000 children, above the national average of 128 deaths per 1,000 children.



Pix 1: BMGF officials interacting with some VHWs after their initial training

1.3 Brief Demography of Gombe State

Gombe State was created October 1, 1996. It is located in the heart of the north east region of Nigeria and is the only State that shares boundary with every other State in the region. It shares boundary with Yobe and Bauchi States in the north, with Bauchi State in the west, with Taraba and Adamawa States in the south and in the east with Yobe and Borno States. Dubbed the 'Jewel in the Savannah' for its unique vegetation and expansive flat Savannah land. Gombe state has an area of 20,265 km² and a population of about 2.4 million people (2006 National Census). The state has 11 local government areas and three senatorial districts, 114 wards and 14 emirates/chiefdoms.



Pix 2: Vast vegetation/flat table land typical of Gombe State

The State is a multi-ethnic society with a dominant Fulani tribe inhabiting the Northern part of the state and other ethnic groups such as the Tera, Waja, Bolewa, Kanuri and Hausa with their different cultural as well as lingual affiliations. The State capital - Gombe, is a reflection of the heterogeneity of the State. The people of Gombe state are primarily farmers producing food and cash crops.

Table 1: Composition of Gombe State LGA's Population and Area.

LGA	Area (km ²)	Census 2006 population	Headquarters	Postal code
Akko	2,627	337,853	Kumo	771
Balanga	1,626	212,549	Tallase	761
Billiri	737	202,144	Billiri	771
Dukku	3,815	207,190	Dukku	760
Funakaye	1,415	236,087	Bajoga	762
Gombe	52	268,000	Gombe City	760
Kaltungo	881	149,805	Kaltungo	770
Kwami	1,787	195,298	Mallam Sidi	760
Nafada	1,586	138,185	Nafada	762
Shongom	922	151,520	Boh	770
Yamaltu/Deba	1,981	255,248	Deba Habe	761

Source: National Population Commission, 2006 Census

1.4 Gombe State Primary Health Care Development Agency (GSPHCDA)

The GSPHCDA was established in November 2011 and commenced operations in 2013. It is headed by an Executive Secretary who is assisted by several directors in its numerous units. Since inception, the agency with the keen support of development partners such as the Bill and Melinda Gates Foundation has developed and progressively implementing both short and Long term plans to address the identified PHC gaps and needs in the states following an initial comprehensive needs assessment survey. One of the major focus is the Maternal and Neonatal and Child health issues in the state



Pix 3: Headquarters of the GSPHCDA located at GRA, Gombe

1.5 Overview of MNCH and the interventions in Gombe State

Gombe state has a history of persistently high MNCH mortality rates and rated one of the highest in the world till date. The efforts of the State Government through its appropriate MDAs and their supporting partners have shown only marginal reductions in recent years. Table 2 below shows some of the current indices on maternal and child health care in the state. Preventable diseases, including those identifiable and in many cases in the homes. The health sector in Gombe is affected by some basic factors that limits its ability to effectively address the undesirable trend in MNCH. Chief among them are weak health systems, financial and cultural barriers and weak community accountability structures. Like in most other parts of Nigeria, access to health services in Gombe is limited by a variety of factors, including uneven infrastructural development and functionality, poor quality of care delivery, supply chain management challenges, inadequate human resources for health, shortages in skilled providers at the facility level in rural and low resourced areas' public facilities. Low health seeking behaviour (or demand for critical services), largely driven by a loss of confidence in the health system is also a critical contributory factor. treatable at household level such as malaria, respiratory infections and under nutrition, account for most of the child morbidity and mortality. Most deaths in rural and hard-to-reach areas occur in the homes.

The health sector in Gombe is affected by some basic factors that limits its ability to effectively address the undesirable trend in MNCH. Chief among them are weak health systems, financial and cultural barriers and weak community accountability structures. Like in most other parts of Nigeria, access to health services in Gombe is limited by a variety of factors, including uneven infrastructural development and functionality, poor quality of care delivery, supply chain management challenges, inadequate human resources for health, shortages in skilled providers at the facility level in rural and low resourced areas' public facilities. Low health seeking behaviour (or demand for critical services), largely driven by a loss of confidence in the health system is also a critical contributory factor. There is therefore urgent need for continuous and intensive promotion of maternal and newborn health education within the communities to improve the care provided to mother and baby immediately after birth, increasing demand and access to available PHC services and strengthening the supply of quality care in PHC facilities.

There have been several Maternal and Child Health interventions in Gombe state most of which were driven by the State Ministry of Health in collaboration with international development partners and local NGOs before the establishment of GSPHCDA. Dating back to 2007, the Society for Family Health (SFH) initiated projects aimed at promoting maternal and child survival to reduce the avoidable death tolls. The focus was initially on making delivery safe improving hygiene behaviour through the use of hand gloves during delivery and using clean delivering kits among others. The next level of interventions was training the Traditional Birth Attendants (TBAs) and involving other stakeholders like FOMWAN, establishing Call Centres, etc. the ETS and Call Centre activities were initiated; all aimed at testing which approach model is most effective so to determine what could be scaled up.

Recently, the BMGF in its relentless efforts to save more lives of mothers and children engaged SFH and other partners in a MNCH project which have been implemented in phases. The first phase was the learning phase which lasted for 2 years. During this phase, innovative approaches were adopted to scale up existing community practices and use this model increase demand and access to skilled health care service for both mother and child at the health care facilities right from the period of pregnancy through to delivery and critical initial post-natal neonate and maternal care.

The first three drivers in the Learning Phase were the TBAs, FOMWAN, and PPMVs, then the ETS and Call Centre activities were initiated; all aimed at testing which approach model is most effective to determine what could be scaled up.



Pix 4: Primary Health Care facility at Tumu community, Akko LGA



Pix 5: Primary Health Care facility in Akko ward, Akko LGA, Gombe State



Pix 6: Some rural sights - Bojude community and Bannin-Belle (a hard-to-reach settlement) both in Kwami LGA, Gombe State

Table 2: Some Current MNCH Indicators In Gombe State

S/N	Indicators	Range	
		2015	2016
1	Percentage of pregnant women who reported for antenatal care before 20 weeks	35%	36%
2	Percentage of pregnant women who reported for antenatal care greater/equal 20 weeks	65%	64%
3	Percentage of pregnant women that attended at least 4 antenatal visits	73%	65%
4	Percentage of pregnant women who received malaria IPT2	31%	24%
5	Percentage of pregnant women who attend post natal clinic visit within 3 days of delivery	13%	14%
6	Percentage of women who had normal vaginal delivery	60%	87%
7	Percentage of caesarian section deliveries	4%	1%
8	Percentage of assisted vaginal deliveries	37%	12%
9	Percentage of all deliveries that are preterm	0.5%	9%
10	Percentage of deliveries – HIV positive women (booked)	50%	68%
11	Percentage of deliveries monitored with partograph	5%	3%
12	Percentage deliveries with skilled birth attendance	27%	19%
13	Percentage of all deliveries that are still birth	*14%	*3%
14	Percentage of fully immunized children under 1 year	38%	36%
15	Percentage of children 0-6 months exclusively breast-fed	16%	19%
16	Percentage of children with diarrhea under 5 years – New cases given ORS & Zinc	48%	37%
17	Percentage of acceptors new to family planning	46%	36%
18	Percentage of females aged 15 – 49 years using methods of modern contraceptives	5%	7%
Colour Keys/Thresholds			
75 – 100% - Good Progress			
50 – 74% - Some Progress			
0 – 49% - Insufficient Progress			

Source: GSPHCDA – District Health Information System 2

1.6. The Village Health Workers Programme in Nigeria

In frantic efforts to reduce the high incidence of maternal, neonatal and child mortality rates in Nigeria, health authorities and other major stakeholders have initiated several interventions to address the issues at different levels, using different approach models to ease off bottlenecks, with the eventuality of creating more demand for skilled birth attendance by the women especially those



Pix 7: Gombe State VHWs displaying their work kits and tools

at the high risk and low resource areas. One of such initiatives is the Village Health Workers (VHW) scheme. The VHWs is a community-based intervention aimed at creating a lower level cadre of community healthcare workers who can be trained quickly to deliver preventive and curative services at the community household level. This special cadre of health care workers are called the Village Health Workers (VHWs) or otherwise called the Community Health Workers in some other countries. The VHWs is a viable model that has proven useful in rural community settings and hard to reach locations to

serve as a first step provision of prompt preventive, diagnostic, and curative services in the community households with a bid to create the needed demand and engagement with primary health care services.

The village Health workers are meant to support the already existing cadres of health care workers which include the Nurses, Midwives, Community Health Extension Workers (CHEWs) and the Junior Community Health Extension Workers (JCHEWs).

The VHW initiative has been tested and implemented in some countries in Africa, South America and Asia to address specific health issues of priority and concern; for example in Brazil, it was designed to address the growing prevalence of HIV/AIDS. While in Tanzania the emphasis was on maternal and child health. Other countries where the model has been used include; India, Ethiopia, Malawi and Zimbabwe.

Gombe State is the first State in Nigeria to develop a State-wide VHW Scheme taking a cue from the recent pilot WHWs implemented in Lagos state, with the support of the Bill and Melinda Gates Foundation (BMGF) and technical aid provided by the Society for Family Health (SFH).

SECTION TWO – Pre- Implementation Activities of the VHWs Scheme

The initiation of the VHWs in Gombe state was preceded by a number of pre-implementation activities to get the appropriate design and direction for the program which were needed to set the right stage for the proper implementation and sustainability of the scheme.

The pre-implementation step wise activities include: *Review of the National Road Map document and other relevant VHW documents; Development of Draft Gombe State VHW Training Manual and other resource materials; Review and ratification of the Draft VHW Training Manual and resource materials by the Donor (BMGF); harmonization of partners' roles and the Development of Implementation work Plan.*

The design of the implementation activities was mostly informed by the lessons learnt from the implementation of the initial MNCH project which was executed through five innovative technical drivers namely the TBAs, FOMWAN, PPMVs, ETS and call centre projects all funded by the BMGF. Lessons learnt from these projects were then deployed to scale up approach to achieve a more impactful results- oriented VHWs program in line with the initial set objectives of the intervention which is to reduce avoidable maternal neonatal and child deaths and improve demand and access to skilled health care service at the health facilities.

The project had five partnering organisations all funded by BMGF to ensure a wide and more effective program coverage of the state MNCH interventions. These include; the Gombe State Government represented by GSPHCDA, the Society for Family Health (SFH), Pact, Evidence for Action (Mamaye) and IDEAS. The program design concept was mainly adapted and customized for Gombe state from the National Roadmap document on Village Health Workers developed by the National Primary Health Care Development Agency (NPHCDA).

2.1 Review of the National VHW Roadmap and other relevant Documents

The project team conducted a detailed desk review of some existing relevant documents of village Health Workers scheme in the country, chief of which was the National village health workers road map document developed by the NPHCDA. The main objective of the review was to extract key information from the frame work documents which can be adapted and customized for implementation in Gombe state. Other key documents reviewed are the SURE-P VHW manual, SFH VHW flip charts etc.

The team, led by the Gombe state primary health care development agency to facilitate ownership and sustainability held series of meetings to conceptualise the program methodology and design of the different stages of activities. The first of such meetings was held on October 30, 2015 at Gombe with representatives from BMGF, NPHCDA, GSPHCDA, SFH and other BMGF-Grantees to review and adapt the National VHW Roadmap document, plan an advocacy visit to the state Governor to ensure political commitment and state leadership of the program, agree on the scope and the various step wise activities for the implementation of the state VHW scheme.

The team agreed that the initial focus of the program should be MNCH and can later be scaled up to include other health issues prevalent in the state and the intervention scope to cover health promotion for Ante natal care, delivery and immediate post-natal and neonate care, preventive



Pix 8: Planning meeting with GSPHCDA officials, SFH and BMGF Grantees.

health and household hygiene tips and selected curative services for basic minor illnesses in the community for the pregnant women, neonates and children under five years. The Village health workers are to refer all obstetric, neonatal and child emergencies to the nearest PHC facility, distribute some basic commodities such as misoprostol, iron and folic acid, IPTp to the pregnant women, chlorhexidine for newborn cord care, dispense ORT and zinc tablet when needed to treat diarrhea, antimalarial when needed to treat malaria and collect health records from the communities.

2.2 Development and Review of VHW Training manual and Resource Materials

The GSPHCDA engaged some consultants with the technical assistance of SFH to develop the project tools and resource materials which include: the zero draft training curriculum manual, facilitator's guidelines, CHEWs supportive supervision guidelines, Interpersonal Communication (IPC) guidelines and pictorial flipcharts.

Review meetings were organized and held between the SFH and the GSPHCDA team in Gombe state to review the various draft documents presented by the consultants in order to come up with a final draft for presentation to the BMGF representatives.

2.3 Review of the VHW Training Manual and Resource Materials by BMGF

The various developed and adopted draft documents were forwarded to BMGF project team for their input and final ratification. Their Feedback was also reviewed and finally added to the draft documents and materials in a meeting held in Gombe by SFH and relevant directors of GSPHCDA.



Pix 9: One of the document review meeting with donor

2.4 Harmonisation of Roles with Implementing Partners

BMGF grantees implementing complimentary MNCH programs in the Gombe state came together to support and strengthen the implementation processes of the VHWs in the state. Series of meetings were held amongst the grantees to identify various areas of their programs which can be aligned to the implementation strategies of the VHWs. They discussed the level and scope of individual collaborative support and leveraged on that to clarify and harmonise their roles for the effective take off and roll out of the program. The purpose of this collaboration is to leverage on the effort of each of the partners to enhance the expected achievements of the overall program goal; to identify areas of overlap and avoid duplication of efforts; to create synergy for high impact among partners. During these meetings some landmark achievements were made for the preparation of the program roll out. These include; the appropriate alignment of the various resource materials and tools adapted from other working partners; BMGF connected GSPHCDA and SFH with key individuals working on community blood pressure monitoring for improved referral and early identification and management of pregnancy related hypertension; BMGF explored whether IDEAS facility survey could include availability of a prioritized set of FP commodities.

2.5 Development and Review of the Program Implementation Work Plan.

The entire program team and support partners held series of meetings to agree on the program design and develop the implementation work plan. The draft work plan was jointly reviewed with the BMGF team present and adopted. The work plan include major activities such as the Selection criteria; Scope of work for the VHWs; Tool kit (content); Supportive Supervisory Visits (SSVs); VHW stipend and Training programs.



Pix 10: Brainstorming activities during one of the VHW planning meetings

SECTION THREE – Implementation Activities of the VHWS

The VHWS program was implemented in line with the jointly agreed work plan in step wise stages of activities. The activities are:

- Selection and Verification of the VHWS
- Procurement of Work Tools and Supplies
- Planning of the Training
- Trainings
- Program Launch and Deployment

3.1. Selection and Verification

The selection process was preceded by advocacy visits to the community gate keepers in their wards and community; the traditional leaders, community leaders, community influencers. These visits were led by the GSPHCDA officials together with the SFH project team. The purpose of the visits was to introduce the new Village health workers scheme to these key stakeholders to get their buy-in and commitment to the program, backed up by their active support and participation at every level of implementation. The advocacy visits also helped to facilitate and strengthen community engagement which is most needed for successful community awareness and social mobilization programs. During the advocacy meetings to the WDCs and community leaders, the project team educated the gate keepers on the VHWS, its goals, objectives, benefits and the adopted selection criteria for selecting the prospective Village health workers within the communities. The SFH project team supported the GSPHCDA team to organize and coordinate the Ward Development Committees (WDCs) in each of the intervention wards to prepare them for the key roles they will be playing in the implementation activities.

For proper program structuring, the communities were grouped into clusters, using the PHC mapping by the GSPHCDA. The project officer from the GSPHCDA shared the clustered community document with the WDC members and community leaders so they could understand the clustering mapping and VHW nomination and selection strategy which is *one VHW to be selected from each clustered community*.

The WDCs were given the list of the selection criteria which they shared with the community leaders in each of the clustered communities and asked to seek out and nominate 3 volunteers within their communities who fits into the criteria as much as possible. The selection criteria were based on the National VHW Roadmap with minor adjustments for Gombe State as jointly agreed by SFH and GPHCDA as follows:

- *Must be female, preferably married with permission from husband*
- *Community resident*
- *Must have a minimum qualification of primary or secondary school certificate*
- *Age 15 - 50 years*
- *Ability to speak local language*

- *Conversant with norms and values of the community*
- *Must have willingness to link activities to ward health facility*
- *Must have the ability to read and write in English; this enables them provide some basic home-based services (where this is impossible , consideration is given to those that can read in Hausa)*
- *Must not be a community leaders wife*
- *Should not be a TBA*

The nominated volunteers in each of the wards were taken through some **verification** process led by the program officer, PHC team and the WDC through verbal and written examination tests to affirm their eligibility and suitability for the task at hand and the successful ones were finally selected. The nominated VHWs were verified with a developed tool to test their reading skills and a bio-data form given to each of them to fill to test their writing skills. An oral interview was then conducted to assess their willingness to work after which the results were communicated to the community leaders for a possible replacement of the unsuccessful volunteers. The successful ones were asked to submit one self-passport photograph each for proper documentation.

The PHC Coordinators of the GSPHCDA provided regular briefs on the selection process to SFH and GSPHCDA management to ensure proper coordination and management. SFH conducted an independent verification to authenticate the women who met the selection criteria. The team used a strategy termed- "operation show your certificate" to confirm the claims of those selected by the WDCs.

The GSPHCDA and SFH held meetings to proffer solutions on areas where the required numbers of volunteers were not met as a result of shortage of qualified personnel. A consensus was reached to drop any Ward that did not have up to 50% of the required number of volunteers to be trained as VHW.

3.2. Procurement of Work Tools and Supplies

One of the major deliverables for SFH outside of providing technical support was the procurement and distribution of commodity (supplies and consumables). SFH commenced the procurement and production of the work tools and training materials on time to meet the scheduled time for the VHWs training; these include: data collection tools and VHW Tool kits (Umbrella, flip charts, VHW register, drugs, water bottle, among others). This was necessary to ensure that the training materials arrived at the training venues before the scheduled dates and the utility kits, drugs and job aid materials were ready for distribution to the trained VHWs as soon as the training program was concluded.



Pix 11: Some VHW work tools and IEC materials that were procured Photo credit: SFH

3.3. Training

The GSPHCDA planned, organized and conducted the training of the selected VHWs with SFH providing technical leadership and monitoring to ensure quality delivery at each level.

The training program was conducted in each of the 11 Local Government Areas. The State primary health care development agency identified trainers from within the system to ensure sustainability. The training approach was a 3 tier strategy which involved the initial training of master trainers; these are senior health officers in the state selected from the GSPHCDA, State Ministry of Health, College of Nursing and College of Health Technology, Local Government Health Officers and SFH Program Officers. This level of training was conducted by engaged consultants from SFH. The trained master trainers then cascaded the training down to selected CHEWS that are to provide supportive supervision to the VHWs. The best performing Master Trainers and Trainers were further trained on facilitation skills for 5days before the training was finally cascaded down to the selected VHWs, which was conducted and facilitated by the trained CHEWS. The adopted training manual and facilitators' guide were used for the training at every level. Table 3 shows the 3 tier training work plan and schedule.



Pix 12: The selected Village Health Worker's (VHW's) Training

The training was both theoretical and practical hands-on sessions, consisting of intensive classroom engagement and practical field experience. The VHWs were trained for approximately three weeks according to the National Roadmap recommendation and a certificate was issued to each VHW at the end of the training program. The plan is for refresher trainings to be organized every year to refresh their skills and strengthen their capacity. The trained VHWs were directly linked to the PHC health facility nearest to their clustered community of deployment.

The training modules include the following:

- Community outreach/mobilization
- Maternal and newborn health
- Nutrition
- Water and sanitation
- Child health
- Communicable and non-communicable diseases
- First aid

The curriculum covered the following areas:

Major roles of VHWs:

- Family Health
- Prevention and control of diseases
- Environmental Health and sanitation
- Health Education and Communication

The specific Job focus for the VHWs:

❖ **Maternal health-**

- Health promotion for ANC, Delivery and referral for postnatal checkups.
- Recognition and referral of all obstetric emergencies
- Administration of Misoprostol
- Collection of health records from the community

❖ **New born**

- Administration of Chlorhexidine
- Promotion of early initiation of breastfeeding
- Promotion of Exclusive breastfeeding

❖ **Child Health**

- Promotion of immunization,
- Prevention, treatment of Diarrhoea and malaria in children
- Deworming and provision of vitamin A
- Identification and referral of all cases of sepsis, pneumonia, severe and acute conditions.

Table 3: VHWs Training Work Plan and Schedule

Training of Trainers for Nurses, Midwives and Community Health Officers				
Participants	Number	Venue	Duration	Facilitators
Nurses, Midwives & CHOs	18	Gombe	6 days (3 days practical, 3days field)	2 SFH Consultants
Training of CHEWs on SSV + VHW manual				
Participants	Class average	Training centers	Training duration	Facilitators
114 CHEWs (2 per ward) + 57 in-charges=171	30 per class. 6 classes	Gombe (3 classes) & Kaltugo (3 classes)	6 days, 18 days concurrently	18 facilitators (Nurses, midwives, CHOs), 3 per class (one -off).
Training of Trainers for CHEWs for Facilitation				
Participants	Class average	Training centers	Training duration	Facilitators
132 57 lead CHEWs from all the focal wards (1 per ward) plus 75 other master trainers.	30-35 per class. 4 classes	Gombe (2 classes) & Kaltugo (2 classes)	5 days, 10 days for each center	SFH Consultants
Training of VHWs by CHEWs				
1,596	40 per class. 44 classes/streams	4 streams in an LGA	One and half week s classroom, one and half field.	3 trainers per class, 12 for a LGA. A total of 132 trainers needed for one-off in 11 LGAs

Source: SFH MNCH-Gates Project April 2016

3.4. Programme Launch

The maiden statewide Village Health Workers Scheme was officially launched in the Gombe state capital on the 13th October 2016. The occasion was graced by the executive Governor of the state; Alhaji Ibrahim Dakwambo, the entire members of Gombe State Executive and Legislative Arms, Local Government Chairmen and members of the Nigeria Governors forum. BMGF, SFH and BMGF grantees were also represented.



Pix 13: A VHW making a comment during the launch of the scheme



Pix 14: Gombe State Governor delivering his address at the official launch of the scheme



Pix 14b: An official of BMGF delivering his address at the official launch of the scheme



Pix 15: Guests (L) and a group pose by the governor; ES-GSPHCDA; MD, SFH and PD, SFH MNCH-Gates at the VHW launch



Pix 16: Guest in front and VHW's behind at the official launch of the VHW Scheme

3.5. VHW Deployment

After the official VHW program launch, commodities and kits were allocated and distributed to the LGAs and wards for onward distribution to the VHWs. The trained VHWs were officially handed over to their respective wards during an open ward level community meeting. The handing over process was led by the GSPHCDA and other project team members. The team met with the community leaders and the WDCs, debriefed them about the progress of the implementation and officially handed over the VHWs to them. The Gombe state population distribution map was used to compute the number of VHWs that were eventually deployed to each ward.

The WDCs members serve as independent monitors for the VHWs' day to day activities and performance within the community and debrief the VHW supervisor during his/her supervisory and monitoring visits to the ward. This is to strengthen the citizen engagement, community ownership and sustainability of this value adding initiative.

Utility Kits -The VHWs were equipped with utility kits which consist of basic supplies and consumables provided on a regular basis to VHWs (See text box for content in the utility kits) and job aid tools needed to effectively carry out their tasks within the community. The content of the kit bag were customised to suit the environmental and cultural demands of the state.

VHWs' Tasks -The VHW will conduct door to door visits to identify target audience. They are expected to hold IPC sessions with pregnant women and new mothers during home visits using approved message guide (Pictorial Flip chart and job aid tools). The Village health worker will interact with a pregnant woman for a minimum of four times in order to influence her uptake of health facility services, as such, VHWs will be required to interact with each client at least 4 times during pregnancy and twice post-delivery. All tasks given cover; Demonstration of skills and drug administration to woman, Health promotion for ANC, delivery and referral for post-natal check-ups and emergencies. The specific tasks include; Promotion of immediate and exclusive breastfeeding for 6 months, demonstrate effective handwashing, correct administration of chlorhexidine for safe cord care, correct administration of Misoprostol to prevent post-natal bleeding, Measuring body temperature, Weighing, counting respiration, recognition and referral of all obstetric emergencies such as sepsis, pneumonia, acute and severe conditions to the health facility, accompany the woman to the health facility as and when needed, administration of OPV, treatment of basic

Gombe VHW Utility Kits

1. Clean kit - Soap, Gloves, Bleach, Gauze, Apron, Bandage & Plaster
2. Forceps and Scissors
3. Macintosh
4. Torchlight- battery operated
5. Chlorhexidine
6. Misoprostol
7. Hijab & Apron
8. Umbrella
9. Re-useable Water bottle
10. ACT
11. ORS & Zinc
12. Paracetamol
13. Iron and Folic Acid
14. Cotton wool (100gm)
15. Sanitary Pad (1 pack - Dr. Browns or Lady Sept)
16. VHWs flipchart
17. Referral Booklets
18. VHWs Register

Diarrhoea and malaria in children, deworming, provision of vitamin A, conduct follow up home visit and collection of health records from the community. The VHWs are also expected to distribute/dispense essential commodities such as 2 weeks supply of pre-packed iron and folic acid tabs to pregnant women (42 tablets of iron and 14 tablets of folic acid in each pre-pack), Misoprostol and Chlorhexidine based on set criteria at the focal facilities in their wards. Resupplies for these commodities is consequently carried out from these focal health facilities during the monthly data collection meeting. Quantities distributed to the VHWs are dependent on the number of registered women in their registers as well as their proximity to the health facilities as those closer to the facilities should be referred to the health facilities.

Specific criteria set for the medicines are;

Iron Folate and Folic Acid –

- ❖ Both medicines will be pre- packed in dispensing envelopes in the focal health facility before distribution to the VHW by the CHEWs
- ❖ **A pre-packed dose will be for two weeks ie 42 tabs (1 tablet three times a day) for Iron tabs and 14 tabs (1 tablet a day) for folic acid**
- ❖ The supervising CHEW will review the VHW commodity tracking form and refill as appropriate
- ❖ Quantities supplied to the VHWs will be based on their location from the focal facilities as those living in distant communities from the facilities will be given more than those close to the facility.
- ❖ Beneficiaries given the drugs are to be encouraged to visit the facility after the first supply.
- ❖ **No particular pregnant woman is to be given more than two pre-packed dispensing envelopes to discourage reliance on the VHW supplies.**

Chlorhexidine-

- ❖ **Women who are due for delivery within the next month (32 Weeks and above) will be identified from the VHW register.**
- ❖ VHWs will subsequently be supplied with quantities of Chlorhexidine corresponding to the number of women identified in their register less their physical count.
- ❖ Supply of Chlorhexidine to a beneficiary should be indicated on the beneficiary home visit card so that intervention facility staff will not supply her from their facility stock
- ❖ Women given Chlorhexidine by VHWs are to pack it as part of their birth preparedness items.
- ❖ Where a woman is given Chlorhexidine by a VHW and still supplied at the intervention facility, she is to return the unused Chlorhexidine to her VHW during her post-natal visit.
- ❖ To ensure the right usage and consistency of use, VHWs are expected to intensify cord care messaging during home visits especially during the last trimester

Misoprostol

- ❖ **The number of women who are due for delivery within the next month (32 Weeks and above) identified from the VHW register that are likely to deliver at home based on the criteria set in the Misoprostol protocol.**
- ❖ Supply of Misoprostol to a beneficiary should be indicated on the beneficiary home visit card so that intervention facility staff will not supply her from their facility stock

· ORS/Zinc

- ❖ While carrying out door to door visits, children under 5 who present with diarrhea diseases in the homes of her registered client, VHWs are expected to administer ORS/Zinc
- ❖ VHWs will receive minimal quantities of ORS and Zinc to treat diarrhea cases

· Artemisinin Combination Therapy (ACT) for Malaria and Paracetamol

- ❖ Quantities distributed to the VHWs are dependent on the number of registered women in their registers as well as their proximity to the health facilities as those closer to the facilities should be referred to the health facilities
- ❖ VHWs will administer Paracetamol to address temperature (while tepid sponging), and **also administer ACTs if the baby cannot access a Health Facility within 24 hours**

· Albendazole

- ❖ VHWs in collaboration with the supervising CHEWs will liaise with WDCs in locations distant from the health facilities to administer albendazole for deworming of children under five years old.
- ❖ Quantities of albendazole corresponding to the expected number of under 5 children will be supplied from the health facility stock.
- ❖ **Deworming of children under five should be carried out once in 6 months**

VHW Stipend – The Gombe State Government decided that the **VHWs are to be paid a regular monthly stipend of 4,000.00 Naira only** as against the 20,000. 00 Naira recommended by the National VHWs Roadmap. This decision was taken so as to ensure and secure the state government's commitment to ownership and sustaining the VHWs program in the state after the exit of BMGF. Meanwhile, the State government agreed to provide counterpart funding for the payment of the agreed stipend in an increasing order starting from 50% to 75% and eventually to 100% at the end of the project after full handover to GSPHCDA.



Pix 17: A VHW on duty during a home visitPix

SECTION FOUR – Role Of Partners In The Implementation Of The VHW Scheme

The Maternal, Neonatal and Child Health Care project in Gombe State has several working partners implementing different aspects of the MNCH interventions. Partners working on the MNCH project in the state funded by the BMGF are as follows:

1. Bill and Melinda Gates Foundation
2. Gombe State Primary Health Care Development Agency (GSPHCDA)
3. Society for Family Health (SFH)
4. PACT
5. Evidence for Action (Mamaye)
6. IDEAS

The roles played by these organisations in the implementation of the VHW program are documented below:

4.1 Bill and Melinda Gates Foundation (BMGF)

VMGF is the main funder of this project. Since 2009, BMGF has funded SFH to carry out MNCH intervention projects in Gombe State focusing on TBAs and later scaled up the intervention to the VHW scheme. Series of innovations evolved from these projects that brought other partners on board to provide requisite expertise to scale up the innovations. Such partners include SFH, E4A, Pact, C4C, Transaid, IDEAS,



-Pix 18: Dr. Ahmed M. Gana, Executive Secretary, GSPHCDA

4.2 Gombe State Primary Health Care Development Agency

GSPHCDA provided coordination for the activities of the program. In addition, it provided the following on behalf of the State Government:

- Payment of agreed stipend as counterpart funding,
- Mobilization and allocation of CHEWS to supervise VHWs on a regular basis,
- Official recognition and certification of VHWs after training,
- Dedication of a Senior level VHW coordinator at the State level,
- Ownership and commitment to State level scale up of the program based on evaluation,
- Database maintenance of VHWs for management and verification purposes.

4.3 Society for Family Health (SFH)

The Society for Family Health (SFH) is the leading partner on the MNHC project funded by BMGF in Gombe State. Based on its capacity in community mobilisation and behavior change communication, SFH started the MNHC project intervention in Gombe State before any of the BMGF grantees in Gombe with the TBA project and gradually scaled up to the present Village Health Workers program. SFH provided mainly technical oversight at every level of implementation and assistance in community mobilisation, behavioural change communication, training and demand creation for skilled service delivery by the women. This involves managing the Village Health Workers, overseeing the Emergency Transport Scheme, Commodity Supply. Oversight of VHW component – including training, supplies and consumables. Mass media messaging aimed at supporting other strategies to generate demand for MNCH services at the community level. This aspect was sub-contracted to BBC Media Action.

4.4 PACT

PACT came on board the MNHC project under the project name SAQIP. Their major role was to strengthen the health institutions and systems. They upgraded the health facilities and build the capacity of health workers. The PACT project ensured that all the quality improvement systems provided are in the PHC health facilities so to facilitate increase in service uptake.

Pact built the capacity of the PHC frontline workers to understand MNCH services to enable them provide quality services. The project is working with the GSPHCDA to ensure redistribution of manpower in some of the PHC facilities to even out the availability of skilled manpower in the various PHC centres and provides support to drive community demand for services through the setting up of mothers' groups across the 57 intervention Wards in the State. Pact also worked with SFH and GSPHCDA to ensure drugs were available in the PHCs.

4.5 Evidence for Action (E4A)

Evidence for Action (E4A) focused on the supply side of the health system. Specifically, its role in the VHW intervention in the state was to advocate for increased funding for health in the state with policy influencers and decision makers using data and the score card as the evidenced based advocacy approach. The Score Card is a tool developed to help keep track of specific indicators such as the maternal and newborn health care indicators. E4A team work with stakeholders to develop the District Health Information Systems (DHIS) data with data collated from all of the service points, the primary health care agents, secondary health care facilities, private hospitals and even the tertiary hospitals in the State. The collated data is then matched against the set indicators being tracking for a period of time. The results reveal areas of good and poor performance and helps to identify bottlenecks in the implementation where the state is not doing so well in terms of maternal and newborn health. overall, E4A supports the VHW program through advocacy, knowledge management, state & local government accountability.

4.6 IDEAS

IDEAS, one of the BMGF partners/grantees is from the London School of Hygiene and Tropical Medicine. Their major role is to generate and analyse data for decision making as well as facilitate partner data workshops. They evaluated and measured the project progress and performance.

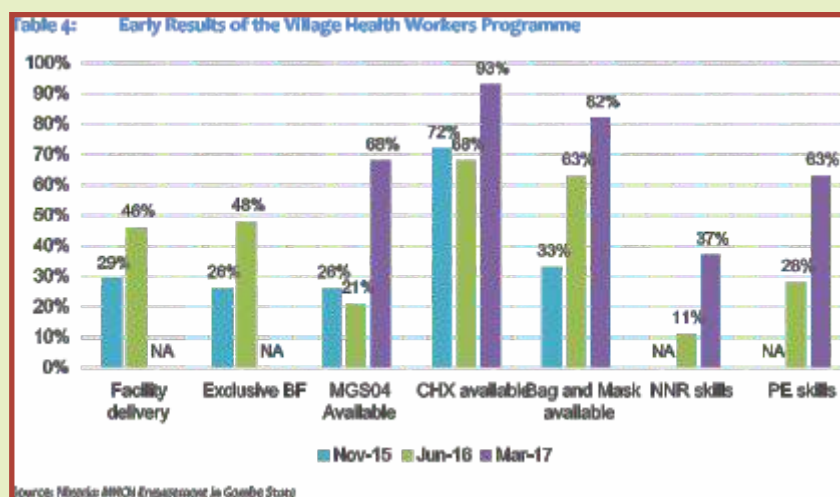
In line with its role, IDEAS developed the One Result Framework that housed the performance indicators/outputs of all the partners working on the state MNHC project. Specifically, they collected data from the field (Gombe State), synthesised it and fed it into the harmonized result framework that has provisions for reporting the performance of all the BMGF Grantees. It is this result framework that indicates and measure progress made and revealed the areas of poor and good performance. IDEAS provided feedback to both the implementer and the donor on performance and also advised the donor on practical and effective way forward. The result framework helped to identify program gaps and areas that required attention and the specific attention needed.

SECTION FIVE– Success Stories, Challenges & Lessons Learnt

This section is to highlights the progress, success stories and lessons learnt from the VHWs implementation.

5.1 Success stories/The Progress So Far

The graph below shows a summary of early results on the VHW programme across several core indicators within a period of 6 months after inception.



Since the inception of the VHWs in Gombe state, there has been an encouraging improvement in the set indicators from all the working partners and stakeholders.

Some of the success stories include:

- ❖ There is improvement in the health-seeking behaviour of community members
- ❖ Increase in facility delivery in the community as more pregnant women are now accessing health care at the PHC facilities. A CHEW in Komfulata PHC, Kwami LGA who was interviewed stated that; *“the condition of clients received at the facility is no longer as critical as it used to be since the VHWs often counsel client to go to the PHC before their condition become worse”*. This implies that the no of emergency cases reaching the PHC facilities has reduced appreciably.
- ❖ Improvement in the community members' health seeking behaviour” as confirmed in Filiya community, Shongom LGA as stated by the WDC secretary who observed that *“the VHW Scheme has helped to improve ANC attendance in the PHCs as women are being constantly prepared to make use of the ante-natal care service”*.
- ❖ Apparent reduction in maternal mortality rate among pregnant women as cases now get to the facilities before complications occur;
- ❖ Some of the beneficiaries expressed their satisfaction about the program and the performance of the VHW. One of such beneficiaries from Filiya in Shongom LGA said: *“there is increased knowledge and awareness not only on health issues but on general living condition and the need to live in harmony. The VHWs also address a lot of issues to promote family bonding and living.*
- ❖ *Most women have improved their hygiene and environmental consciousness because of the educative awareness created by the VHW”*.

- ❖ The VHWs themselves have acquired knowledge and skills that will continually boost their self-esteem and confidence. A VHW from Tumu Community, Akko LGA stated: *"My interpersonal communication skills and flair for visitation have improved. I even feel like visiting those who are not my clients. Also, I am now popular and well recognised in the community. People even stop me on the road to say well done for the services I am rendering to the community. This makes me happy."*
- ❖ Increased community confidence in the health system at the PHC level. A VHW from Akko community in Akko LGA confirmed this findings with this statement; *"we always feel happy because of the benefits the women derive from the program. Sometimes they even call me when they do not see me. Also, when I tell them what to do, they do it"*.

5.2 Challenges

Despite the encouraging success stories recorded in this intervention so far, the implementers also encountered some challenges. Some of the challenges documented by the consortium of partners are:

- ❖ It was difficult aligning the program design to the National WNW road map recommendations. i.e it was not possible to get the 50% VHW ward coverage as recommended by the National road map in Gombe State due to the disparities of the community location. Therefore the VHW distribution was computed using the state population as against the 20 VHW per ward national recommendation. This is due to the huge population of some Wards as some were found to have up to 40,000 persons or more.
- ❖ In some of the implementing communities, there were several factions of the WDC. it was quite a challenge for the project team to harmonize and unify these factions who were hitherto not in synergy with one another for their key roles in the intervention.
- ❖ The selection of the required level of volunteers poised very challenging as the exercise had to be repeated about 3 times and at an instance the set selection criteria had to be reviewed for some of the wards that couldn't produce the required numbers and standard of VHWs nominees. This accounted for the major reason why the targeted 1200 VHWs could not be attained at the inception of the program. *Some LGAs like Nafada and Kaltungo did not have volunteers who met the criteria in some wards. The selection process was also faulted with nepotism and favoritism by the community leaders.*



Pix 19: A Village Health Worker on duty in a local community in Gombe State



Pix 20: Access road to a hard-to-reach community in Kwami LGA



Pix 21: Scene from Dirri Community, Bojude Ward, Kwami LGA

- ❖ The implementation only covered half of the state as against the whole state which makes it difficult to measure the actual impact of the program.
- ❖ The payment of a monthly stipend of N4000 to the VHWs which should also cover expenses incurred to carry out the number of visits required of them was unanimously described as inadequate considering the nature of the work they are faced with. This led to the attrition of some of the recruited and trained VHWs.

Some VHWs reported the challenges they often experience with transportation especially when they have to visit hard-to-reach areas as they hardly get vehicle in such routes.

5.3 Lessons Learnt

Key lessons learnt during implementation of the state VHW program include:

- ❖ Low literacy level especially amongst women in Gombe state created a compromise to the integrity of the VHWs' selection criteria and overall VHW recruiting process.
- ❖ Adequate remuneration for the VHWs is a major factor for good performance and low attrition rate of the VHWs and possible sustainability of the program. A good remuneration at least within the minimum wage level will in no doubt serve as an additional incentive to the VHWs considering the poverty level of the communities in this part of the country and the distance each VHW may need to cover monthly as a result of wide distances between the target communities especially the hard to reach areas.
- ❖ Allowing the state government to take the lead from inception of program implementation has strengthened state ownership and commitment to program success at every level which is a major factor required for the sustainability of the program. With their leadership role, the government has been able to learn firsthand and understand the intricacies of the program and the importance of the implementation operational process at every stage of the program.
- ❖ A strong and well established citizen's engagement especially with the community gate keepers will always pave the way for easy access into target communities and facilitate successful social mobilization. A close and cordial working partnership with the Ward Development Committee in target areas in which the WDC shares responsibilities and roles with the implementing partners ensures community buy- in and good program uptake and response from the beneficiaries.
- ❖ Despite the obvious gains of partnering directly with the state government to implement programs, it often slows down the rate of progress and achievement of work plan timelines due to the long bureaucratic processes of the civil service. In future, extra time need to be factored into the work plan to accommodate these long bureaucracy. This may help to ease off some bottlenecks in the flow of events along the pipeline of activities planned for the program.
- ❖ Giving the role of day to day monitoring of the VHWs performance to the WDC who live in the same community with the VHW and their place of deployment is a key strength to the success of the program as it promotes faithfulness and integrity of the VHWs to the job and consistency in the required quality of service delivery being rendered by the VHWs.
- ❖ Synergizing the goals and objectives of the program with other implementing partners in the state reduces cost, avoids replications, expands scope of program delivery and coverage which will produce greater impact and expected outcomes.
- ❖ Simple written and oral test conducted for the VHWs during the recruitment process to confirm their literacy level before their training is a key success factor to the program due to the fact that a major intervention such as improving MNCH and reducing mortality rates needs every detail of information and data as much as can be gotten, recorded, collated, analysed and interpreted. Any intervention without adequate data extracted from it cannot be easily measured for impact level, neither will there be any or adequate evidence based information available to inform better decision making for specific focus areas in implementation improvements or gaps to be bridged or closed to improve program results and outcome now or in future planning for similar or related interventions.

5.4 Programme Sustainability

From the onset, BMGF secured the State Government's commitment, leadership and ownership of the program. At the planning/design stage, meetings and discussions were held on how to hold the state Government accountable through their State Primary Health Care Development Agency.

The following were agreed:

- ❖ Provision of technical assistance to Gombe State government for budget development to ensure that health and MNCH are prioritized,
- ❖ Monitor the budgetary process to ensure that the item stays in the budget as it evolves. The release of funds for this purpose is also to be monitored throughout the year.
- ❖ Civil Society Organisations in Gombe State to hold the government to account based on budget allocation and government's commitment.
- ❖ The State Government to be encouraged to establish an account with joint signature authority for both commodity procurement and payment of VHW stipends.

The Executive Secretary stated that plans are on to scale up the scheme to all the Wards and LGAs in the State and the State Government intends to fund the remaining 57 Wards.



Pix 22: On the right is an IPC session with husbands as influencers



Pix 24: ETS operators after a training session on the left



Pix 23: Kolo Bajoga, DHSD, GSPHCDA making a clarification

References

- Society for Family Health (2017); Nigeria: Overview of MNCH Engagement in Gombe – A Powerpoint presentation of MNCH engagement in Gombe State, Nigeria
- National Primary Health Care Development Agency (2014); National Village Health Worker (VHW) Programme.
- "[Nigerian Population 2006](#)". Nigerian News. Archived from [the original](#) on May 9, 2008. Retrieved 2007-05-09.
- UNICEF, WHO, the World Bank Group, and the United Nations (2015) "Levels and Trends in Child Mortality Report 2015 – Estimates Developed by the UN Inter-Agency Group for Child Mortality Estimation." www.childmortality.org/files_v20/download/IGME%20 (accessed September 15, 2017)
- Save The Children: Nigeria State Data Profiles an Accountability Tool for Maternal, Newborn and Child Health In Nigeria - <http://www.healthynewbornnetwork.org/hnn-content/uploads/Nigeria-State-Profiles-Complete-Booklet.pdf>
- National Population Commission (NPC) [Nigeria] and ICF International. 2014. Nigeria Demographic and Health Survey 2013. Abuja, Nigeria, and Rockville, Maryland, USA: NPC and ICF International.
- IDI Interview session with GSPHCDA - Executive Secretary and Director, Health Systems Department – September 2017
- IDI Interview sessions with SFH – Project Director, State Programme Manager, Gombe – September 2017
- IDI Interview session with Gombe State Director, Pact – September 2017
- IDI Interview session with Gombe State Coordinator, Evidence for Action – September 2017
- IDI Interview sessions with WDC Chairmen – Akko Ward, Akko LGA and Filiya Wards, Shongom LGA – September 2017
- IDI Interview session with CHEWs in Komfulata Ward, Kwami LGA – September 2017
- IDI Interview sessions with VHWs in Akko and Tumu Wards, Akko LGA – September 2017
- IDI Interview sessions with Beneficiaries in Filiya Ward, Shongom LGA – September 2017

APPENDIX 1 – **Gombe State VHW TOR** (as adapted from the National Roadmap)

TERMS OF REFERENCE FOR A VHW- Gombe State

1. Goal and Duties

The VHW is based in the community and is an integral part of the health system and helps in the overall achievement of the goals and objectives of the primary health care system. She is often the first contact with the health system and interacts with community members, helping to:

- a) Promote healthy lifestyle choices and behaviors through household visits and interaction with the community,
- b) Carry out prevention activities at the household level, and
- c) Identify and appropriately refer or in selected cases treat sick patients in a timely manner.

The VHW works under the direction of a pre-selected CHEW or JCHEW in their catchment area. The main duties are to carry out and document regular home visits, as well as more frequent follow-up for vulnerable groups. This includes the following activities:

Community Outreach and Home Visits

- Identify pregnant women in the community, conduct home visits (including home visits for post-natal care)
- Community based drug and commodity dispensing e.g. Iron/Folic Acid, IPTp-SP, chlorhexidine, and misoprostol for imminent deliveries
- Community sensitization, mobilization for development issues; attend WDC meetings
- Identify community water and food supply sources
- Identify other potential source of nuisances to households

First Aid and Treatment

- Constitute the first point of care for community members
- Provide basic first aid services - treatment of minor cuts and injuries
- Treatment of common uncomplicated ailments: Diarrhoea, Malaria
- Promote cleanliness and hygiene including hand washing
- Promote safe waste disposal practices

Referrals

- Refer pregnant women to the PHC for ANC, delivery, PNC and other MNCH services
- Refer community members to PHC as needed for illnesses that require referral
- Report / Refer cases of poor sanitation and hygiene for necessary action
- Provide home based care when referral is not possible or feasible
- VHWs shall have a referral linkage and a working relationships with the PHC staff

Coverage & Record Keeping

- VHW provides services in community or village areas of approximately 500 people
- Identification of conditions of ill-health and effecting referrals in target population
- Create, compile, and maintain records on pregnant women in community and other relevant health data

Supportive supervision

- To further develop their capacities , VHWS will be regularly supervised by CHEWS and others PHC staff
- CHEWS will be conducting on the job and refresher training to VHWs to reinforce the skills that the VHWs have acquired during the pre-service training

APPENDIX 2 – Village Health Workers Training Curriculum

PHASE 1

INTRODUCTORY MODULE

Session 1: Training Overview

MODULE A: COMMUNITY OUTREACH/MOBILIZATION

Session 2: VHW Role and Community Outreach

MODULE B: MATERNAL AND NEWBORN HEALTH

Session 3: Antenatal Care

Session 4: Labour and Delivery

Session 5: Post Natal Care

Session 6: Common Newborn Problems

Session 7: Healthy Timing and Spacing of Pregnancy

MODULE C: NUTRITION

Session 8: Maternal Nutrition

Session 9: Infant and Young Child Feeding (IYCF)

MODULE D: WATER AND SANITATION

Session 10: Clean water

Session 11: Sanitation

Session 12: Hygiene

PHASE 2

MODULE E: CHILD HEALTH

Session 20: Pneumonia

Session 21: Diarrhoea

Session 22: Malaria

MODULE F: COMMUNICABLE AND NON-COMMUNICABLE DISEASES

Session: 13: Cholera

Session 14: Tuberculosis

Session 15: HIV

Session 16: Diabetes Mellitus

Session 17: Hypertension

MODULE G: FIRST AID

Session 18: Introduction to First Aid

Session 19: Wound Management

APPENDIX 2 – Village Health Workers Training Curriculum

Item	Specifications	Quantity in Toolkit	Relation to VHW Scope of Work
Torchlight	Battery operated (includes x batteries)	2 (two) torchlights Duracell batteries per month (for each VHW)	General-Most rural communities may not have a steady power supply and most of the connecting roads in the communities are foot paths without light. The torchlight will aid movement at night when VHW is called for help by a client. If VHW is given only one her husband or mother-in law could deprive her of it.
Hijab/ Apron	Aprons and Hijabs will be branded as state desires for identification of VHWs in the community	Every VHW will be supplied 2 Apron or Hijab each depending on their religion. The Muslim wears a Hijab while the Christian VHW will use an Apron	General -Branded Aprons will be worn every time the VHW is at work visiting women at home to pass key MNH messages. Northern culture restricts free entrance into homes without permit ('Baa shiga' is written at some entrances, meaning no entry) This aprons/ Hijabs once launched, will serve as identity for recognition of VHWs in the community. This will enable them gain entrance into most homes with little or no hindrances. Two Aprons will also enable them keep them clean and appear neat at all times.
Umbrella	The umbrella will be branded as specified by the SPHCDA	Each VHW will have 2 (two) umbrellas.	General- umbrellas will serve to shield VHW from the harsh northern weather to enable them achieve their door-to-door visits. If VHW is given only one her husband or mother-in law could deprive her of it.
Re-usable water bottle	A simple water-bottle to contain about 150mls of water or their local refreshing drink (kunu)	1 (one) per VHW	General- VHWs may walk long distances in between communities. Water is not readily available in the rural northern Nigeria and clean water is more difficult to come by. VHWs will need some drinks to quench their thirst in harsh and dry weather periods. These water bottles will serve to motivate them on their job.
VHWs flipchart	Picture coded materials to enable discussion with clients including messages for early, late pregnancy and postpartum period. 15-20 Pages	1 (one) per VHW	Community Outreach- VHW will use this job aid to facilitate her one-on-one interactions with the pregnant woman at the home level to pass key MNH messages.

APPENDIX 3 – VHW Kit Contents
(as Adapted From The National Roadmap)

Phase 1

Item	Specifications	Quantity in Toolkit	Relation to VHW Scope of Work
Torchlight	Battery operated (includes x batteries)	2 (two) torchlights Duracell batteries per month (for each VHW)	General-Most rural communities may not have a steady power supply and most of the connecting roads in the communities are foot paths without light. The torchlight will aid movement at night when VHW is called for help by a client. If VHW is given only one her husband or mother-in law could deprive her of it.
Hijab/ Apron	Aprons and Hijabs will be branded as state desires for identification of VHWs in the community	Every VHW will be supplied 2 Apron or Hijab each depending on their religion. The Muslim wears a Hijab while the Christian VHW will use an Apron	General -Branded Aprons will be worn every time the VHW is at work visiting women at home to pass key MNH messages. Northern culture restricts free entrance into homes without permit ('Baa shiga' is written at some entrances, meaning no entry) This aprons/ Hijabs once launched, will serve as identity for recognition of VHWs in the community. This will enable them gain entrance into most homes with little or no hindrances. Two Aprons will also enable them keep them clean and appear neat at all times.
Umbrella	The umbrella will be branded as specified by the SPHCDA	Each VHW will have 2 (two) umbrellas.	General- umbrellas will serve to shield VHW from the harsh northern weather to enable them achieve their door-to-door visits. If VHW is given only one her husband or mother-in law could deprive her of it.
Re-usable water bottle	A simple water-bottle to contain about 150mls of water or their local refreshing drink (kunu)	1 (one) per VHW	General- VHWs may walk long distances in between communities. Water is not readily available in the rural northern Nigeria and clean water is more difficult to come by. VHWs will need some drinks to quench their thirst in harsh and dry weather periods. These water bottles will serve to motivate them on their job.
VHWs flipchart	Picture coded materials to enable discussion with clients including messages for early, late pregnancy and postpartum period. 15-20 Pages	1 (one) per VHW	Community Outreach- VHW will use this job aid to facilitate her one-on-one interactions with the pregnant woman at the home level to pass key MNH messages.

Item	Specifications	Quantity in Toolkit	Relation to VHW Scope of Work
Referral Booklets	Booklet of about 100 pages	1 per 80% of expected pregnant women in VHW catchment area	Referrals- every pregnant woman that interacts with the VHW is referred to the HF for services. This referral card is redeemed at delivery in the HF for mother to get a gift of a tablet of soap and so also the VHW gets performance based incentive as agreed with SPHCDA
VHWs Register	Register with 100pages	1 per VHW some extras will be produced in case it is misplaced or lost	Coverage and Record Keeping-This record will serve to monitor her coverage and performance.
Health Education (IEC on core project indicators)	Picture code leave-behind materials for the pregnant woman to serve as resource for her and reminder of all key MNH messages discussed with her by the VHW.	1 per 80% of expected pregnant women in VHW catchment area	Community Outreach- VHW will after educating the pregnant woman leave her with a copy of this material as a constant reminder.
Chlorhexidine	7.1% Chlorhexidine digluconate (delivering 4% Chlorhexidine) produced by a NAFDAC approved manufacturer in 3 gram tubes.	VHW will be supplied a quantity agreed with SPHCDA	Community Outreach - newborn health- VHWs will carry Chlorhexidine with them in their work bags as they visit the new mothers to supply and educate them on best practices of clean cord care.
Misoprostol	Three tablet pack of 200 mcg Misoprostol tablets for prevention of Post-Partum Haemorrhage.	VHW will be supplied a quantity agreed with SPHCDA for imminent deliveries only.	Community Outreach - maternal health- Misoprostol tablets is used for prevention of Post-Partum Haemorrhage. VHWs will carry Misoprostol to supply to mothers who have imminent deliveries at home to prevent excessive bleeding.
Iron Folic Acid	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	
Simplified blood pressure apparatus	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	

Phase 2

Item	Specifications	Quantity	Relation to VHW Scope of Work
C o t t o n wool	100gm	200gm Per week per VHW	First Aid & Treatment- this will be used for dressing only fresh wounds.
Soap	Tablet form	2 Bars per week per VHW	First Aid & Treatment- Soap will be needed to wash hands at all times before and after procedures.
Gloves	Disposable gloves	2 p a c k s o f disposable glove per VHW per month	First Aid & Treatment- Disposable gloves will be used during dressings and other procedures to protect the VHWs, and prevent infection.
Bleach	500ml per bottle	500mls per VHW per week	First Aid & Treatment- this will be needed to disinfect the forceps and scissor and sometimes to wash hands if the VHW comes in direct contact with body fluids like blood.
Gauze	Roll of gauze	A s n e e d e d – e s t i m a t e d 1 medium roll per month per VHW	First Aid & Treatment- this will be used for dressing wounds
Bandage	Medium sizes	10 Per week per VHW	First Aid & Treatment This needed for dressing wound and improvised as splint when there is an accident that involves a fracture.
Plaster	Stripes	20 Per week per VHW	First Aid & Treatment- This will be used to dress wounds, by holding dressings in place
F o r c e p s (Dressing forceps)	Dressing forceps for holding cotton wool during dressing of wounds (breaking the continuation of skin, classified by the severity)	2 per VHW	First Aid & Treatment- Forceps are used to pick and hold cotton wool balls during dressing.
Scissors	Medium size	2 per VHW	First Aid & Treatment- this is used to cut bandages and gauze during dressings.
Mackintosh	A mackintosh is a yard	2 Per VHW	First Aid & Treatment- A mackintosh is a yard of rubber used to protect soiling a surface by blood or any body fluid. It is also use during dressings of wounds

Item	Specifications	Quantity	Relation to VHW Scope of Work
Paracetamol	Tablet	1 tin of 100 tablets per month per VHW	First Aid & Treatment- Paracetamol is an antipyretic and could be administered by VHWs to relief pain and reduce temperature during fever as part of malaria management.
Thermometer	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	
ACT	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	
Malaria RDT	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	
ORS/Zinc	To be defined with SPHCDA per national guidelines	To be defined with SPHCDA per national guidelines	

