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Maternal and Child Survival Program

Findings from the *Enhancing Quality iCCM through Proprietary and Patent Medical Vendors (PPMV) and Partnerships* (EQuiPP) Approach

"Can PPMVs provide quality health services in the communities where they serve?"

Photo: Karen Kasmauski/MCSP

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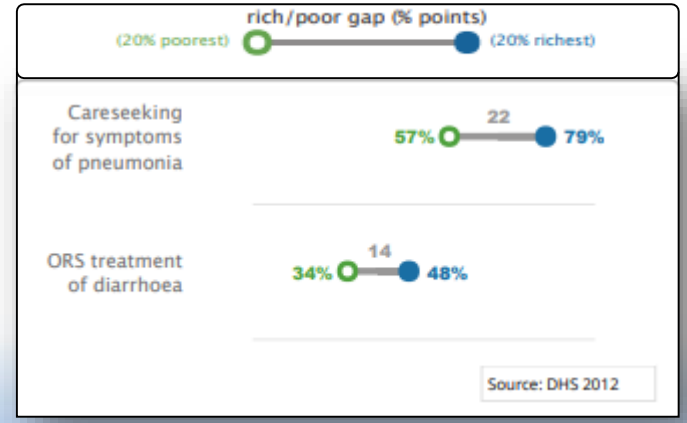
Outline

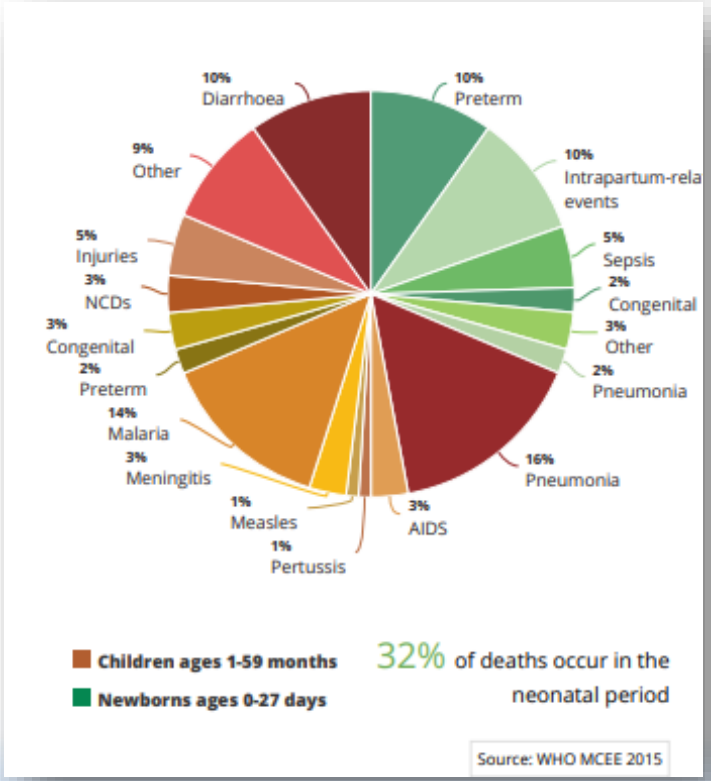
1. Introduction
2. Formative findings
3. EQuiPP Implementation
4. Quality of care and lessons learned

1. Introduction

Nigeria Context

- High under-five mortality
- Malaria, diarrhea and pneumonia account for large proportion of post-neonatal under-five mortality
- Inequitable coverage between rich and poor





PPMVs in Nigeria are…..

- Frequently first source for child care services and medicines
- Organized under associations such as NAPPMED
- Regulated and monitored by Pharmaceutical Council of Nigeria (PCN)
- Located in rural areas (although less so in hard-to-reach areas)

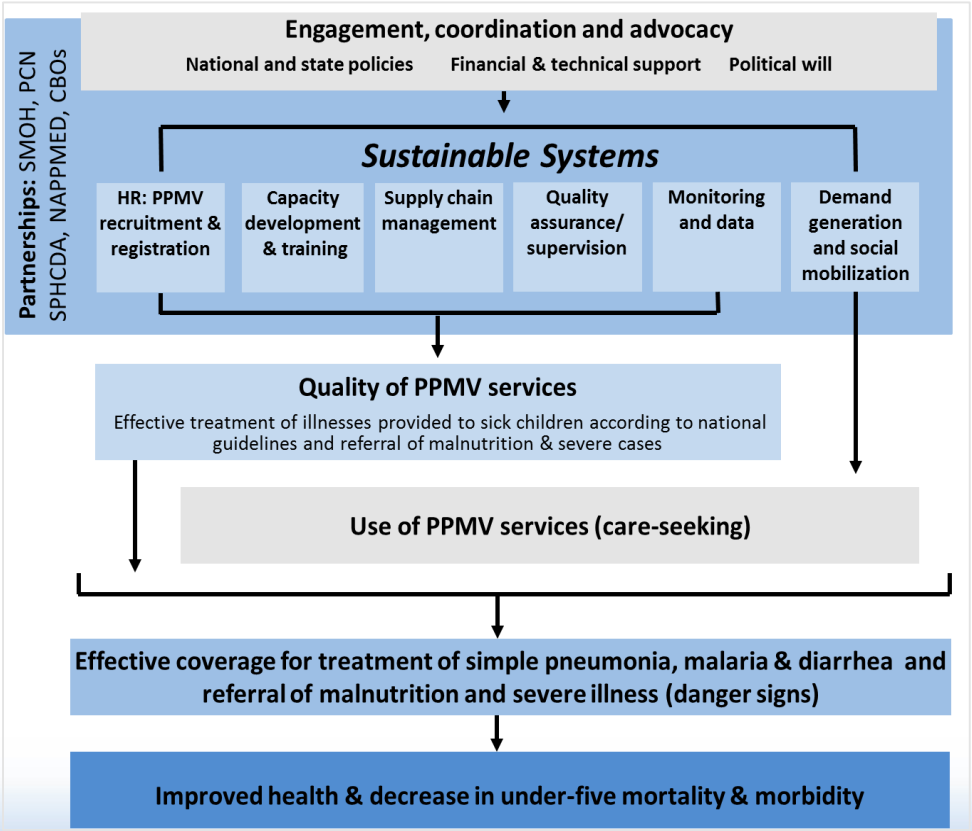
Key Project Focus

Photo: Karen Kasmauski/MCSP

Quality Healthcare Services
+ **Sustainability**

Through **collaboration** with FMOH, SMOH, SPHCDA, PCN and NAPPMED to implement and **test a sustainable approach** to supporting PPMVs in providing high quality iCCM services to sick children

The EQuiPP Approach

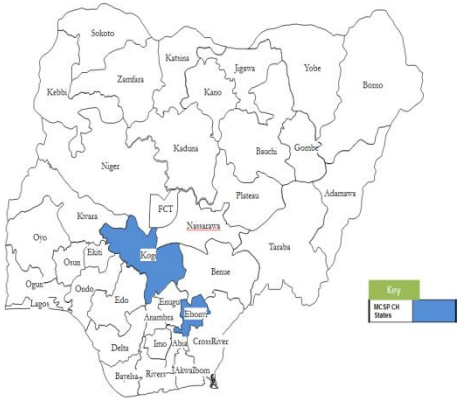


Scope of Implementation:

862 PPMVs trained (total)

Kogi State
- **2** LGAs
- **366** PPMVs
- **282** Outlets

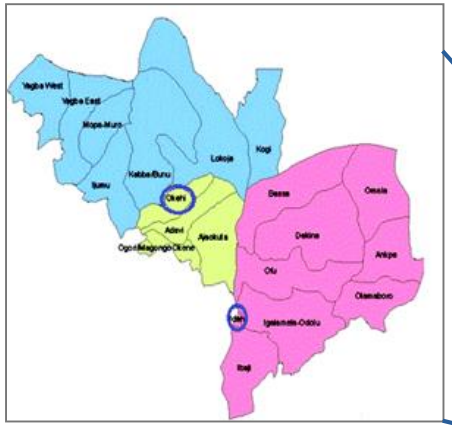
Ebonyi State
- **2** LGAs
- **496** PPMVs
- **400** Outlets



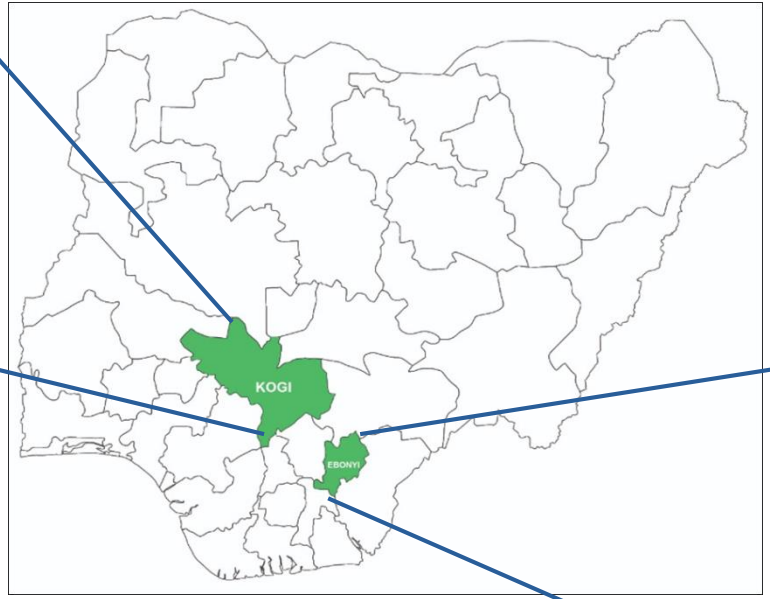
Measurement and Evaluation Throughout:
- *Formative assessments*
- *Routine monitoring*
- *Documentation of promising approaches and challenges*
- *Assessing quality of care of PPMV practices*

Implementation and Study Areas

4 LGAs in Kogi and Ebonyi State



Nigeria



Kogi State

Idah

Okehi

Ebonyi State

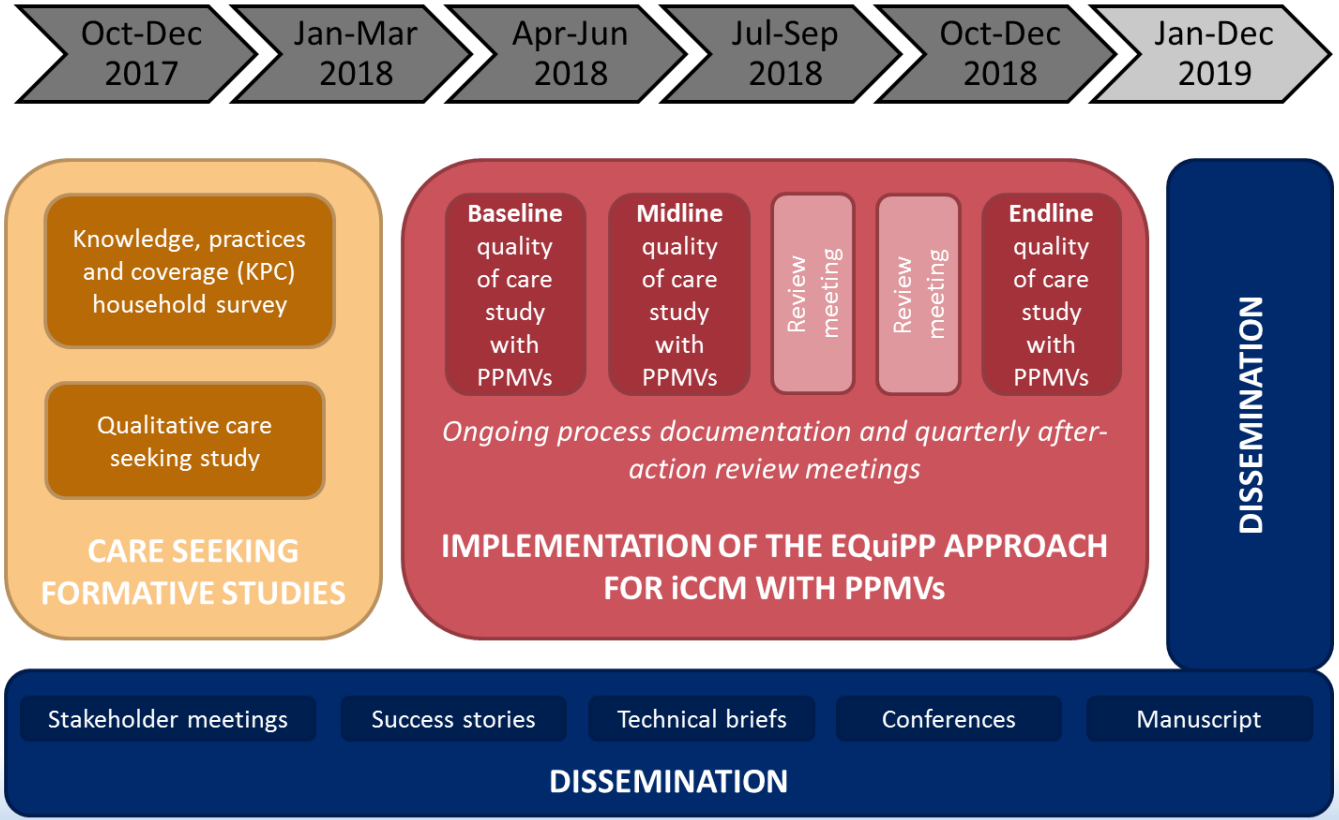
Izzi

Ohaozara

How is EQuiPP Different from other PPMV Work?

- Focuses on **all iCCM conditions** (malaria, diarrhea, pneumonia and referral for danger signs)
- Co-designed with broad **partnerships** across private and public sector (SMOH, SPHCDA, PCN, NAPPMED, PPMVs)
- Built on **sustainable systems** (e.g. non-incentivized, peer supervision, non-subsidized drug supply through links to wholesalers & manufacturers)
- PPMV **data** flows into public system (LGA M&E office to DHIS2 community module, when ready) and to NAPPMED
- Training and support provided to **all eligible PPMVs** in target LGAs
- Robust assessment conducted of **quality of services** provided by PPMVs

EQuiPP Studies and Assessments



2. Formative Findings

Formative KPC and Care-Seeking Studies

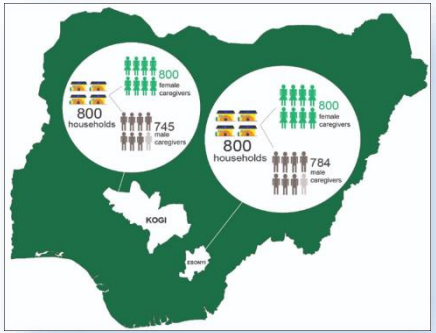
1. To generate evidence about **levels & patterns of care-seeking** for child illness
2. To better understand **drivers & barriers to seeking care** for child illness

Knowledge, practices and coverage (KPC) household survey

Qualitative care seeking study

CARE SEEKING FORMATIVE STUDIES

Household survey: 1,600 caregivers. *Household description (assets), gender, perceptions of PPMVs, illness management and care seeking.*



Care seeking assessment: *In-depth interviews with parents of sick children, focus group discussions with community leaders, in-depth interviews with service providers.*

	EBONYI	KOGI
	sought care / did not seek care	sought care / did not seek care
IDIs with mother of child under the age of five reported to have child illness in two weeks preceding survey	12 (4 for each child illness)*	12 (4 for each child illness)*
IDIs with father of child under the age of five reported to have child illness in two weeks preceding survey	12 (4 for each child illness)*	12 (4 for each child illness)*
FGDs/vignettes with community leaders (chiefs, health workers, etc)	3 groups of 8–10 respondents	3 groups of 8–10 respondents
IDIs with service providers (i.e. PPMV, community nurses, shops/pharmacies	6 private, 6 public (10 total)	6 private, 6 public (10 total)

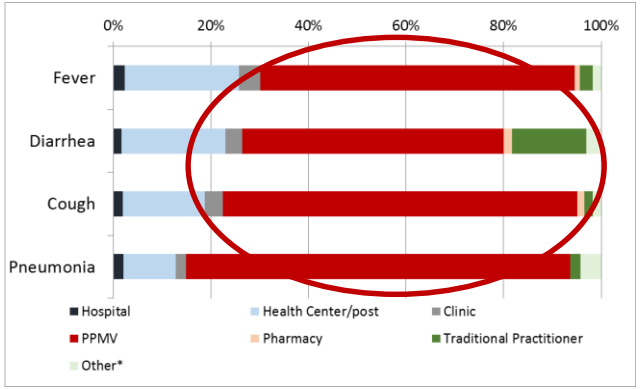
*fever, cough with fast breathing (suspected pneumonia) and diarrhea

Quantitative Findings: Care-Seeking for Any Illness (fever, diarrhea, cough, pneumonia)

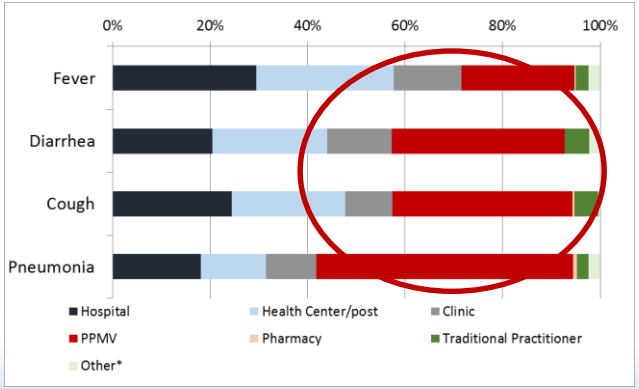
	Ebonyi N=788	Kogi N=795
Sought care/treatment for any illness:	89.3%	83.9%
Sought care/treatment from:		
Hospital	2.4%	25%
Health Center	22.1%	27.2%
Clinic	4.1%	11.6%
PPMV	65.1%	33.2%
Pharmacy	2%	0.5%
Traditional Practitioner	6.9%	4.9%
Other	2.5%	2.5%

Quantitative Findings: Patterns of Care-Seeking: 1st Source of Care

Ebonyi State



Kogi State



Quantitative Findings: Factors Associated with Care-Seeking

Characteristics of Female Caregivers Seeking Care

Ebonyi State (n=788)

	Any care sought	Sought care from health provider	Sought care from PPMV/Pharmacy
Education			
None	80.2%	11.3%	67.9%
Primary	89.6%	21.2%	68.7%
Secondary +	91.6%	36.4%	61.9%
Wealth quintile			
Lowest	83.5%	15.2%	62.0%
Second	89.2%	17.7%	68.4%
Middle	94.3%	31.2%	66.9%
Fourth	89.9%	35.4%	64.6%
Highest	89.8%	38.9%	63.7%

Kogi State (n=795)

	Any care sought	Sought care from health provider	Sought care from PPMV/Pharmacy
Education			
None	66.2%	53.4%	16.2%
Primary	87.6%	61.6%	36.0%
Secondary +	88.2%	62.5%	37.8%
Wealth quintile			
Lowest	77.0%	51.0%	33.8%
Second	80.0%	59.1%	29.6%
Middle	88.6%	71.5%	25.9%
Fourth	88.1%	65.4%	30.2%
Highest	86.8%	57.9%	45.3%

Qualitative Findings: Patterns of Care-Seeking

- Families recognize most illness symptoms, but don't always understand medical causes and attribute illness to spiritual causes or teething
- Families lack terms for illness severity
- Traditional medicine, like herbs, is often used before seeking care outside the home
- Social and gender norms influence household decision-making on when and where to seek care

Photo credit: Karen Kasmauski/MCSP. Wandi Village, Nigeria 2018

3. Implementation of EQuiPP

Health Workforce: PPMV Recruitment and Registration

EQuiPP Approach – the what

- Coordinate with NAPPMED, PCN, SMOH for PPMV registration & selection
- Select PPMVs who are committed, literate, over 18, registered with PCN, have a permanent structure, reside in the community and be willing to document activities

Implementation – the how

- Mapping of PPMVs using PCN and NAPPMED lists and snowball technique; final list validated by PCN
- Orientations with PPMVs to encourage registration
- PCN attended NAPPMED meetings and set-up registration desk at the LGA level in Kogi

Health Workforce: PPMV Recruitment and Registration

Learning

- Importance of PCN registration recognized by PPMVs
- Difficult to track PPMV registration within PCN structures
- On-going tension between PCN & NAPPMED in Kogi is challenge
- Payment of PCN fees is difficult for some PPMVs ($50 new registration - $30 renewal - $15 continuing education)

Health Workforce: Training of PPMVs in iCCM

EQuiPP Approach

- Used the FMOH iCCM curriculum and PCN continuing education
- Added Logistics Management Information System training module (based on PCN)
- Added module on community health management information system (CHMIS)

Implementation

- FMOH iCCM master trainers trained State trainers
- State trainers trained LGA trainers (PCN, tutors from schools of health technology and nursing) - non-residential
- 30 PPMVs per class and 5 trainers per class - 6 full training days in communities close to PPMVs
- Clinical practices at PHC and hospital

Health Workforce: Training of PPMVs in iCCM

Results

Ebonyi

472 iCCM certified PPMVs at **400** outlets

Kogi

361 iCCM certified PPMVs at **282** outlets

Learning

- Low literacy PPMVs can be asked to get someone else from their shop => another PPMV from shop certified
- Overall a large percent of trained PPMVs were certified (95% in Ebonyi & 98% in Kogi)
- In some training sessions were in local languages (especially to describe illness/symptom terminology)
- More emphasis/time should be placed on data management (LMIS & CHMIS) in training

Quality Assurance and Supervision

EQuiPP Approach

- Introduce mixed supervision model: NAPPMED peer-supervisors (private) paired with PHC (govt) supervisors
  - Each supervisory pair responsible for 10 PPMVs
- Monthly supervision visit to improve quality (complete supervision checklist) and ensure service provision data reporting

Implementation

- iCCM trainers identified candidates for PPMV peer supervisors based on iCCM performance during training
  - Some PPMVs agreed, some did not agree
- PHC supervisors selected from 1 PHC per ward (trained in IMCI)
  - 1 day orientation on iCCM
- PHC and PPMV supervisors trained in iCCM supervision and data management (together in residence) for 3 days
- **NO INCENTIVES GIVEN**

Quality Assurance and Supervision

- Stakeholders found supervision model acceptable
  - PCN strongly recommends that community pharmacists should be included in the model
  - FMOH/SMOH and SPHCDA supportive of PHC supervision of PPMV/private sector

- Lower levels of supervision than planned in the model (**No incentives were given)**
  - Solutions proposed:
    - Explore sustainable incentives (e.g. from drug revolving fund or RBF for PHC supervision)
    - Increase number of supervisors (in hard to supervise areas – e.g. more than 10 PPMVs in area and /or long distances between PPMVs) However, sometimes only one health worker per PHC, etc.
    - Executive secretary of SPHCDA Ebonyi asked for names of PHC health workers not supervising
    - Explore mentoring at NAPPMED meeting
    - Supervision added as quarterly task to PCN-led PPMV committee at state level

Medicines and Health Supplies

EQuiPP Approach

- PCN's approved NEML for PPMVs (including Amox-DT) disseminated*
- Linkages between local manufacturers, wholesalers, distributors and PPMVs facilitated to ensure access to affordable, quality medical supplies/drugs
- Improve inventory management through tools developed based on PCN materials

Implementation

- Identify local manufacturers and distributors with high quality product (pre-qualifications) and encourage them to participate in NAPPMED meetings
- Continuous engagement with these manufacturers, distributers, CP and stakeholders (to ensure product availability)
  - Wholesalers sent distributors to NAPPMED meetings to sell
- PPMVs trained on and provided with inventory management tools (tally cards, purchase booklets, daily sales registers)
- Stock-keeping included in the supervision checklist

**MCSP collaborated with the FMoH and NEML advisory committee to facilitate inclusion of Amox-DT on 6th edition of NEML*

Medicines and Health Supplies

- Increase affordability and availability of high quality medicines
  - Ebonyi NAPPMED provided low-interest loans to members to buy commodities
  - mRDTs are imported and expensive
    - Negotiate prices with importers; encourage local production; explore other qualified brands of RDTs
  - Amox-DT and ACTs are relatively expensive
    - Scale up iCCM => increase demand may drive cost reduction
- Inventory management practices still need improvement
  - Inventory tools could be distributed at PCN registration
  - Training and supervision should emphasize practical data use and how the tools can improve business (and profits)

Information Systems

EQuiPP Approach

- Use FMOH iCCM data tools
- Build on data structure and flow developed for iCCM/CHMIS in both states
  - PPMV -> PHC -> LGA -> State -> National (HMIS data only)
- Leverage NAPPMED meetings for data validation and reporting
- Feedback through existing structures & iCCM supervisors' meeting

- Pilot FMOH CHMIS tools on DHIS2 platform

Implementation

- iCCM & CHMIS tools printed in triplicate (1 for PPMV, 1 for NAPPMED/MCSP, and 1 for PHC)
- PPMVs trained on data management at iCCM training
- iCCM supervisors trained on data management
- Data summaries collected during supervision visits and NAPPMED meetings

- Review overall implementation (and results) and discuss data quality at iCCM supervisors' meetings, child health technical working group and core technical committee meetings

Information Systems

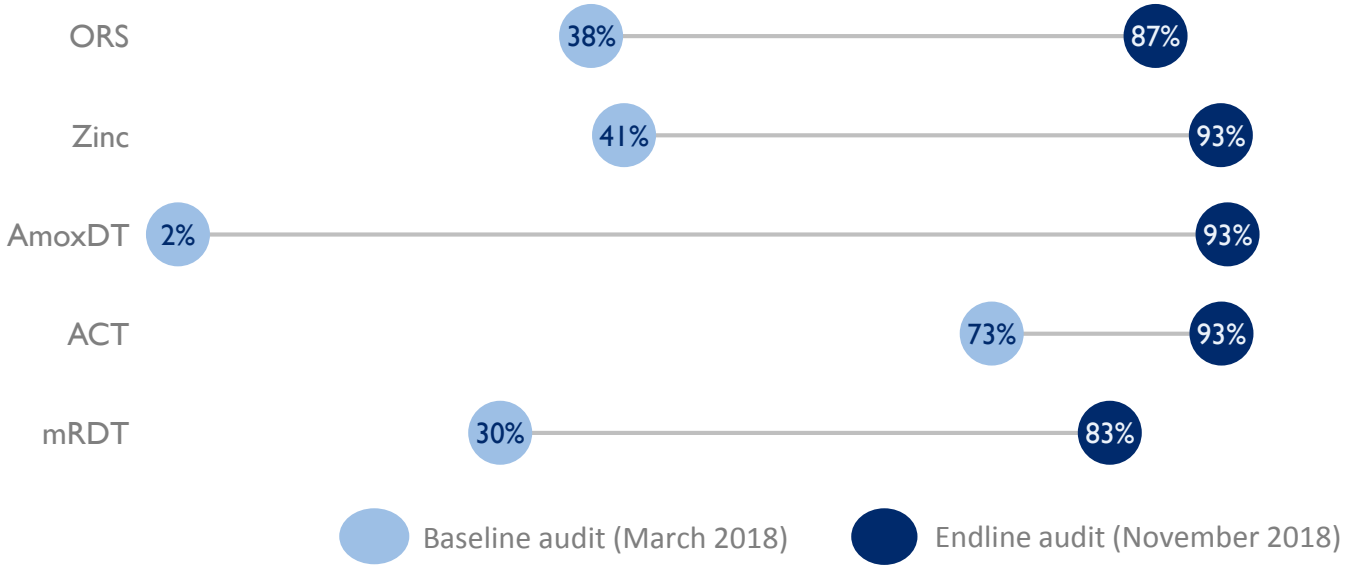
- Community-based information can be collected with relatively high rates of reporting
  - Sustaining reporting without MCSP support will increase burden on LGA M&E Officer
- iCCM and CHMIS tools
  - PPMVs had challenges completing sections of the CHMIS that were not directly iCCM related (e.g. human resources) ➔ Mid-course correction to amend CHMIS tool
  - Age grouping in the iCCM daily register does not exactly conform with those in the CHMIS (for instance the age category 0-28 days is not in the daily CORPS register but captured on the CHMIS MSF)
- PPMVs did not use the data at their level

Referral

- There is a gap for referrals in cases where secondary health facilities are further away than PHCs – (when/if there is a need to skip a level in the referral process)
  - Consider two kinds of referrals (one for illnesses that PHCs can manage and others that require higher levels)
  - Incorporating the private hospitals as referral centers by training them on IMCI

4. Quality of care findings and lessons learned

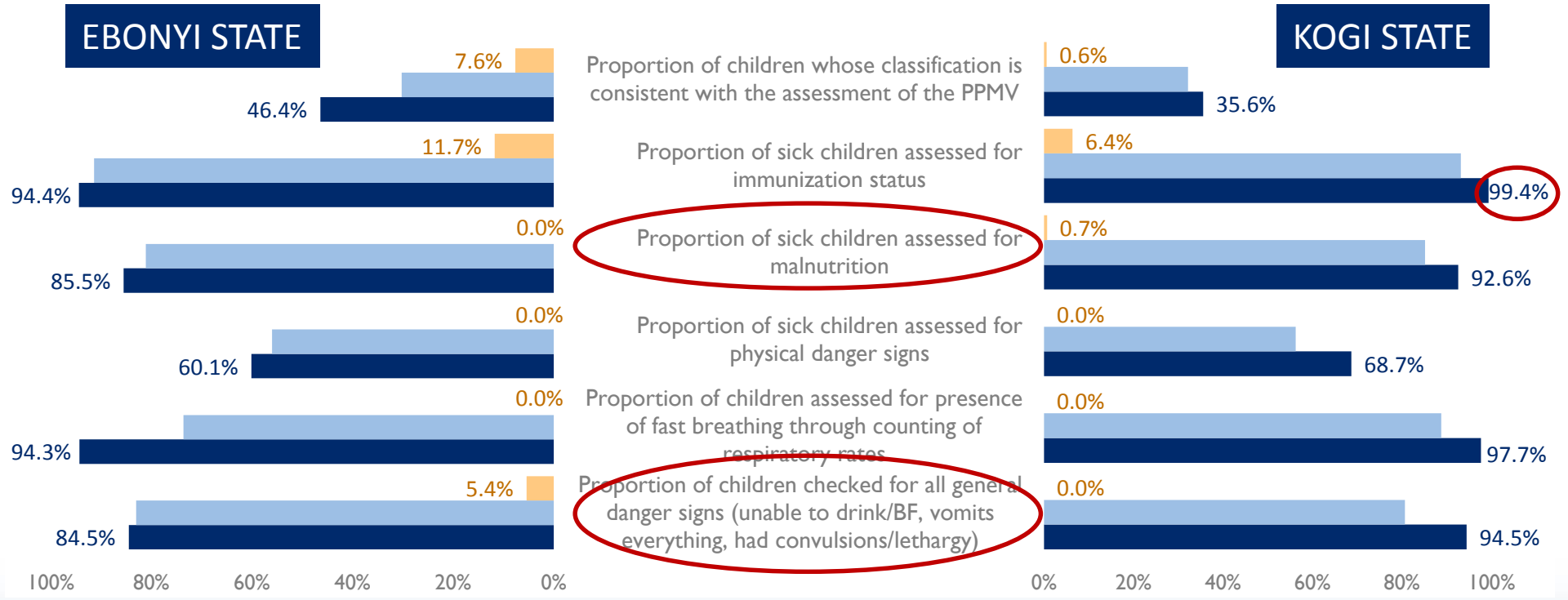
Findings: Proportion of PPMVs with Stock on Day of Visit (Kogi and Ebonyi states)



***ORS**: Oral Rehydration Solution; **Amox DT**: Amoxicillin DT;*
***ACT**: Artemisinin Combination Therapy (for malaria); **RDT**: Rapid Diagnostic Test (for malaria)*

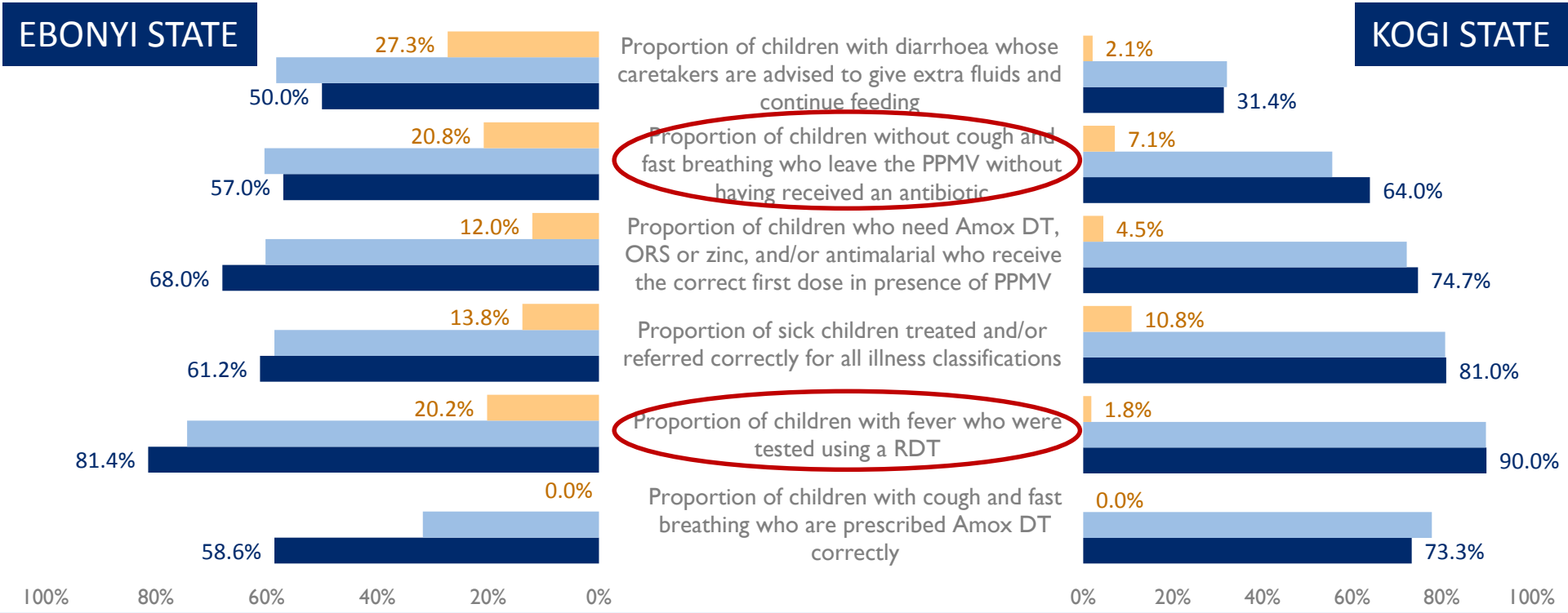
Findings from QoC Assessments: Classification

Quality of assessment for sick children U5 at 176 PPMVs before, during and after EQuiPP implementation (MCSP Nigeria program data from 88 PPMVs in Kogi and Ebonyi states)



Findings from QoC Assessments: Treatment & Counseling

Quality of treatment and counseling for sick children U5 at 176 PPMVs before, during and after EQuiPP implementation (MCSP Nigeria program data from 88 PPMVs in Kogi and Ebonyi states)



End of Program Handover Workshop

Service Delivery

Kogi: Next steps towards improvement and sustainability

Gap	Actions	Timelines	Responsible persons
Poor service delivery at community level	**Scale –up to 4 more LGAs**	2019	State and Local Govt, NAPPMED and PCN
Lack of budgetary allocation for iCCM in 2019	Leverage on IMCI budget allocation for 2019 iCCM activities	2019	SMoH and SPHCDA

Ebonyi: Next steps towards improvement and sustainability

Gaps Identified	Actions	Timelines	Responsible Persons
Non-Institutionalization of EQuiPP Approach	Institutionalize EQuiPP approach in the SMOH and capture it in SPHCDA Budget	July 2019	ES SPHCDA
Funding gap for the sustainability and scale of the EQuiPP approach due exit of MCSP	Advocacy to other Implementing partners in the State to key into the EQuiPP Approach	Jan 2019	Director Public Health

Not Planned for "Success"

- Local manufacturer gets involved from the training period
  - One local manufacturer's (NEMEL) head is son of a PPMV went to pharmacy school "paid for by the income of a PPMV shop" and is now a champion and supporter of PPMVs
  - NEMEL supported iCCM training in 1 LGA
  - NEMEL has approval from PCN registrar to scale-up iCCM (still need support from FMoH)

Overall Challenges

- Short time frame
- No population based endline household survey
- Delays in approval by USAID, but gave us time to:
  - Have full team on board and more time for design
  - For adding design meeting with stakeholders about what exists and how to build on it
  - No seed stock worked in favor of sustainability oriented thinking/planning
- Tension between regulators and PPMVs

Photo: Karen Kasmauski/MCSP

Lessons Learned

- EQuiPP-trained PPMVs showed promise for:
  - Providing quality child health services
  - Conducting routine iCCM data reporting using the National HMIS grid
- The joint supervision model can be supported and made to work.
- Effective stakeholders involvement (including NAPPMED, SPHCDA, LGA and State IMCI and HMIS unit) is key for sustainability of service delivery and iCCM data reporting through PPMVs

Photo: Karen Kasmauski/MCSP

Questions?

Photo Credit: Karen Kasmauski/MCSP, Nigeria

For more information, please visit
www.mcsprogram.org

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