Project Summary Report

Strengthening Community Health and HIV Response in Nigeria

December 2016

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Authors:

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Christian Aid specially recognize the enormous contribution and support from our partners; Water Aid Nigeria (WANG), Marie Stopes International Organization Nigeria (MSION) and Vitamin Angels Incorporated. We sincerely appreciate the collaboration as it helped in meeting the expressed health needs of the project communities and spurred them to demand for such services from their local health authorities.

A huge thank you to the National Primary Health Care Development Agency (NPHCDA) and Federal Ministry of Health (FMoH), the State Ministries of Health for Plateau, Benue and the FCT Health and Human Services Secretariat, the directors of public health and primary health care and the local government chairpersons for their continuous support, constructive suggestions and cooperation throughout the project implementation, which contributed immensely to the success of the project.

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Special appreciation goes to Charles Usie, Christian Aid Nigeria Country Director, whose vision, continuous support and encouragement was instrumental to the successful implementation of the SCHHR Project.

Kazeem Balogun
Ag. Programme Manager, Community Health
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Contents

Cover: <Click here and insert Cover Photo description>

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List of Acronyms

ADDS	Anglican Diocesan Development Services
CA	Christian Aid
CDC	Community Development Committee
CeGHaD	Centre for Gospel Health and Development
CHA	Community Health Agent
CHEW	Community Health Extension Worker
CLTS	Community Led Total Sanitation
DFID	Federal Department for International Development
FCT	Capital Territory
FGD	Focus Group Discussion
GEADOR	Gender Empowerment and Development Organizing Resource
HIV	Human Immuno-deficiency Virus
JDF	Jireh Doo Foundation
KDDWS	Kubwa Diocesan Development and Welfare Services
LGA	Local Government Authority
LLIN	Long Lasting Insecticide Net
NACA	National Agency for the Control of AIDS
NINERELA+	Association of Religious Leaders Living with and personally Affected by HIV/AIDS
OCAG	Ohonyeta Care Givers
ODF	Open Defecation Free
PPA	Programme Partnership Arrangement
PLWHIV	People Living With HIV
SCHHR	Strengthening Community Health and HIV Response
SLA	Savings and Loans Group
WASHCOM	Water, Sanitation and Hygiene Committee

Background

Christian Aid (CA) is an international development organisation dedicated to the eradication of poverty worldwide, helping people to overcome poverty for more than 70 years with a global reach and work to tackle the causes and effects of poverty in 47 countries across Asia, Africa, the Middle East, Latin America and the Caribbean. Twenty two (22) African countries benefit from CA programmes which focus on delivering long-term development projects that enable poor and marginalised people to access thriving and resilient livelihoods, whilst also challenging the systems and structures that keep people poor.

CA takes a distinct partnership approach to development; we work mainly through partnerships with local organisations ranging from small grassroots organisations to larger agencies working to affect systemic change. This reflects our firm conviction that it is local people who are best placed to understand the issues in their communities and to drive lasting change. CA has a commitment to ensuring transparency, participation and representation which is built into all our work with poor communities.

Christian Aid began operations in Nigeria in 2003. Christian Aid Nigeria focuses on Community , Governance, Gender and Humanitarian interventions, working with over 20 local partners across FCT, Anambra, Benue, Edo, Kaduna, Borno, Gombe and Plateau states.

The Community Health and HIV programme aims to work with individuals and communities to create an environment in which every member of society can enjoy the right to health services, hold governments and health systems to account.

The “Strengthening Community Health and HIV Response in Nigeria” (SCHHR) was a five year project (2011-2016) implemented by Christian Aid UK, Nigeria funded under the UK Government’s Department for International Development (DFID)/Programme Partnership Arrangement (PPA). The project was implemented in partnership with five community-based partners and one advocacy network. It combined integrated community health promotion with health governance (strengthening community systems for health and resilience, health advocacy including policy review and analysis). The project adopted a “fruit bowl disease –integrated approach” which provided an integrated delivery of a wide range of healthcare services based on community priorities and health needs. Emphasis was placed on health promotion, advocacy and governance. This meant that interventions were all encompassing and not just health-related but also addressed the social determinants of health aimed at empowering communities to thrive and be increasingly resilient and adaptive to face the challenges of resource constrained health settings.

The approach sought to increase adoption of safe preventive practices, increase uptake of healthcare services, reduce the incidence of targeted diseases and reduce stigma and discrimination against people living with HIV. At the heart of the project was the empowering of communities through newly established and resuscitated structures to demand for quality health services and take ownership for outcomes. Five local Christian Aid partners, Jireh Doo Foundation (JDF), Anglican Diocesan Development Services (ADDS), Ohonyeta Care Givers (OCAG), Centre for Gospel Health and Development (CeGHaD), Kubwa Diocesan Development and Welfare Services (KWDDS) and the Association of Religious Leaders Living with and personally Affected by HIV/AIDS (NINERELA) implemented the project in in three states; Benue, Plateau and the Federal Capital Territory, Abuja since 2013. ADDS Igarra and ASWHAN (up to 2014) were part of the project in the earlier stages while others provided consultancy services at different times.

The overall goal of the project was to achieve **improved health for target households and communities, particularly women, children and people with HIV**.

The project had the following objectives:

1. To reduce the number of the most vulnerable women, men, youth and children who suffer from illnesses related to HIV infection, malaria and other communicable diseases.
2. To increase the number of marginalised women, men, youth and children who have access to quality health services in poor communities and urban areas.
3. To increase the voices of people who suffer from HIV-related stigma and discrimination thereby creating an enabling environment for persons living with or personally affected by HIV to live fulfilled lives.
4. To strengthen the network and movement that advocates for the rights of women, men, youth and children who are living or personally affected by HIV/AIDS, by ensuring that relevant government policies and laws are set to protect their livelihoods and basic human rights.

The project had three outcomes and achievements on the project over the five years were across these outcomes

1: Number (and description) of cases of partners and/or marginalised community actions directly informing national/local policy, plans and/or budgets related to resilient livelihoods and health

2: Percentage of people (m/f, children and young people, people living with HIV (PLWHIV)) supported by partners who report increased adoption of safe preventive practices and/or more equitable access to health services.

3: Percentage of people reporting that changes in social norms have improved their health outcomes

Summary of Achievements

Community actions directly informing policy, plans and budgets related to resilient livelihoods and health

Building and Strengthening Community Structures

Part of the efforts put in place by the project was the establishment of Community Development Committees (CDCs) and re-activation of moribund CDCs. A total of ***110 functional Community Development Committees (CDCs)*** were established across the different communities, with a membership of **1,387 persons (F – 561; M – 826).** This process empowered and mobilized communities to drive change and development. This played a strategic role in achieving improved community health seeking behaviour and empowering communities to hold local government councils and other duty bearers to account for social amenities and services. The results show that the CDCs understood their roles, and took these seriously; the communities appreciated and supported their work.

Below: Members of the Community Development Committee in Olakpoga Community of Benue State

This strategy played a huge role in the sustainability of the project. Through the CDCs, the communities made demand for better health services from the government using their list of health and development priorities, they also developed and implemented self-help projects and were able to approach other development agencies for needed services. For instance, some CDCs' Water Sanitation and Hygiene subcommittee (WASHCOM) stopped open defecation across communities by building community toilets and encouraged households to build their own toilets too. The communities felt that they were able to build a strong relationship with the local government officials. The CDCs in project communities were able to identify problems, proffer solutions and ensure that households participate to provide solutions to their own needs. The CDCs emerged as the backbone of structured community governance system, advocating for various needs of communities.

Increased awareness on right to essential health services

The project recorded an increase in awareness of the community's right to essential services. Focus group discussions (FGDs) were carried out in communities and it revealed that prior to the SCHHR project, communities did not understand their right to basic essential services such as clean sources of water, electricity, schools, primary health centres, to name a few. Across all communities the CDC members had regular meetings with the communities and with the local partners who built their capacity in advocacy skills to approach government and make demands for those essential services.

Having received capacity building from CA partners, CDCs in communities were able to agree on their own health priorities and submit or share these with the relevant local government authorities. CDC members in one of the project communities said, *"We wrote letters to the government to fix our roads. If the roads are not good, people are not able to come here to help us"*.

"The existing PHC in this community is a house given to us by an individual; however government has approved a piece of land to build a permanent site"

In another community, the CDC members said: Speaking about their roles, CDC members in Tarka LGA said, *"We are involved in community development; fast tracking renovations in facilities, supporting of digging of wells. Also when it is time for immunization we go out and make sure women attend by creating awareness".*

At Otukpo the CDCs highlighted their roles as *"monitoring the community to keep their environment clean; to discuss with our people and take the issues of the people outside; appeal to the government to help with providing water, electricity, clinic and primary school, monitoring the digging of toilets in the community"*

In addition to developing agendas for the government, the CDCs also mobilized their communities to embark on various self-help projects. A CDC member in Dayisna (FCT) one of the project communities said, *"We came together to repair our borehole, KDDWS helped with organizing us, and we paid 500 naira per house. Houses that didn't pay were written in the book, warned and later fined. We were also able to build three classrooms for our primary school and create designated dumping areas".*

The partners using participatory approaches supported each community to develop their health priorities referred to on the project as community health agenda. The communities identified other development needs – social determinants of health. These agendas were submitted to their local government authorities and discussed during interface meetings facilitated by the partners.

Empowering communities through structured governance

The HOD health at the Local Government Secretariat in one of the LGAs where the project was implemented said: "*I am aware of CDCs in my community. They sensitize people on how to access services at the PHC level, and tell women how to access antenatal services in the PHC closest to them. The services they render include telling people about hygiene, introducing Ventilated Improved Pit latrines, educating people about knowing their HIV status, mobilizing women of the community as village health workers to go and educate people. They give out test kits for testing, anti-worming drugs, zinc, and nutrients. They are integrating; each time they develop a health agenda they give us a copy of the document. Sometimes they come to my office and give me a copy. They willingly share with us and willingly integrate/implement in that community. The unfortunate thing is that the LGA chairmen don't want to see anybody, or want to receive them."*

Percentage of people (males/females, children and young people, people living with HIV (PLWHIV)) supported by partners who report increased adoption of safe preventive practices and/or more equitable access to health services

The **"fruit bowl approach"** proved to be an effective strategy in increasing the adoption of safe preventive practices. The project did not focus exclusively on specific vertical health interventions, but included several interventions including local ownership and responsibility. When commodities are combined with health education, it eases the conversation and enables interventions to go beyond health promotion.

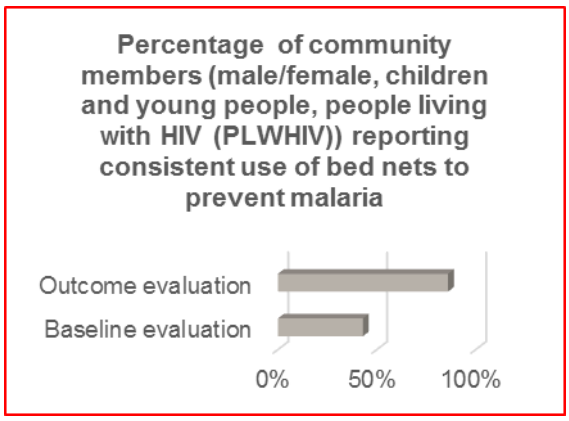
Partnering with other Non-Governmental Organisations (NGOs) such as Vitamin Angels, Water Aid and Marie Stopes was an added value to the project, all the organizations brought their unique expertise which led to an increased uptake of family planning services/commodities, increased Vitamin A supplementation and administration of Albendazole for deworming in children aged 5 years and below and improved sanitation and hygiene practices in supported communities.

Improvement in preventive practices

The project documented significant success in the adoption of safe preventive practices; percentage of people who reported consistent use of bed nets for prevention of malaria increased from 43% at baseline to 86% at the end of the project. More women also reported the use of malaria preventive methods this proportion moved from 60% at baseline to 75% at the end of the project. This is shown in Figure 1:1 and 1:2 below:

Prevention of malaria by community members

Below: Figure 1:1



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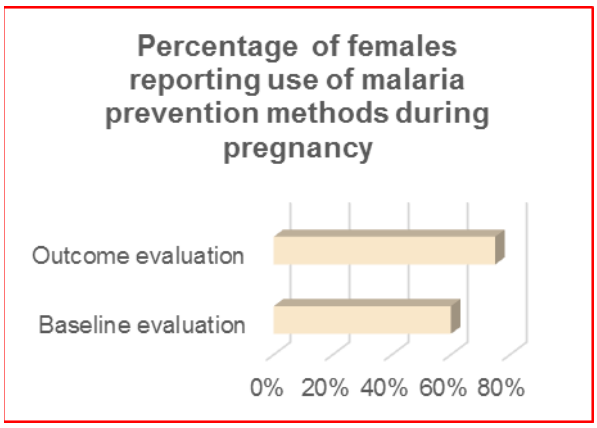


The communities shared various ideas about the use of long lasting insecticide-treated nets (LLINs) before they were enlightened. Community Women in Logo LGA said they used to believe that, *"The LLINs were used for covering corpses at funerals"* but with the knowledge they have gained about the use of net to prevent malaria, most of them now sleep under nets. In Danto community a member of the CDC said, *"A lot of our people were using the nets to cover nursery beds and protect plants from the sun"*. Most of the communities now understand the importance of sleeping under the nets and testify of how drastically it reduced the number of times they go to the hospital to be treated for malaria.

Community members across most of the communities were enthusiastic about having their children vaccinated. In Dayisna community, they complained about measles outbreaks being the major cause of death of children in the community. The health education provided in that community made them understand that when their children are vaccinated they avoid childhood illnesses such as measles. One participant said *"Measles killed a lot of children in the past before the immunization people came here; now that they have come it has reduced drastically".* A similar situation was seen in Kwande LGA, where the community women said, *"We used to have measles; however with the improvement of immunization our children don't face those issues anymore."* This is evidence of how health education has increased their knowledge to understand the link between their children being vaccinated and preventing measles and other childhood diseases.

Awareness of and Promotion of HIV/AIDS prevention practices

Awareness of HIV/AIDS was high in project communities; more than 50% of the community members have heard about HIV and were conversant with the safe practices that they needed to adopt in order to prevent themselves and their loved ones from being infected with HIV. Although no significant change was recorded over the project period, during qualitative interviews virtually all respondents in communities were aware of different methods of HIV prevention. They reeled

out these methods effortlessly when asked. Respondents also expressed the desire to provide support to those in their communities who were living with HIV.

In Tarka LGA, Benue State, CDC members said, "*We don't know who HIV positive is because their status is declared privately to them. We cannot claim to know by looking at them. If we know someone who is HIV positive, we will not discriminate against them, because we know that it cannot transmit through eating. If it is not for blood contact it can't be transmitted. We will treat men and women the same. Before we used to have a horrible fear, immediately someone falls sick and starts deteriorating, we will all run away. It was Jireh Doo who has taught us about HIV practices. The benefits of using a condom include protection from sexually transmitted diseases and also from unwanted pregnancy. The benefit of HIV testing is that if you know your status, you know how you stand. Secondly, if you find out your status, you will be able to put yourself on drugs. If you know your status, you know how to use your wife and you also will know not to leave sharp objects around*."

Partnership to Deliver Child Spacing Services

Provision of family planning services and commodities was one of the interventions within the SCHHR Project. The collaboration between Marie Stopes and Christian Aid was mainly to ensure that communities have increased access to quality child spacing services. The partnership involved CA partners mobilizing communities including the facilitation of dialogue to address misconceptions around family planning, solicit men and other community stakeholders support. Marie Stopes also supported the capacity building of health care workers in some Primary Health Centres from project communities to provide quality services to community members. Child spacing services provided include injectables, implant, intrauterine contraceptive device (IUCD) and condoms.

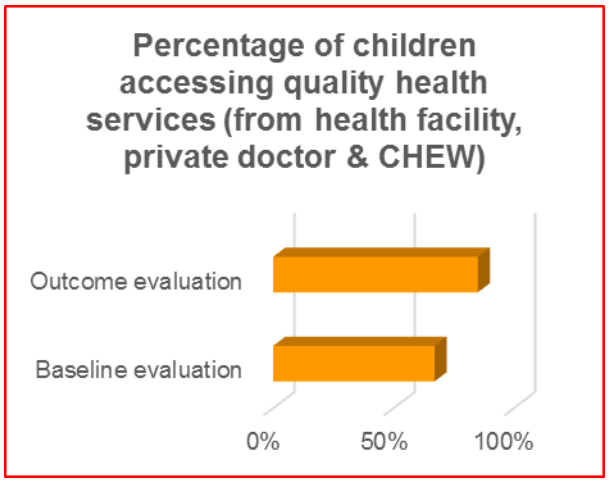
Below: Iornenge and his wife Mkuma, members of a Christian Aid project Community agreed to uptake family planning services to enable them focus on their existing children

Increase in the uptake of essential health services

Increased utilization of essential health care services was one of the main deliverable of the project. Community Health Agents (CHAs), recruited from the communities were trained on key household health practices using a Federal Ministry of Health (FMoH) approved manual adapted from the PATHS programme and the *'Where There's No Doctor'* manual. The CHAs visited households to deliver health education and also encouraged community members to utilize healthcare services when sick by going to the PHCs and avoiding self-medication. The intense community mobilisation by a group of committed community members, strong governance oversight as well as the combination of commodities with health promotion were some of the factors that led to this increase in utilisation.

Uptake of essential health services for children under-five years

Below: Figure 2:1



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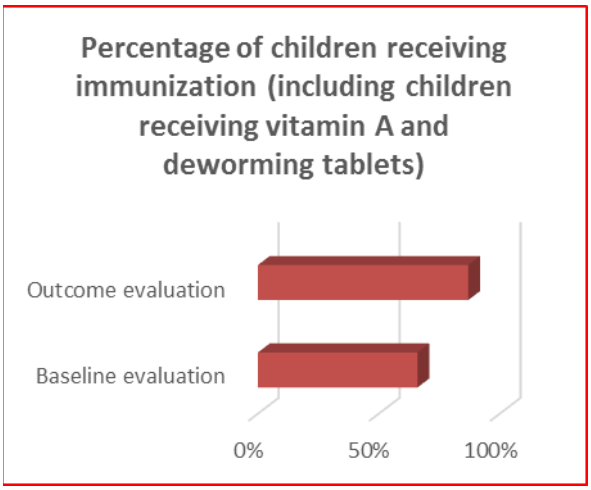
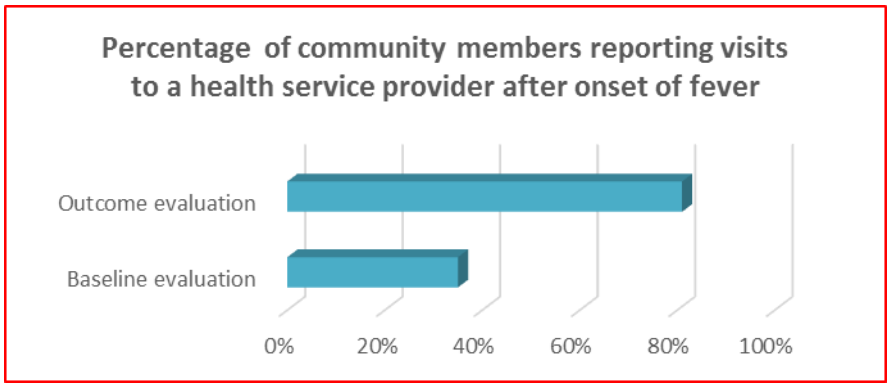


Figure 2:1 and 2:2 above shows the Proportion of children accessing quality health services from health facility, private Doctor or CHEW which improved from 67% as reported by the baseline survey at inception of the project to 85% at the end of the project. Children receiving immunization also increased from 66% at baseline to 87% at the end of the project.

Community members that reported visits to a health service provider at onset of fever increased from a baseline of 35% to 81% at the end of the project period as indicated in the figure 2:3 below:

Community members visiting health service provider at onset of fever

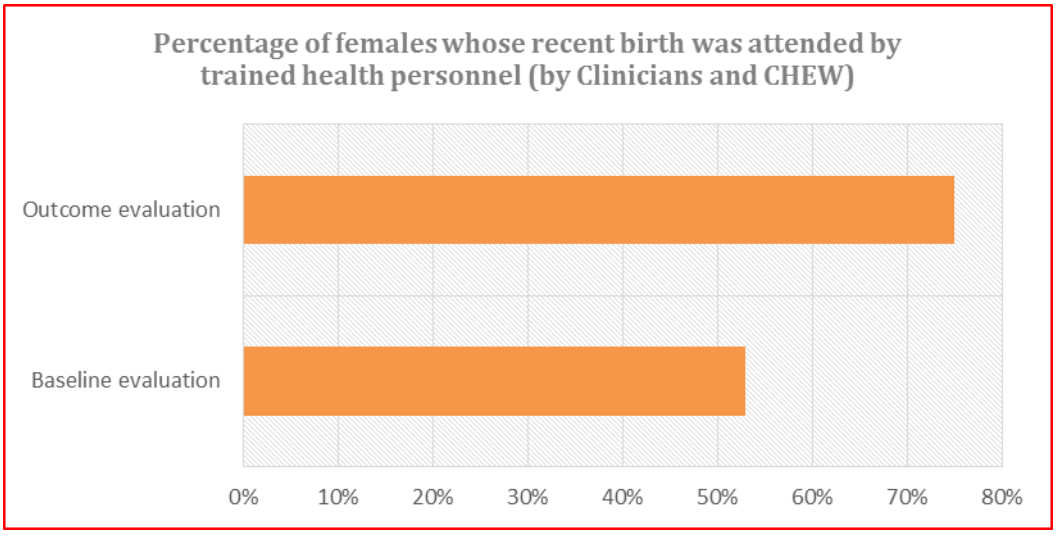
Below Figure 2:3



Proportion of females whose recent birth was attended by a trained health personnel (Clinician or CHEW) also increased during the project period with 53% attended to by a skilled birth attendant at baseline to 75% at the end of the project as shown in figure 2:4 below

Females whose recent birth was attended by trained health personnel

Below: Fig 2:4



When asked specifically about their healthcare advocacy, the CDC members in one of the communities said, *"We advise them to go to the hospital or health centre. Most people want to go to hospital, but some don't go because of money. People used to go to traditional healers, but now because of the education of Jireh Doo, they don't go anymore".* CDC members also pointed out that the health seeking behaviours have increased in the community *"now that the* place *is civilized, people are rushed to the hospital. Up to 80% go to the clinic ".*

Community members shared their experiences about improved health outcomes due to actions of community health agents and community development committees. There were deliberate attempts by these two community groups to educate their people about healthy living. In most cases, the CDCs also enforced existing laws aimed at keeping the environment clean and safe. CDCs supported the construction of household and community toilets, actively discouraged open defecation and ensured that community water sources are protected.

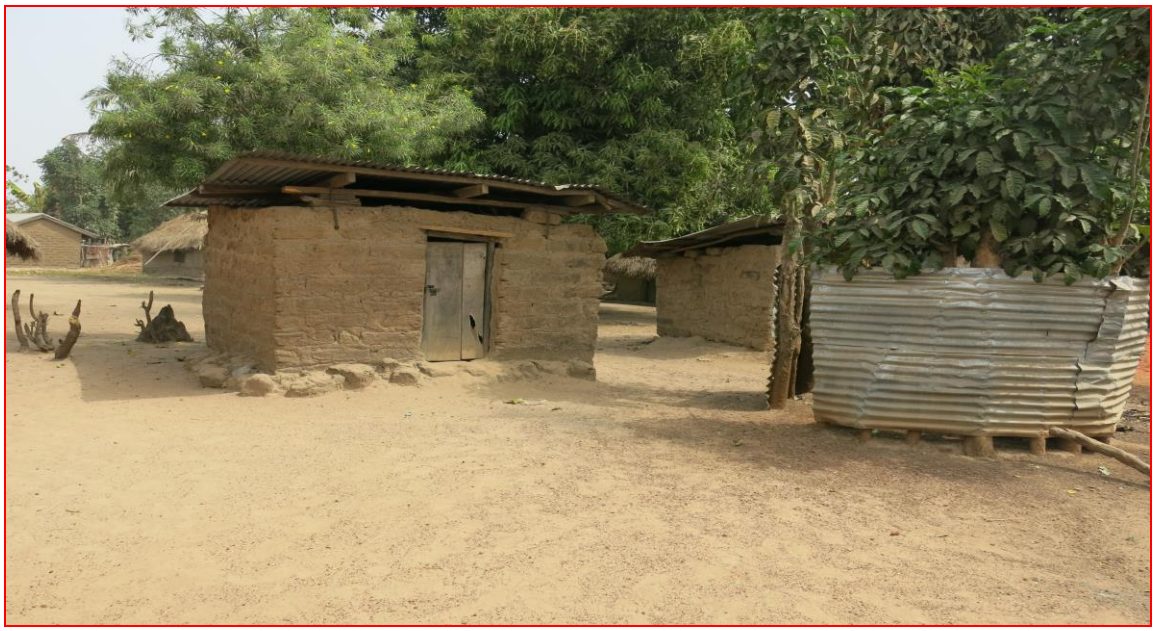
Percentage of people reporting that changes in social norms have improved their health outcomes

Changes in social norms and improvement of health outcomes

The flexible nature of the grant allowed for learning, this was well used by CA and her partners. In order to address root factors responsible for low uptake of health services, provide safe spaces for women to voice their opinion; take active part in health promotion and advocacy, CA and partners implemented an innovative approach called GEADOR- Gender Empowerment and Development Organizing Resource. This led to more women taking up leadership roles in their communities, becoming CHAs which were hitherto left for men only.

One of the major areas of intervention was in sanitation, where members of the community were enlightened about the relationship between good health and cleanliness, and they then took it upon themselves to maintain clean surroundings. The key implementing platforms CDC and CHA members were trained by the local partners on how best to keep their surroundings clean, they encouraged participation in these sanitation activities by constantly reinforcing the message to members of the community relating to the benefits of improved sanitation processes. **Considering that ODF status takes time to achieve, remarkable progress has been made in many of the triggered communities with three communities declared Open Defecation Free by the Local Government Task Group on sanitation in Benue State**.

Below: A toilet and bathroom constructed through CDC activities in one of the project communities



One of the community members said *"Before the creation of the CDC, actually if you entered this community, you won't be able to eat. It was very dirty. But when the CDC was organized, we were taught lots of things including how to clean our environment. Secondly, people were attacked by cholera due to the dirty environment but presently we don't have such problems".*

Certain laws were put in place in some of the communities to ensure improved sanitation and hygiene practices. The CDC members enforced participation of all community members during sanitation activities, which attracted charges to defaulters.

In some communities specific days are set apart for environmental sanitation a CDC member in one of the communities said, *"We now carry out sanitation once every month. In the past, we carried out sanitation once a year and it was just because we had to prepare for a traditional festival".* When asked what happens if households don't participate, the CDC member said, *"They will be forced to pay the sum of 500 naira".*

In some communities, the construction of toilets was made compulsory by CDC members in order to stop open defecation. A CDC member explained that, "*We made it compulsory for every house to dig a pit toilet, and the ones that haven't built have to pay 1000. Even people who started digging their own pit toilet but are taking too long will still have to pay*."

Sustaining Changes/Achievements

The project strategies adopted was with strong consideration for sustainability. The project communities indicated willingness to sustain the project gains. This they attributed to how the project had not only benefitted them but changed the way they lived as a community. One of the social norms that most communities agreed has led to a healthier lifestyle for them is the increase in awareness of malaria prevention practices. Some of the Community members in Logo LGA said they could not recall how much anti-malaria drugs cost at their PHC because "*we have not had to go to the PHC for malaria since we started using our nets*." Another intervention that appears to have made strong impact on the social norms of the communities sampled is sanitation practices. CDC members in Kwande LGA, said, "*The CHAs told us that we should clean all the bushes close to our house, and wash our hands after using the bathroom, and use ash to wash hands and toilets. Open defecation is reducing because of the enlightenment of Jireh Doo through the CHAs*."

In some communities, particularly in Benue, the construction of dish racks in the kitchen was another intervention that community members found useful and noted as a change in their societal norms that helped them lead healthier lifestyles. One community member in Logo LGA told the story of visiting a friend's house in a neighbouring village. He said he saw one of the goats ate something from the ground, and a moment later dip its mouth into a plate that would be used for serving food. "*From that day I knew I could not eat food out of plates that were left on the ground, and I understood the importance of dish racks to my health*," he said. The community employed its youth to help construct dish racks for community members where dishes and pots and pans can be kept far above the ground after they are washed.

A project beneficiary from one of the communities had this to say about the SCHHR "*There is a big difference in malaria incidence in the communities, compared to five years ago. Our environment is very neat and clean. Everyone in the area has his or her own latrine now in comparison. You will see that the place looks like London. It is bringing good water to us. Some of our communities are getting boreholes. Some women were giving birth every year, but now they are not having babies every year. Women are going to antenatal care very much now*,"

The impact of the SCHHR intervention on the lives of the children in the community was also another highlighted benefit of the fruit bowl approach. The communities sampled all seemed to agree that their children benefitted immensely through the provision of Vitamin A, albenzadole and de-worming tablets, and that these interventions allowed their children to be healthier and stronger. One community member in Igbon Village, Logo LGA, said the SCHHR intervention has greatly improved the health of his community. "*It met our expectations, especially in deworming. Our children used to defecate worms, even my own daughter. When we gave her the drug, in the morning she was much better. In family planning, we knew that having access will allow us to space our children, and have sizeable number of children. This has helped us to save money and improve our financial status. For us, it is good and suitable. It is also timely. Before now our children's eyes will be red, but they have been strengthened with vitamin A. It has been beneficial to our children because they do not fall sick anymore*."

Below: A Community Health Agent trained on the SCHHR project prepare to give Vitamin A supplements provided by Christian Aid in partnership with Vitamin Angels

Community members maintained that the interventions of the SCHHR Project had implemented in their communities would not be left to die once the project ended. CDC members in Tarka LGA said, "*We like the project, whether Jireh Doo is here or not we will continue doing the work. We have so many benefits from the project, we have learnt a lot about open defecation, so we will like to sustain these benefits*." When asked how they plan to sustain the gains of the project, they said, "*We are farmers, most of our income comes from there. We can save money from our farms and use the proceeds from the farm to cater for self-help projects in the community. We are also willing to source for help from our illustrious sons of the community*." A woman leader in Logo LGA said, "*We see that it is sustainable even after ADDS (CA Partner) pulls out because it has been a learning experience for us. We have benefited from this learning, particularly the WASH (Water, Sanitation and Hygiene). Now I am used to using the latrine, so I have gotten the benefit of it now and it will be hard for me to go back to using the bush to defecate, even if it means building a new toilet. We have also gotten the benefit of family planning, so we will continue to pursue the services"*

Consolidation, Learning and Sustainability

At the end of the project in March 2016 was a nine month extension period (April to December 2016) which was meant to consolidate project activities, ensure that projects are completed, project achievements are sustained, exit strategies implemented and learning captured.

Some of the achievements documented at the end of the nine month extension period include training on the formation and running of Savings and Loans Association (SLA) and market access in order to strengthen resilience in supported communities through economic empowerment. The training was facilitated by a technical specialist on resilient livelihoods/markets to partners who in turn stepped down the training and supported CHAs and CDCs to form SLA groups in supported communities. So far, a total of 92 (57M; 35F) SLA management committee members have been trained and 8 SLA groups have been established with more groups expected to formed. It is expected that the economic benefits would have a ripple effect on other households and members of the communities. Centre for Gospel Health and Development (CeGHAD), our Plateau partner facilitated a linkage between communities and the Agricultural Service Training

Centre of Plateau state to educate members on modern farming techniques and provide access to improved seedlings

Gender and power analysis was used during the Gender Empowerment and Development Organizing Resource (GEADOR) training to increase understanding of community members of the power play in the community and the effect on development. GEADOR sub circles were formed with equal participation of women and girls who successfully identified harmful social norms affecting their well-being in their communities. Women report improved participation in decision making in their communities and community members are being sensitized on the importance of leaving no one behind in development.

Ten gender model families have been identified to challenge some of the socio cultural norms and practices which promote inequality in the communities. Identified families have been educated on the importance of equity in task distribution, decision making and resource management. It is expected that these families will motivate other members of their community to change some of the practices that promote inequality and inequity.

Economic strengthening activities such as SLA training/formation and access to markets were tailored to include women and it is expected that the associations would empower and strengthen resilience amongst women by providing access to additional resources to be able to expand businesses, seek healthcare and improve overall quality of life.

At the National level CA worked with NiNERELA+ to ensure continued strategic engagements with the National Agency for the Control of AIDS (NACA), other partner organisations and PLHIV network. These collaborations and platforms provided opportunities to advocate for the protection of the rights of PLHIV and other disadvantaged and vulnerable groups at community level.

With support from Christian Aid, the advocacy activities of Nigerian Network of Religious Leaders Living with or personally affected by HIV/AIDS (NINERELA+) resulted in the final development of a national HIV stigma reduction strategy for the first time in Nigeria. It was launched by NACA on 15th November 2016. NINERELA+ has also developed simplified versions of the national HIV anti-discrimination act with the inclusion of verses from the Bible and Quran.

Below: At the launch of the National Anti-Stigma Reduction Strategy with officials of National Agency for the Control of AIDS

During the consolidation period, we engaged the White Ribbon Alliance Nigeria (WRAN) to strengthen the capacity of community based organizations (CBOs) including our partners and the

media on advocacy for sustainable healthcare financing and universal health coverage (UHC) using the National Health Act (NHAct) 2014, the PHC Under One Roof Policy and reports of the PHC assessment and CBHIS scoping, among others. The results of the engagement include reports of the political economy analysis of health in the two states, simplified version of the NHAct, advocacy briefs and empowered CBOs and media on PHCUOR and NHAct in Benue and Plateau states.

What we have learnt

The "fruit-bowl" approach was effective in delivering integrated healthcare promotion to communities, and empowering them to be resilient - find solutions to their problems and holding government to account in delivering social services. The project learning was used at different stages to inform programming and respond to the health needs of the communities. The delivery of integrated health education at household level unlike a vertical approach was a success factor on the project. The "fruit-bowl" integrated approach meant that there was a health benefit for every member of the household – either on safe motherhood, child health care, sanitation and hygiene, HIV, malaria, family planning, Lassa fever, Tuberculosis, among others. The increased knowledge (for example on preparation of oral rehydration solution- ORS) was empowering for the project community members.

The gender sensitive and inclusive programming approach adopted on the project was also significant. The deliberate effort ensured that all members of the project communities took part in project activities and benefitted at their different levels. This is also in response to the SDGs "leave no one behind".

The strengthening of community systems highlighted the important roles of community members in identifying and targeting health-related issues. The various principles implemented in the SCHHR project ideally sought to enhance the chances of sustained benefits at endpoint by empowering the community members to seek help out for themselves. This approach gave the project its best chance of sustainability, while still achieving most of the short-term indicators. The self-help projects and self-initiated advocacy activities embarked upon by the CDCs are relevant examples.

Most community members said they believed that they would carry on with all they learnt. The establishment of structures in the communities such as the CDCs and the CHA would provide a platform for continuous mobilization and engagement with Government, Private Sector and other stakeholders at various levels for provision of essential services as well as advocacy for changes or shift in policies to bring about better health outcomes and improved livelihood of communities.

Partnership with other organizations as Marie Stopes, Vitamin Angels and Water Aid to provide a wide range of services in response to community needs. These organizations brought in their expertise and skills to provide various services and other capacity building activities in the project communities which were instrumental in delivering the mix of different health services and commodities as prescribed by the "fruit bowl" approach.

These partnerships have proven to be an effective strategy in increasing access to quality health services. Marie Stopes supported the strengthening of community health extension workers (CHEWs) to deliver quality family planning services in primary health care centres in our communities. With technical support from Water Aid, our partners were trained on community led total sanitation (CLTS) to facilitate/'trigger' communities to achieve open defecation free (ODF) status, CDC members were trained by partners as Water, Sanitation and Hygiene Committee (WASHCOM) to provide community education and coordination on WASH on an on-going basis.

The collaboration with Vitamin Angels has increased access to vitamin A supplement and albendazole for children in our implementation communities.

The use of alternative reward to motivate CHAs as against monthly stipend is one of the strategies implemented on the project. This approach proved to be empowering economically for many of the volunteers thus contributing their resilience and sustained motivation throughout the project lifespan. This would have far reaching benefits in the communities. The use of faith leaders to influence and promote care and support for PLHIV and stigma reduction was also a learning that came out from the implementation of the project.

Summary of Achievements during Extension Period (2014-2016)

Programme Theme	**Number reached**		**Number of communities**
	Male	Female	
Family Planning Services	3258	3342	
Vitamin A Supplement and deworming	14761	17795	80
CLTS – Sanitation and Hygiene	5875	6589	49
Community Development Committees (CDCs)	561	826	80
Savings and Loans Association (SLA) groups			46

Recommendations

- The fruit-bowl approach was effective in delivering healthcare to communities, empowering them to find solutions to their problems and holding government to account in delivering social services. This further buttresses the benefits of integrated approach to community health. We encourage all stakeholders to adopt this approach as appropriate.
- The collaboration between Christian Aid, partners and other organizations contributed immensely to the overall success of the project. Such partnerships are encouraged for adoption by all implementers and should be built into similar projects at the design stage.
- A lot of capacity building and advocacy was built into the project; this was evident in the capacity of CDCs to engage with government stakeholders at various levels. However, Government commitment could further be strengthened in order to ensure sustainability of projects beyond exit of partners.

End notes