# “The Role and Impact of Partners for Development (PFD) in the Targeted States High Impact Project (TSHIP).”

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*Photos of PFD activities of TSHIP photographed in Northern Nigeria*


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# List of Acronyms

| | |
|---|---|
| BEmONC | Basic Emergency Obstetric and Newborn Care |
| CAC | Community Action Cycle |
| CBHV | Community Based Health Volunteer |
| CDI | Community Directed Intervention |
| CHEW | Community Health Extension Worker |
| DRF | Drug Revolving Fund |
| FP | Family Planning |
| ETS | Emergency Transport Scheme |
| HMIS | Health Management Information System |
| HSS | Health System Strengthening |
| IMCI | Integrated Management of Childhood Illnesses |
| JSI | John Snow International |
| LGAs | Local Government Areas |
| MMR | Maternal Mortality Rates |
| MNCH | Maternal, Newborn and Child Health |
| PHC | Primary Health Care |
| BSPHCDA | Bauchi State Primary Health Care Development Agency |
| PPH | Post-Partum Hemorrhage |
| QIT | Quality Improvement Team |
| RH | Reproductive Health |
| SBA | Skilled Birth Attendant |
| SMoH | State Ministry of Health |
| UN | United Nations |
| USAID | United States Agency for International Development |
| USG | United State Government |
| WDC | Ward Development Committee |

## 1. Background/Rationale

*History/Background/Context/Rationale*

With a population of approximately 180 million, Nigeria is the seventh most-populous country in the world, with some forecasts showing it as the third most populous by 2050. Despite Nigeria's considerable physical and human resources, more than 50% of the population lives below the poverty line.

Nigeria's health system is generally weak, and thus a great many vulnerable persons, especially children 0-5 years of age and women of child-bearing age, have high rates of mortality and morbidity. Despite improvements since the 1990s, as of 2014 Nigeria still had some of the worst health indicator rates in the world. For children under five years of age, the death rate is 117 for every 1,000 live births; and the maternal mortality rate is 560 for every 100,000 live births (World Bank, 2014).

Health status is generally poorer in northern Nigeria, thus USAID focused TSHIP resources on Sokoto in the northwest and Bauchi in the northeast. These two states have a combined population of more than eight million persons, with Bauchi at 4.7M and Sokoto at 3.7M.

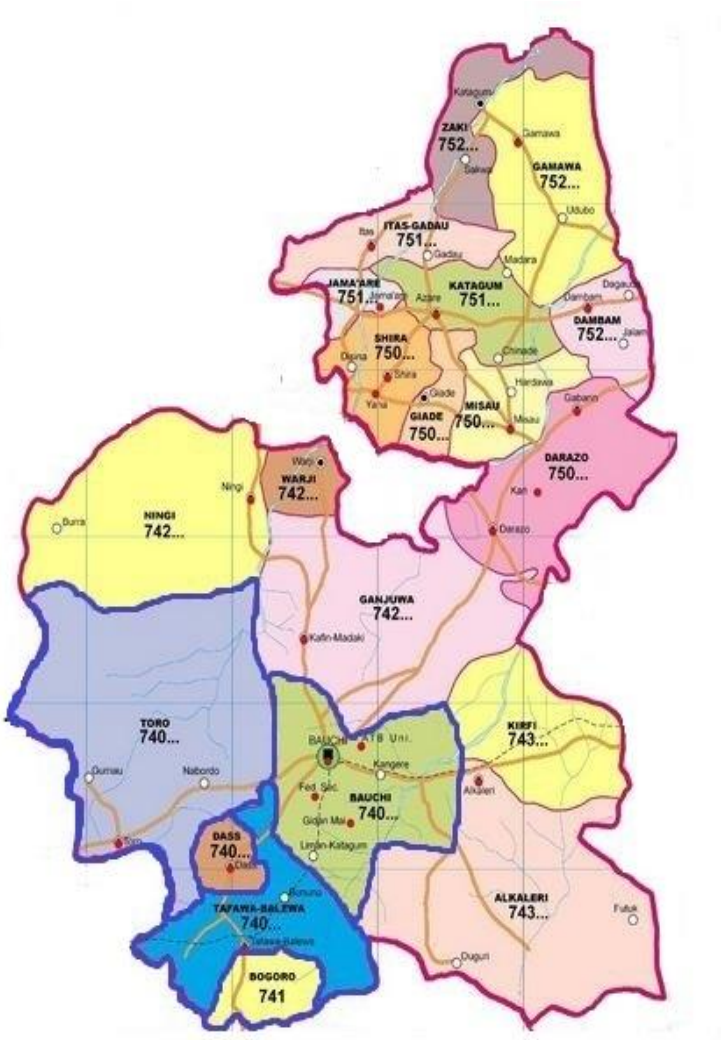
USAID selected John Snow Research & Training Institute (JSI) to implement TSHIP's five year, $95 million project from 2010-15. TSHIP's focus is on high impact and integrated maternal, newborn and child health, family planning, and reproductive health interventions. Anticipated end-of-project outcomes in Bauchi and Sokoto states include:

- Improved health practices among the most vulnerable groups: women of childbearing age, pregnant women, and infants and children under the age of five.
- Reductions in maternal and infant mortality rates and increases in contraceptive prevalence rates.
- Improved health systems and management, including health information systems, use of data for decision-making, and use of standards-based health management.
- Improved health facilities and logistics systems and an improved overall capacity to plan, manage and evaluate primary health care programs.
- Strengthened policy environment at the state and local government area levels, improved allocation of resources for primary health care, as well as more efficient and effective use of resources.
- Empowered communities and key stakeholders, including religious and traditional leaders, social and political decision-makers, and the private sector.
- More active involvement of women in primary health care programs and social mobilization. (TSHIP Website)

Under TSHIP, Partners for Development (PFD) won a sub-grant of $1,615,612 for the 38 month period, February 1, 2012 - March 31, 2015. In TSHIP, PFD worked in five Local Government Areas (LGA) in Bauchi state whose total population is over 1.6 million persons. This report highlights how PFD significantly contributed to TSHIP's Outcome Goals, and thus helped improve the health care system for vulnerable populations in northern Nigeria. The report concludes with PFD's Findings and Recommendations.

## 2. Map of PFD TSHIP Activities

*The five LGAs where PFD implemented TSHIP programs are outlined in Blue:*




*Map of Bauchi LGAs*


*Map of Nigeria illustrating location of Bauchi state*

## 3. PfD's Performance in TSHIP:

**3.1 Overview:** PFD supported TSHIP initiatives in five LGAs in Bauchi State: Bauchi, Tafawa Balewa and Toro, Bogoro and Dass. PFD contributed to meeting TSHIP's objectives in three key areas: institutional capacity building, service delivery, and community participation & promotion. PFD achieved this mainly through:

3.11 Training and mentoring health care personnel, including nurses/midwives, Community Health Extension Workers (CHEWS) and Community-Based Healthcare Volunteers (CBHV) at 53 ward health facilities responsible for delivering reproductive health/family planning and Maternal, Newborn and Child Health (MNCH) services;

3.12 Establishing 79 Ward Development Committees (WDC) and 3 LGA Coordination Committees and building their capacity to promote health seeking behaviors within their communities; and

3.13 Mobilizing and sensitizing communities through counseling/services, educating on best health practices, and identifying CBHVs to help perpetuate the success of established activities.

## 3.2 Overall Performance Against Objectives:

| TSHIP Objective | PFD Results | Targets | Achievements | Indicative Outcomes |
|---|---|---|---|---|
| 1. Capacity Building<br><br>To strengthen coordination between Ward Health Facilities (WHFs) and LGA level Coordination Committees (CCs) and upgrade health service delivery skills | # of people trained in FP/RH with USG funds | 220 | 322 | |
| | # of people trained in Malaria prevention/treatment | 220 | 704 | |
| | # of people trained in maternal/newborn health in USG facilities | 110 | 157 | |
| | # of people trained in child health/nutrition | 220 | 587 | |
| 2. Service Delivery<br><br>To support 53 Ward Health Facilities (WHF) to deliver improved services for reproductive health/family planning (RH/FP) and Maternal, Newborn and Child Health (MNCH) services | # of deliveries from skilled attendants in USG supported facility | 4,227 | 54,851 | 54,851 pregnant women gave birth with trained birth attendants assistance --- a 1000% increase over our assigned target in this area and which mitigates risk of maternal and child mortality/morbidity. |
| | # of pregnant women with at least one ANC visit | 11,787 | 128,028 | Attendance rate at Antenatal Care (ANC) sessions increased by 180% indicating a heightened awareness of appropriate care. |
| | # of women receiving IPT for malaria in prenatal care | 6,667 | 108,086 | 18,108 and 17,814 women received doses of Misoprostol and applied Chlorhexidine respectively, likely resulting in a reduction in number of post-partum hemorrhage and cord infections |
| | # of cases of childhood diarrhea treated through USG supported facilities | 4,733 | 34,181 | |
| | # of FP counseling visits by men/women of reproductive age | 4,200 | 94,411 | |
| 3. Participation and Promotion<br><br>To establish and/or strengthen 3 LGA Coordination Committees and 53 ward development committees (WDCs) and train them to promote health seeking behaviors | # of LGA Coordination Committees established and functioning | 3 | 3 | An increase in community ownership of health and other development interventions as manifested in: construction/provision of additional infrastructure at health facilities; improved road access; & creation of self-help structures, including 95% of target WDC establishing Emergency Transport Systems |
| | # Ward Development Committees established and functioning | 53 | 79 | |
| | # of WHFs with coordination between CBDs, CHEWs and CBHWs established | 53 | 79 | |

## 4. Findings & Recommendations

Disparity in Distribution of Health Personnel in Urban and Rural Areas: During visits to the health facilities by PFD staff, one common occurrence was overstaffing of health personnel in facilities in urban areas, while facilities in the rural areas were without qualified nurses and midwives. The disparity of these services and their potential to negate the benefits of these services was brought to the attention of government authorities. PFD's offered solution was to create incentives for rural area postings in addition to training CHEW to take leadership positions in rural facilities that fell into this category.

Transfer of Trained Personnel: During monitoring visits by PFD staff to supported health facilities, there were several incidences of PFD-trained health personnel that have been transferred to other health facilities by the government. This resulted in PFD needing to dedicate additional time and resources to train newly acquired staff to assure quality services at these health facilities. PFD also suggested to BSPHCDA, the government agency responsible for transfer of health personnel, to ensure there is overlap between rotating staff so as to assure best training for incoming staff.

WDC activities: These activities have also been very effective in monitoring the health facilities and at the community level -creating Emergency Transport Schemes (ETS) and Drug Revolving Funds (DRF). The WDC served as a pressure group ensuring that the health facilities have basic equipment. The ETS and DRF have also helped in transporting clients from communities to health facilities in emergency situations or provide first aid services. PFD therefore recommends that the LGA formally coordinates this group to sustain the WDC approach to programming.

CBHV & health messages: The use of CBHV for providing health messages to households and making referrals to health facilities contributed significantly to the success of this project. However, this group that was put together by the project should be incorporated into the LGA for ease of coordination and support. Toro LGA has officially incorporated CBHV into the LGA and will be supporting them in their activities. Also, other stakeholders at the close out dissemination meeting organized by PFD suggested that the monthly review meetings for verifying CBHV reports and engaging them in experience sharing be conducted at ward level.

# Appendix

*Additional Information on Results in Capacity-Building, Service Delivery, and Participation and Promotion:*

**1. Capacity Building/Training**

On July 10, 2012 PFD completed the assessment of health care facilities providing maternal and child health services in Bauchi, Tafawa Balewa and Toro LGAs' 53 wards to identify capacity gaps, tailoring its trainings to the needs of targeted programs, introducing evidence-based knowledge and skills in its health care procedures, with a particular focus on maternal, newborn child and reproductive health, accompanied by family planning, while fortifying strategies for reducing maternal and neonatal morbidity rates for Bauchi State. PFD staff trained health facility staff and continued to mentor and supervise their activities; further detail on the level of participation and scope of these trainings is provided below:

1.1. *Reproductive Health and Family Planning:* PFD trained 53 health care personnel, one from each ward health facility in Bauchi, Tafawa Balewa and Toro LGAs, to strengthen their abilities to address issues such as non-acceptance, misconceptions and rights of clients, especially for updates on contraceptive technology and family planning.

1.2. *Basic Emergency/Essential Obstetric and Newborn Care (BEmONC):* PFD provided BEmONC training to 61 health care providers from 53 ward health facilities in Bauchi, Tafawa Balewa and Toro LGAs, introducing and institutionalizing evidenced-based, life-saving skills for obstetric and newborn services.

1.3. *Quality Improvement in Maternal, Newborn and Child Health*: PFD trained 52 nurses and midwives from targeted health facilities to use Standards-Based Management and Recognition (SBM-R) to promote proper performance in accordance with standards for safe and affordable interventions and reduce mortality, morbidity, disability and malnutrition.

1.4. *Integrated Management of Childhood Illnesses*: PFD trained nurses, midwives, and Community Health Extension Workers (CHEWs) to identify, treat and manage childhood illnesses, aiming to promote child healthcare and reduce child morbidity and mortality due to illnesses such as diarrhea, measles, fever, cough or pneumonia, malaria, acute ear infection, HIV, micronutrient deficiency, and malnutrition.

1.5. *Interpersonal Communication (IPC) and Balanced Counseling Strategy (BCS):* PFD introduced 165 nurses, midwives and CHEWs to new counseling techniques in order to improve family planning counseling by better tailoring it to clients' reproductive needs.

1.6. *Integrated Malaria Case Management*: PFD administered a 5-day, intensive training to enable 170 healthcare providers to manage uncomplicated malaria and referrals using the National guidelines and to carry out rapid malaria diagnostic tests and reduce malaria mortality and morbidity.

1.7. *Proper use of Misoprostol and Chlorhexidine*: PFD trained 530 Community-Based Health Volunteers (CBHVs) in the proper use of misoprostol to prevent post-partum hemorrhage for women who deliver at home, and in the correct application of chlorhexidine to a newborn's umbilical cord to prevent neonatal sepsis.

1.8. *Community Action Cycle (CAC)*: PFD implemented 5-day trainings for 136 executive members of ward development committees (WDC) in Bauchi, Tafawa Balewa and Toro LGAs in techniques to mobilize communities to take ownership of health issues.

1.9. *Community Directed Intervention (CDI) Plus service delivery*: PFD taught 534 CBHVs about CDI Plus service delivery in order to equip CBHVs with the knowledge of key family and community health practices and awareness of available health resources.

1.10. *Health Management Information System (HMIS)*: PFD supported both 59 health care providers and also monitoring and evaluation officers from the three LGAs to improve their understanding of quality health data collection, which forms the basis for planning, monitoring and evaluating a project.

1.11. *Child Health and Nutrition*: Fifty-two individuals (eight nurses/midwives and 44 CHEWS) were trained on skills needed to promote optimal child 0-5 years and maternal nutrition that will effectively reduce the incidence of child malnutrition, which is directly linked to high child morbidity and mortality rates for the region.

1.12. *Expanded Men as Partners (EMAPs)*: Twenty-seven male volunteers were trained to sensitize and promote high impact MNCH, RH and FP within their communities with the objective of gaining higher male participation and support for MNCH, RH/FP issues.

**2. Service Delivery Results**

During the project's implementation[1], PFD staff strengthened community health and awareness by training health facility staff on delivery of quality health care services. By strengthening referral practices for appropriate follow-up treatment, providing health education, and informing community members on available health services, PFD-trained Community Health Extension Workers (CHEWs) and volunteers were able to help support their communities' services by engaging in mobilization/sensitization activities.

**3. Participation and Promotion Results**

To create community buy-in and ownership (participation and promotion) towards health seeking behaviors for MNCH, RH/FP and child health services, PFD utilized a strategy of mobilization and training of community institutions and linked them to health care providers, health facilities and their respective LGAs for coordination. Specific activities designed to promote community participation included:

3.1. ***Community-Based Health Volunteers (CBHV):*** These are volunteers (790 in the 5 LGAs where PFD implemented TSHIP activities) without health background within the communities that were selected, trained and supported by PFD. These volunteers provide basic health education, counseling and referral services on MNCH, RH/FP, nutrition, personal and environmental hygiene by moving house to house in the communities.

3.2. ***Ward Development Committee (WDC):*** WDCs are elected representatives of each ward who are responsible for mobilizing resources, promoting and sensitizing community members on health seeking behaviors and other developmental needs within their communities.

3.3. ***Emergency Transport Scheme (ETS):*** The scheme provides emergency transport services for community members requiring emergency transport to the nearest health care facility even when they do not have the resources to pay for it. This ETS is usually operated by community members who volunteer their vehicle, motorcycles or other means of transportation.

3.4. ***Drug Revolving Fund (DRF):*** PFD supported WDC members to pool finances together to purchase initial stock of basic health commodities, which are then replenished from sales revenue. This did not only make available ready supply of basic health commodities in the communities but also generated modest income to support the running costs of the WDC activities.

3.5. ***100 Women Group Coalition:*** PFD facilitated the amalgamation of interest self-help women's groups in each LGA to form The 100 Women Group. This group utilizes the economic empowerment platform (which is their common interest) to engage women in discussions around health and other development challenges.

[1] PFD's partnership with JSI began February 1, 2012, and ended March 31, 2015.