Overview of Niger State iCCM programme and RAcE project

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Niger State
Outline

• Introduction
• Project goal, objectives and strategy
• Approach, methodology and achievements
• Sustainability plan
• Lessons learnt
• Challenges
• Recommendations
Introduction
Nigeria country profile

Location: West coast of Africa
Capital: Abuja
Land area: 923,768 sq km
Population: 186 million
Major languages: English (official), Yoruba, Igbo, Hausa
Religions: Christianity, Islam, Indigenous beliefs
Life expectancy: 52 years
Birth rate: 37.3/1000 (2016 est)
Death rate: 12.7/1000 (2016 est)
MMR: 814/100,000 live births
U5 mortality: 128/1000 live births
IMR: 69/1000 live births
Nigerian health system

• Health is on the concurrent list in Nigeria and is the responsibility of all tiers of government
  o **Federal government** - coordinates tertiary health care provided by university teaching hospitals and federal medical centres
  o **State government** - manages secondary healthcare provided by general hospitals
  o **Local government** - is responsible for primary healthcare, though regulated by the federal government through the NPHCDA

• Private healthcare providers have a visible role to play in healthcare delivery
**Niger State profile**

**Niger State**: located in Nigeria’s North Central Zone  
**Land area**: land mass of 76,263 km²  
**Total population**: 5,586,003 (projected 2017)  
**Literacy rate**: under 50% of adult population cannot read  
**U5 mortality**: 100 per 1,000 live births  
**Health seeking behaviour**:  
  - Fever 38%  
  - Diarrhoea 42%  
  - ARI 29%  
  - Children fully immunised for age: 23%  
  - GAM: prevalence 6.1%  
  - SAM: prevalence: 0.5%  
  - MAM: prevalence: 5.6%
iCCM in Niger State (RAcE)

- Total population: 1,377,395
- Population of 2-59 months: 275,479
- Population of 2-59 months in HTR (55%): 161,513 (projected 2014 population)

Map of Niger State showing the six RAcE intervention local government areas
Project goal, objectives and strategy
The goal of the RAcE programme is to contribute to the reduction in under-five mortality and morbidity among children (2-59 months of age) thereby accelerating progress towards the post-2015 health and development agenda.

Four key strategic outcomes:

SO1: Increased access to iCCM services
SO2: Improved performance of CORPs
SO3: Strengthen links between iCCM services and communities to increase demand
SO4: Strengthen FMoH and SMoH capacity to support and sustain iCCM scale-up

Objective 1: Increase access to correct diagnosis, treatment and referrals for malaria, pneumonia and diarrhoea at the community level
Objective 2: Stimulate policy review and regulatory update on disease case management in countries with high health burden and low health systems at community level

Aligns with the national iCCM Policy which mandates a state-led implementation of iCCM, with defined roles for SMOH, LGAs, PHC teams, community members and implementing partners.

RAcE Conceptual Framework

Aligns with the national iCCM Policy which mandates a state-led implementation of iCCM, with defined roles for SMOH, LGAs, PHC teams, community members and implementing partners.
Approach and methodology

- Wash your hands and child’s hands with soap after using the toilet.
- If your child has diarrhoea, give enough fluids.
- Take your child to the nearest CORPs.
Thematic areas

Service delivery
- SO1: Increased access to iCCM services
- SO2: Improved performance of CORPs

Demand creation
- SO1: Increased access to iCCM services
- SO3: Strengthen links between iCCM services and communities to increase demand

Commodity logistics management
- SO1: Increased access to iCCM services
- SO4: Strengthen FMoH and SMoH capacity to support and sustain iCCM scale-up

Monitoring, evaluation and operations research
- SO4: Strengthen FMoH and SMoH capacity to support and sustain iCCM scale-up
- SO2: Improved performance of CORPs

Supervision and quality of care assessment
- Training and kitting of CORPs
- Supervision and quality of care assessment

Visiting and community sensitisation and dialogues, social mobilisation
- Community sensitisation and dialogues, social mobilisation

Visibility materials for CORPs

Equipment and commodities supply pipeline monitoring

Mentoring of SMOH on iCCM commodity LMIS

Routine monitoring, data management and evidence generation

Using data to improve quality of care
Inception and start-up process

Stakeholder engagement

Baseline survey

Mapping of hard-to-reach communities and health facilities

Development of iCCM Decision Tree, implementation plans, tools and roll out

Selection and validation of CORPs and supervising health facilities
### Description of the cadre of workers delivering iCCM services

<table>
<thead>
<tr>
<th>Name of cadre</th>
<th>• CORPs and CHEWs</th>
</tr>
</thead>
</table>
| Size of cadre in project LGAs | • CORPs: 1,320  
• CHEWs: 154 |
| Niger state  
Literacy/education level | • No education: Female 62%, Male 40% |
| Salaried, incentive worker,  
or volunteer | • CHEWs are salaried  
• CORPs are volunteers |
| Distance from health facility | • Communities >5km from the nearest health facility |
| CORP selection criteria | • literate  
• lives in the community  
• nominated by the community  
• willing to serve as a volunteer |
Approach and methodology
iCCM core interventions

<table>
<thead>
<tr>
<th>Malaria case management</th>
<th>Pneumonia management</th>
<th>Diarrhoea</th>
<th>Severe illness</th>
<th>Malnutrition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnosis:</strong> malaria RDTs</td>
<td><strong>Diagnosis:</strong> respiratory timers</td>
<td><strong>Treatment:</strong> zinc and low osmolarity ORS</td>
<td><strong>Refer to health facility</strong></td>
<td><strong>Screen all cases</strong>&lt;br&gt;<strong>Refer RED on MUAC to health facility</strong></td>
</tr>
<tr>
<td><strong>Treatment:</strong> with ACTs</td>
<td><strong>Treatment:</strong> amoxicillin dispersible tablets</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Capacity building

- Orientation of managers on iCCM
- Training of CORPs
- 1,689 CORPs trained, 1,504 kitted
- Training of CHEWs
- 154 CHEW supervisors
- Retraining of CORPs
- 1,320 CORPs retrained on iCCM
- Training of CHEWs on IMCI skills
- 156 CHEWs
CORP supervision

- Each CHEW oversees 7-10 CORPs and has a schedule to see 3-4 CORPs per month.
- Each CORP gets at least one supervision contact with CHEW per quarter.
- CHEWs are paid transport and lunch allowance for each visit.
- Weak CORPs identified by CHEWs are supervised more closely until skills improve.

Monthly

- Each CHEW oversees 7-10 CORPs and has a schedule to see 3-4 CORPs per month.

Monthly

Initially monthly after training, then quarterly

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Quality of care

• CORP clinical competence is monitored biannually and weak CORPs are identified and closely mentored to improve their skills

• CORPs receive at least one supervision every quarter

• Quarterly mentoring and coaching of CORPs are conducted by supervisors at the health facility
Approach and methodology

Monitoring and evaluation
<table>
<thead>
<tr>
<th>Sn</th>
<th>Indicator</th>
<th>Result (Oct 2014 - July 2017)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No. of cases of fever among children 2-59 months tested with an RDT</td>
<td>309,571</td>
</tr>
<tr>
<td>2</td>
<td>No. of cases of cough of difficulty with breathing among children 2-59 months old with a high respiratory rate for age treated with amoxicillin</td>
<td>58,849</td>
</tr>
<tr>
<td>3</td>
<td>No. of cases of diarrhoea among children 2-59 months old treated with ORS and Zinc</td>
<td>199,429</td>
</tr>
<tr>
<td>4</td>
<td>No. of cases of confirmed malaria (positive RDT) among children 2-59 months old treated with ACTs</td>
<td>301,359</td>
</tr>
<tr>
<td>Percentage</td>
<td>Achievement</td>
<td>Target</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------</td>
<td>--------</td>
</tr>
<tr>
<td>% of CORPs who correctly count respiratory rate</td>
<td>76%</td>
<td>85%</td>
</tr>
<tr>
<td>% of CORPs who demonstrate correct knowledge of management of sick child case scenarios</td>
<td>67%</td>
<td>85%</td>
</tr>
<tr>
<td>% of CORPs who completed a clinical assessment during the prior 6 months where a sick child visit or scenario was...</td>
<td>69%</td>
<td>80%</td>
</tr>
<tr>
<td>% of trained supervisors that provided routine supervision on data quality and stock management within the last quarter</td>
<td>57%</td>
<td>85%</td>
</tr>
<tr>
<td>% of iCCM trained CORPs with no stock outs (of more than 7 days) of key commodities within the last 3 months...</td>
<td>91%</td>
<td>85%</td>
</tr>
</tbody>
</table>
Monitoring and evaluation activities

• Routine collection and collation of service utilisation data occurred monthly
• Coordination platforms established for data review and feedback at the:
  o LGA level between CHEWs and iCCM focal persons
  o State level between iCCM focal persons and State iCCM coordinator/project office
• Sampled register reviews used to identify capacity gaps amongst CORPs and to institute correction
• Periodic mentoring, monitoring and supervision of LGA iCCM focal persons, CHEWs and CORPs by SMoH and RAcE project team
• Data quality assessments with TA from ICF
Project monitoring

- Bi-annual monitoring
- Quarterly
- Monthly

WHO/MC

National

FMoH

State

SMoH/SPHCDA

LGA

LGA Team (iCCM Focal person, HE and M&E)

Health facility

CORPs
Approach and methodology

Demand creation
Demand creation strategy and activities

- **Targeted advocacy to key stakeholders:**
  HCH, ED SPHCDA and directors of the SMoH, emirs and district heads and LGA chairmen and religious leaders

- **Community mobilisation:**
  Through community dialogues, community sensitisation and engagement using social mobilisers

- **Mass media:**
  Production of IEC materials for BCC, radio jingles and public announcements to increase demand for and uptake of iCCM services

- **Building partnerships:**
  With other related projects and organisations to promote iCCM
Approach and methodology

Health system strengthening and coordination, commodity and logistic supply
Coordination platforms

Sub-committee leads:
1. ACRM-UNICEF
2. M&E - PMI/USAID
3. PISRO - WHO

Sub-committees:
1. Advocacy, communication and resource mobilisation (ACRM)
2. M & E
3. Programme implementation and state roll-out (PISRO)

National iCCM Task Force
Co-chaired by FMoH, NMEP and NPHCDA

State iCCM Task Force

LGA Coordination and review meeting

Members include PMI/USAID, WHO, UNICEF, implementing partners, NPHCDA, Child Health, Nutrition Unit, FMOH

Co-chaired by SPHCDA SMOH. Members include Ministry for LG, Ministry of Information

Chaired by DPHC. Members include LGA iCCM FP, HE, M&EO, OICs
Commodity and logistic supply

- iCCM commodity logistics was built on the existing system in the state and was state-led. Tools were adapted and printed for use
- State Logistics Officer and iCCM focal persons, CHEWs and officers-in-charge of supervising facilities were trained on iCCM Logistics Management Information System
- The RAcE project supported procurement and supply of commodities to the state stores; thereafter distribution plans are developed by the State Logistics Officer with support from project staff
- Periodic monitoring and mentoring of SHF workers on correct iCCM LMIS reporting
- Commodity pipelines were regularly monitored to maintain an unbroken supply chain and inform distribution
- Procurement and distribution of 1,500 medicine boxes for kitting of trained CORPs
Sustainability plan
Niger State Sustainability Roadmap and Transition Plan was developed using a consultative and participatory approach. A TWG was constituted for this purpose.

<table>
<thead>
<tr>
<th>Major thrusts of the roadmap/plan</th>
<th>Transition strategy 1</th>
<th>Transition strategy 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Improve quality of iCCM services</td>
<td>• Capacity building for SMoH and other key stakeholders on program management, planning and budgeting</td>
<td>• Advocacy for resource mobilisation for iCCM drug supply, service delivery and support activities</td>
</tr>
<tr>
<td>• Increase in access to iCCM services</td>
<td>• Support MoH in annual operational plan development and budgeting</td>
<td>• Hands on mentoring and coaching</td>
</tr>
<tr>
<td>• Strengthening linkages between iCCM services and communities</td>
<td>• Joint planning and implementation of activities</td>
<td>• RAce will wean off all activities to the state and assume supervisory roles</td>
</tr>
<tr>
<td>• Strengthening national systems to support, sustain and scale-up iCCM</td>
<td></td>
<td>• Proposal of state iCCM structure for the project take over</td>
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</tbody>
</table>
Challenges and lessons learnt
Challenges and solutions

• The need to ensure good quality continuum of care was identified during implementation; the project trained all supervising CHEWs on IMCI skills

• Involvement of health workers (CORPs supervisors) in multiple activities e.g. immunisation, LLIN campaigns, etc. addressed through better planning and coordination with other programmes

• Poor attitude of health workers towards supervision. Close monitoring and supervision of supervisors

• Few female eligible volunteers as CORPs and relocation of some of the few trained due to marriages

• Poor communication network in project communities
Lessons learnt

• CORPs have the capacity to treat malaria, pneumonia and diarrhoea when given adequate supervision
• Provision of iCCM services requires an effective logistic supply system
• ICCM is accepted and well embraced by all project communities
• Sharing best practices across LGAs/communities supports the delivery of quality services and resource mobilisation
• Data management set up at the onset of a project lead to effective data management
• ICCM was accepted and embraced by all project communities
Recommendations

• Meaningful, transparent and empowering engagement should commence for effective community resource mobilisation and sustainability of iCCM

• The success of any intervention does not lie in the resources available but in the resourcefulness of partners and government personnel

• Community sustainability of iCCM lies in the ability of community members to own the programme from the very beginning by carrying out meaningful engagement, sharing community/LGA performance score card, commending positive efforts and allowing the community to take the driver’s seat while providing support

• The government of Nigeria and Niger State should use the best practices and lessons learnt from this project to scale up
THANK YOU

FROM NIGER STATE & PARTNERS, NIGERIA