Breaking the Norm:

Overcoming Negative Maternal, Neonatal and Child Health Outcomes through Village Health Workers Scheme in Gombe State

GOMBE STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY

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Acronyms

Acronyms	Meaning
AMTSL	Active Management of Third Stage of Labour
ANC	Ante Natal Care.
BMGF	Bill and Melinda Gates Foundation
CDK	Clean Delivery Kit
CHEW	Community Health Extension worker
CTV	Community Transport Volunteer
DDLM	Data Driven Learning Meeting
ETS	Emergency Transport Scheme
FLW	Front Line Worker
FOMWAN	Federation of Muslim Women's Associations
GSPHCDA	The Gombe State Primary Health Care Development Agency
HF	Health Facility
HRH	Human Resource for Health
IPC	Inter Personal Communication
IPCA	Inter Personal Communication Agent
KMC	Kangaroo Mother Care

Acronyms	Meaning
LGA	Local Government Area
MNCH	Maternal Newborn and Child Health
MoH	Ministry of Health
NR	New-born Resuscitation
NURTW	National Union of Road Transport Workers
PHC	Primary Health Center
PHCC	Primary Health Care Centers
PNC	Post Natal Care.
PPMV	Patent and Proprietary Medicine Vendors
SFH	Society for Family Health
SM	Social MobilizationS
MoH	State Ministry of Health
SOP	Standard Operating Procedure
TBA	Traditional Birth Attendant
VHW	Village Health Worker
WDC	Ward Development Committee

Foreword

The Village Health Worker Scheme was co-funded by the Bill and Melinda Gates Foundation (BMGF) and the Gombe state Government. The scheme's conception, design and implementation were in close collaboration with Society for Family Health under the leadership of Gombe State Primary Healthcare Development Agency. The design of the VHW scheme builds on lessons learnt from the MNCH grant phase I and II in the state and aligns with the national Village Health Workers program, now called CHIPS.

Using community-based activities aimed at increasing knowledge, improving health seeking behavior, and eliminating harmful household practices that negatively affect the health of mothers and newborn, the scheme has impacted positively on MNCH outcomes whilst bridging critical health manpower shortages in Gombe State. The project's primary strategy includes the use of trained village health workers (VHWs) who go from house-to-house identifying and linking pregnant women to health care facilities in the state. The project also worked to create an enabling environment at household, community and facility level for pregnant women and newborns to seek essential MNCH services as required. This was done through key influencer engagements, commodity distribution, Emergency Transport Scheme and the Community Transport Volunteers as well as collaborations that built capacity of health care workers at facility level to support the increase in uptake of MNCH services.

Gombe State is pleased with the outcomes from the scheme implementation and hopes that this effort will contribute to a sustained progress in reduction of maternal and newborn deaths as well as progress towards attaining Universal Health Coverage of life saving maternal newborn and child health interventions in the state.

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Background

High maternal and newborn mortality is a major health challenge for Nigeria's health system. The North East of Nigeria including Gombe state bears a large percentage of this burden resulting from household, community and health system challenges that are detrimental to the health and survival of neonates, children and pregnant women. For example, the national total fertility rate is 5.7 children per woman in Nigeria and 6.5 children in north eastern Nigeria; in Gombe the fertility rate was 7.1 children per woman of reproductive age 15-49 years (NDHS, 2008). Antenatal attendance and facility delivery were low as only 17.2% of pregnant women delivered in a facility (despite free Maternity Care and under five children services in Gombe State as at 2008) far below the 35% average.

In Gombe, majority of women gave birth at home. The high fertility rate, low level of institutional births where women could receive advice on antenatal and post-natal care meant exposure to a higher risk of neonatal and maternal deaths

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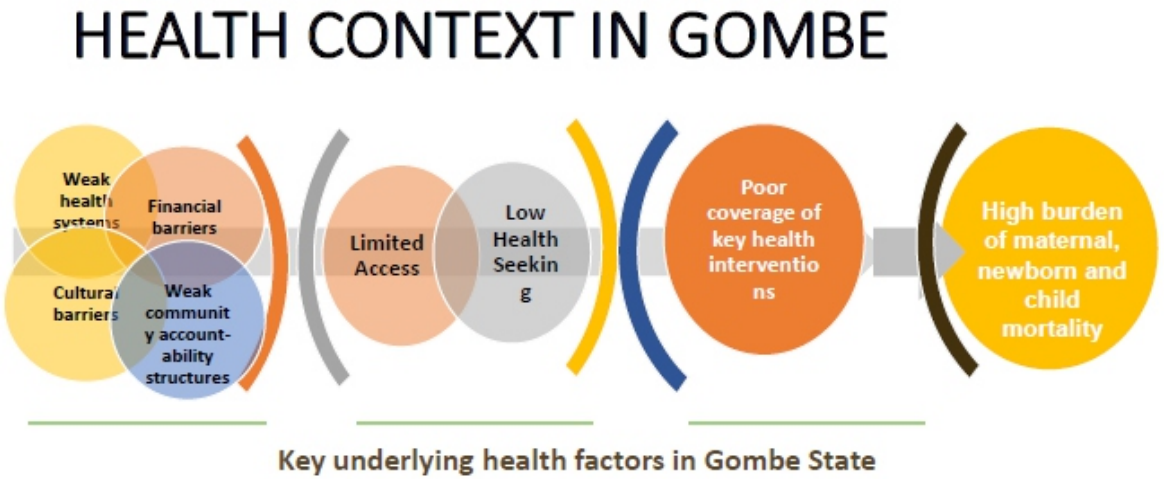

Figure I : Health Context in Gombe

A myriad of factors such as long distance to facilities, lack of understanding about the need for antenatal care, lack of confidence in antenatal care providers, health system related factors (poor provider attitude, long waiting times at health care facilities, commodity stock out etc.) contribute to poor access. Others such as poor access to transportation, cultural and financial considerations, also contribute to women's non-attendance at antenatal care clinics. These reasons are especially pertinent amongst women residing in the rural areas. Hence the need for interventions that go beyond the reach of the facility to deliver essential information and medicines at the household level.

The Gombe State Primary Health Care Development Agency (GSPHCDA), Society for Family Health (SFH) with funding from the Bill and Melinda Gates Foundation implemented the Maternal Neonatal and Child Health (MNCH) Project in Gombe state that has catalyzed change in household orientations, improved the adoption of positive health seeking behavior, changed attitudes and norms at household, community, PHC and government levels to be more supportive of facility based antenatal care, facility delivery and better health care for women and children.

INTRODUCTION

The Village Health Worker (VHW) Project was the fulcrum of the Maternal Neonatal and Child Health projects co-funded by Bill & Melinda Gates Foundation, led by the Gombe State Government through the Gombe State Primary Health Care Development Agency (GSPHCDA) with technical support from Society for Family Health. The project was the first government led and owned village health workers program in Nigeria; Implemented in 57 priority wards of 11 LGAs in Gombe State. The scheme improved access to MNCH services, bridged gaps in Human Resource for Health (HRH) especially at the Primary Health Care Centers (PHCC), increased commodity availability, health promotion and effective behaviour change at community, PHC and government levels.

The VHW scheme was the last in a series of phased project interventions implemented to address maternal, newborn and child health challenges in Gombe state. The phased project interventions were unique and addressed specific health seeking limitations and contributed to changing individual behaviours, attitudes and community norms around MNCH in the state. Changes in norms and attitudes recorded at community, PHC and government levels have improved access to and uptake of MNCH services and created an enabling environment for women to seek and receive prompt care.

Phase one (learning phase), implemented statewide between 2009 and 2011, designed and piloted four models in different LGAs that had the potential to deliver critical MNCH messages and interventions at the household level using existing networks of providers. These were traditional birth attendants (TBAs) (Model 1), the Federation of Muslim Women's Associations in Nigeria (FOMWAN) volunteers (Model 2), a 'Combined' model that consisted of TBAs and FOMWAN volunteers (model 3) and a fourth 'model' which consisted of Patent and Proprietary Medicine Vendors (PPMVs).

Phase two (scale up phase), implemented between 2012 – 2016 scaled up the winning model from phase one across all wards in 10 LGAs in Gombe state. This phase scaled-up the Front-Line Worker model (adaptation of learnings from the TBA and FOMWAN models), found to be an effective and efficient approach to improving maternal and new born health practices in the home, as well as facilitating enhanced facility-based MNCH.

Phase three was the Village Health Worker project implemented from 2017 to 2019, a continuation of the 2nd phase but with programme modifications that improved quality of services and transitioned SFH roles to the government for greater sustainability of interventions.

The scheme improved access to MNCH services, bridged gaps in Human Resource for Health (HRH) especially at the Primary Health Care Centers (PHCC),

The scale up phase of the MNCH project was designed to be implemented in Gombe and Adamawa states. However, following donor directives to densify interventions in Gombe and insecurity in Adamawa, project scale up was implemented in Gombe alone.

CHAPTER ONE:
BREAKING BARRIERS TO CLEAN DELIVERIES AT HOUSEHOLD AND COMMUNITY LEVELS

Child delivery at home attended by traditional birth attendants (TBAs) has been the widely practiced norm in Gombe communities. This is because male-figures control healthcare decisions, as 94% of women have no say in decisions affecting their own health; women, who are often without funds have limited power to counter reluctant attitudes of heads of households towards accessing health services from facilities. Where the will exists, households often cannot afford available health care services, this coupled with an overall dissatisfaction with quality of care at the health facilities has contributed to the low access of services at the health care facilities.

Traditional Birth Attendants (TBAs) though highly utilized within the communities do not have formal medical training on obstetrics care like the facility healthcare providers. They lack capacity to identify and manage complications, infection control during delivery, and to advise women on good maternal and newborn care practices therefore occasioning injury and death of mothers and neonates.

The MNCH project at the learning phase designed and tested four models with the potential to deliver critical MNCH messages and interventions at the household level using an existing network of providers. These were Traditional Birth Attendants (TBAs) (Model 1), the Federation of Muslim Women's Associations in Nigeria (FOMWAN) volunteers (Model 2), a 'Combined' model (Model 3) that consisted of TBAs and FOMWAN volunteers and the fourth 'model' consisting of Proprietary Patent Medicine Vendors (PPMVs). These providers were trained to become promoters of MNCH practices that aided the survival of both mother and newborn. The 11 LGAs of the state were purposively divided into these four model types. The TBAs at this phase assisted home deliveries using clean delivery kits and followed standard infection control measures while supporting referrals to health facilities.

The project goal at this point was to demonstrate effective, scalable approaches to improved critical maternal, newborn and child health (MNCH) practices in the home and position successful approaches for scale up. The project set up a state-wide hotline facility (call center) and provided 24-hour services by trained midwives, who promptly responded to queries, needs for information and calls for assistance from TBAs, FOMWAN, PPMVs, pregnant women and their families. The call center facilitated emergency transport service assistance in response to requests for referrals and transportation to health facilities through volunteer drivers. The call center responded to an average of 3,402 calls per month and in the two years of the learning phase assisted 81,658 client calls. Furthermore, recognizing that last mile distribution of life saving commodities such as clean delivery kits etc. to pregnant women at the point of child birth was a critical barrier to survival, the project empowered the various community-based providers through the different models with lifesaving commodities such that every woman and newborn received intervention at their point of need within their location to ensure the survival of mother and newborn.

Using a combination of capacity building activities for providers in the different models – providers were trained on the recognition of danger signs and referrals, use of clean delivery kits, handwashing, Kangaroo Mother Care (KMC), clean cord care, delayed bathing, immediate and exclusive breastfeeding and benefits of facility delivery (ANC and PNC). Similarly, trainings included health promotion using interpersonal communication, commodity provision, call center services and emergency transport service. Following these interventions, the project reached pregnant women and newborns in the households; engaged the communities and influencers to build understanding, prioritization and acceptance for maternal and neonatal health within the household and the community. This marked the beginning of a shift from ignorance and preference of pregnancy and child birth practices that risked the health of mothers and newborns to openness, understanding of benefits and willingness to accept standard interventions that promoted maternal and newborn survival in the communities. Each FLW was kitted with a bag containing a picture bottle for data collection, an umbrella, TBA register water bottle, apron hijab, torchlight, flipcharts and a mobile phone. The same kits were used for phase I and II.

The table below highlights some results achieved by individual models and state level changes within the two years of the learning phase.

Table : Learning Phase: Results of piloted Models on some indicators

	Model 1: TBAs		Model 2: FOMWAN		Model 3: Combined		Model 4: PPMVs		State Level	
Indicators	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline	Baseline	Endline
% of home births in the year where a clean delivery kit was used	6.5	8.3	2.4	11.1	3.4	13.4	1.5	24.8	3.8	12.8
% of births where newborns were given clean cord care	3.8	25.2	12.0	34.5	18.8	19.0	0.2	1.2	9.6	21.8
% of newborns not bathed in the first 24 hours	8.4	16.2	24.0	13.2	11.9	26.5	11.0	26.5	14.1	20.1
% of new mothers who practice immediate breastfeeding within an hour of birth	62.4	79.3	80.4	59.1	69.5	65.3	59.5	66.1	69.0	68.0
% of newborns that slept under a treated bed net within the first 7 days of delivery	22.4	72.1	18.1	84.3	16.6	73.2	36.2	77.5	22.2	76.4

Lessons Learned that Informed Scale Up

Identification of winning approaches from the four models implemented. The project harnessed what worked best from each model to inform scale up of project intervention in phase two.

- There was an underlying appreciation and genuine desire of households and communities to see mothers and newborns survive. However, ignorance and lack of understanding of better survival interventions for mothers and newborn, access constraints, cultural norms and age-old community practices that are counterproductive threatened maternal and neonatal health.

- Engaging the drivers of cultural norms and practices concerning MNCH as agents to strengthen these practices and make them safer while conducting health promotions and better practices, made the households more receptive to the project and promoted better MNCH behaviors and practices.

- State leadership is paramount to enshrine ownership, build capacity and sustainability of project interventions. This ensures that beyond donor funding, the intervention is sustained.

CHAPTER TWO:

BREAKING BARRIERS:

SHIFT FROM HOME DELIVERY TO FACILITY-BASED CARE AND LAST MILE DISTRIBUTION OF LIFE SAVING COMMODITIES

Phase II of the MNCH project (2012-2016) scaled up effective and efficient approaches from phase I that improved maternal and newborn health practices in the home and facilitated enhanced facility-based MNCH services in Gombe State.
Phase I result showed that front line workers (FLW) - TBA & FOMWAN proved more successful with intra-partum care and referral of pregnant women with danger signs while FOMWAN referred more women in labor with complications. Rural communities were reached more by TBAs whereas urban areas were reached more by community volunteers based in urban areas.

Guided by evidence of winning approaches from phase one, the project increased the number of front-line workers to 1160 TBAs and 290 FOMWAN and built their capacity on Care During Pregnancy, Care During Labour and Delivery, Immediate Care After Delivery and Post-Partum, Referral and Record Keeping resulting in greater home and facility-based interactions. The frontline workers were supervised and mentored by community health extension workers and nurses from the primary health care centers in each intervention ward. The project continued the Emergency Transport Scheme, recruited and trained 716 volunteer-drivers who are resident in project communities who offered 24-hour free emergency transportation to 8,355 pregnant women and neonates. The drivers were trained on danger signs, lifting and transporting a woman or neonate in an emergency and locations of referral centres.

The Gombe MNCH Call Center was upgraded to promote information, linkages and referrals to health care services. Following the success of the call center in phase one of the project, upgrades; both technical and infrastructure were done to increase coverage and target a wider range of health-related issues. This expansion of services and upgrade of facilities included the addition of new health areas such as malaria and family planning, caller identification (soft phone such that callers' identification (name, phone number and other details) were recorded into the system for follow up calls. An SOP that detailed every thematic area that a caller might have issues with as regards MNCH including malaria and family planning were provided for the trained call center staff (midwives). The center was handed over to MOH Gombe on July 15, 2016.

Achievements before the handing over are:

The call center reached over 241,931 callers with maternal and neonatal health care messages.

- The highest number of calls were recorded from pregnant women and new-born mothers
- The center assisted frontline workers to reinforce health messages at community level
- It supported the increase of knowledge on pregnancy danger signs
- It referred over 81,000 pregnant women for health facility services
- It referred about 27,361 new-borns for treatment

To ensure referral health facilities had adequate capacity to manage the increase in MNCH services demand, the project identified, trained and worked with 114 skilled providers at PHCs and 22 skilled providers at secondary health facilities in all wards in 10 LGAs (excluding Gombe LGA) to improve quality of service. Quality of care was enhanced at health facilities through capacity building in New-born Resuscitation (NR), Kangaroo Mother Care (KMC), Active Management of Third Stage of Labour (AMTSL). Mass media (radio jingles and dramas) were employed to disseminate information and facilitate good MNCH home-based practices and uptake of facility services.

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The FLW project intensified engagement with

Government and communities. The acceptance and shift in behaviour from home births as the norm to facility delivery, could not have been achieved without the support and buy-in of community gatekeepers and heads of households who became advocates of the new MNCH behaviours. These influencers performed oversight and monitoring roles at the community and health facilities. These activities promoted respect, acceptance and compliance with new MNCH behaviours. The project at scale up collaborated with the government of Gombe (state ministry of health).

The SMoH provided the referral facilities and actively supervised implementation of FLW activities at all levels. The project in collaboration with the SMoH worked with 136 referral health facilities within the 10 intervention LGAs to improve quality of MNCH service delivery. These health facility staff were supported through mentoring and coaching to address exclusive breast feeding, delayed birth and clean cord care as lifesaving interventions during ANC health education. The staff were supervised and guided to utilize the resuscitation skills (Helping Babies Breathe) and ensure clean delivery. Job aids on new born resuscitation - "Helping Babies Breathe Chart" were adapted, printed and strategically pasted in the labor rooms of all the referral facilities. Consistent distribution of resuscitation kits was ensured to prevent stock out.

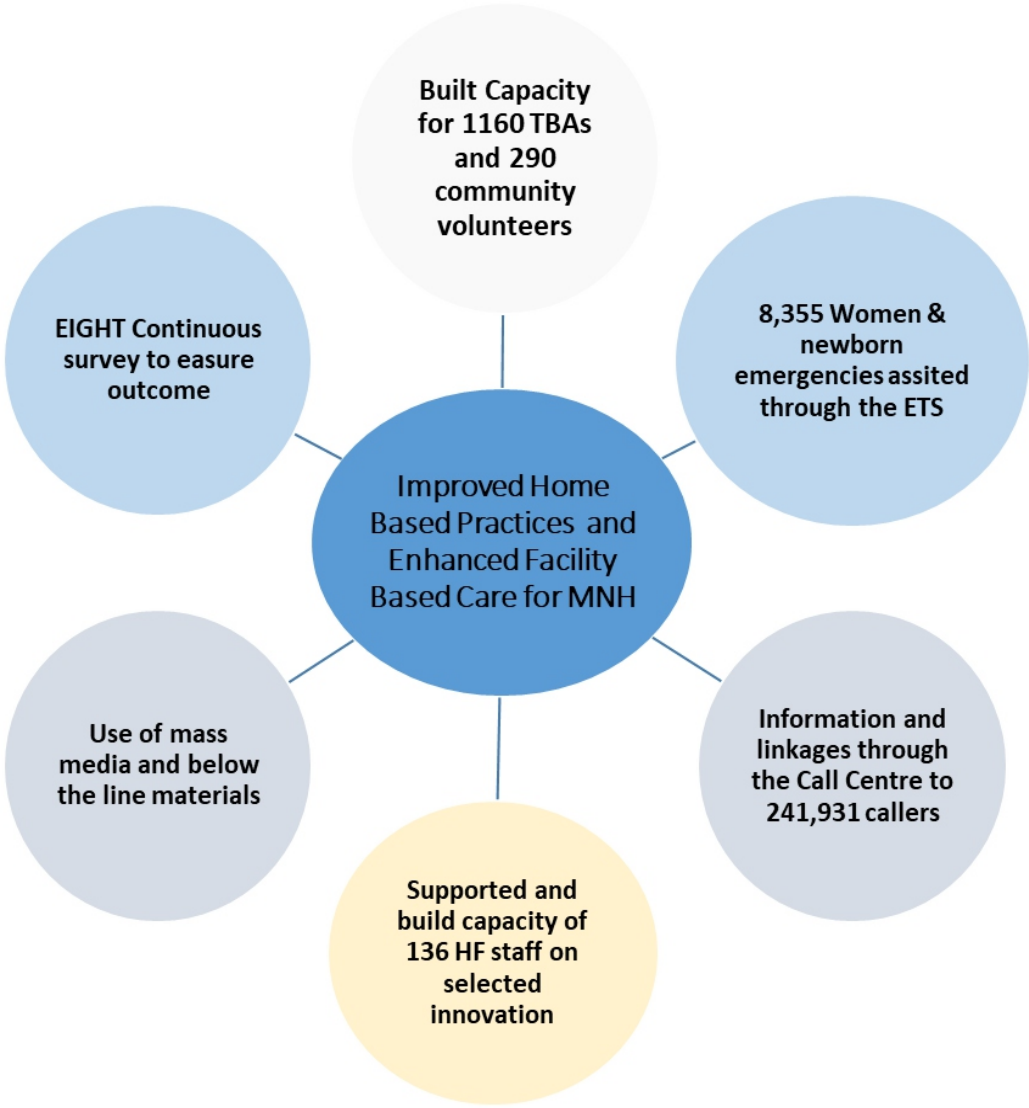


Figure II : Key project interventions and results 2012 - 2016

Success Story

Malama Hauwa, her Husband Malam Hassan, their 2 children with the TBA
Malama Hauwa and her Husband Malam Hassan live in Jigawa community of Nafada LGA, they have benefitted from the MNCH project since it's inception. They narrated how their lives were positively impacted by the project. "When my wife was pregnant for our first baby, Hauwa Garba a TBA visited us and educated us on the benefits of ANC and facility delivery.

I allowed my wife to attend ANC. She visited the clinic 4 times for ANC. My wife was warned by the TBA not to attempt delivery at home during labour explaining that facility delivery attended by skilled staff minimised the risks of injury and death due to complications.

When my wife was in labour, I called on the TBA who followed us to Jigawa PHC where my daughter who is now two years old was born. My wife practiced exclusive breast feeding because the TBA educated us on the benefits of exclusive breast feeding for both mother and child. Before then, I never heard of exclusive breastfedding and wondered how possible it would be to give a child only breast milk only, without water in our very hot weather.

The TBA expalined that it was the best for the child as breastmilk contains adequate water. I was convinced by her explanation, I agreed and permitted her not to give water to the baby. The TBA visited from time to time to check on the baby and my wife. Just like the TBA told us the baby grew big and strong. Because of this when my wife got pregnant for the second time, at 2 months I went and informed the TBA who came to see her and told her to start ANC . Because I have seen the benefit of facility delivery my wife delivered our second baby at facility. We did not bath the baby till the following morning, we practiced clean cord care as we were taught by the TBA and at the health facility. We also practised exclusive breast feeding for six months"

Lessons Learned from Phase Two implementation:

- It is possible to change negative health care worker attitude through training, coaching, mentorship, supervision and provision of job aids (such as SOPs, posters on good practices).
- Building capacity plays a substantial role in increasing adherence to MNCH best practices. Linking untrained TBAs who did not participate in the project to project trained TBAs (FLW) facilitated referrals and adherence to MNCH best practices.

CHAPTER THREE:

VILLAGE HEALTH WORKER SCHEME BREAKING BARRIERS: GOVERNMENT LEADERSHIP, INVESTMENT AND QUALITY OF CARE

The Gombe State VHW scheme was the phase III of the MNCH project and the first state-led community health worker program in Nigeria. It was the product of years of evidence-based modeling, modification and redesign of winning MNCH interventions commenced since 2009. The scheme revolutionized access, coverage and uptake of MNCH interventions and helped to reverse the negative MNCH indices of the state by changing norms that were detrimental to maternal and child survival. It supported the scale up of conventional MNCH interventions that promote maternal and newborn survival across the state. The VHW scheme is implemented in 57 wards in the 11 LGAs of Gombe state.

The Gombe State Primary Health Care Agency (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 implemented both short- and long-term plans to address identified PHC gaps and needs in the state following an initial comprehensive needs assessment survey. One of its major focus is the Maternal, Neonatal and Child health issues in the state. One of such responses of the Agency was the initiation and implementation of the VHWs scheme, with the financial and technical support of the Bill and Melinda Gates Foundation (BMGF) and the Society for Family Health (SFH) respectively.

The state Government through the Gombe State Primary Health Care Development Agency owned and led the VHW Programme. The project goal was to increase coverage of prioritized life-saving interventions through improved and increased adoption of behaviors that promote maternal and newborn survival, including timely care-seeking for maternal and newborn health; improved quality of care during antenatal, intrapartum and postpartum/postnatal periods.

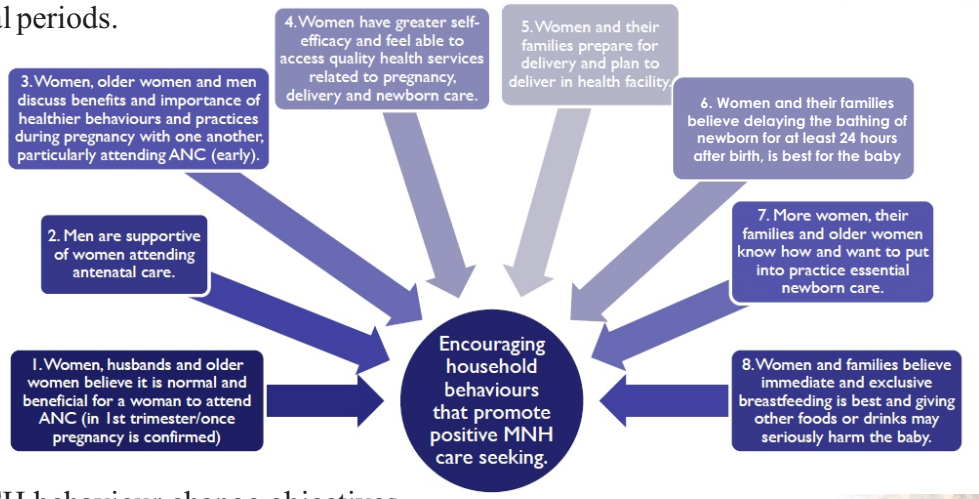


Figure III :
VHW Project MNCH behaviour change objectives

Through a combination of interventions, strong partnerships and collaboration, active community participation and government leadership and commitment the project achieved its MNCH behaviour objectives as indicated in fig. 1.

The Village Health Worker: MNCH Barrier Breaker and Change Agent

The Village Health Worker (VHW) was the pivot for the MNCH intervention at the community. She was a community member, identified by the community and resident in the community. She was conversant with, and respected the norms and values of her community. She underwent a 21 days extensive training on basic Maternal Neonatal and Child Health (MNCH) services. She was equipped with the knowledge and skills necessary to effectively carry out preventive, promotional and basic curative intervention for MNCH and change age old cultural norms and barriers on MNCH. She could read and write in English and Hausa, preferably married and less than 50 years.

In carrying out this role, she identified pregnant women, registered and referred them to the health facility for Antenatal Care (ANC) services, to address challenges associated with poor health seeking behaviour by women and children already identified as a big challenge in Gombe State. Through door-to-door health promotion, she encouraged the pregnant women to access institutional delivery, as well as post-natal care for her and the neonate, providing linkages for other services where danger signs were identified in both mother and the baby for prompt referral. She also provided other essential services such as community distribution of essential lifesaving drugs. The village health worker did not stop her work with the pregnant woman but engaged the entire household – the husband, mother in-law and other significant household decision makers to build support and acceptance for MNCH interventions that have enabled women and newborns to access and receive lifesaving MNCH services.

Selection and Verification

The project's collaboration with Ward Development Committees (WDCs) across all 57 intervention wards helped in identifying, assessing and registering the VHW, based on the following criteria:

1. Female, preferably married and with permission from husband
2. Community resident
3. Literate: Minimum qualification of First School Leaving Certificate
4. Aged, 15 years and not above 50 (May be flexible to enlist secondary school leavers who are more likely to be able to read and write)
5. Ability to speak the local language.
6. Conversant with norms and values of the community
7. Willingness to link activities to ward health facilities

Training of Village Health Workers

Training of Village Health Worker

The training of the VHW was planned, organized and conducted with SPHCDA taking lead and providing guidance, ensuring active participation of the agency staff as trainers and supervisors in the entire training process. Her training covered a period of 21 days, with 9 days spent in the classroom and 12 days on-the-field practical training. The adult learning methodology accompanied with role plays, pictorials, simulations, practical demonstrations and plenary sessions and use of available local resources was adopted.

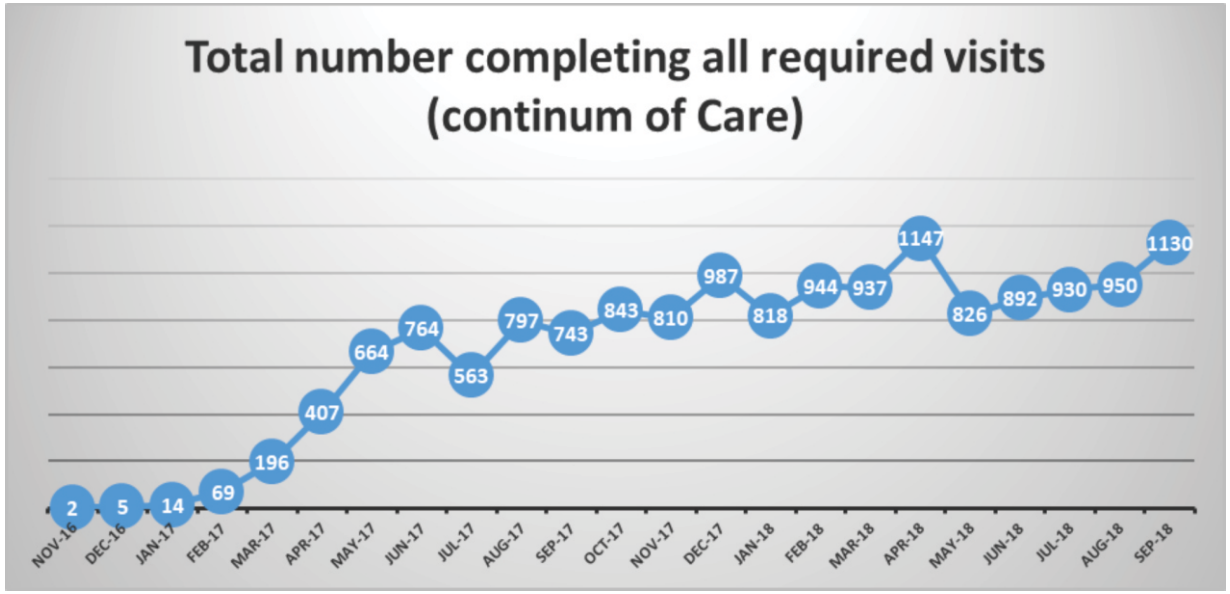
The training flow involved an initial training of Master Trainers (State MCH Coordinator and the 11 LGA MCH Coordinators), who stepped down training to the Supervisory CHEWs at the ward level; who now trained the selected VHWs. The supervisory channel followed a similar flow. By this therefore, capacity now resided in the state to conduct training of VHWs beyond the life of the project. Gombe state has become a beacon for MNCH interventions and has hosted learning tours and facilitated VHW trainings in other states such as Borno, Kaduna, and, Niger.




Kitting/Deployment: The VHW was mobilized and deployed with a pack containing tools and materials needed for her daily work routine and visits to homes. These included

1. Interpersonal communication Pictorial flip chart
2. Leave-behind home visit cards on various MNCH topics
3. Registers
4. Umbrella
5. Mobile phone
6. Water bottle
7. Branded Apron or Hijabs (identifiers)
8. Job aids
9. Weighing scale
10. Thermometer
11. Blood Pressure Cradle Device Apparatus

The VHW metamorphosed since 2009 through the various phases of the MNCH project and had an enhanced status in her community as, going beyond religious and cultural confines, she became a community resource person on matters of MNCH. She was held in high esteem in the community and had become a reservoir of health knowledge and voice for change. Since the implementation of the VHW scheme in November 2016 to its closeout in 2019, **157,232** women had been enrolled into the scheme. During the project period, the VHWs conducted a total **535,889** home visits (ANC, PNC and other follow up visits) to the registered women on the scheme. Of these, a total of **40,442** women completed ANC, **54,679** deliveries were recorded in health facilities; it is worth noting that **15,438** women completed the continuum of care (four ANC visits, facility delivery and two PNC visits). All these occurred in the 57 (50%) intervention wards in the state.



(Data source, SFH monitoring data)
Figure IV : Number completing all required visits (ANC, delivery and PNC)

Table 2: Outcomes for Newborn Care

INDICATOR	Data source	Jul-12	Aug-16	Aug-18	2012 - 2018 % change (95% CI)	2016 -2018 % change (95% CI)
Newborns with delayed bathing for the first 24 hours of life	HH survey	11% (7-15)	44% (36-52)	60% (50-69)	445.5%% (284.464 - 606.536)	36.4% (13.051 - 59.749)
% of newborns having CHX 7.1% w/v an appropriate formulation) applied to the cord stump within the first 24 hours of life	HH survey	no data	18% (13-24)	51% (42-61)	-	183.3% (117.042 - 249.558)
% of newborns breastfeeding within 1 hour of delivery	HH survey	40% (33-47)	53% (46-60)	69% (62-75)	72.5% (48.202 - 96.798)	30.2% (9.182 - 51.218)

CI-Confidence Interval, HH- Household

% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to pregnancy	HH survey	50% (40-50)	68% (63-72)	85% (80-89)	70.0% (44.697 - 95.303)	25.0% (6.647 - 43.353)
% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to labor and delivery	HH survey	36%	49%	73%	102.8% (65.641 - 139.959)	49.0% (31.288 - 66.712)
% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to the postnatal period	HH survey	no data	11% (7-16)	21% (15-28)	-	90.9% (39.231 - 142.569)

CI-Confidence Interval, HH- Household

Table 3: Changes in Maternal Health Care Seeking (IDEAs Evaluation Survey)

INDICATOR	Data source	Jul-12	Aug-16	Aug-18	2012 - 2018 % change (95% CI)	2016 -2018 % change (95% CI)
% of women who were attended at least four ANCs during their last pregnancy by any provider for reasons related to the pregnancy	HH survey	40% (30-51)	46% (39-53)	64% (56-71)	60.0% (36.315 - 83.685)	39.1% (16.340 - 61.860)
% of live births with a SBA (doctor, nurse, midwife or CHEW)	HH survey	-	49% (38-60)	61% (53-69)-	-	24.5% (2.826 - 46.174)
% of women who had a post-partum check-up within 2 days of the last birth	HH survey	7% (4-9)	11% (7-17)	12% (8-17)	71.4% (8.404 - 134.396)	9.1% (-33.274 - 51.474)

CI-Confidence Interval, HH- Household

Table 4: VHW linkage activities and Maternal Knowledge. (IDEAs Evaluation Survey)

INDICATOR	Data source	Jul-12	Aug-16	Aug-18	2012 - 2018 % change (95% CI)	2016 -2018 % change (95% CI)
% of women reached by Village Health Worker volunteers during their last pregnancy	HH survey	5% (1-8)	21% (14-31)	48% (38-58)	860.0% (549.13 - 1170.87)	128.6% (82.115 - 175.085)
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% of women reached by Village Health Worker volunteers during their last pregnancy	HH survey	5% (1-8)	21% (14-31)	48% (38-58)	860.0% (549.13 - 1170.87)	128.6% (82.115 - 175.085)
% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to pregnancy	HH survey	50% (40-50)	68% (63-72)	85% (80-89)	70.0% (44.697 - 95.303)	25.0% (6.647 - 43.353)
% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to labor and delivery	HH survey	36%	49%	73%	102.8% (65.641 - 139.959)	49.0% (31.288 - 66.712)
% of women with a live birth in the last 12 months with knowledge of at least two danger signs relating to the postnatal period	HH survey	no data	no data 11% (7-16)	21% (15-28)	-	90.9% (39.231 - 142.569)

CI-Confidence Interval, HH- Household

Success Story:

The Knowledge of Misoprostol led Aishatu to the Health Facility

Aishatu is a 25year old married mother of 6 children. 3 males and 3 females ranging from ages nine to 2 years. She has an Islamic school education. Aishatu Ali's last child delivery ended with her losing consciousness as a result of excessive blood loss, she ended up being rushed to the healthcare facility for resuscitation and blood transfusion. This has happened in all her previous 6 deliveries and women in her community also experienced excessive loss of blood at delivery, some of the women even died. She had never attended ANC nor
delivered at the health facility throughout her previous pregnancies. Each pregnancy was a period of intense fear for this young lady that she might bleed to death.

During her last pregnancy which was her ninth she was visited for the first time by a VHW in her

fourth month and registered into the MNCH program. She was educated on the importance of ANC and facility delivery and informed that there is a drug called Misoprostol that can prevent and control excessive bleeding. She was provided with hematinics and Chlorhexidine as motivation to visit the facility. As a result of these interventions she visited the health facility for ANC, and was so pleased with the care she received, she decided to deliver in the facility. Aishatu had three (3) ANC visits and was delivered of a baby girl without complications for the first time. She was so grateful that she named her baby after the VHW who visited her. She has become an advocate for facility delivery in her community and as a result more women are enrolling in the health facility for ANC and delivery. 'I am so grateful, the VHW came to my house, and I named my baby daughter after her.' (Coincidentally, the VHW and the mother share the same name)

Government leadership and active participation

The conceptualization, design and implementation of VHW intervention was led and driven by the Gombe state government through the GSPHCDA. The agency with support of development partners such as the Bill and Melinda Gates Foundation conducted a health needs assessment which identified gaps in MNCH knowledge, access and services especially at community and PHC levels. Following this, the agency developed and progressively implemented development plans that addressed identified MNCH needs. One major health gap identified was the Maternal and Neonatal and Child health challenges in the state. The MNCH intervention through the VHW scheme was initiated by the state in response to the needs assessment. The VHW scheme was co-financed by the state and Bill and Melinda Gates Foundation (BMGF) with Society for Family Health (SFH) providing technical support.

The role of the agency on the project was all encompassing from building consensus on the VHW profile, scope of work, incentives, selection process through training and supervision. This ensured government's cooperation from start to finish of the project and through the transitioning period from project based to state owned. The agency appointed desk officers for the VHW program at the state and LGA levels, provided functional health facilities with skilled staff that provided 24hr services across 57 focal facilities (one per ward). The adaptation of existing VHW training materials and job aids under the project was led by the state agency while the selection of VHW was carried out by district heads, Ward Development Committees (WDC) with supervision from GSPHCDA for verification while validation of women selected was done by GSPHCDA & SFH. The state led the process for the nomination and presentation of staff for training as Master trainers and VHW Trainers/Supervisors, and the planning, and also conducted and supervised VHW training.

The selection of Master-Trainers from the staff of the GSPHCDA, training and supervision of VHWs by CHEWs at the ward levels, pairing of project staff by corresponding agency staff – (Program Officers at state level and VHW Desk officers at LGA level), ensured adequate transfer of skills, competency development and a pool of skilled trainers and staff within the system. It is worth noting that the state's emphasis on recruiting all trainers from the pool of government employees was to reside resources within the system. Staff of GSPHCDA participated in the supportive supervision and monitoring of VHWs along with SFH programme officers. The state government co-funded the regular monthly stipends for the VHWs and supported with commodities for community distribution. The state adopted a clustered model where a focal PHC in a ward was selected, upgraded and equipped. All other PHCs referred complicated MNCH cases to this focal PHC in the ward.

Community Engagement Interpersonal communication (IPC) to influencers

Northern Nigeria operates a compound family structure and tradition. This necessitated the need to identify persons of influence, key decision makers and bread winners in a home and target them for increased MNCH support. The IPC strategy under the Gombe MNCH VHW project was a complementary approach to the village health worker scheme which involved engaging with secondary targets such as key decision makers, through group IPC sessions, with the overall objective of improving MNCH goals for the state. These sessions aimed at gaining increased support for pregnant and new mothers to freely access healthcare at medical facilities. Activities under this approach entailed IPC Consultants (2males &2 females per LGA) engaging with influencers and home decision makers to gain increased support for MNCH outcomes. The IPC consultants were equipped to conduct routine IPC sessions with community leaders, husbands and mothers-in-law in an impactful manner using pictorial flipcharts to communicate key messages on MNCH. The IPCA conducted routine sessions for a maximum of 6

times rendering different messages per session.

Systems strengthening (capacity building for IPCA): IPCA were trained on how to conduct group IPC sessions with community leaders, young husbands and mothers-in-law. The consultants who were in male-female pairs, identified and worked in 10 communities each per quarter. While the females conducted 6 sessions per quarter with mothers-in-law groups, the males held 6 sessions each with community leaders and young husband's groups, respectively. The selection of communities was done with the consent of WDC Chairmen and WDC Focal Persons. The supervision of IPCAs prioritized the emphasis and summary of key messages during sessions. It also prioritized a call to action as a means of motivating these influencers to support and actively seek care for pregnant women and newborns at the health facility.

She has become an advocate for facility delivery in her community and as a result more women are enrolling in the health facility for ANC and delivery. 'I am so grateful, the VHW came to my house, and I named my baby daughter after her.' (Coincidentally, the VHW and the mother share the same name)

Emergency Transport Service (ETS) & Community Transport Volunteers (CTV)

Availability and provision of free transport in the intervention communities provided an essential service that could mean the difference between life and death for a pregnant woman and her unborn or newborn child.

Emergency Transportation Scheme (ETS): In cases of obstetric emergencies, the ETS provided transportation from the community to the nearest health facility. The services were provided by community volunteers, who were members of the National Union of Road Transport Workers (NURTW) that had received basic training on lifting women in labour or with complications to the nearest health facility. The success of the ETS birthed the Community Transport Volunteer (CTV) intervention, which involved community members volunteering their vehicles for lifting of women during emergencies. The Ward Development Committees (WDCs) provided oversight monitoring and coordinated the activities of the volunteer ETS/CTV drivers. Although the need for emergency transport was expected to diminish as awareness and health-seeking practices increased, the remoteness of some locations meant that the services were still critically needed by some women. The provision of emergency transport reduced the delay between the onset of an obstetric emergency and receipt of appropriate care.

All the Village Health Workers (VHWs) had access to contact details of volunteer drivers in their areas of coverage, which were also pasted on the walls of the ANC units (The facility staff shared the phone details of the drivers nearest to each pregnant woman's community during ANC, who in turn shared with her husband and family to use in times of emergency). The numbers of these drivers were pasted on all labour rooms (so the facility staff could call on the volunteer drivers for referrals in times of delivery complications), at the intervention facilities. The driver recorded his efforts into his log book (a picture coded log book) and returned to his base where he reported to the NURTW LGA park secretary for NURTW volunteer drivers while the CTV driver reported to the WDC/Ward Focal Person. With support from the state government, most intervention wards received functional ambulances. In order to leverage on this opportunity, the VHW scheme integrated the ambulance drivers into the ETS.

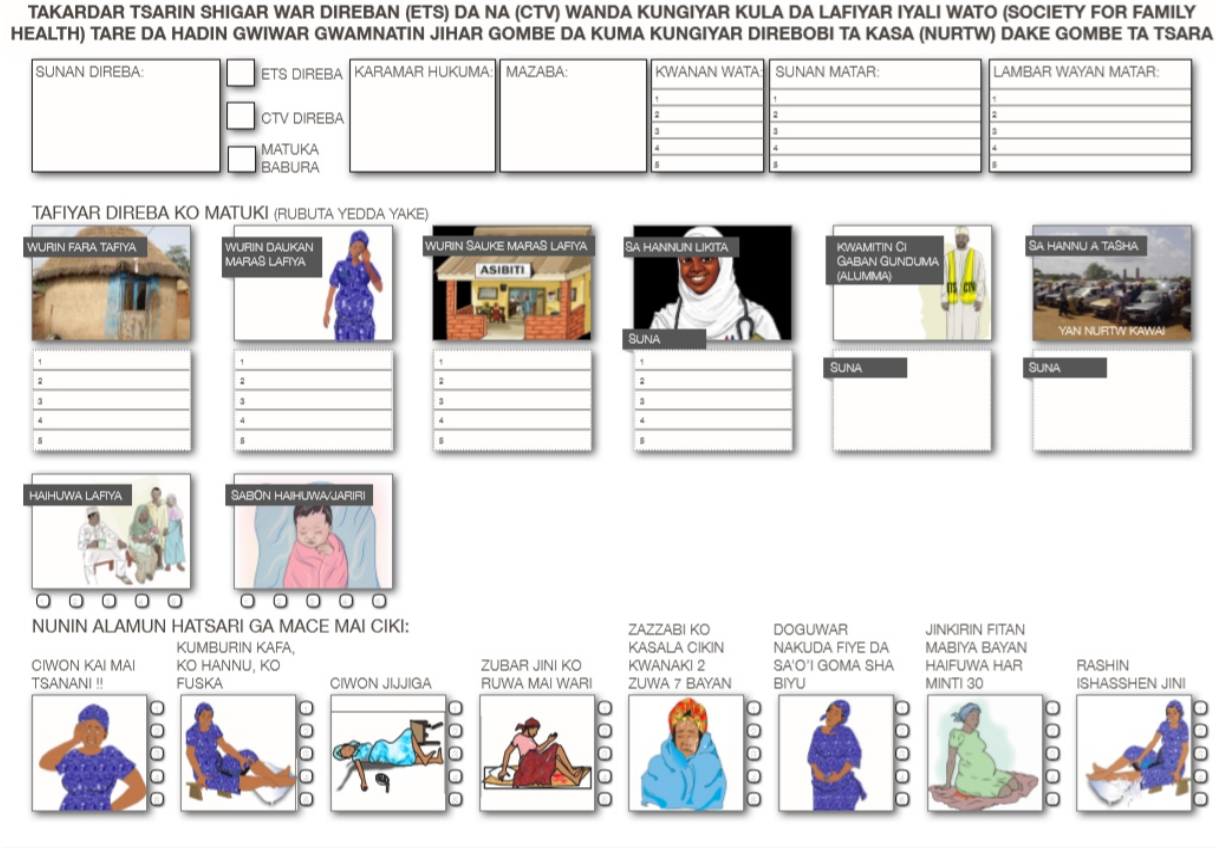

Figure V: ETS/CTV Color Coded Log Book

Results: A total of 7,481 cases (women and newborns) were lifted by 389 (208 NURTW; 171 CTV) volunteers under the scheme from November 2016 to July 2018. 3044 of these cases resulted in normal deliveries, while 3,575 presented with different complications. Challenges encountered by ETS drivers were: high level of attrition, some do not own their cars, accidents, cars packed due to inability to repair damaged parts, some pulled out owing to hike in fuel price, death of some volunteer drivers.

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Table 5: Results from IDEAs Survey: Utilization of Emergency Transport Scheme

INDICATOR	Data source	Jul-12	Aug-16	Aug-18	2012 - 2018 % change (95% CI)	2016 -2018 % change (95% CI)
% women who reported using ETS for their last delivery.	HH survey	1% (0-1)	1% (0-2)	2% (1-5)	100.0% (-74.391 - 274.391)	100.0% (-74.391 - 274.391)

Success Story

Dulyamba Modi from Sansani community is a trained CTV. One night in July 2018 he was called by a VHW named Lynda Jesse from Kalindi community, in Billiri North. One of the VHW's clients had been in labour for about 24hrs at the health facility and there was little progress. The nurse at the facility referred them to the general hospital Billiri for a Caesarean section to be done. Immediately, Dulyamba Modi brought his vehicle and took the woman and the VHW that accompanied her to General Hospital Billiri, where she had an emergency Caesarean section. The woman was safely delivered of a baby boy. As a result of the swift and selfless effort of the CTV a maternal crisis was averted. The CTV did not charge for his services and both mother and son are in good health.

Provision of Essential Lifesaving Commodities

Availability of essential MNCH medicines and commodities at points of need could be a life and death deciding factor for a woman during delivery or for her newborn. Prior to the project's intervention, stock out/non-availability of essential medicines and commodities such as misoprostol for postpartum hemorrhage, Chlorhexidine for umbilical cord care etc., at PHC facilities in rural areas was a norm and these commodities and medicines were completely non-existent at households where most deliveries took place at the beginning of the project. The cost of buying drugs and commodities for these communities was beyond the reach of many families thus the non-utilization.

In addition to the free distribution of drugs and commodities, the government's initiative to freely distribute delivery kits which in earlier phases of the MNCH intervention were sold at a subsidized rate contributed to improved uptake of MNCH services at the facilities. The free distribution of delivery kits and drugs under the VHW scheme prevented informal purchase and sale of drugs by healthcare workers. These lifesaving commodities which were provided both at household level through the VHW and at PHCs, improved utilization. Commodities and drugs were provided to every woman at the PHCs and in the households by VHWs thereby ensuring that every woman or newborn received interventions at point of need.

Commodities distributed through VHWs at the community were Folic Acid, Fersolate, Misoprostol and Chlorhexidine. Focal health facilities served as hubs for redistribution of these commodities through the VHWs, who in turn dispensed to beneficiaries especially in hard to reach communities. An initial push system was used in issuing the commodities to the VHW and later a pull system based on utilization was deployed.

The free distribution of delivery kits and drugs under the VHW scheme prevented informal purchase and sale of drugs by healthcare workers.

Table 6: Project Impact through commodity distribution

Project Impact – Nov. 2016 to Sep. 2018			
Commodities	**Quantity Dispensed/ Consumed**	**DALYs Averted**	**Possible Deaths Averted**
Misoprostol	79,209	460	8
ORS/Zinc	28,020	2,521	29
ACTs	25,864	9,191	107
CDK	27,024	3,416	45
Chlorhexidine	87,265	8,784	102
Amoxicillin Dispersible	210,151	211,359	2,477
Sulphadoxine/Pyrimethamine	47,425	400	147
Magnesium Sulphate	2,838	8,127	110
Total		-247,859	2,925

Saidu Galadima, the Nurse in charge of Bogo Model PHC said "**VHW program has changed the behavior of the community people of Garko ward in the aspect of Facility ANC and Facility deliveries. Also care of the cord with the use of Chlorhexidine, exclusive breast feeding, and delayed bathing has much being improved at the rural communities".**

Success Story

Asma'u Baba is a young married woman from Madugu Yashi in Kwami LGA. She has had seven (7) pregnancies and deliveries at home but only two (2) living children. She reported that all her deliveries were accompanied by heavy bleeding. A VHW registered her into the MNCH program and educated her about ANC and facility delivery, she also told her about a drug that prevents bleeding after delivery (Misoprostol). The VHW also talked to her husband and mother in law regarding facility delivery and the dangers of bleeding. Her husband was convinced, and he gave her permission to deliver in the health facility. At nine (9) months Maryam delivered at the facility and was given the misoprostol, this time she did not bleed or lose her baby. Maryam has become an advocate for hospital deliveries and regular ANC attendance.

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Table 7: Commodities Distribution

Commodities	2016	2017	18-Sep	Total
Amoxicillin Injection	-	6,382	7,649	14,031
Amoxicillin Tablet	-	32,141	178,010	210,151
Benzathine Penicillin	1,090	7,757	25,416	34,263
CDK	570	13,593	12,861	27,024
Chlorhexidine	5,215	41,761	40,289	87,265
Fersolate (Iron)	3,368,000	7,260,280	6,245,381	16,873,661
Folic Acid	1,223,500	3,272,140	2,598,430	7,094,070
Gentamycin 80mg Injection	-	9,775	8,697	18,472
Magnesium Sulphate	-	1,468	1,370	2,838
Malaria RDT	-	-	17,169	17,169
Misoprostol	14,600	48,879	57,489	120,968
ORS/ZINC	-	7,120	19,666	26,786
Oxytocin	-	8,354	8,220	16,574
PCM Syrup	-	-	-	9,740
PCM Drop	-	-	-	7,862
Soap	-	2,932	6,167	9,099
Sulphadoxine/Pyrimethamine	-	24,289	32,131	32,131
Suction Bulb	1898	19,109	6,286	6,286
ACT 1 (Quantity Received during the month)	-	15,294	-	-
ACT 2 (Quantity Received during the month)	-	6,515	-	-
Albendazole (Quantity Received during the month)	-	11,621	-	-

Partnerships and Collaborations

Six project partners worked on the Gombe MNCH project, each with a unique value-add. These were the Gombe Primary Health Care Development Agency (GSPHCDA), Bill and Melinda Gates Foundation (BMGF), Society for Family Health (SFH), pact, IDEAS and Mamaye. Collaboration was fostered through shared responsibility that focused on outcomes. There were initial challenges between partners without a history of collaboration, however, focusing on broader outcomes for women and children, and engaging in regular data analysis and discussions, facilitated collaboration and maintained the focus on the bigger picture.

The Ward Development Committee

The WDC is a community structure with the responsibility to facilitate development and organize interventions at the community level. WDCs are the gateways to the community. They are very influential and instrumental to the success of community level interventions. The VHW scheme leveraged the WDCs to garner the support and buy-in of key stakeholders at the community level as well as institutionalize activities of the VHW scheme. At inception, the project observed that the WDCs had challenges especially in the areas of coordination and capacity. The MNCH project strengthened the WDCs and made them functional to facilitate good outcomes. This included a mapping of WDCs to know the actual status of WDCs in the state. This was followed by a harmonization process that reconstituted the WDCs with a clear composition of membership, structure, roles and enhanced capacity to perform – oversight, monitoring, social mobilization and other roles. The Gombe MNCH project enabled sustainability of the VHW scheme through the harmonization and working with a unified WDC structure.

Following the harmonization, the under listed were achieved.

- Encouraged community participation in primary health care and other health related programs.
- Made interventions easier and sustainability of such interventions more effective.
- Made acceptance of the project's promotedbehaviours and interventions easier and less time consuming.
- Reduced repetition and uneven distribution of interventions.
- Promoted ownership, follow-up/oversight by the WDC as well as integration Zof VHW scheme activities into the WDC structure.
- Harmonization facilitated linkage between the PHC and the community through a representative of the community that interfaced with health workers in primary health care facilities.
- Mobilized resources (human and material) for MNCH intervention.
- Bridges between the community and Government, NGO and other partners in the implementation of health program were fostered.

Social Mobilization

In addition to individual engagement of community and religious leaders, community mobilization involved the assembling of community members at some central locations within the target community (such as the central market square or the community leader's residence). These social mobilization activities were led by the WDCs and designed to create an enabling environment for the promotion and improvement in the uptake of MNCH services, foster behavior change through direct interactions with the eligible women and their husbands and actively mobilize support from key influencers and the health providers practicing in the community, using various IPC and community-based interventions and approaches. This was done by creating awareness on the various thematic health areas of the project with emphasis on the most critical issues plaguing the community. The primary target audience for the mobilization exercises were the married Women of Reproductive Age (MWRA) and their Husbands.

Some of the issues emphasized at these meetings included PNC attendance, delivery at HFs, exclusive and immediate breastfeeding, thermal and cord care, etc. The activity involved the pooling together of community members on a set date for awareness creation. The mobilization of

community members was either in the form of town criers or through messages sent to local group leaderships by the community leaders. SM activities were anchored by the WDCs under the supervision of the LGA Social Mobilization Officers (LGA SMO). Other key stakeholders who participated in the SM activities included the community heads, VHWs, IPC consultants, supervising CHEWs, etc. The activities included edutainment (in form of music and drama conveying our key messages) and talks around the project's key health areas. A key outcome of the SM activities was the tracking of women (nursing or pregnant mothers) or influencers (husbands or parents) and their linkage to VHWs after the events for referral to focal HFs. These sessions also provided an added advantage as they were used to reach pregnant women missed through household visits. A total of 164 SM events held with 11, 315 persons reached between January and October 2018.

SMO Kaltungo LGA Yunana Moljengo: **"There is tremendous improvement with the coming of SFH empowering the WDC to carry out social mobilization activity in the communities. This has brought about significant rise in ANC attendance and facility delivery and practice of the use of Chlorhexidine and immediate and exclusive breast feeding among mothers has improved over the years".**

Mass Media and Health Messaging

The Gombe MNCH program extensively used mass media messaging to compliment the VHW scheme's community activities. The media messages enabled pregnant women and their families to make informed, safer decisions about MNCH. The strategy fostered positive knowledge, attitude, skills, norms, motivation, community support, self-efficacy and accountability around MNCH issues. These comprised of;

- Radio magazine programming that promoted lifesaving interventions and dispelled myths and misconceptions related to MNCH.
- Spots/jingles targeting religious leaders and mothers/mothers-in-law aimed at generating discussions around good MNCH practices.
- Radio drama that galvanised community support for MNCH and promoted program and partner activities.
- Capacity building activities for health producers at partner stations that improved the quality of content.
- Equipment donation to partner stations to improve the quality of program production and coverage.
- Social media engagement (Facebook, SMS, WhatsApp).
- Community engagement and social mobilisation activities to support uptake of skilled and healthier MNCH practices.

Feedback forum: LGA Data Driven Learning Meeting (DDLM)

Community leaders were invited every quarter for a Data Driven Learning Meeting where the results/performance of the VHW Scheme were presented to all key decision makers for review as well as to discuss solutions for challenges identified. This data driven feedback and review process informed positive changes at LGA levels in improving the MNCH practices within the communities. For example, the district head of Zange ward in Dukku LGA of Gombe state, once summoned all the men of reproductive age in his community through the various village heads and complained this will be the last time he will be humiliated before his peers during the DDLM, where his community always had the highest number of home deliveries recorded, he gave the order that any husband whose wives delivered at home would have to pack and leave his domain. The outcome was an increase in facility delivery and a corresponding decrease in home delivery.

Sustainability and phased transitioning of project activities

Elements of sustainability were laid from the beginning with the government of Gombe state owning the project. The provision of leadership from the conceptualization, design, implementation and contribution to funding of the VHW scheme entrenched sustainability from start. Active implementation of project as designed, the creation of a budget line for the VHW allowances in the GSPHCDA's pay structure and payment of the allowances though the life span of the project were hallmarks of state ownership and leadership.

The selection of Master-Trainers from the staff of the GSPHCDA, and direct responsibility of training and supervision of VHWs by CHEWs at the ward levels, shadowing of project staff by corresponding agency staff - Programme Officers at state level and VHW Desk officers at LGA level, ensured adequate transfer of skills, competency development and a pool of skilled trainers and staff within the system.

Other activities geared toward sustainability were the direct involvement of WDCs and Community Leaders in monitoring and oversight of project implementation, thus institutionalizing accountability checks within community structures. This did not only improve acceptance, it made the community leadership advocates for MNCH as they saw failure of activities to represent deaths of loved ones – wives, sisters, mothers and children. Also, the continuous tracking and reporting of VHW activities on the state HMIS meant that data from the project counted and informed policy decisions. State ownership and community participation in the selection and deployment of VHWs enabled high acceptability of VHWs in their various intervention communities.

Lessons learnt under the VHW scheme

- **Achieving greater impact through Active Government Participation**

All partners noted the strong leadership of the Gombe State government, and its commitment to actively applying learning to improve program performance.

- For any form of implementation to succeed and be sustained, the buy-in of the highest level of State government is imperative.
- Mentorship, hand-holding and collaboration with the government is a panacea for sustainability.
- When government leads as drivers of an intervention, community enlightenment, trust, acceptability and responsiveness is high particularly regarding healthcare.
- **Achieving greater impact through Mass media involvement**

The use of mass media activities in local languages, particularly in Hausa have an immense impact on behaviour change amongst the target audience.

Community involvement

- The targeting of Influencers and heads of households for IPC is an effective way of addressing religious and cultural barriers to adoption of healthy MNCH behaviours. This approach became imperative in the light of the compound family structure typical of the VHW intervention sites, whereby household decisions are the sole prerogative of the Household Head.
- Early involvement of influencers can have a positive impact on uptake or acceptance of new innovations.
- Communities accept innovations quickly when they are well informed, especially when it comes from persons whose views or opinion they respect.

Collaboration with Partners

- Collaboration was fostered through shared responsibility and a focus on outcomes: While there were initial challenges between partners without a history of collaboration, focusing on broader outcomes for women and children, and engaging in regular data analysis and discussions, facilitated collaboration and maintained the focus on the bigger picture.
- Evaluation
- The six-monthly evaluation conducted by an independent evaluator was very instrumental and informed key refinements of project strategy. These strategic decisions informed positive changes that guided implementation and attainment of project results.

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Learnings for BMGF

- Donor-driven support for collaboration was critical. In the process of trying to understand the landscape, the foundation facilitated partners working together to identify their niche areas of work, potential overlaps, common messages and approaches, opportunities to support each other, and a shared results framework.
- Through this process, partners agreed to a new way of working together, which they had never pursued previously but was likely to influence the quality of support provided by the VHW program and beyond in the longer-term.
- The VHW scheme is new way of working internally. For the foundation, this program demonstrated a new way of working. Coordination and collaboration between internal teams was notable, particularly between programs. The shared results framework by all partners set clear expectations in terms of roles and responsibilities of the various parties working toward a common goal.
- Ultimately, this collaboration (both internally and externally) translated into a multi-sector, multi-faceted approach in Gombe State.

PARTNERSHIPS

Gombe State Primary Healthcare Development Agency – GSPHCDA (https://www.gsphcda.org.ng/)
The GSPHCDA was established in 2013 to provide quality, effective, comprehensive, affordable and accessible health services for the promotion of the general wellbeing of the people in Gombe State. This it achieves through implementation of appropriate policies and programs for Primary Health Care Services in partnerships and collaboration with all stakeholders. With co-funding from the Gombe State Government, the Agency led the community level implementation of the VHW program as well as other similar programs

Society for Family Health – SFH (http://www.sfhnigeria.org)
Founded in 1985, SFH is an indigenous, nonprofit, non-political, non-governmental organization in Nigeria with a mission to empower Nigerians particularly the poor and vulnerable to lead healthier lives. Working with private and public sectors, SFH uses social marketing and evidence-based behavior change communication to improve access to essential health information, services and products to motivate the adoption of healthy behaviors. SFH implements and demonstrates significant impact in various health fields including maternal and child health, malaria prevention and treatment, HIV & AIDS prevention, reproductive health, family planning and safe water systems. SFH also provides health products and clinical services to Nigerians in urban and rural areas, especially among the most vulnerable. SFH works in close partnerships with several international donors, Ministries of Health and other organizations to create health solutions that are built to last.

IDEAS (https:// ideas.lshtm.ac.uk)
IDEAS aim to improve the health and survival of mothers and babies through generating evidence to inform policy and practice. Working in Ethiopia, northeast Nigeria and India, IDEAS use measurement, learning and evaluation to find out what works, why and how in maternal and newborn health programs. IDEAS is funded between 2016 and 2020 by a grant from the Bill & Melinda Gates Foundation to the London School of Hygiene & Tropical Medicine

Pact (https://www.pactworld.org/)
Pact is an international development organization at work in nearly 40 countries. By strengthening local systems and building the capacity of local institutions to improve services, Pact is giving people better access to vital health and social services. Pact focuses on improving the health and well-being of those who are challenged by poverty and marginalization worldwide. Founded in 1971, Pact strives for a world where all people are heard, capable and vibrant.

Evidence for Action – E4A (https://mamaye.org/countries/nigeria)
Evidence for Action-MamaYe (E4A) is a program managed by Options, with financial support from the Bill & Melinda Gates Foundation. E4As advocacy activities are currently focused in Nigeria and Kenya, while also working across sub-Saharan Africa on advocacy specific to health budgeting and the Global Financing Facility. E4A supports key stakeholders or systems to translate complex health system data into simple graphic formats and make sure that the right people have the capacity to interpret and use it. E4A contributes to saving the lives of mothers and babies through a strategic combination of evidence, action and accountability. Interventions are made possible with management support from Options and funding from the Bill & Melinda Gates Foundation.

Champions for Change – C4C (https://www.gatesfoundation.org/Where-We-Work/Africa-Office/Champions-for-Change)
Champions for Change (C4C) works with the Bill & Melinda Gates Foundation to provide funding for local Nigerian programs that improve the health of women, children, and youth. This combination of field-tested methodology and motivated local advocates helps Nigerians rise to create sustainable change together. C4C creates change at the local level and inspires the political will for improved approaches to health care and services across Nigeria.