BILL & MELINDA GATES foundation

NIGERIA: MNCH ENGAGEMENT IN GOMBE STATE

Overview

August 2017

Photo Credit: Society for Family Health

OVERVIEW OF GOMBE STATE

2.4 million

population of Gombe

11

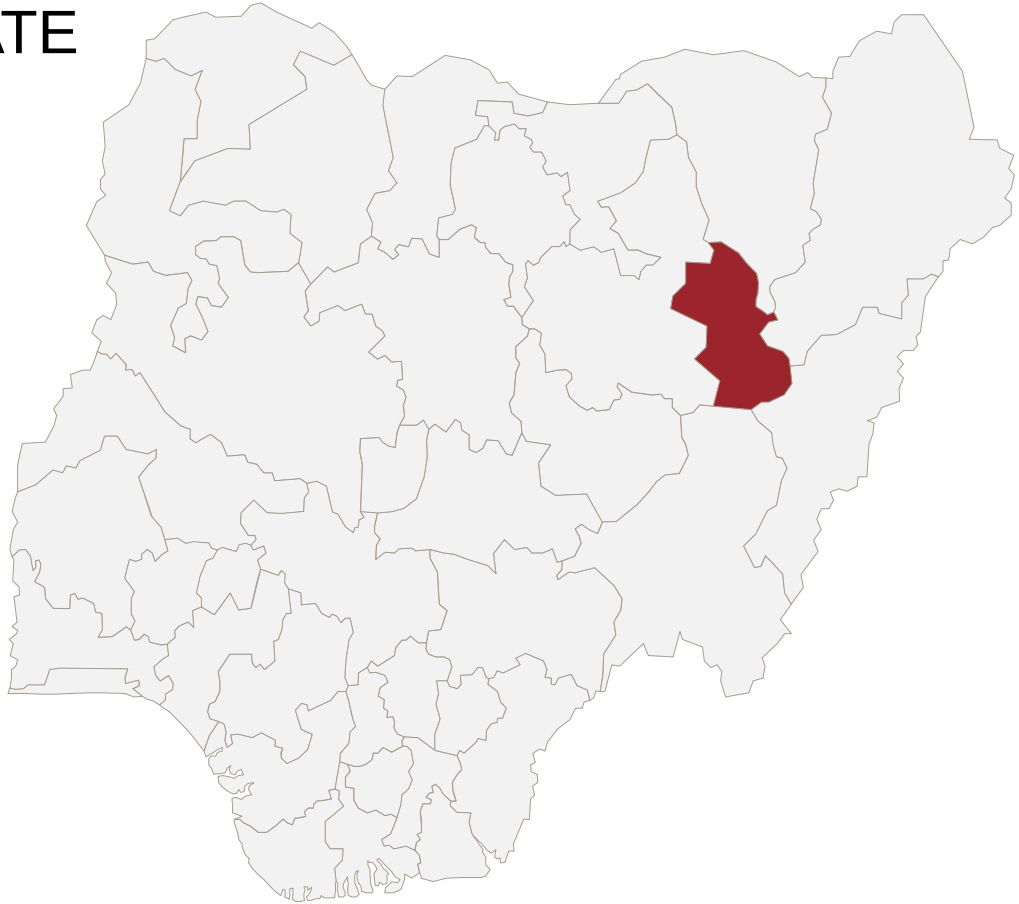
local government areas

114

wards

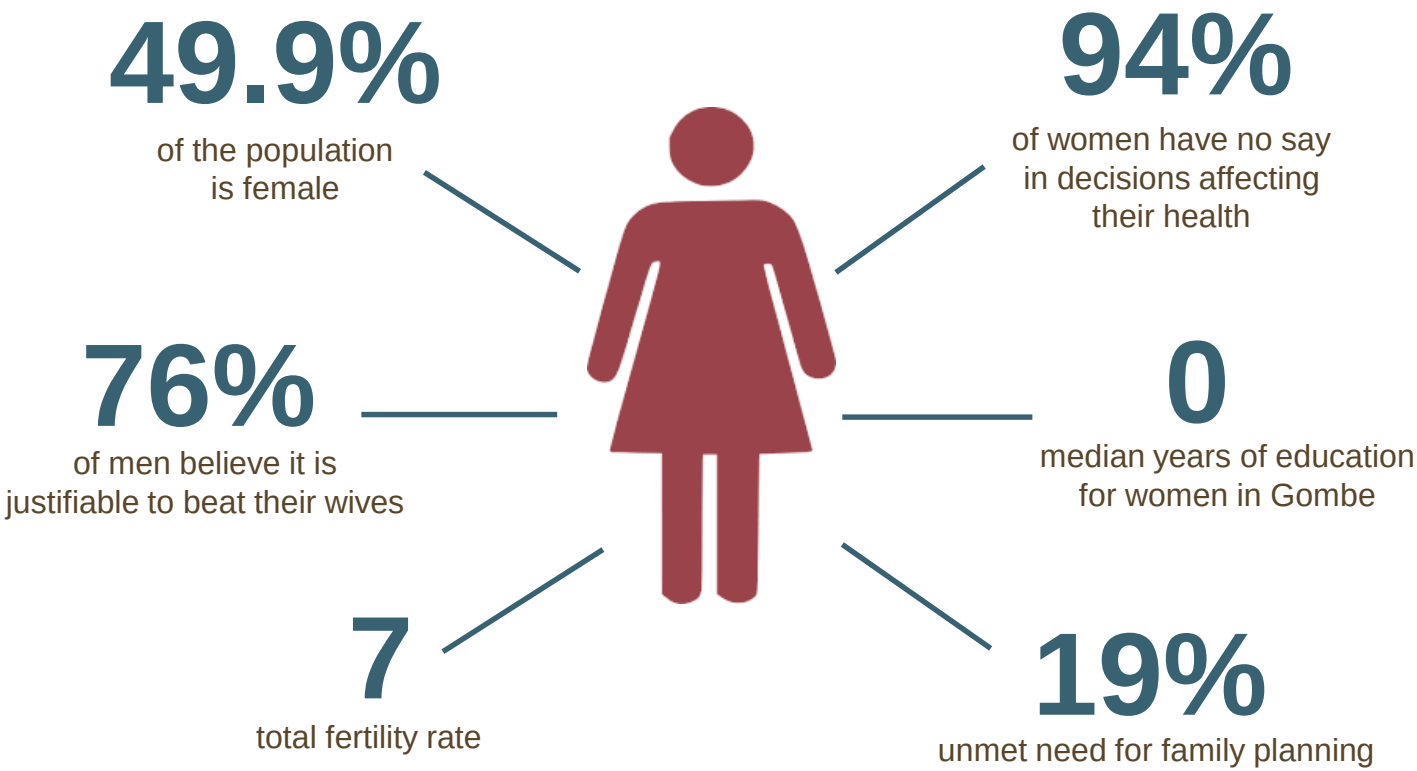
72.2%

of citizens live on less than $1/day



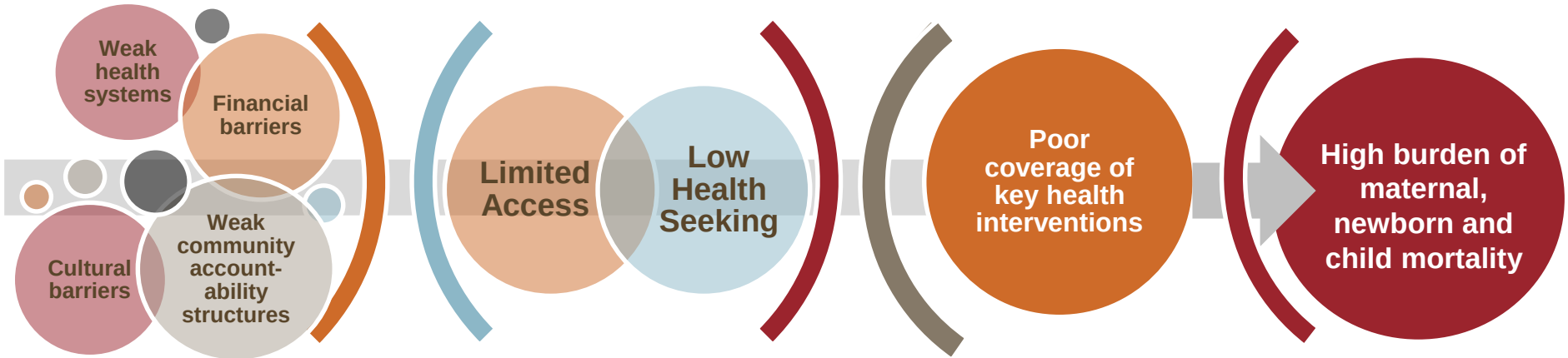
Data Sources: www.nigeria.gov.ng; Gombe State SSHDP

WOMEN IN GOMBE STATE



Data Sources: Gombe State SSHDP; DHS 2013

HEALTH CONTEXT IN GOMBE



Key underlying health factors in Gombe State

43%
of Gombe residents reported at least 1 problem in accessing health care

51%
of women complete 4 ANC visits

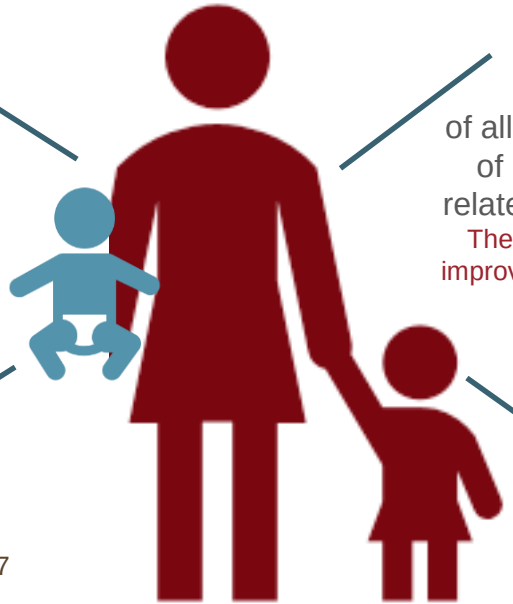
10%
of women get postnatal care

25%
of women deliver in a facility

22%
of children receive all basic vaccinations

Data Source: DHS 2013, IDEAS 2016

HIGH BURDEN OF MATERNAL, NEWBORN AND CHILD MORTALITY



800

Maternal deaths per 100,000 live births

Above the national estimate of 576 per 100,000 live births

23%

of all deaths among women of reproductive age are related to maternal mortality

There has been no significant improvement in maternal mortality in Nigeria since 2008.

43

Newborn deaths per 1,000 live births

Above the national estimate of 37 per 1,000 live births

Primary Causes:

- Asphyxia (29%)
- Preterm (23%)
- Infection (20%)

160

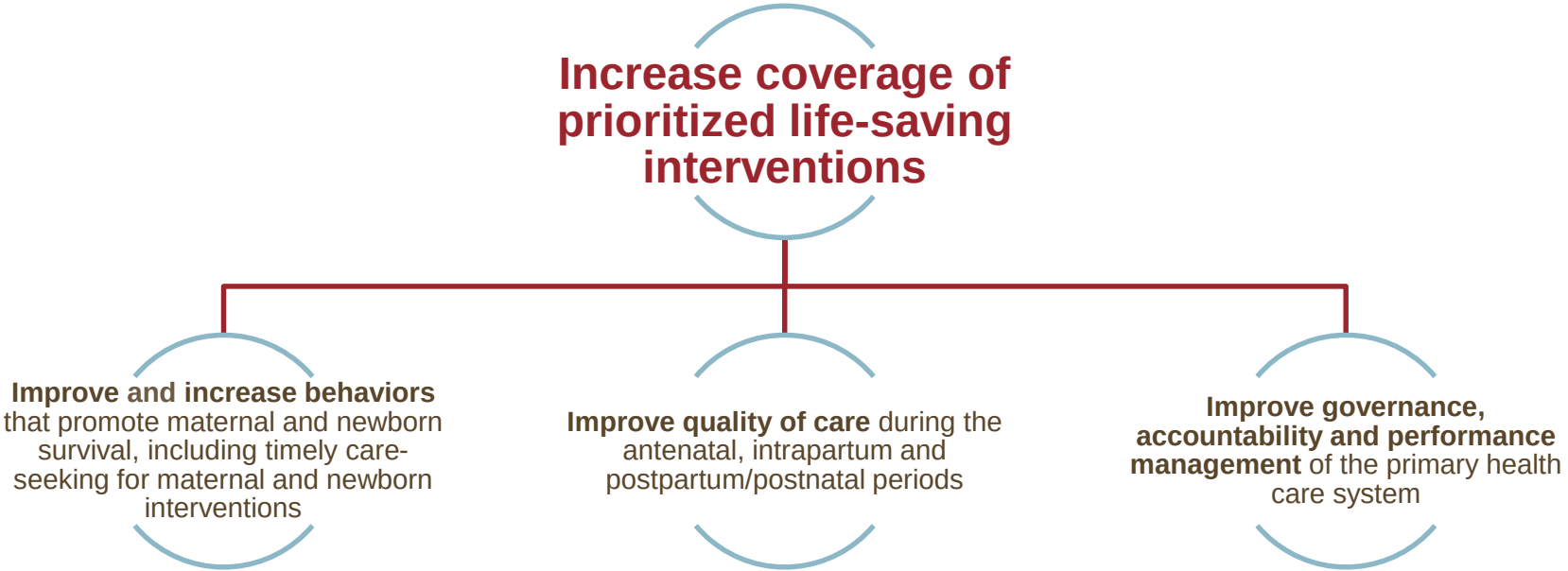
Child deaths per 1,000 children under 5

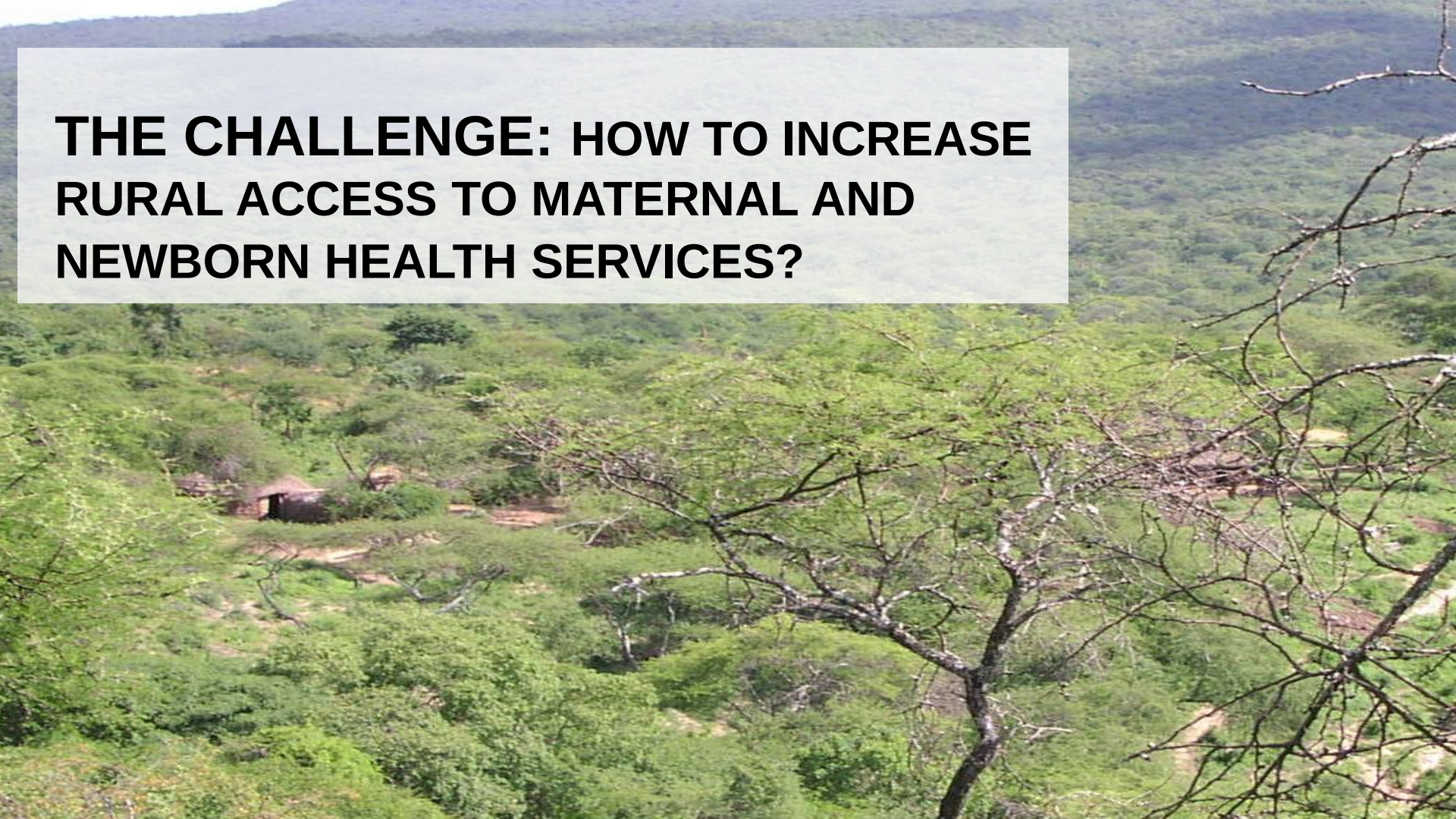
Above the national average of 128 deaths per 1,000 children

Data Source: BMGF-Gombe MOU; Nigeria State Data Profiles (Federal Ministry of Health)

BMGF INVESTMENTS IN GOMBE STATE

Since 2012, the Foundation has supported MNCH programs in Gombe State with these overarching goals:





THE CHALLENGE: HOW TO INCREASE RURAL ACCESS TO MATERNAL AND NEWBORN HEALTH SERVICES?

GLOBAL EVIDENCE FOR COMMUNITY-BASED HEALTH SERVICES

- Community Health Workers (CHWs) and Village Health Workers (VHWs) are internationally recognized for reducing morbidity and averting mortality in mothers, newborns and children
- African countries that have achieved maternal and child health MDGs have implemented formalized CHW or VHW programs at scale
- In Northern Nigeria, VHWs are associated with improved immunization coverage, improved care and treatment seeking for sick children, ANC and skilled birth attendance, immediate breastfeeding, and knowledge of maternal and child danger signs

Photo Credit: Pact

NIGERIA'S NATIONAL VHW PROGRAM

The National Primary Health Care Development Agency (NPHCDA) leads the Village Health Worker program, guided by a "Roadmap" (2014), and implemented by individual states. ***While the Roadmap provides national guidance, implementation is up to the states.***

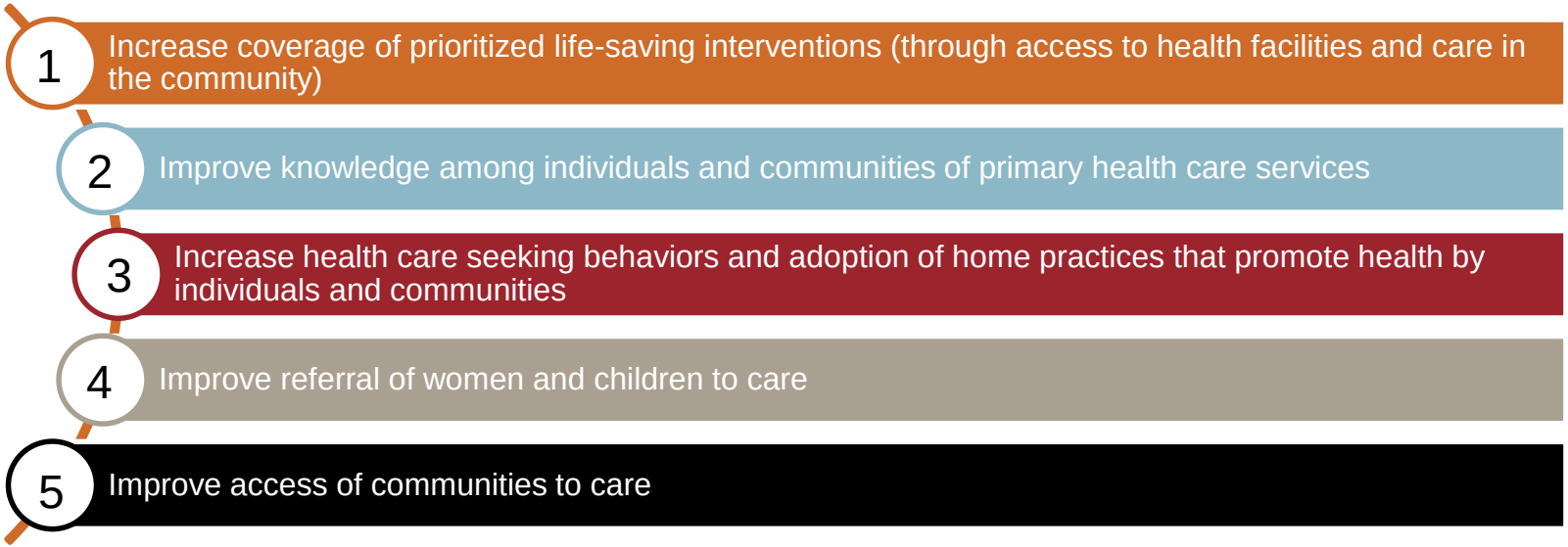
NPHCDA's Guidelines for the VHW:

- ✓ Ratio of 1 VHW per 500 population or 20 per Ward
- ✓ Receive stipend
- ✓ Work exclusively in community
- ✓ Respected community members, selected by WDCs
- ✓ Formalized role within PHC System
- ✓ Clear line of supervision via CHEWs and JCHEWs
- ✓ Provide preventative, diagnostic, and basic curative services
- ✓ Provided with a three week skill-based training, plus monthly review meetings with mentor and periodic refresher courses
- ✓ Carry a utility kit with basic supplies and commodities

The national VHW program was piloted as part of the SURE-P MCH Program in 2014, but without state level ownership it was not maintained.

GOMBE STATE VHW PROGRAM

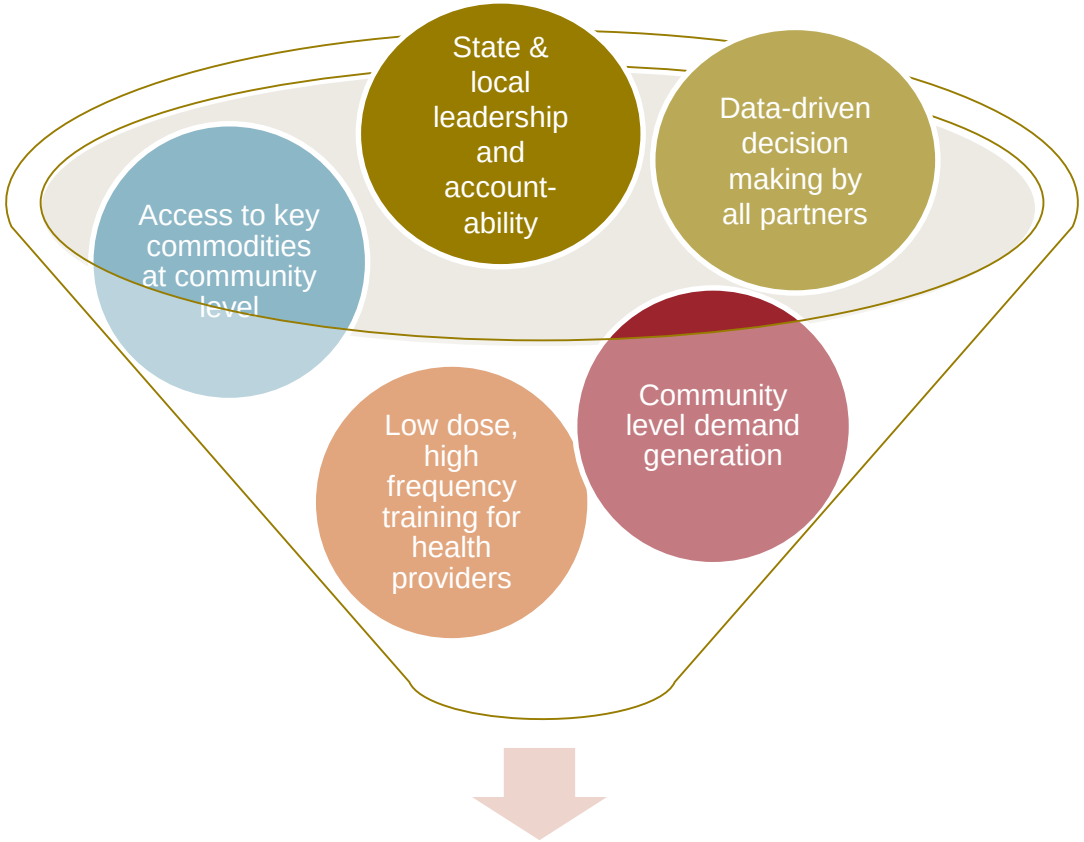
Through home visits by VHWs to pregnant women and families, combined with capacity support for health care workers to improve care relating to pregnancy, delivery and the newborn, this program seeks to:



> **“They [VHWs] will make sure that every pregnant woman in the state is assisted [at a health facility], especially during and after delivery.”**
>
> *Dr. Ahmed Gana, Executive Secretary,*
> *Gombe State Primary Health Care Development Agency*

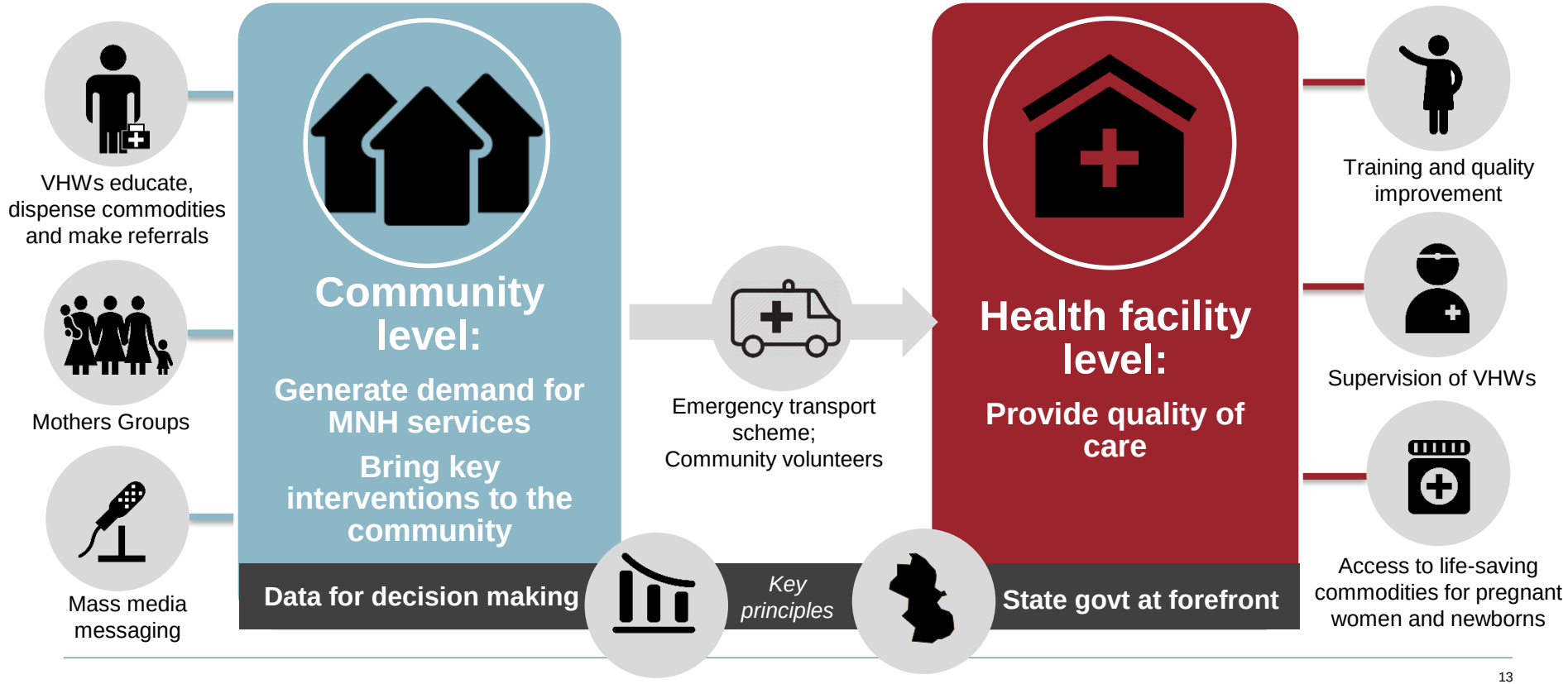
Photo Credit: IDEAS

GOMBE MNCH PROGRAM: KEY COMPONENTS



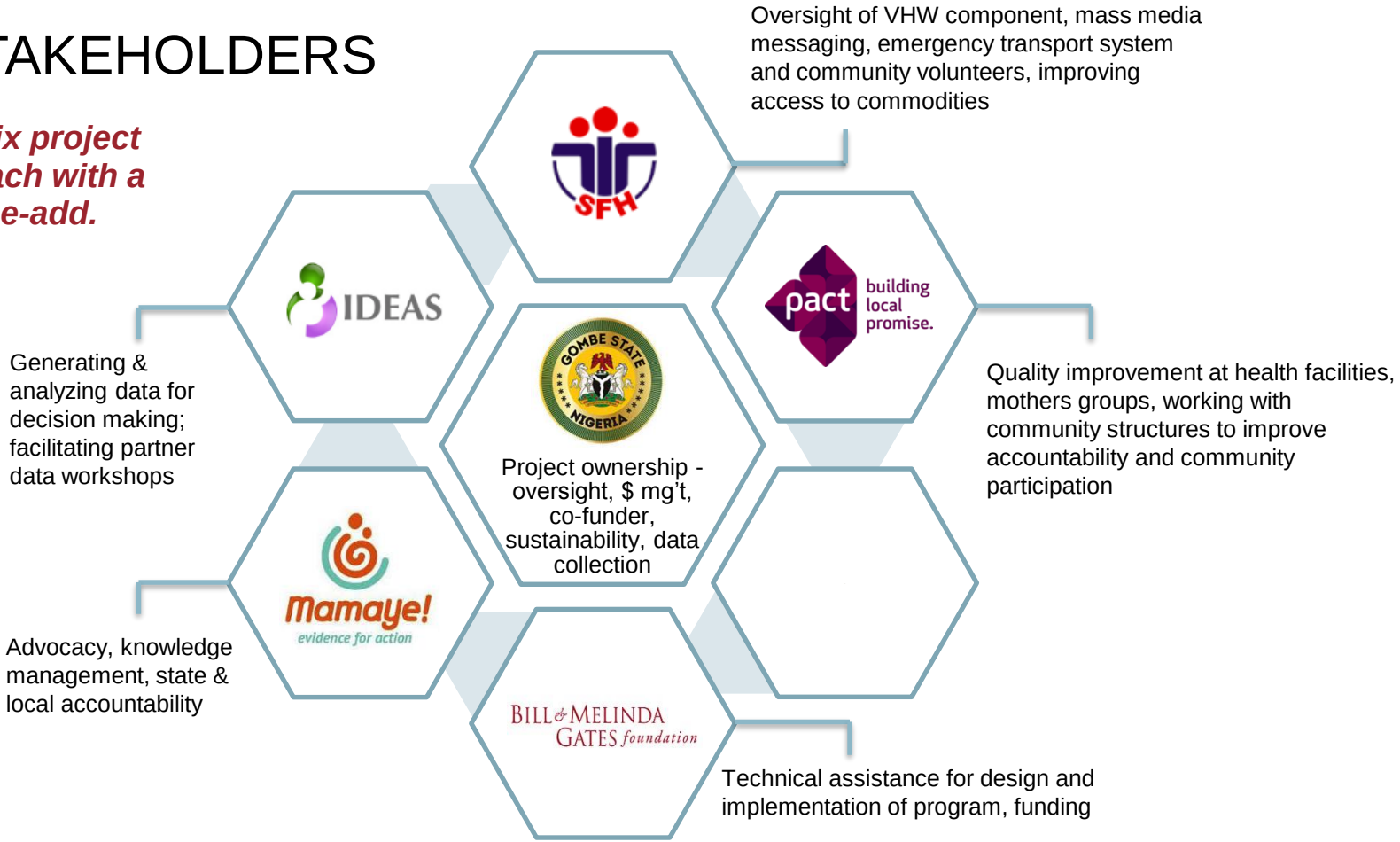
Improved health outcomes for women and newborns

CREATING A CONTINUUM OF CARE FOR PREGNANT WOMEN AND NEWBORNS



KEY STAKEHOLDERS

There are six project partners, each with a unique value-add.

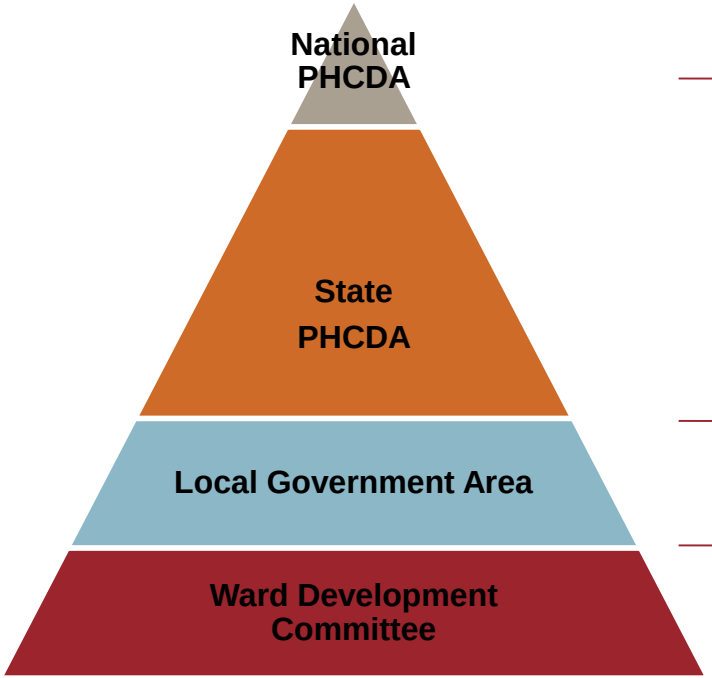


WHAT MAKES THIS WORK UNIQUE?

Photo Credit: Society for Family Health

GOVERNMENT IN THE DRIVER'S SEAT

The Gombe State VHW Program is the first state-led CHW program in Nigeria. Government owns and leads the VHW Program across all levels:



- ✓ National VHW program guidelines developed and owned by the National PHCDA

- ✓ Ownership by the state, via the State PHCDA
- ✓ Oversight of design and implementation of the VHW program; leadership of the Steering Committee (consisting of all implementing partners)
- ✓ Co-funding for the program, including: stipends for VHW; support for strengthening basic infrastructure and adequate staffing at priority health centers (one PHC per ward).
- ✓ Oversight of a state-level technical working group on MNCH
- ✓ Data collection

- ✓ Local gov't representatives, including the MCH coordinator and LGA officer, involvement with program implementation

- ✓ Promotion of health messages
- ✓ Oversight of facilities; selection and oversight of VHWs

ROLE & CHARACTERISTICS OF VHWS

1. Female, literate, from the community

- Women have access to the home and are socially accepted in this role.
- Community members; selected by their community and accountable to the community
- **Must be literate** (ideally completed secondary school)

2. Trained

- Provided with **high quality training**; training is **practical and skills-based**
- The scope of work and curriculum is clearly defined

3. Receive Stipend

- Receive regular **monthly stipend** (4,000 Naira per month)

4. Formalized role within PHC system

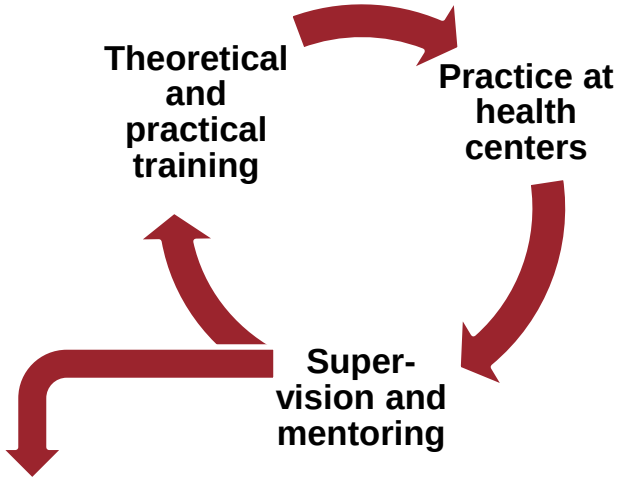
- **Supervised by health facilities** to ensure quality and linkage to formal health services
- Continuous and regular supportive supervision is essential; clear line of supervision via CHEWs and JCHEWs, including monthly review meetings and refreshers

5. Regularly supplied with commodities

- Provided with **regular supply of commodities** needed to do their work (misoprostol, CHX, ORS/Z, malaria RDTs/ACTs, etc.)

LOW DOSE, HIGH FREQUENCY (LDHF) MODEL OF TRAINING AT HEALTH FACILITIES

LDHF is a capacity-building approach that promotes maximal retention of clinical knowledge, skills, and attitudes through short, targeted in-service simulation-based learning activities, spaced over time and reinforced with structured, ongoing practice sessions on the jobsite.



Improved clinical performance and quality of care


Photo Credit: BMGF/Andrew Esiebo

STATE LEVEL MULTI-PARTNER SHARED RESULTS FRAMEWORK

Partners are jointly responsible to support the state for the delivery of program outputs and outcomes, such as:

Categories	Sample Indicators	Directly Responsible	Other partners contributing
LIFE-SAVING INTERVENTIONS AND FACILITY READINESS FOR LIFE-SAVING INTERVENTIONS			
Magnesium Sulfate (MgSo4)	% of facilities with MgS04 available	**SFH**	**MamaYe, Pact**
	% of women with pre-eclampsia who are treated with IV/IM MgS04	**Pact**	
Immediate Breast-feeding	% of newborns breastfeeding within 1 hour of delivery	**SFH (community)/ Pact (facility)**	
Infection Prevention	% of newborns with suspected sepsis treated with antibiotics	**Pact**	**SFH**
	% of facilities with soap and running water or alcohol based hand rub		**Pact**
INTERACTIONS AND QUALITY OF CARE			
ANC 4	% of women who were attended at least four times during their last pregnancy by any provider for reasons related to the pregnancy	**SFH**	**Pact, MamaYe**
Maternal PNC	% of women who had a post-partum check-up within 2 days of the last birth in a facility	**SFH**	**Pact**
Newborn PNC	% of newborns who had a post-natal check-up within 2 days for last live birth in a facility	**SFH**	**Pact**
Institutional delivery	% of live births in facilities (public & private)	**SFH**	**Pact, MamaYe**

SYSTEMATIC, MULTI-PARTNER PERFORMANCE MANAGEMENT & ACCOUNTABILITY

Partners are involved in regular, systematic data analysis, performance management, and accountability.

Every month:
Data collection and analysis at both intervention and non-intervention sites

Every quarter:
LGA data meetings

Every 6 months:
Facility surveys, Data-Driven Learning Workshop for all program partners

Every year:
Household survey

Regular collection and review of data results in proactive management of challenges and bottlenecks; shared ownership of solutions; and accountability for results

PARTNER FEEDBACK

"The change that has happened has been around **the appreciation and use of data**… looking at the outcomes, not just the process. There is no longer a mistrust of the data, but a focus on figuring out the systems issues and each partner's role (in addressing them)."
– IDEAS staff member

"This is new and unique and it is really working. We are able to **see our performance and make adjustments**."
– PACT staff member

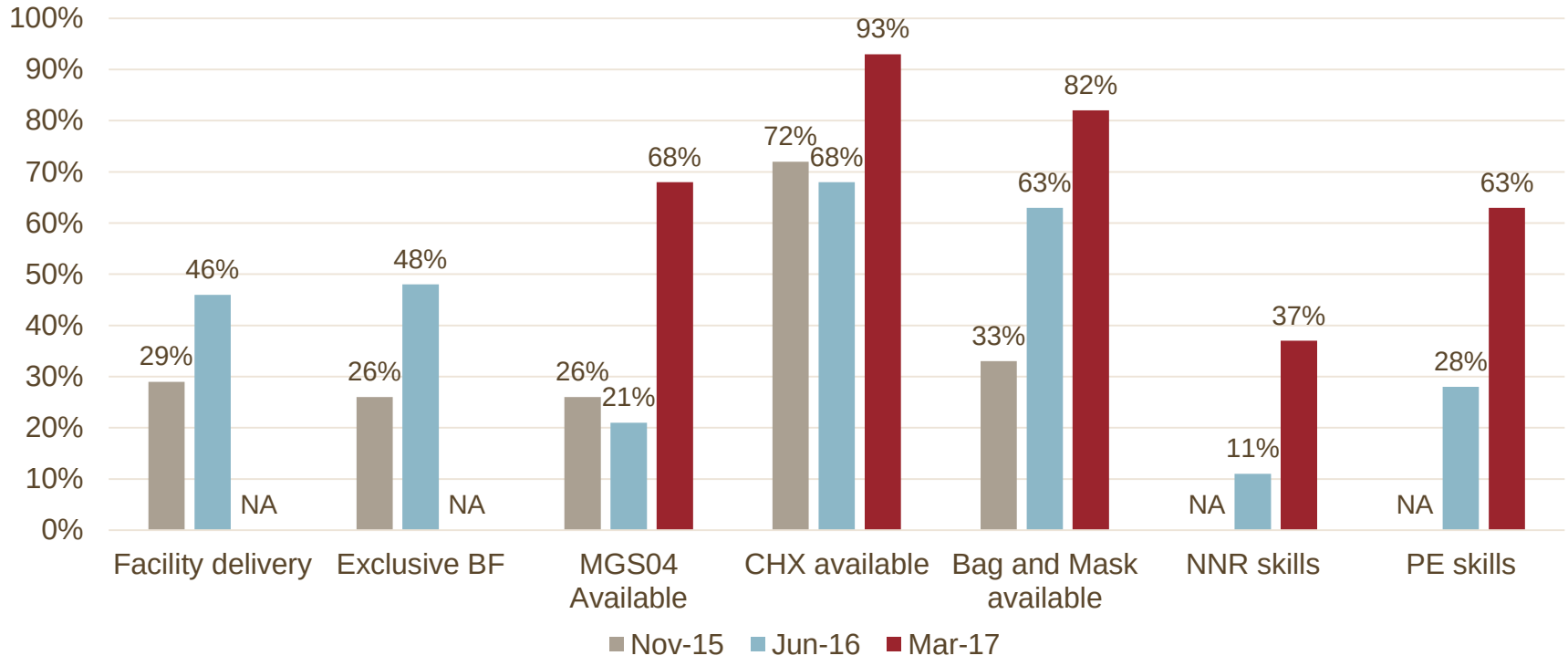
Photo Credit: Society for Family Health

EARLY RESULTS AND LEARNING

Photo Credit: Pact

EARLY RESULTS

Substantial improvement has been observed across several core indicators.



INITIAL PROGRAM LEARNINGS

While it is too soon to see tangible outcomes, there have been several key learnings from the initial phase of the VHW program:

- **Documenting lessons from setting up the VHW program is critical:** Key lessons learned from recruitment (e.g. literacy challenges, attrition), importance of community buy-in, and establishing working mechanisms among partners, should be documented to facilitate learning for future implementing states.
- **Government as the leading partner:** All partners noted the strong leadership of the Gombe State government, and its commitment to actively applying learning to improve program performance. The state even requested MamaYe's return in the state to support advocacy and accountability.
- **Collaboration is fostered through shared responsibility and a focus on outcomes:** While there were initial challenges between partners without a history of working together, focusing on broader outcomes for women and children, and engaging in regular data analysis and discussion in which each partner has a role, has facilitated collaboration and maintained focus on the bigger picture.

LEARNINGS FOR THE FOUNDATION

- **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 will likely influence the quality of support provided by the VHW program and beyond in the longer-term.
- **A new way of working internally**. For the foundation, this program demonstrates a new way of working. Coordination and collaboration between internal teams is notable, particularly between programs and advocacy. The shared results framework sets clear expectations in terms of roles and responsibilities of the various parties working toward a common goal, and has helped to align programmatic and advocacy work.
- **Ultimately, this collaboration – both internally and externally – has translated into a multi-sector, multi-faceted approach in Gombe State.**

BACKUP SLIDES

Photo Credit: Society for Family Health

MOTHERS GROUPS

- **The need**: Male-figures control healthcare decisions; women, without their own funds, have limited power to counter reluctant attitudes of heads of households towards accessing health services. Further, households often cannot afford available health care services and there is overall dissatisfaction with quality of care at health facilities.
- **The intervention:** Mothers groups blend MNCH training, economic empowerment for women, and household financial security in order to generate demand for MNCH services in the community.
  - Mothers save together and take out loans to expand business; funds generated give them the ability to pay for health services as needed
  - Participants learn about MNCH and benefits of care during pregnancy, delivery and postpartum

Mothers groups have reached more than 8,000 women in the 57 target wards in Gombe State.

Photo Credit: Pact

EMERGENCY TRANSPORTATION SCHEME AND COMMUNITY TRANSPORT VOLUNTEERS

Emergency Transportation Scheme (ETS):

- In the case of obstetric emergencies, the ETS provides transportation from the community to the nearest health facility. The service is is donation-based and provided by community volunteers, who are members of the National Union of Road Transport Workers (NURTW), who have received basic training.

Community Transport Volunteers:

- Although the need for emergency transport is expected to diminish as awareness and health-seeking practices increase, it will still be critically needed by some. Therefore a community-driven transportation scheme has been established with the support of Ward Development Committees and volunteer car owners in the community.

The provision of emergency transport reduces the delay between the onset of an obstetric emergency and receipt of appropriate care.

Photo Credit: Society for Family Health

MASS MEDIA AND HEALTH MESSAGING

Gombe's MNCH program includes a mass media component that aims to enable pregnant women and their families to make informed, safer decisions about MNCH. The strategy aims to foster knowledge, attitudes, skills, norms, motivation, community support, self-efficacy and accountability around MNCH issues through:

- **Radio magazine programming** that promotes lifesaving interventions and dispels myths and misconceptions related to MNCH.
- **Spots/jingles** targeting religious leaders and mothers/mothers-in-law to generate discussion around good MNCH practices.
- **Radio drama** to galvanise community support for MNCH & promote program and partner activities.
- **Capacity building activities** for health producers at partner stations to improve quality of content.
- **Equipment donation** to partner stations to improve 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.

SUPPORTIVE ADVOCACY

Advocacy and accountability efforts by MamaYe support an enabling environment for advancing MNCH and the shared outcomes of the MNCH program, through policies, budget lines, and multi-stakeholder accountability platforms:

- **MPDSR.** MamaYe provides support to the state for maternal and perinatal death surveillance and response, which trains health workers in facilities, and provides another complementary mechanism for data analysis, performance management, and accountability.
- **Budget tracking.** MamaYe and C4C work closely with the Ministry of Finance and other stakeholders to review the state budget, including line items for MNCH, and to track the disbursement of funds.
- **Accountability mechanisms and champions.** MamaYe facilitates the Gombe State Level Accountability Mechanism – a multi-stakeholder state-level platform for addressing MNCH issues – and they train “super activists” at the local level to hold local governments accountable for commitments.