



The Village Health Worker Partnership in Borno State and What It Means for Humanitarian Localization in Nigeria

Learning Brief

July 2022

The Women's Refugee Commission (WRC) improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

The Borno State Primary Health Care Development Agency's mandate is to have full ownership in the implementation process of community based health programs, including supportive supervision, data quality, and community participation and ownership.

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Cover photo: Village Health Worker Program materials and tools for distribution at launch in Bayo.
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Executive Summary

Borno, a state in northeast Nigeria, has faced violent conflict between insurgent groups and the Nigerian military since 2009. After more than 12 years of conflict, over 1.5 million people remain displaced in Borno and less than half of the state's health facilities are fully operational. The protracted crisis has heightened pre-existing health inequities in Borno. High rates of maternal death, gender-based violence, child marriage, and infant mortality mean that women, adolescents, children, and newborns in Borno experience some of the worst health outcomes in Nigeria and in the world.

The response to the conflict in Borno has involved a diverse set of actors, including the significant presence of international organizations. The humanitarian sector increasingly calls for "localization" of humanitarian response to include local organizations and communities, most prominently in the Grand Bargain at the World Humanitarian Summit of 2016. However, international institutions and agencies based in the Global North continue to be lead implementers of response in crises. Within these dynamics, the localization discourse has been converging around "partnership-based humanitarian action." Humanitarian actors concerned with localization have focused on developing guidance on how to design and implement effective and "equitable" partnerships.

In Nigeria, a consortium of government and humanitarian actors developed an Operational Framework for Local and International NGOs in Nigeria in 2019. The framework laid out a vision of a humanitarian response in Nigeria "that is locally driven and fosters development," and provided principles and key elements and characteristics. Notably, it laid out state government leadership in humanitarian response alongside capacity-strengthening provided by international and national NGO partners.

The RMNCAHN Project: Applying a localization approach to health and nutrition programming in Borno State

To work toward addressing the conflict-driven health crisis in Borno, while adopting a localized approach to strengthen public health systems within the State, in 2017, the Women's Refugee Commission (WRC) developed the Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition (RMNCAHN) Project, with its cornerstone component, the Village Health Worker (VHW) Program. The community-based VHW Program aimed to increase demand for RMNCAHN services, while complementary interventions strengthened government provision of health services, in order to improve RMNCAHN health outcomes.

The project also had a process-related goal: to use a localized approach to the design, implementation, and learning of the VHW program and systems strengthening package. The project positioned the Borno State Primary Health Care Development Agency (BSPHCDA) as the lead implementer. WRC sought out and invited other consortium partners based on their technical added value, with each partner contributing a specific skill set. In doing so, WRC applied the principle of "as local as possible, as international as necessary." It also prioritized women-led or women-majority organizations. The RMNCAHN Project brought together four partners in addition to WRC and BSPHCDA: Mwada-Gana Foundation; M-Space; i+solutions; and a long-term research consultant.

To advance principles of equitable and effective partnership, WRC facilitated a partnership co-design process to collaboratively define how the consortium would function in practice. Two key documents guided the consortium's functioning. First, the consortium updated the project's theory of change to explicitly integrate localization, drawing on discussions in which partners described what changes they wished to see and how they would be achieved. Then, partners developed consensus-based decision-making guidance that placed WRC and SPCHDA in joint primary decision-making roles – WRC as the

consortium lead tasked with fiscal responsibility and accountability toward the donor, and SPHCDA as implementation lead tasked with responsibility and accountability toward inhabitants of Borno State as to the services delivered. The project operated within this structure for approximately two years.

Evaluating the partnership model

In 2021, WRC engaged an external evaluator to design and carry out an evaluation of the partnership. The evaluator interviewed all 20 key personnel from the consortium, including government, national NGO, and international NGO representatives. The health and nutrition outcomes of the program were evaluated and published separately.¹

The evaluation found that the equitable partnership approach adopted by the partners was successful in engaging state government and national NGOs, strengthening stakeholders' capacity, and heightening the acceptability of the community health program. VHW consortium partners held positive views of the partnership model, testifying that the consortium was well organized, with each partner leveraging their unique capacities to deliver on project objectives. Partners noted that the equitable partnership model enabled them to provide input openly on key decisions. These outcomes facilitated effective decision-making because partners were placed to make strategic decisions that affected their scope of operations.

Recommendations

Recommendations to project designers

- Engage a government agency as lead implementing partner on the project, and ensure they are involved from the concept and proposal development stage onward.
- Facilitate capacity-sharing across national NGOs (NNGOs) and state government by engaging NNGO partners in working with the government to meet project goals.
- Integrate strategic advocacy engagements targeting budget allocations processes to ensure the sustainability of programming.

Recommendations to partners during the project:

- Conduct a partnership co-design process as early as possible in the project cycle to achieve consensus on governance dimensions of the project, especially decision-making modalities, communication, accountability, and financial and administrative responsibilities.
- Establish robust communication practices, including adopting tools and technologies that promote transparent synchronous and asynchronous communication.
- Adopt a data-driven approach to measuring equitable partnerships.

Recommendations for federal-level actors in Nigeria

- Increase government funding to support humanitarian projects with localized modalities.
- Continue to support space for NNGO, civil society, and community-based organizations and groups to participate in government responses and lead their own responses.
- Increase government funding allocated to community health programs in humanitarian settings in Nigeria.

1 See Women's Refugee Commission, *On the Frontlines of Community Health: An Endline Evaluation of a Village Health Worker Program in Borno State, Nigeria* (June 2022) for a report on this project. <https://wrc.ms/endline-evaluation-borno-state>.

Borno State: Existing health inequities exacerbated by protracted conflict

Borno, a state in northeast Nigeria, has faced violent conflict between insurgent groups and the Nigerian military since 2009. After more than 12 years of conflict, over 1.5 million people remain displaced in Borno State, parts of the state are inaccessible due to insurgencies, and less than half of the state's health facilities are fully operational.²

Civilians, displaced people, government staff, and aid workers in Borno live and work with an almost unimaginable constellation of risks and violence: in one shooting in 2020, insurgent gunmen killed 81 civilians, including reportedly murdering at least four teenagers who were collecting water for handwashing to prevent COVID-19.³ Meanwhile, reports continue of children dying from malnourishment due to food insecurity driven by chronically interrupted livelihoods related to insurgent looting, stealing, and burning of farms and villages.⁴

The protracted, violent conflict has heightened pre-existing health inequities in Nigeria and in Borno, and has led to a crisis of reproductive, maternal, newborn, child and adolescent health and nutrition (RMNCAHN) in Borno State. High rates of maternal death, gender-based violence, child marriage, and infant mortality mean that women, adolescents, children, and newborns in Borno State experience some of the worst health outcomes in Nigeria and in the world.^{5,6,7}

Within an extremely challenging situation, the federal government of Nigeria, the Borno State Government, and local civil society organizations have risen to address the health crisis in Borno State through government-funded social services—such as public health facilities—as well as through international humanitarian aid coordinated among government, international nongovernmental organizations (INGOs), national nongovernmental organizations (NNGOs), and United Nations (UN) agencies. In 2020, over half of the functional health facilities in Borno State received funding, training, or both from one or more such nongovernmental partner. Since 2016, this coordination and partnership between government and nongovernmental actors has yielded results: based on Demographic and Health Survey (DHS) data, key health outcomes for women and children in Borno State, while still low, have improved to a less dire state.⁸

- 2 International Organization for Migration. 2020. "Nigeria — Displacement Dashboard 33 (August 2020) | Displacement." 2020. <https://displacement.iom.int/reports/nigeria-%E2%80%94-displacement-dashboard-33-august-2020>.
- 3 Daniel Paquette and Ismael Alfa. 2020. "A Massacre in Nigeria's Borno State Left More People Dead than Months of Coronavirus." *Washington Post*, 2020. https://www.washingtonpost.com/world/africa/nigeria-borno-state-attack-coronavirus/2020/06/10/0147e06a-ab1b-11ea-a43b-be9f6494a87d_story.html.
- 4 Amnesty International. 2021. *Nigeria: Boko Haram Brutality against Women and Girls Needs Urgent Response – New Research*. 2021. <https://www.amnesty.org/en/latest/news/2021/03/nigeria-boko-haram-brutality-against-women-and-girls-needs-urgent-response-new-research/>.
- 5 British Council Nigeria. 2012. *Gender in Nigeria Report 2012: Improving the Lives of Women and Girls in Nigeria*. Koninklijke Brill NV. https://doi.org/10.1163/2210-7975_HRD-9834-0041.
- 6 National Population Commission (NPC), and ICF. 2019. *Nigeria Demographic and Health Survey 2018 Key Indicators Report*. <https://dhsprogram.com/pubs/pdf/FR359/FR359.pdf>.
- 7 Chitra Nagarajan. 2020. *Impact of COVID-19 on Conflict, Gender and Social Exclusion in Borno Policy Brief*. British Council.
- 8 Jennifer A. Tyndall et al. 2020. "The Relationship between Armed Conflict and Reproductive, Maternal, Newborn and Child Health and Nutrition Status and Services in Northeastern Nigeria: A Mixed-Methods Case Study." *Conflict and Health* 14 (1): 75. <https://doi.org/10.1186/s13031-020-00318-5>.

Localization: Global discourse and national political economy

Localization and equitable partnerships

It is not unusual that the response to conflict in Borno State has involved a diverse set of actors, including significant presence of international organizations. Ever since its rise in the mid-20th century, the humanitarian response sector has been characterized by a high degree of “internationalization”: while most displacement and crisis contexts are in the Global South, its funding, high-level strategic priorities, and implementation have historically tended to be set by actors and organizations in the Global North.⁹ As a result, there have been repeated calls for “localization” of humanitarian response to include local and place-based actors with geographic and other affinities to the context. While demands for localization have existed for decades, the Grand Bargain at the World Humanitarian Summit of 2016 elevated localization as a priority, with signatories such as government and UN agencies committing to providing more funding to and better engagement with “local” partners.¹⁰ Since then, localization advocacy and implementation have increased, and COVID-19’s effects have accelerated these trends.¹¹

Localisation is “the process of recognising, respecting and strengthening the independence of leadership and decision making by national actors in humanitarian action, in order to better address the needs of affected populations.”

–International Federation of Red Cross and Red Crescent Societies, 2021

The definitions of, rationale for, and dynamics of localization vary. However, they share commonalities of enabling “local” individuals, communities, organizations, and institutions—as compared to “non-local” ones external to the context—to lead and manage a humanitarian response.¹² Creating an enabling environment for actors more local to the context—whether by geography or affinity—to lead is inherently more inclusive and can improve the quality of response, from early response and community access and acceptance to cost effectiveness.¹³ For many humanitarian responders and activists engaged in localization advocacy, the ultimate vision of localization would be for place-based government agencies, NNGOS and civil society organizations, and community-based organizations, groups, and mutual aid networks to directly receive financial resources from funding agencies in order to design and implement their own solutions and responses to conflict- and crisis-related shocks, with international or non-place-based actors playing a supporting or facilitating role.¹⁴ Some activists link the localization agenda with shifting power within the sector to “centre on the dignity and agency of crisis-affected

9 Global Mentoring Initiative. 2020. *From Eco-System to Self, Support Rather than Replace: Systems Change in the International Relief Industry PART I: Why, Why Now and for What Purpose?* Resource Centre. 2020. <https://resourcecentre.savethechildren.net/node/18633/pdf/gmi-supportingnotreplacingnationalactors-why.pdf>.

10 IFRC. 2018. “Grand Bargain Localisation Workstream - Home.” Grand Bargain Localisation Workstream (blog). 2018. <http://gblocalisation.ifrc.org/grand-bargain-localisation-workstream-2/>.

11 Veronique Barbelet, John Bryant, and Barnaby Willitts-King. 2020. ‘All Eyes Are on Local Actors’: Covid-19 and Local Humanitarian Action. Overseas Development Institute, 12.

12 Kristina Roepstorff. 2020. “LOCALISATION AND SHRINKING CIVIC SPACE: TYING UP THE LOOSE ENDS,” 18.

13 OECD. 2017. *Localising the Response: Putting the Policy into Practice*. 2017. <https://www.oecd.org/development/humanitarian-donors/docs/Localisingtheresponse.pdf>.

14 Inter-Agency Standing Committee. 2021. *IASC Guidance on Strengthening Participation, Representation and Leadership of Local and National Actors in IASC Humanitarian Coordination Mechanisms*. 2021. https://interagencystandingcommittee.org/system/files/2021-07/IASC%20Guidance%20on%20Strengthening%20Participation%2C%20Representation%20and%20Leadership%20of%20Local%20and%20National%20Actors%20in%20IASC%20Humanitarian%20Coordination%20Mechanisms_1.pdf.

people” through “equity, decolonization, solidarity, accountability, participation, and trust.”¹⁵ Others link versions of this approach to economic justice, with aid conceptualized as “reparatory justice” in response to histories of colonialism.¹⁶

However, the current structures of humanitarian aid financing continue to position those with most proximity and affinity to the conflict/crisis as “downstream” to many types of humanitarian funding, much of which still flows from funders to Global North-based institutions and international agencies, which then design and implement the response. This structure limits the ownership and leadership of governments and place-based actors in response and recovery, and inhibits sustainability of the processes and capacities related to humanitarian response.

Within this context and structure, the localization discourse has in recent years been converging around “partnerships” and “partnership-based humanitarian action” as a crux of localization within the current dynamics and structures of humanitarian aid and action.¹⁷ Partnerships can take many forms, from more directive to more egalitarian.¹⁸ Humanitarian actors concerned with localization have focused on elaborating guidance as to what kinds of partnerships are most effective and “equitable,” what their principles are, how to implement these kinds of partnerships, and how to measure them.¹⁹ Other topics being explored with the localization agenda are gender-responsive localization²⁰; improving risk management²¹ and financing mechanisms to align with localization goals²²; and “responsible transitions” from INGOs to NNGOs.²³

Localization in Nigeria

Governmental and nongovernmental actors within Nigeria have engaged in localization advocacy and the localization of humanitarian aid and action within the country.²⁴ A country-level dialogue between Nigerian governmental, nongovernmental, and international partners was held in 2018

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- 15 Sarah Cechvala, Sabina Robillard Carlson, and Grace Boone. 2020. *From Where We Stand*. CDA Collaborative (blog). December 16, 2020. <https://www.cdacollaborative.org/blog/from-where-we-stand/>.
- 16 Uzodinma Iweala. 2017. “Reparations as Philanthropy: Radically Rethinking ‘Giving’ in Africa.” *Le Monde.fr*, 2017. https://www.lemonde.fr/afrique/article/2017/11/10/reparations-as-philanthropy-radically-rethinking-giving-in-africa_5213130_3212.html. See also Zeinab Badawi. 2021. “Reparations from Former Slave-Owning Countries Are Long Overdue.” *Financial Times*, July 28, 2021. <https://www.ft.com/content/d47cc0e1-4dab-4f35-ada5-a3e653b62131>.
- 17 Inter-Agency Standing Committee. See also, Liz Harrison. 2020. “Partnerships in Humanitarian Action.” CDA Collaborative (blog). 2020. <https://www.cdacollaborative.org/blog/partnerships-in-humanitarian-action/>.
- 18 Abby Stoddard, Monica Czarwano, and Lindsay Hamsik. 2019. *NGOs and Risk: Managing Uncertainty in Local-International Partnerships*. 2019. https://www.humanitarianoutcomes.org/sites/default/files/publications/riskii_partnerships_global_study.pdf.
- 19 Inter-Agency Standing Committee. See also, Veronique Barbelet and Gemma Davies. 2021. *Interrogating the Evidence Base on Humanitarian Localisation: A Literature Study*. Odi.Org. 2021. <https://odi.org/en/publications/interrogating-the-evidence-base-on-humanitarian-localisation-a-literature-study/>.
- 20 UN Women. n.d. *Guidance Note - How to Promote Gender-Responsive Localization in Humanitarian Action*. <https://reliefweb.int/sites/reliefweb.int/files/resources/Guidance%20note%20-%20how%20to%20promote%20gender-responsive%20localization%20in%20humanitarian%20action.pdf>.
- 21 Abby Stoddard, Monica Czarwano, and Lindsay Hamsik.
- 22 Andy Featherstone and Tasneem Mowjee. 2020. *Desk Review on Enhancing the Potential of Pooled Funds for Localisation*. 2020. <https://interagencystandingcommittee.org/system/files/2020-11/Desk%20Review%20on%20Enhancing%20the%20Potential%20of%20Pooled%20Funds%20for%20Localisation%20-%20September%202020.pdf>.
- 23 Farzana Ahmed and Isabella Jean. 2020. “Responsible Transitions and Partnerships: Issues at Stake.” *Stopping as Success: Transitioning to Locally Led Development*. <https://www.stoppingassuccess.org/wp-content/uploads/2020/02/Thought-piece-Responsible-Transitions-and-partnerships-issues-at-stakev3.pdf>.
- 24 Howard Mollet and Donkin Laura. 2021. “Localisation and Humanitarian Action: Capacity-Strengthening and Localisation: Perspectives from CAFOD and Its Local Partners.” *Humanitarian Exchange*, no. 79.

and informed a set of recommendations.²⁵ In 2019, a consortium of humanitarian actors, along with Nigerian federal government actors, used the recommendations to develop an *Operational Framework for Local and International NGOs in Nigeria*, which was endorsed by the federal Ministry of Finance.²⁶ The *Operational Framework* laid out a vision of a humanitarian response in Nigeria “that is locally driven and fosters development,” and provided principles and key elements and characteristics. Notably, the *Operational Framework* laid out state government leadership in humanitarian response alongside capacity-strengthening provided by INGO and NNGO partners.

These commitments have begun to be reflected in humanitarian response planning. In the *Nigeria Humanitarian Response Plan 2021*, the Resident Humanitarian Coordinator called for “localis[ing] and adapt[ing] our actions to the immediate needs of the affected people” and for “strengthen[ing] the capacity of state and federal government to bring Nigeria’s considerable national resources to bear on crisis response.”²⁷ Calls for localization are also driven by activists and aid workers at the grassroots level within Nigeria. A 2019 editorial, titled “Localisation: We are frustrated, not stupid!” starkly noted the structural barriers to NNGOs in Nigeria realizing leadership roles within humanitarian response.²⁸

Explicitly localized projects with Nigerian health service provision have been on the rise, with such projects involving health agencies and taking place in states throughout Nigeria.²⁹ Notably, capacity-strengthening roles are not limited to programmatic capacities: An initiative in 2020 delivered trainings to Nigerian NNGOs on organizational development, strategic planning, networking, and diversification of funds.³⁰

“Ownership of humanitarian action by national and local actors, especially the government (local government taking the lead) supported by other local actors is the way to a quicker, effective, result driven and sustainable response to humanitarian crisis...”

“Inherent in this plan is that the international community in Nigeria will continue to strengthen the role of government counterparts and other local actors, including civil society and the private sector for humanitarian response.”

–Operational Framework for Local and International NGOs in Nigeria, 2019.

25 IFRC, SDC, OCHA, and Accelerating Localisation Through Partnerships Project. 2019. *Mission Report: Grand Bargain Localisation Workstream Demonstrator Country Field Mission to Nigeria*. 2019. <https://reliefweb.int/sites/reliefweb.int/files/resources/nigeria-mission-report-final%20%281%29.pdf>.

26 Accelerating Localisation through and Partnerships consortium Nigeria. 2019. *Operational Framework for Local and International NGOs in Nigeria*. 2019. <https://www.christianaid.org.uk/sites/default/files/2020-08/Operational%20Framework%20for%20Local%20and%20International%20NGOs%20in%20Nigeria.pdf>.

27 OCHA. 2021. *Humanitarian Response Plan: Nigeria, Humanitarian Programme Cycle 2021*. https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/ocha_nga_humanitarian_response_plan_march2021.pdf.

28 Listowell Efe Usen. 2019. “Localisation: We Are Frustrated, Not Stupid!” *Forced Migration Review*, 3..

29 For example: Ajibola Awotiwon et al. 2018. “Using a Mentorship Model to Localise the Practical Approach to Care Kit (PACK): From South Africa to Nigeria.” *BMJ Global Health* 3 (Suppl 5): e001079. <https://doi.org/10.1136/bmjgh-2018-001079>.

30 Elise Baudot Queguiner, Jubril Shittu, and Esther Christen. 2021. “Strengthening Local Actors in Northeast Nigeria: A Nexus Approach.” *Humanitarian Exchange* 79.

The Reproductive, Maternal, Newborn, Child, and Adolescent Health and Nutrition (RMNCAHN) Project

To work toward addressing the conflict-driven health crisis in Borno State, while adopting a localized approach that would strengthen public health systems within the State, in 2017, the Women's Refugee Commission (WRC) developed the RMNCAHN Project, with its cornerstone component, the Village Health Worker (VHW) Program. With coordination support from WRC, the RMNCAHN Project brought together five partners: The Borno State Primary Health Care Development Agency (BSPHCDA); M-Space; i+solutions; Mwada-Gana Foundation; and a long-term research consultant.

The overall goal of the RMNCAHN Project was to implement a community health worker program, the VHW Program, in selected areas of Borno State. The aim of the VHW Program was to increase demand for RMNCAHN services, while complementary interventions strengthened government provision of health services, in order to improve RMNCAHN health outcomes. The project developed two community health curriculums, linked to standards in community health programming while tailored to the Borno State context and communities, and a tailored monitoring system. The SPHCDA, with support from MGF, trained 219 VHWs in three local government areas, and by June 2021 VHWs had conducted more than 50,000 household visits.

An endline assessment carried out by the monitoring and evaluation (M&E) consultant with WRC suggested that the VHW Program was effective in increasing demand for health services. The VHW Program improved health-seeking at facilities through household visits providing health information and referrals. In addition, endline consultations with community members, including VHWs, indicated that the communities felt ownership and acceptance of the program.³¹ Ultimately, many of the VHWs transitioned into community health worker roles under the Community Health Influencers, Promoters, and Services (CHIPS) Programme, a national program that was rolling out in Borno State as the VHW Program was ending.

The RMNCAHN Partnership

Alongside the programmatic goals, the RMNCAHN Project had a process-related goal: to use a localized approach to the design, implementation, and learning of a community health worker program. In the role of consortium lead, WRC drafted the proposal, applied for and received project funds from the funder; WRC was therefore responsible for identifying partners and fulfilling sub-contracting to partners.

To that end, WRC identified and onboarded partners in keeping with the commitment to localization and advancing women-led organizations. WRC sought out and invited partners based on their technical added value to the consortium, with each partner contributing a specific skill set.³² In doing so, WRC applied the principle of "as local as possible, as international as necessary": specifically, it prioritized partners that were organizations or professionals currently based in Borno State; partners based elsewhere nationally in Nigeria were considered next; and partners based outside of Nigeria were included only if the targeted technical expertise could not be identified in

31 For results of the VHW Program, see: Women's Refugee Commission, *On the Frontlines of Community Health: An Endline Evaluation of a Village Health Worker Program in Borno State, Nigeria* (New York, NY, 2022). <https://www.womensrefugeecommission.org/research-resources/on-the-frontlines-ofcommunity-health-an-endline-evaluation-of-a-village-health-worker-program-in-borno-statenigeria>.

32 The SPHCDA agreed with WRC leading the process of partnership selection, with SPHCDA sign-off on partners. The donor did not have competitive bid process requirements. Formally, all partners were subcontractors of WRC, who took the lead on administrative and financial processes between the project and the donor.

Nigeria. WRC also prioritized women-led or women-majority organizations. Identifying local partners—which are not always as “visible” as international organizations—required careful partner mapping through meetings with a wide range of local stakeholders, taking significantly more time than if WRC had just onboarded international organizations into the consortium. The relatively long duration of the grant for humanitarian action (initially the grant was three years, but later it was extended to four years) and flexibility of the donor enabled WRC to carefully build this consortium inclusive of local partners that brought extensive local knowledge and expertise.

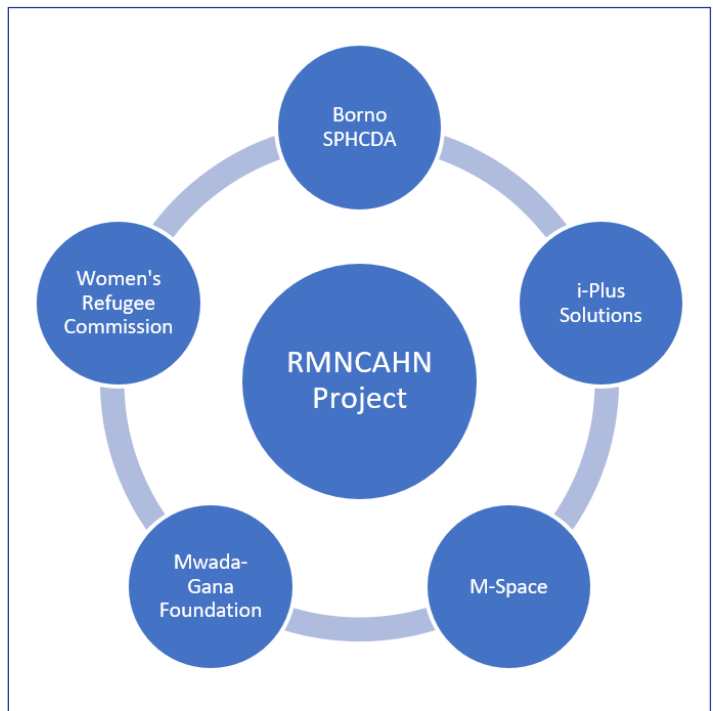
As WRC worked to onboard technical partners, the SPHCDA and WRC began the VHW Program material and curriculum co-development process. The VHW training curriculum was the first to be co-designed, as it served as a framework for the program overall. Two similar program curriculums from Nigeria—the CHIPS curriculum and a VHW Program implemented in neighboring Gombe State—were adapted to create the final VHW curriculum. The VHW curriculum also included technical inputs from a community health curriculum expert and from other VHW consortium partners. Program materials were co-developed in a similar fashion; using technical knowledge and expertise, consortium partners adapted existing frameworks to meet programmatic contextual needs.

As the Project progressed, the partners found that some decisions required expertise and inputs from multiple partners and had to be made collectively. (For instance: To what extent would the VHW curriculum be grounded in Nigerian minimum standards of primary health service provision versus international standards [where they differ]?) Meanwhile, throughout the process, WRC was continuously reflecting on potential power dynamics associated with the default financial and administrative structure of the partnership: Was WRC’s role as “consortium lead” affecting how partners were making decisions?

In the second year of implementation, WRC suggested, and VHW Partners agreed on, the need to explicitly describe the partnership approach and decision-making processes. This organic process of collaborative action and reflection led WRC to suggest the development of the VHW Partnership Model.

VHW Partnership Model Co-Design Process

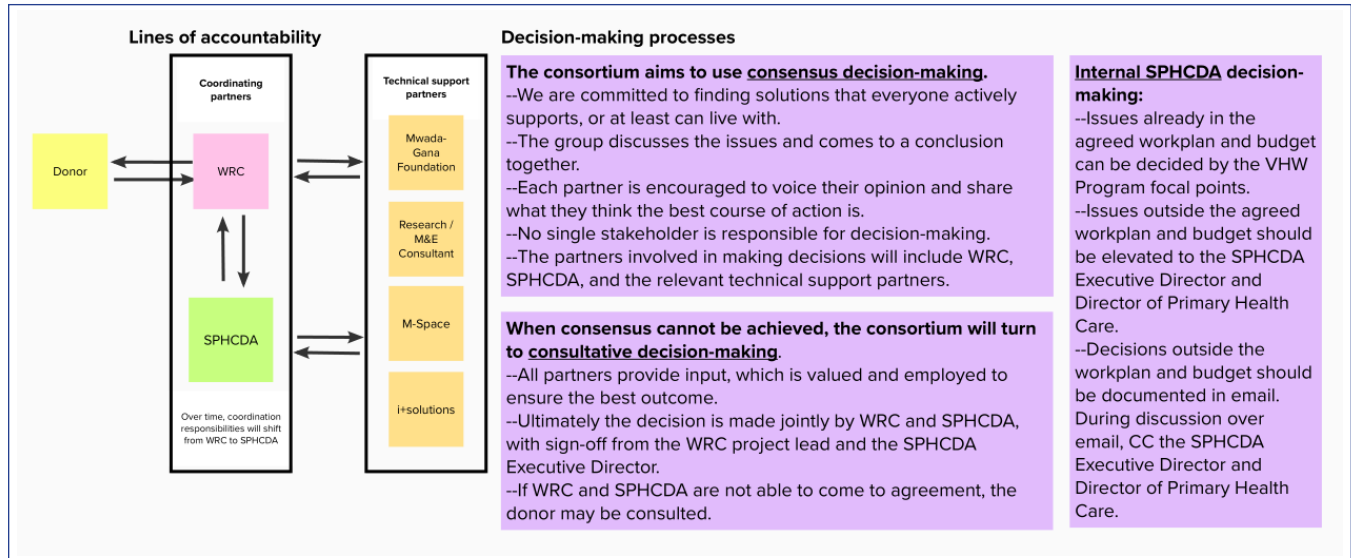
Once all the partners were onboarded, WRC proposed a partnership co-design process to co-define how the partnership would function in practice. First, WRC facilitated a collective process to update the project’s theory of change (TOC), drawing on discussions in which partners described what changes they wished to see and how they would be achieved. Then, partners discussed: How would decisions be made? WRC gathered inputs from discussions and used this information to develop an initial decision-making and partnership structure, which was presented to partners. Over the course of several working meetings, the decision-making structure was iterated and contextualized. WRC



facilitators presented a final version to the whole consortium, which discussed and then approved. The partnership model was finalized and added to the TOC.

VHW Partnership Co-Design Results

Figure 1: Partnership Model for the RMNCAHN Project



The key dimensions of equitable partnership, as identified by the VHW partners, were *decision-making*, *information-sharing*, and *accountability*. In terms of decision-making, the partnership approach was *consensus-based*, with decisions made jointly by all partners whenever possible. However, partners need to have access to key information to contribute to decisions in an informed way. Therefore, partners agreed that any information needed to make the decision would be made available to all partners via agreed platforms, such as email and Dropbox. Monthly meetings among all partners and quarterly strategic retreats, as well as bilateral and dedicated specialized meetings, would provide opportunities for partners to assess the information and discuss what decisions to make. In the case that a decision could not be reached by consensus, WRC and the SPHCDA would make the decision, using inputs from all partners. WRC and SPCHDA had *joint* primary decision-making roles because WRC was the consortium lead and tasked with fiscal responsibility and accountability toward the donor, while SPHCDA was the program lead and tasked with responsibility and accountability toward inhabitants of Borno State as to the services delivered. The model specified that if agreement could not be reached between WRC and the SPHCDA, the donor would be consulted; however, this was not needed as WRC and SPCHDA were always able to come to consensus.

External Evaluation of the Partnership Model

Methods for the Partnership Evaluation

After project partners designed the Partnership Model in August 2019, partners used it to guide project activities for 23 months. By mid-2021, partners wanted to learn how well it worked. WRC, in its role in the consortium as research and M&E lead, engaged an external evaluator to design and carry out an evaluation of the Partnership. The evaluation aimed to address the following questions:

1. How did consortium members experience and perceive the partnership model and approach of the RMNCAHN Project?
2. Did consortium members perceive the partnership model and approach of the RMNCAHN Project to strengthen the capacity of the government to meet its health objectives and to advance the long-term sustainability of community health programming? And of NGO partners to continue to support the government in meeting health objectives?
3. What recommendations did consortium members have to improve the partnership approach for similar projects in the future?

The external evaluation team designed methods and created an interview guide. The evaluation team, using expert-informant purposive sampling, invited all 20 key VHW Partnership members to participate in interviews for the evaluation.³³ The invited members were those who were the key personnel assigned to the RMNCAHN Project within each partner organization, and included seven government representatives, six NNGO representatives, and seven INGO representatives (four of whom worked for an organization with offices in Nigeria). All 20 respondents agreed and participated in in-depth interviews in April and May 2021. Researchers conducted interviews either in-person in Maiduguri, the capital of Borno State, or remotely via Skype.³⁴ Prior to each interview, evaluators administered a voluntary and informed consent form to obtain consent for participation and recording. The external evaluation team transcribed the interviews; used a qualitative comparative analysis methodology to synthesize data into key themes; validated the preliminary findings in a virtual meeting with VHW partners; and reported the findings in a full internal evaluation report and in this consolidated briefing.

Findings from the VHW Partnership Evaluation

Evaluation findings showed that VHW consortium partners held positive views of the partnership model co-designed and adopted by the VHW partners. When asked what they thought about decision-making processes, respondents described a decision-making process that was appropriate and backed up by sufficient information to support the decision-making process. Partners testified that they felt comfortable to express their opinions.

Respondents in the evaluation noted that the project design clearly delineated the scope of consortium partners' engagement on the project, with each partner having a clear and distinct role. Respondents in the evaluation thought that the composition of the project consortium was well organized, with each consortium partner leveraging their unique capacities to deliver on project objectives. This facilitated

³³ The evaluation methods were submitted to the Borno State Ministry of Health Ethical Review Committee, which provided ethical review and approval for the study methods.

³⁴ The evaluation took place during the COVID pandemic. Therefore, in-person interviews followed COVID-19 safety precautions of physical distancing and use of face coverings.

effective decision-making because partners were placed to make strategic decisions that affected their scope of operations.

Respondents noted that communication and coordination efforts were well planned from the beginning and were continuously strengthened throughout the project. WRC and each VHW consortium member met bilaterally on a biweekly or monthly basis. The partners also held monthly consortium meetings to share information and coordinate on next steps, and convened quarterly strategic retreats to discuss project progress, identify challenges, develop solutions, and make collaborative decisions. This structure provided multiple opportunities to maintain effective communication and ensure robust coordination efforts. Local partners were also able to organize meetings in Maiduguri and collaborate on project activities. This situation strengthened collaboration among partners and built closer working relationships. One respondent, however, noted that such a collaborative approach demanded a significant time just in communications, and suggested that a more efficient communications platform should be identified.

Respondents commended the active involvement of the Borno State government in the implementation of the VHW program package and noted that it highlighted the success of consortium partners in promoting a sense of ownership. The government did not ultimately allocate its own funding to continue the VHW program, which was the notable drawback identified from evaluation; however, transitioning the VHWs into the CHIPS program offered a measure of sustainability.

Recommendations for the VHW Partnership

The evaluation found that most respondents had positive experiences of the RMNCAHN Project partnership approach. However, some learnings emerged from the findings.

Pursue additional strategic advocacy engagements. With the current humanitarian situation in Borno State, there are competing priorities for limited state resources. Future project engagements should explore targeting the annual state budget allocations to the health sector through meetings with state legislators, committee members, and community leaders. Amplifying the voices of NNGOs, community leaders, and target beneficiaries will elevate their priorities and center the attention of the state government. A strategic communication campaign could be useful in developing and disseminating human interest stories showcasing both the benefits of investments in community health programs in Borno State and the human and financial costs of neglecting them.

Adopt a data-driven approach to measuring equitable partnerships. The project gathered information related to the RMNCAHN Project implementation; however, it did not collect measures on indicators of equitable partnership. An alternative partnership approach for future iterations of the project should identify data-driven processes to promote strategic learning about the partnership, with a view to ascertaining alternative options that encourage action learning and foster active collaboration among partners. It would have been useful to adopt a more data-driven approach to adaptive management for project course correction.

Implement domesticated health policies and domesticate other national health policies using learning from the RMNCAHN Project. The domestication of national health policies in Borno state, including the national task-shifting/task-sharing policy, can serve as a roadmap in sustaining the achievements of the VHW Program. Although the consortium engaged government (Federal Ministry of Health and SHPCDA) on the policy front through M-Space, Borno State's implementation of domesticated policies and domestication of other national health policies remains a challenge. The tools developed for the VHW Program can inform the CHIPS project to facilitate the domestication of national health policies.

Conclusions

The future of humanitarian aid and response is for it to be led and managed by agencies and actors with local and place-based affinities to the conflict or crisis. The federal government of Nigeria has recently made significant commitments to such localized humanitarian action. Implementing localization via equitable partnerships at the state level in Nigeria will require structures and partnership approaches that leverage what has been learned.

Based on the experience with and learnings from the RMNCAHN, the consortium recommends the following practices when international humanitarian actors partner on humanitarian projects to achieve health objectives in humanitarian and displacement settings in Nigeria, many of which align with and validate the recommendations within the *Operational Framework for Local and International NGOs in Nigeria*.

Recommendations to project designers:

- Ensure that a state government agency is a leading partner on the project. Facilitate capacity-sharing across NNGOs and state government by engaging NNGO partners in working with the government to meet project goals.
 - » Ensure sufficient, qualified staff allocations within government and NGOs. In the RMNCAHN Project, each state government role was “mirrored” by a role in a partner INGO or NNGO.
- Engage all government, NNGO, and INGO partners at the concept and proposal development stage.

Recommendations to partners during the project:

- Conduct a partnership co-design process during conceptualization and proposal development, or as early as possible in the project cycle, to achieve consensus on governance dimensions of the project, especially decision-making modalities, communication, accountability, and financial and administrative responsibilities.
 - » Transparently discuss which partner will take on roles/responsibilities of financial and administrative compliance related to the donor, and how this might affect power dynamics within the partnership.
 - » Establish robust communication practices.
 - » Adopt tools and technologies that promote transparent synchronous and asynchronous communication.
- Proactively address inclusivity of tech-based communication tools.
- Co-develop a capacity-strengthening plan.
 - » Ensure the capacity-strengthening plan includes elements that enable organizational strengthening of partners: e.g., donor relations, financial administration.
- Clearly specify scopes and responsibilities of each partner.

Recommendations for federal-level actors in Nigeria:

- Ensure that future iterations of the *Operational Framework for Local and International NGOs in Nigeria* include guidance to promote gender-responsive localization in humanitarian health programs in Nigeria.
- Continue to support space for NNGO, civil society, and community-based organizations and groups to participate in and lead their own responses.
- Increase government funding allocated to community health programs in humanitarian settings in Nigeria.
- Increase government funding to support humanitarian projects with localized modalities.

Annex 1: Acronyms and Abbreviations

BSPHCDA	Borno State Primary Health Care Development Agency
DHS	Demographic and Health Survey
INGO	International nongovernmental organization
NNGO	National nongovernmental organization
RMNCAHN	Reproductive, maternal, newborn, child, adolescent health and nutrition
IFRC	International Federation of Red Cross and Red Crescent Societies
IASC	Inter-Agency Standing Committee
SFH	Society for Family Health
UN	United Nations
VHW	Village Health Worker
WRC	Women's Refugee Commission

Annex 2: Glossary

Borno State Government: The group of agencies and government staff that administer government processes and services in Borno State.

Localization: As defined by IFRC, the process of recognizing, respecting, and strengthening the independence of leadership and decision-making by national actors in humanitarian action, in order to better address the needs of affected populations.

RMNCAHN Project: The set of interventions implemented by the RMNCAHN Consortium, including the Village Health Worker Program and several complementary interventions, including provider training, supply chain strengthening, an emergency transport system, and policy support.

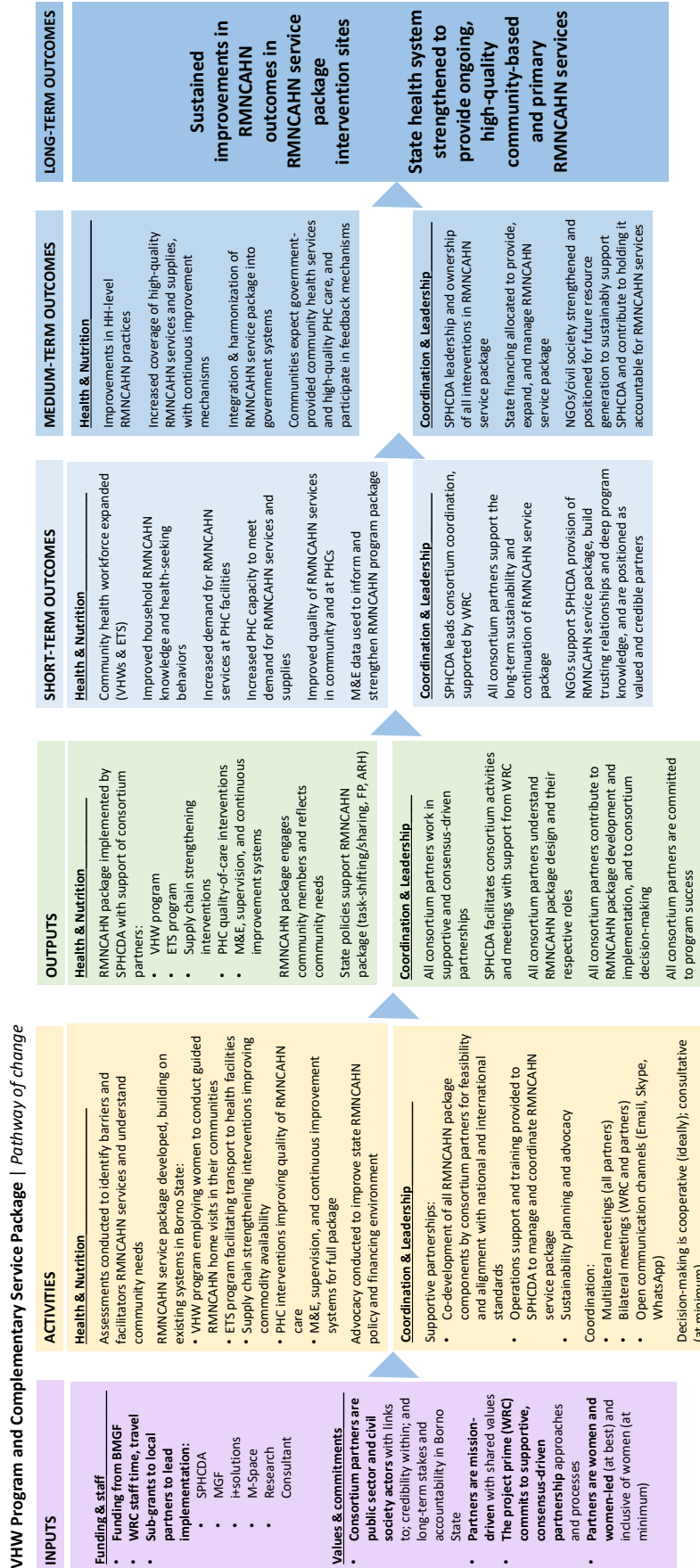
RMNCAHN Consortium: The RMNCAHN Consortium was a group of five partner organizations that worked in Borno State, Nigeria, to deliver a community health worker program and complementary interventions.

RMNCAHN Partnership Model: The RMNCAHN Partnership model was an egalitarian partnership model using consensus-based decision-making.

VHW Program: The Village Health Worker Program trained and deployed a corps of community health workers. It was the cornerstone of the RMNCAHN Project.

WRC: The Women's Refugee Commission is a nongovernmental organization based in the United States, staffed by US citizens, and funded through grants mainly from the US government, US private foundations, and European government

Annex 3: VHW Program and Complementary Service Package Theory of Change



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