NURHI

Nigerian Urban Reproductive Health Initiative

Gateway Behaviors Project Document

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Center For Communication Programs Nigeria

Johns Hopkins Bloomberg School of Public Health | Center for Communication Programs

Building Healthy Families Together

Abbreviations and acronyms

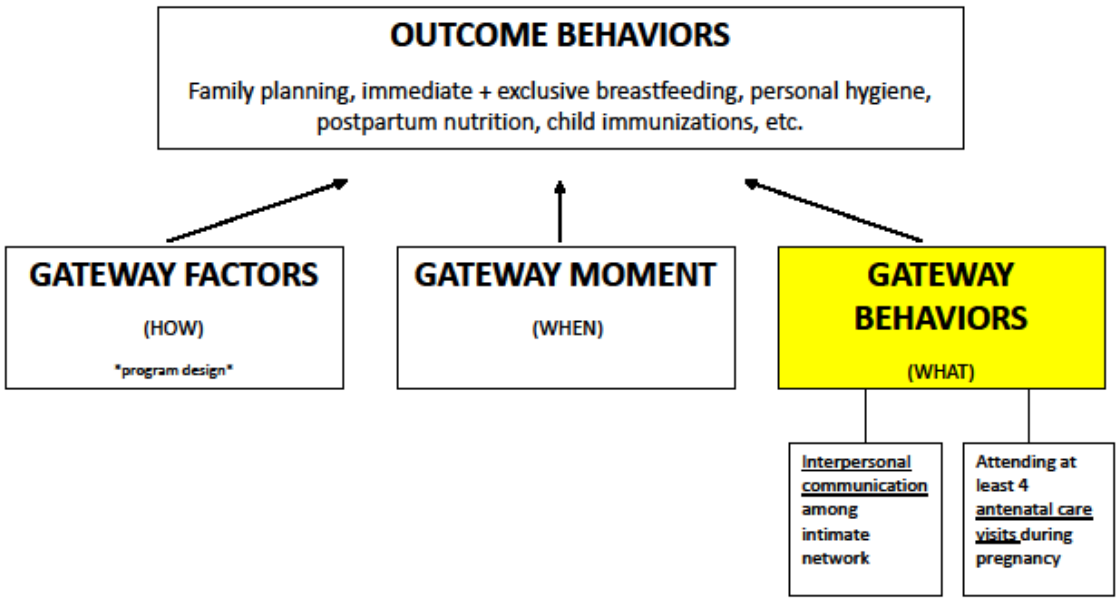
ANC – Antenatal Care
BCC – Behavior Change Communication
BHC – Basic Health Center
BMGF- Bill and Melinda Gates Foundation
CHEWs – Community Health Extension Workers
D2Dm - Door-to-door mobilization
EBF – Exclusive Breastfeeding
FANC – Focused Antenatal Care
FP – Family Planning
IEC – Information, Education and Communication
IPC – Interpersonal Communication
KM – Kilometer
LGA – Local Government Area
MNCH – Maternal, Newborn and Child Health
NGO – Non-Governmental Organization
NPC - National Population Commission
NURHI – Nigerian Urban Reproductive Health Initiative
SAFIN - Save the Future of Children Initiative
SMS – Short Message Service

Introduction

Background

The Gateway Behaviors' Study is a supplement project of the Nigerian Urban Reproductive Health Initiative (NURHI) funded by the Bill and Melinda Gates Foundation (BMGF) implemented in Ilorin South LGA, Ilorin, Southwest Nigeria. The main objective was to identify potential Gateway Behaviors and test the effect of interventions designed to increase these Gateway Behaviors and their down-stream impact. The Project premised on the concept of gateway behaviors, tested the concept of getaway behaviors and factors as the ability to increase the uptake of gateway behaviors and factors has a great potential to have positive impact on multiple desirable health behavior outcomes. Gateway behaviors are healthy behaviors that can trigger or facilitate the adoption of other healthy behaviors. The interventions of the Project were designed to promote the two gateway behaviors which are: Completion of all recommended (at least four) antenatal care (ANC) visits and interpersonal communication on family health. The adoption of these gateway behaviors has a great potential to influence the uptake of family planning, exclusive breastfeeding and immunization (these are the multiple health behavior outcomes).

Figure 1: Gateway Model



Project Site

Ilorin, the capacity city of Kwara State was selected for the implementation. Specifically, Ilorin South Local Government Area was selected as the intervention while the neighboring Ilorin West LGA served as the control site. Ilorin South LGA has a total population of 209,251. The project was implemented in all the 11 political wards of the LGA. Due to the fact that the control and intervention sites are located in close geographic range therefore sharing media markets, communication strategies that were selected focused on interpersonal and community-based interventions.

Audience segmentation

The segmentation of the target audience was conducted in line with the two gateway behaviors. The target audience was segmented into both primary and secondary as shown in below:

Table 1: Programmatic segmentation of target audience

ANC Component		IPC Component	
Primary audience	Women with first pregnancy/newly-wedded women	**Primary audience**	Couples-in-union
Secondary audience	Partners of pregnant women	**Secondary audience**	Family Influencers
	Healthcare providers		Peers of couples

Project strategies

The project is communication-driven and the approaches focused exclusively on interpersonal communication and community-based interventions. This was to prevent the diffusion of the information/intervention into the control site. The key strategies of the project were behavior change communication, and social mobilization. Support strategies were community-based advocacy and ANC service quality improvement (through trainings and provision of equipment).

Behavior Change Communication (BCC)

Behavior Change Communication is the flagship of the project strategies. In implementing this strategy, a 3-day participatory workshop was held in January 2013. Participants included BCC experts, ANC service providers, community representatives, State and LGA MNCH key officials, a graphic artist, local NGO staff and the Project team. During the workshop, messages and materials tailored towards the communication needs of the target audiences were developed. A tripod message of '**Register** (early for ANC), **Complete** (all recommended visits) and **Deliver** (your baby in the health facility) was developed and was dominant in all the materials. Materials developed included posters, leaflets, flip charts, job aids and discussion guide. Messages on tips to spousal communication on family health matters as well as exclusive breastfeeding, immunization and family planning were also developed.

Table 2: Messaging content, type and target audience

Thematic Area	Content	Materials	Target Audience
Antenatal care	Register early, complete all recommended visits, and deliver in the health facility. Benefits of each step	Poster (2) Leaflet (3)	Pregnant women Partner (Men) Pregnant women Partner (Men) Mother-in-law
Interpersonal communication on family health	Tips to initiating discussions on family health and the benefits	Leaflet (1)	Couples
Interpersonal communication on family health	Tips to initiating discussions on family health and the benefits	Leaflet (1)	Couples
Exclusive breastfeeding, immunization and family planning	Benefits and roles of couples	Leaflet	Couples
Interpersonal communication	Key steps to initiating discussion with community members on antenatal care	Discussion guide	Social mobilizers
Interpersonal communication and counseling	G-A-T-H-E-R approach in ANC service delivery	Job aid	Service providers

ANC and related topics	Danger signs, nutrition, HCT, EBF, safe delivery, immunization and family planning	Flip chart	Service providers

Social mobilization

The social mobilization strategy was what was used to bring the interventions right to the community and household levels. Key steps were taken in the implementation of this strategy are the following.

1. **NGO Selection:** For the effective implementation and coordination of all social mobilization activities, Save the Future of Children Initiative (SAFIN), a local NGO was engaged. The scope of work included the implementation of social mobilization activities as well as training and supervision of social mobilizers.

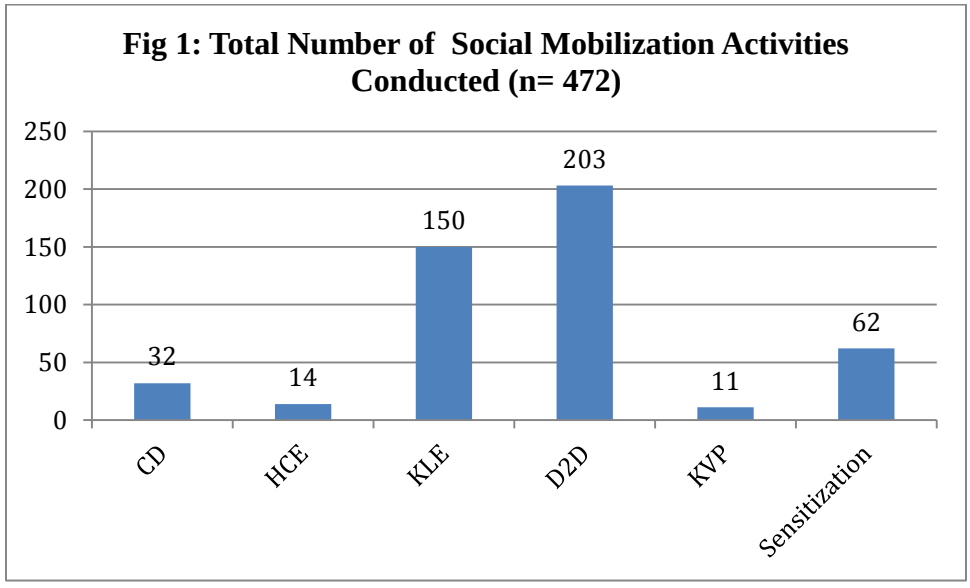
2. **Community mapping:** This exercise was to identify the number of localities/communities in the LGA, their peculiar features such as markets, health facilities, religious houses as well as community/trade associations. Community mapping of the LGA was conducted together with SAFIN. Using the National Population Commission (NPC) list of localities, one hundred and fifty-one (151) communities/localities were identified from the eleven (11) political wards were identified. Community/religious leaders, street and neighborhood markets as well artisans'/trade associations were also identified.

3. **Stratification of intervention communities:** This served two purposes. First was to identify specifically the localities and the coverage areas of the intervention health facilities. This was to guide the implementation of the interventions. The second purpose it served was to guide the team in determining communities where social mobilizers will be selected from.

4. **Selection and training of social mobilizers:** For the effectiveness of the social mobilization strategy, volunteers were selected from the intervention communities and trained as social mobilizers. A total of forty-six social mobilizers were selected with 85% (or 39) selected from host communities of the health facilities (primary intervention wards) while the remaining 15% were selected from communities in the secondary

intervention wards. Mobilizers selected were literate, had lived in the community for two years or more, were respected in the community and also had a verifiable means of livelihood (majority were artisans and traders). In addition, they were willing to volunteer their time without pecuniary gains attached and were within the age range of 18-45 years. The social mobilizers were trained on the concept of gateway behaviors, basic antenatal care messages, interpersonal communication and community mobilization. Using demonstration and return-demonstration methods, the mobilizers were also trained on conducting referrals and follow-up of pregnant women as well as the use of IEC materials. Using role play, they were also introduced to the various community mobilization activities.

Implementation of the social mobilization strategy



The social mobilization strategy was implemented through the following activities:

1. **Door-to-door mobilization (D2Dm)**

   For the purpose of the door-to-door mobilization, the 46 social mobilizers were grouped according to the seven main intervention areas, thus forming seven groups. Each group conducts the door-to-door mobilization on days chosen by the group (see Table 3). During the D2Dm, social mobilizers move from one house/shop to another to speak with community people on the benefits of antenatal care, giving them tips on how they can engage in interpersonal communication with their spouse on family health matters such as family planning, immunization, and exclusive breastfeeding. In the process, they refer

pregnant women who have not yet registered in the health facility to the nearest intervention health facility using the referral card. Mobilizers use megaphones and also distribute leaflets promoting antenatal care, exclusive breastfeeding and spousal communication after speaking to household members. They also document the number and details of referrals made, the frequently-asked questions and the challenges encountered.

Each door-to-door mobilization was supervised by a SAFIN program staff and a consultant hired by the Project. A brief is conducted prior to the commencement specifying the locations that will be reached, checks conducted to ensure IEC materials are adequate and megaphones are working perfectly. The supervisors collate the referrals made after the D2Dm. After the collation, a joint decision is made about the communities that will be reached the following week. The Project team and SAFIN meet on a weekly basis to review the reports of the D2Dm and other activities conducted during the week. Challenges and complaints are noted and steps taken to address them. Some of the steps taken to address these included visits to the community leader of the community concerned or health facility visits to notify the head when there are complaints.

Table 3: Breakdown of social mobilizers and door-to-door mobilization (D2Dm) schedule

S/n	Contact points	Number of Social mobilizers	D2Dm schedule
1	**Ero-Omo**	5	Wednesdays
2	**Tanke**	4	Thursdays
3	**Sango**	15	Wednesdays
4	**Edun**	6	Saturdays
5	**Saboline**	8	Tuesdays
6	**Gaa-Akanni**	4	Wednesdays
7	**Sobi**	4	Fridays
	Total	**46**	

For effectiveness of the door-to-door mobilization, the 46 mobilizers were categorized into 7 groups in line with the 7 host communities of the intervention health facilities (see table 4). The contact points are the host communities of the intervention health facilities. The 127 communities in the primary and secondary were divided into seven groups and allocated to the mobilizers in each of the 7 contact points for the purpose of door-to-door mobilization.

2. **Community dialogue**

In this forum, key representatives of the community such as community/association leaders, women leaders, pregnant women, and household heads and youths come together in a community gathering where they talk about how women can utilize ANC services in the community. They also listen to health talk on ANC and spousal communication on family health matters. Most times, the ANC talk also extends to key issues such as exclusive breastfeeding, immunization and family planning. Thereafter, community members have the opportunity to ask questions and make comments. Community/religious leaders also utilize the avenue to speak in support of the adoption of healthy behaviors such as early ANC registration, adoption of family planning and interpersonal communication on family health. Social mobilizers are also present at the community dialogues and document the names and phone numbers of participants. Text messages (SMS) are sent to the phone numbers of those who attended the dialogue to serve as reminders for the main action points discussed at the community dialogue session. Participants are also given leaflets that contain take-home message.

3. **Key life events**

These are celebrations such as naming and wedding ceremonies. During the event, a 5-7 minute presentation is made which features popular ANC songs, ANC tripod message to well-wishers and a reminder to the couple to adopt family planning, completion of child's immunization and exclusive breastfeeding. ANC leaflets are distributed to all who attend while social mobilizers utilize the ceremony to conduct referrals. Branded souvenirs like umbrella, towel, bag and long lasting insecticidal net are presented to the couple.

4. **Sensitization at community association meetings**

The project with the NGO utilizes the meeting days of various community/artisans' associations to sensitize the members on the benefits of early ANC registration and strengthened interpersonal communication on family health. Following the community mapping where these associations were identified, a one-day orientation was conducted for all the leaders. The orientation included a presentation on antenatal care, its components and other related health matters discussed during antenatal care visits. There was another presentation on the role of the leaders in sensitizing their members while

participants also made contributions to the avenues they can utilize to sensitize their members. These avenues are the inclusion of the ANC tripod message in the routine announcements on their meeting days and during general meetings. Thereafter, the details of each association including their meeting days, venues and the specific day they would want their association to be visited were collected. Commitments were made by the leaders to include in their meeting announcements the need for their pregnant wives/women to register early for ANC and for couples to engage in interpersonal communication on their family health to benefit the health of the whole family.

5. **Happy Couples' Event**

Every quarter, a special event tagged Happy Couples' Event is conducted in selected health facilities. The purpose is to further promote male participation particularly in family health matters including family planning, antenatal care and exclusive breastfeeding. Participants at the Event are newly-married couples, pregnant women and their spouses as well as nursing mother attending immunization clinics and their spouses. The Happy Couples' Event takes place in the evening time thus allowing more men to participate. It features health-promoting songs, drama and health talk. Social mobilizers perform the songs and drama while service providers conduct the health talk. Ample time is given for questions and answers after the health talk. Another feature of the Event is couples' quiz. The purpose is to assess the extent and scope of communication between couples. Couples' testimonial is another segment where couples who have both came to the health facility at a time or adopted a health-promoting behavior e.g. family planning share their experience.

6. **Knowledge and visibility parade**

Every quarter, a parade is organized where social mobilizers supervised by the project team and NGO use entertainment education techniques to promote early ANC registration. During the parade, the mobilizers are engaged in various activities. Some sing ANC-promoting songs and dance to the beasts supplied by a local band while some others use megaphones to disseminate messages. Mobilizers also engage in one-on-one interactions with community members, distribute IEC materials and conduct referrals of unregistered pregnant using the referral card.

7. **SMS blast:** A customized SMS package was used in sending SMS (short message service) periodically to pregnant women who were referred by social mobilizers, participants of community-level activities as well as to service providers. Social mobilizers help in collecting the names and phone numbers of participants of community-level activities. After the events, text messages, which summarize information disseminated during the activity, are sent to the phone numbers of the participants. In addition, the details of pregnant women referred by the social mobilizers are collected after each D2Dm and other community-level activities. Text messages are sent to them few days after reminding them to register for ANC. Follow-up text messages are also sent to them every week reminding them to keep their next appointment and giving them tips on how they can discuss what they were told in the hospital with their spouse.

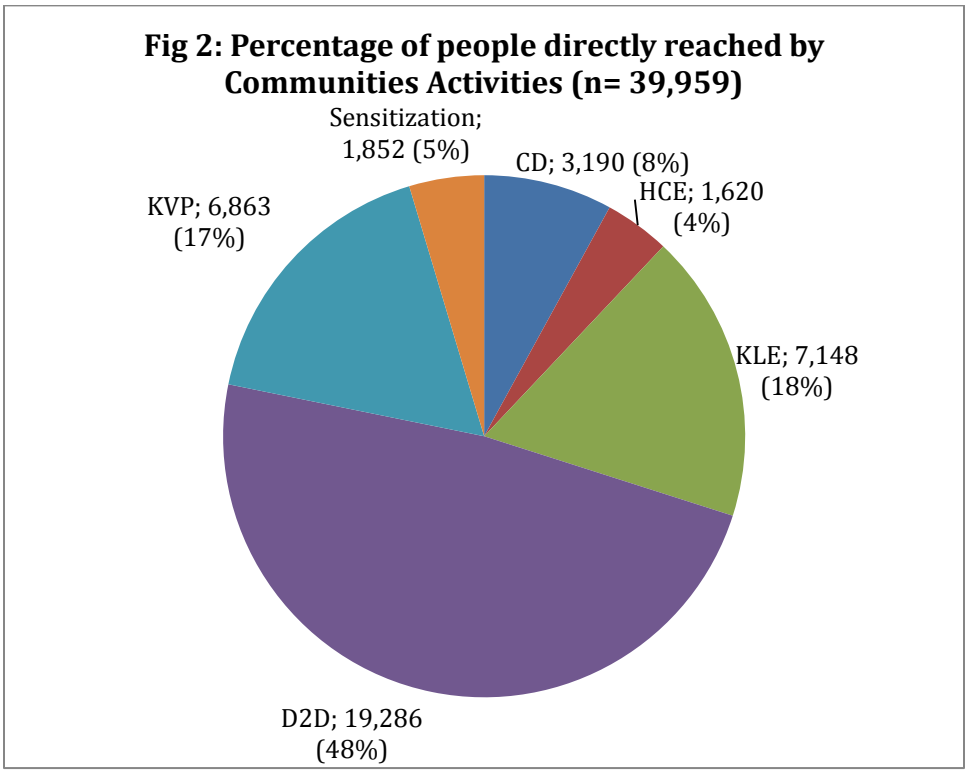
8. **72-hours follow-up strategy**

   When social mobilizers make referrals, a follow-up is made by the mobilizers 72 hours (3-days) after the referral to ensure the woman has gone to register and to find out the outcome of her going to register. This enables the mobilizer, SAFIN and the project team to get feedback on service provision and reasons for not going to register if the woman has not gone. The feedback, especially the complaints is presented to the health facilities/health workers during weekly visits and/or periodic meetings for prompt intervention. The follow-up takes two forms. The mobilizers are to visit the pregnant woman referred in her house/shop and/or make a phone call.

9. **Social mobilizers' review meetings**

   At the end of every month, SAFIN organizes a meeting where all the social mobilizers are present and the activities they did in the outgoing month are reviewed. Mobilizers give a feedback of the door-to-door mobilization, areas covered, number of referrals made, challenges encountered after which they go into groups to do the work plan for the in-coming month. The workplan involves communities that will be targeted, meeting place and other necessary information. The review meeting also provides the avenue for mobilizers to present complaints of pregnant women referred in terms of service provision. These complaints are compiled according to the health facilities concerned. These complaints are presented during routine visits to the health facilities and during

joint review meetings that involve service providers and the State with LGA MNCH units.



Community-based advocacy

To get the support and commitment of leaders in various communities in the Local Government, advocacy interventions were conducted following the mapping of communities in Ilorin South LGA. The targets of the advocacy were community/traditional leaders, male and female religious leaders of both the Christian and Islamic faiths as well as leaders of various artisans'/trade associations in the LGA.

Capacity building for service providers

In Ilorin South LGA, antenatal care services are provided basically in public and private health facilities. In order to enhance the capacity of service providers in quality service delivery, trainings were conducted for the providers. The trainings conducted in batches focused on the concept of gateway behaviors, focused antenatal care and interpersonal communication and counseling. Service providers were also trained on birth plan and complication readiness. A total

of one hundred and twenty-eight service providers of different cadres were trained. The trainings were followed by step-down orientations which was conducted at each of the health facilities from each training participants were drawn.

Table 4 showing the type of training, cadre and number trained

Type of training	Participants	Number trained
FANC/IPCC/data management training (Batch 1)	Nurses and midwives	14
FANC/IPCC/data management training (Batch 2)	Nurses and midwives	15
Refresher training on FANC/IPCC/patient rights	Nurses and midwives	30
FANC, birth plan and complication readiness	Nurses and midwives	38
FANC and social mobilization	CHEWs	31

Description of interventions

Stratification and Project Coverage

Ilorin South LGA has 11 political wards consisting of 151 localities/communities. For programmatic purpose, the 11 wards were stratified into 3: primary, secondary and peripheral.

Primary wards: These are the wards in which the intervention health facilities are located. These wards are five in number. Communities in these wards received the highest priority as the social mobilization activities commenced in these communities while 75% of social mobilizers were selected from these communities, specifically, the host communities of the intervention health facilities.

Secondary wards: These are four in number and none of the intervention facilities is located there. The communities in these wards are however within 10km range of the health facility. 15% of the social mobilizers were selected from communities in the secondary wards.

Peripheral wards: These are wards whose communities are at the outskirt of the town. They are two in number.

Table 5: Stratification of intervention areas

Category	Ward	No of Localities/ Communities	Intervention Health	Host community/ points of contact
Primary	Akanbi 3	27	Ero Omo BHC (Public) Ola-Olu Hospital (Private)	Ero Omo Gaa Akanbi
	Akanbi 4	16	AnchorMed Hospital (Private)	Tanke
	Akanbi 5	21	Kulende BHC (Public) Olutayo Hospital (Private) Kwara State Specialist Hospital (Public)	Sango Sobi
	Oke-Ogun	10	Olufadi BHC (Public)	Edun
	Balogun Fulani (BF) 2	13	Temitope Hospital (Private)	Saboline
Secondary	BF 1 BF 3 Okaka 1 Okaka 2	14 13 7 10	Nil	Nil
Peripheral	Akanbi 1 Akanbi 2	12 12	Nil	Nil

Project interventions' coverage

The project interventions covered one hundred and twenty-four (124) communities out of the one hundred and fifty-one communities in the LGA giving 82% coverage. A community where at least a key activity was conducted that reached at least 50 people is classified has been covered. Such key activities include door-to-door mobilization, community dialogue and happy couples' event. Others are key life events, community associations'/leaders' sensitization as well as knowledge and visibility parade.

Table 5: Coverage of interventions

Category of ward	Communities	No (%) covered
Primary	87	83 (95%)
Secondary	40	40 (100%)
Peripheral	24	1 (4%)
Total	**151**	**124 (82%)**

Intervention timelines

Some key activities preceded the facility and community-level interventions. These included the strategy design, development of messages and materials, pretest and revision of messages and materials as well as the production of the communication materials. These activities took place from December 2012 to April 2013. Timelines of other interventions are contained in the box.

Table 6: Timelines of interventions

Strategy	Activities	Timeline
Community–based advocacy	Advocacy to community leaders in primary wards	April 2013
	Advocacy to community leaders in primary & secondary wards	August–December 2013
	Advocacy to religious & association leaders	January – December 2014
Social mobilization	Selection and training of social mobilizers	May-July 2013
	Door-to-door mobilization	August 2013-March 2015
	Sensitization at key life events	August 2013-March 2015
	Community dialogue	November 2013-March 2015
	Happy Couples' Event	December 2013-March 2015
	Sensitization of community associations	October 2013-June 2014
	SMS blasts	December 2013-February 2015

Capacity building of service providers	Training of nurses/midwives	June 2013 December 2013 September 2014 November 2014
	Training of CHEWs	December 2014

Intervention Channels

Multiplicity of channels was utilized in the implementation of the project. Many communities in the intervention and control sites share close proximity and have the same media markets and in order to prevent diffusion of information/interventions into the control site, the electronic media wan not utilized. The intervention channels used are the following:

1. **BCC/IEC materials**: Behavior change communication materials on antenatal care, interpersonal communication and EBF, FP and immunization were also developed, distributed to health facilities and given out to clients coming for antenatal care, delivery and immunization in the health facility. Materials developed included posters, leaflets and discussion guide.
2. **Social mobilizers:** These are community members trained to conduct door-to-door mobilization in their communities and hold face-to-face interaction (interpersonal communication) with community members to sensitize them and refer unregistered pregnant women to the health facility using the Project's referral card. A total of 619 Women were referred to the health facility from August 2013 to January 2015.
3. **SMS blasts**: The project utilized short message service using a customized SMS platform in sending text messages to community members. These messages include summaries of discussion points to participants of community dialogues, reminders to pregnant women referred to register at the health facility and useful health tips on ANC, exclusive breastfeeding, interpersonal communication and family planning to pregnant women and nursing mothers.
4. **Service providers**: Nurse, midwives and CHEWs were also trained to provide quality and client-friendly services. They were also trained and disseminated ANC, EBF, FP and immunization messages to their clients. Job aid in form of a flip chart was developed for this purpose. Apart from the facility-based health talks and counseling, some service

providers were also involved in the weekly door-to-door mobilization and community-level activities such as community dialogue