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LEARNING BRIEF | AUGUST 2026

Lessons from the TSTS Investment in Kaduna and Kano States

Strengthening Primary Health Care through Networks of Care (NoC)

SUMMARY

Between October 2025 and June 2026, the Task Shifting Task Sharing (TSTS) investment integrated a Network of Care approach into existing clinical mentorship, supervision, quality improvement, and government management structures in Kaduna and Kano States. The approach was introduced because improving provider skills was not enough: health workers who had been trained and mentored still met delays caused by weak coordination across levels of care. This brief does not present the Network of Care as a separately evaluated intervention. Rather, it documents how Network of Care principles were integrated into an existing task-shifting investment, what implementation experience revealed, and what this means for institutionalization and scale. It is intended for state and LGA health managers, implementing partners, and funders planning to adapt or scale the approach.

PROJECT

Task Shifting Task Sharing

Implementing States
Kaduna and Kano, Nigeria

Funded by:
Gates Foundation

Timeline
2024 - 2026

222 primary health care facilities:
77 in Kaduna across 9 LGAs,
145 in Kano across 26 LGAs

What was task-shifted
Basic emergency obstetric and newborn care, postpartum hemorrhage management using the E-MOTIVE bundle, newborn resuscitation, and postpartum family planning — shifted to CHEWs and JCHEWs

Implemented in partnership with

- Impact Catalysts
- Kaduna State Ministry of Health
- Kaduna State Primary Health Care Board
- Kano State Ministry of Health
- Kano State Primary Health Care Management Board

BACKGROUND

The Task Shifting Task Sharing (TSTS) investment sought to improve maternal, newborn, and child health outcomes by strengthening the competencies of frontline primary healthcare (PHC) workers in Kaduna and Kano State. However, experience from implementation demonstrated that improving provider skills alone was insufficient to achieve sustained improvements in service delivery. Effective care also depended on stronger coordination between communities, PHC facilities, referral hospitals, and health system managers.

Despite improvements in provider competency, early implementation highlighted persistent system bottlenecks that limited the ability of trained providers to deliver quality care. Weak referral pathways, limited communication between PHC facilities and referral hospitals, inconsistent clinical feedback, and fragmented coordination across levels of care often delayed appropriate management of complications. These challenges meant that strengthening provider skills alone was insufficient to improve client outcomes.

A **Network of Care** was introduced to strengthen the relationships, communication, and coordination needed to ensure that clients receive timely, continuous, and quality care across the health system. A Network of Care is an interconnected web of health facilities, community actors, and health workers. It coordinates resources and multidisciplinary teams to deliver comprehensive, person-centered care spanning from the community up to higher-level facilities. This approach was embedded within the investment's mentorship and systems strengthening model, bringing together frontline providers, mentors, referral hospitals, communities, and health managers into a coordinated system with shared accountability. By leveraging the current health system structure, this approach connected existing actors to ensure clients received timely, continuous, and quality care, while also strengthened existing relationships, communication, and referral pathways to improve continuity of care.

> *The mentors were experienced senior midwives and nurses, including active and retired, selected to provide structured clinical mentorship. They were not LGA administrative authorities, although the mentorship process was implemented in coordination with relevant state and LGA health officials.*

Within the broader TSTS investment, the Network of Care served as the systems-strengthening mechanism that enabled trained providers to function more effectively. It complemented competency-based training and mentorship by strengthening referral coordination, improving provider communication, reinforcing supportive supervision, and creating stronger links between PHC facilities, referral facilities, and communities.

Together, these interventions improved facility functionality and helped translate provider competency into better service delivery.



Health Awareness Talk at Rahama Facility Bebeji, Kano State

IMPLEMENTATION APPROACH

The TSTS investment adopted a systems-strengthening approach that integrated Network of Care principles into existing government structures and routine service delivery processes. Rather than implementing the Network of Care as a standalone activity, TSTS integrated its principles across all

improvement, referral strengthening, and state performance review processes were deliberately used to improve coordination between facilities, providers, and managers. This integration ensured that Network of Care principles became part of routine service delivery rather than an additional project structure. Figure 1 summarizes the design: the actors the network connects, how referrals and feedback flow between them, and the three engines through which it operates.

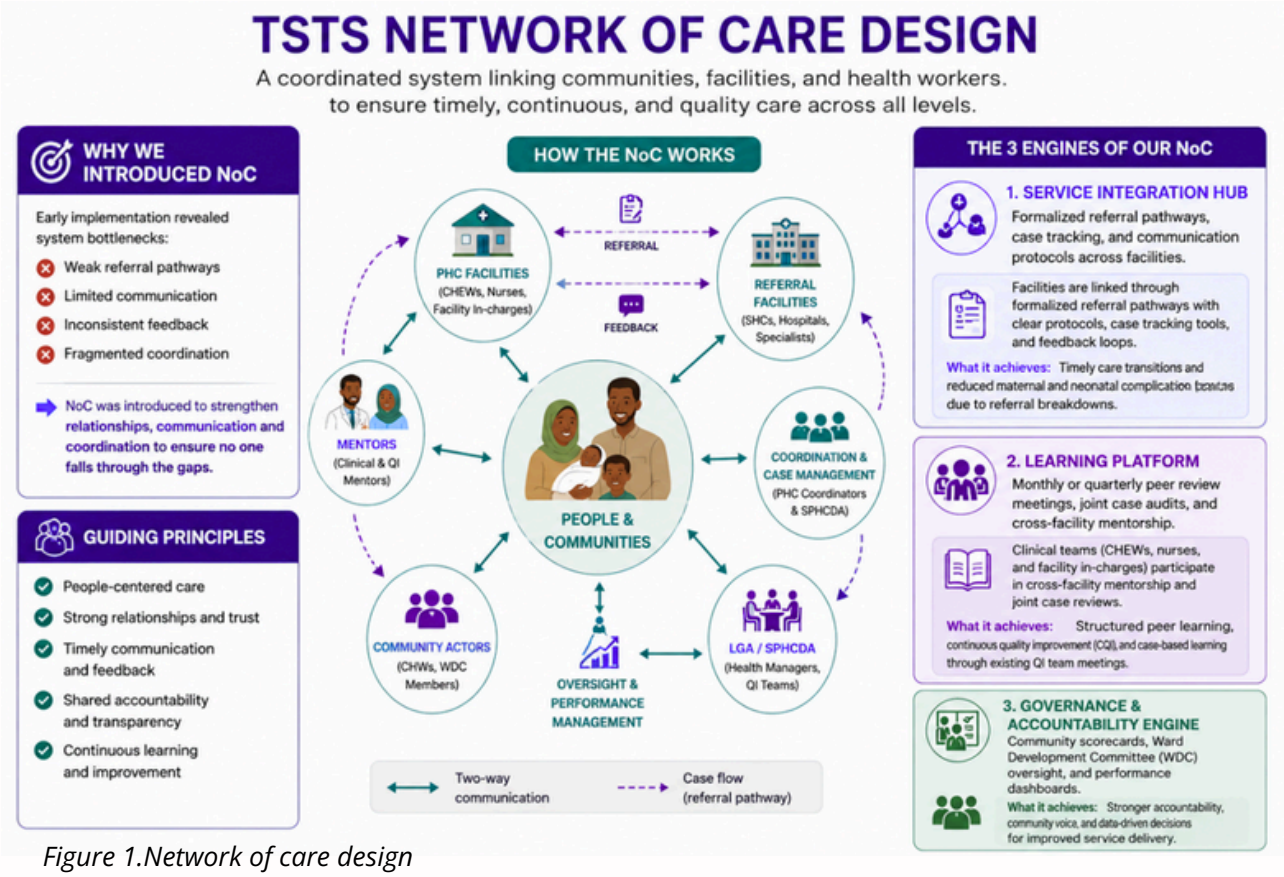


Figure 1.Network of care design

The Network of Care approach responded to practical coordination gaps between supported PHCs and higher-level referral facilities. At the start of implementation, referral relationships were often informal and inconsistent. PHC providers did not always know whom to contact at the receiving facility; advance notification of referrals was limited, and feedback on the management and outcomes of referred clients was not routinely provided. This affected continuity of care and limited opportunities for frontline providers to learn from referral cases.

TSTS did not establish a separate Network of Care structure. Instead, it used the clinical mentorship platform to strengthen connections among supported PHCs, mentors, referral facilities, and government managers. Supported PHCs were linked to designated referral facilities, and providers were encouraged to establish direct referral contacts, notify receiving facilities in advance where possible, document referrals, and seek feedback on referred clients. Mentors supported this process during routine facility visits by reviewing referral cases, reinforcing appropriate referral decisions, and helping providers address communication or coordination barriers.

> *"Regarding referrals, there is a referral slip that we sign, and she always encouraged us to obtain feedback from the General Hospital after referring clients. She consistently reminded us to ensure that referral feedback was returned to the facility.*
> *— OIC, FGD_KD OIC_SOZ (Kaduna)*

In practice, this meant ensuring that PHC providers knew the appropriate contact persons at referral facilities and could communicate with them before or during a referral. Mentors also served as a bridge between frontline providers and more experienced clinicians, supporting clinical decision-making, escalation of complicated cases and follow-up after referral. During subsequent mentorship visits and review meetings, referral cases could be discussed to identify what worked, what caused delays and what needed to change.

Mentor cluster meetings, zonal learning sessions and mentorship review meetings provided additional platforms for providers and managers to discuss difficult cases, examine recurring referral bottlenecks, and agree on practical solutions. Referral performance and service-delivery constraints were also discussed during supportive supervision, quality-improvement processes, and Pause and Reflect sessions. These mechanisms helped move referral coordination from an isolated transaction toward a continuing relationship among providers, facilities, and health-system managers.

Through this approach, PHC providers had clearer points of contact at referral facilities, greater access to mentors for clinical guidance, and more opportunities to receive feedback and learn from referred cases. The approach also strengthened shared problem-solving and accountability across facilities

What We Observed

The Network of Care was built into mentorship and supervision during implementation, so it was not tracked with its own outcome indicators. This section therefore draws on implementation records, routine referral data where available, and what providers, mentors, and managers reported. It shows how widely the approach was applied and what changed in practice, rather than measuring its effect on health outcomes.

222

PHC facilities connected to designated referral facilities through the TSTS implementation approach

59

mentorship visits that incorporated referral review

These figures describe the scale of implementation rather than measured outcomes. They show how Network of Care principles were built into routine mentorship and referral-related activities across TSTS-supported facilities.

Referral Practice

In Kaduna, 223 postpartum hemorrhage cases were identified at supported PHCs between October 2025 and June 2026; 192 were managed on site and 31 were referred. Stabilizing most cases at PHC level and referring those that needed higher-level care is the kind of decision-making the Network of Care was designed to support, through mentor guidance and clearer contact with referral facilities.

A Referral in Practice

A newborn presented at a Manchok PHC with jaundice. The mentee gave pre-referral treatment using the IMCI chart booklet, then called the LGA RH Coordinator, who came to the facility, confirmed the case, and telephoned the secondary facility to coordinate the transfer. The baby was referred the same day. Before the mentor's next scheduled visit, the facility called her with the outcome: the baby had survived. The sequence is the one mentors taught: stabilize first, involve the LGA coordinator, agree on the receiving facility by phone, and close the loop by following up on the outcome rather than assuming it.

KEY LESSONS

Network of Care can be embedded within existing government systems through clinical mentorship

One of the strongest lessons from the TSTS investment is that Networks of Care do not require separate coordination structures. Instead, NOC principles can be woven into existing clinical mentorship, supportive supervision, cluster learning sessions, state performance reviews, and other routine management processes. Clinical mentorship provided a practical platform for strengthening relationships between providers, reinforcing referral practices, reviewing client management, and jointly addressing system bottlenecks. Over time, these interactions extended beyond clinical coaching to strengthen communication, referral coordination, peer learning, and shared accountability across facilities and levels of the health system. Continuous engagement with state and LGA leadership further strengthened ownership and demonstrated that Networks of Care can be integrated into routine government systems rather than maintained as a parallel project process.

Strong provider relationships are as important as referral tools

While referral forms and guidelines remain important, implementation demonstrated that functional referral systems depend primarily on trusted relationships between providers. Regular interaction between PHC staff, mentors and referral facilities improved communication, encouraged advance notification of referrals, strengthened referral feedback and increased provider confidence in managing complicated cases.

Continuous learning strengthens health system performance

Routine mentor review meetings, peer learning platforms and Pause and Reflect sessions created opportunities for health workers, mentors and government teams to review referral performance, identify implementation challenges and develop locally owned solutions. These collaborative learning platforms reinforced quality improvement while strengthening accountability across all levels of care.

Network of Care strengthens coordination beyond referrals

Implementation demonstrated that the Network of Care approach extends beyond referrals. By strengthening communication, collaborative decision-making and continuous learning, the approach contributed to improved coordination of care, stronger provider confidence and a culture of shared problem-solving across supported facilities.

Build referral indicators into the network from the start

Because the Network of Care was embedded as TSTS progressed, it was not tracked with dedicated indicators, and its contribution is visible mainly through implementation records and what providers and mentors reported. Future investments should define a small set of referral indicators at design stage — such as referrals made, advance notification, referral completion, and feedback received — and integrate them into routine information and performance-review systems.

GAPS REQUIRING FURTHER ATTENTION DURING ADAPTATION AND SCALE-UP

The TSTS experience also identified system gaps that future efforts to adapt or scale the Network of Care approach will need to address:

- Referral documentation and feedback - standardize tools and integrate follow-up into mentorship and supervision.
- Emergency transport - connect referral coordination with functional community and state emergency transport arrangements.
- Commodity and equipment shortages - include referral-facility readiness in Network of Care planning.
- Variable implementation capacity -adapt the model to LGA and facility readiness.
- Weak routine referral data - integrate priority referral indicators into routine information and performance-review systems.

Addressing these constraints will require continued investment in health system strengthening beyond provider training alone.

INSTITUTIONALIZATION AND SUSTAINABILITY

The TSTS experience demonstrates that Networks of Care are most sustainable when embedded within routine government health systems rather than implemented as standalone project interventions. By integrating referral coordination, clinical mentorship, collaborative learning, and quality improvement into existing supervisory and management structures, the investment strengthened system functionality without creating parallel coordination mechanisms.

This approach not only improved collaboration between providers and facilities but also reinforced government ownership by leveraging existing PHC management platforms, mentorship structures, and state performance review processes. As a result, many of the practices introduced through TSTS can continue beyond the life of the project with minimal additional investment.

Implementation highlighted the importance of strengthening the interface between communities and health facilities. While TSTS primarily focused on facility-level capacity strengthening, mentorship and referral coordination, the experience demonstrated that stronger engagement with community structures such as Ward Development Committees could further improve referral completion, community accountability and continuity of care.

Looking ahead, Kaduna and Kano States are well positioned to institutionalize these approaches within routine PHC management systems. Future investments, including the Community Access to RMNCAH+N Innovations and Services (CARMNIS), can build on this foundation by expanding community-facility linkages, strengthening referral coordination, and further embedding Networks of Care as a core component of resilient, people-centered primary health care.



FGD Session with Mentees in Gezewa Cluster, Kano



Health Awareness Talk at Rahama Facility Bebeji, Kano State



FGDs with OICs in Nassarawa Cluster, Kano State.



FGDs with Mentees in PHC Hanwa, Sabon Gari, Kaduna

References

1. Clinical Mentor P4, focus group discussion, FGD_KD_CLINICAL MENTORS_IBR, Kaduna.

The Task-Shifting/Sharing initiative, implemented in partnership with Impact Catalysts and state governments, strengthens primary health care services in Kaduna and Kano and seeks to improve health workforce distribution and service quality in rural and underserved areas. The initiative takes a holistic strategy to supporting current health systems and personnel, providing high-quality, sustainable, and gender-responsive health care for all.

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