[NIGERIA]

SESSION 3: COUNTRY EXPERIENCES FROM SCALING UP ICCM WITHIN COMMUNITY HEALTH SYSTEMS

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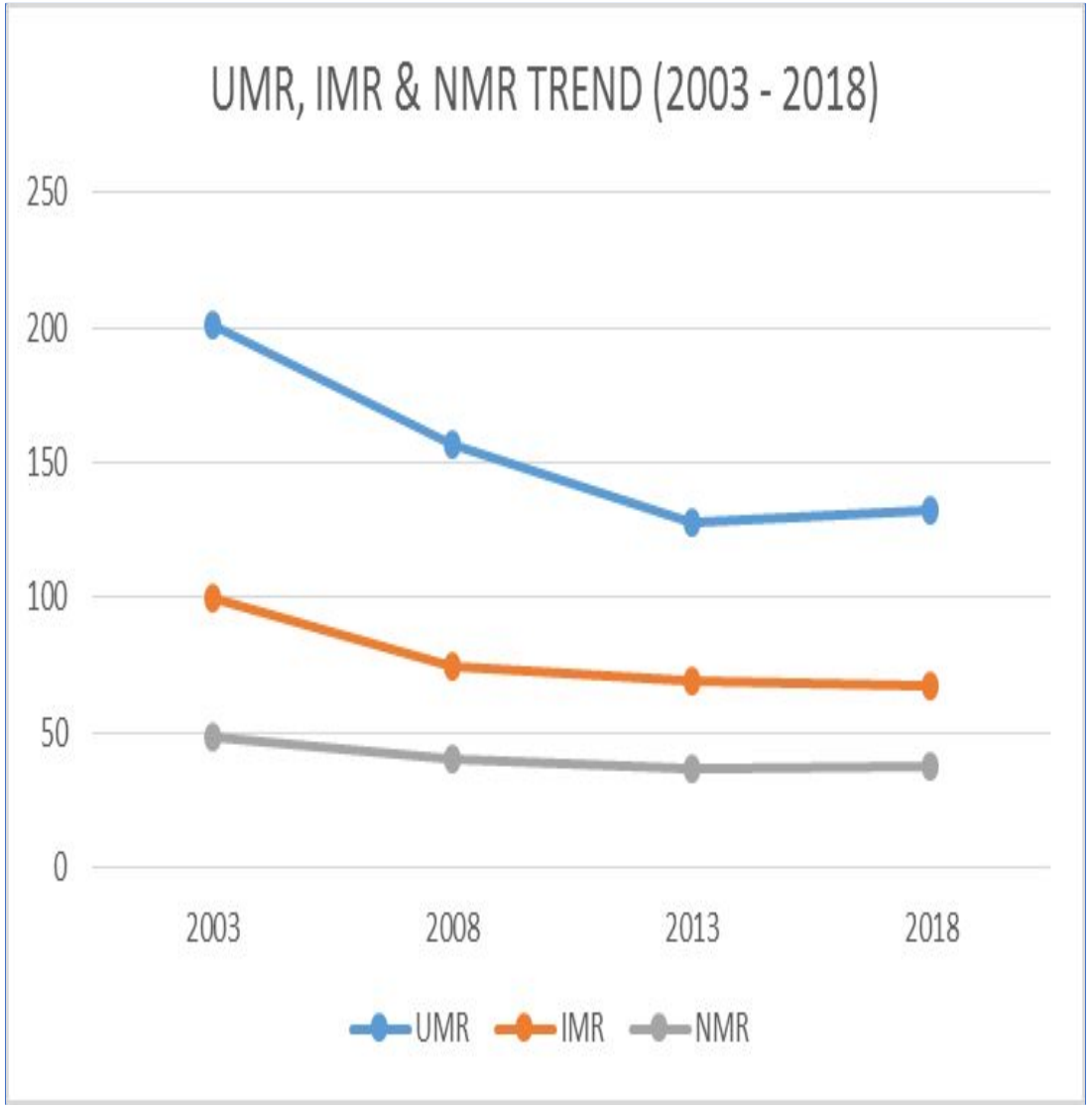
COUNTRY PROFILE

- Total population: 182,867,631
  - Population of under 5s: 23%
- Administrative/governance structure:
  - 36 states and Federal Capital, 774 LGAs + 6 Area councils & 7,800 - 11,700 wards
  - Decentralized
- Status of key indicators
  - U5MR - 132, IMR -67, NMR -38 (NDHS 2018)
- Major causes of child mortality
  - Malaria, Diarrhea, Pneumonia, Measles, Neonatal causes, Meningitis, AIDS
  - 24%, 3% and 13% under five deaths due to malaria, pneumonia and diarrhea respectively (NDHS 2018)



OVERVIEW OF NATIONAL ICCM PROGRAMME

2012

- Malaria, diarrhea and pneumonia with nutrition screening and referral.
- Child Health policy
- 2 States – 15 and 6 LGAs. Donor –WHO, implementing partner – SFH and MC

Scale-up

- From 23 LGAs to additional 136 LGAs (157 LGAs)
- Still malaria, diarrhea and pneumonia and promotion of KHHP
- UNICEF supporting in 9 States – focusing on the most hard to reach communities
- MC in 2 states and CA in 1 state

Governance

- Lead Management - FMoH
- Lead Technical Unit – Child Health Division, Family Health Dept.
- National iCCM Task Force led by DFH (FMoH), co-chaired by NMEP (FMoH) and CHS (NPHCDA) with all iCCM stakeholders as members

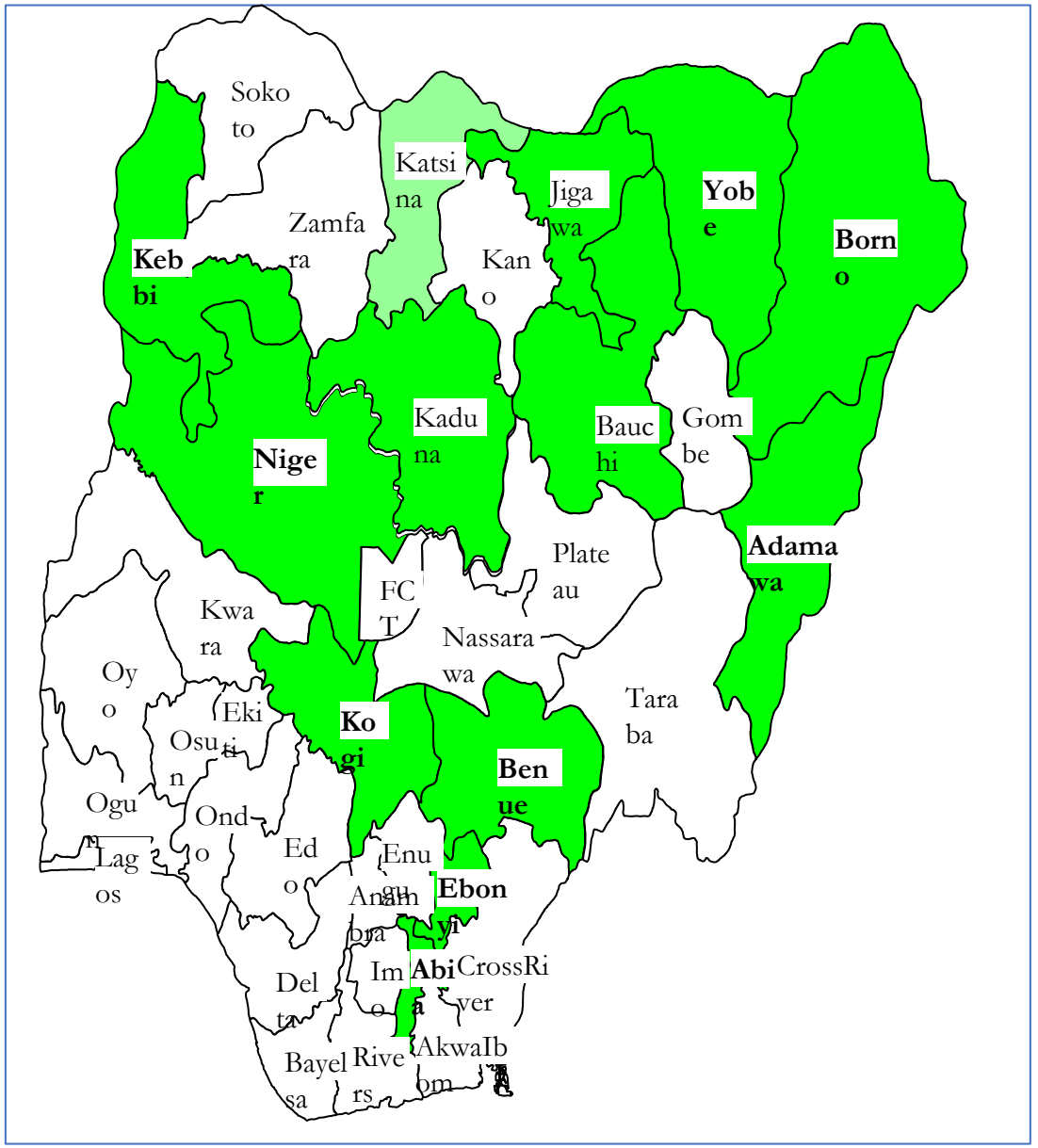
Protocols and Guidelines

- Standardized training protocols and guidelines , treatment registers and reporting tools exist
- Protocols and guidelines adapted from WHO

ICCM COVERAGE

- Hard to reach areas mapped: variable across States
- Proportion of hard to reach areas served by iCCM CHWs 6095 HTR
- 157 LGAs out of 780 implementing iCCM
- Treatment numbers (insert available data):

	2016	2017	2018
Malaria	-	-	255,844
Pneumonia	-	-	87,551
Diarrhoea	-	-	90,643
Malaria Positivity rate	-	-	-



HUMAN RESOURCES: COMMUNITY HEALTH WORKERS

Status

- CHWs (CORPs) are voluntary lay persons providing iCCM services
  - 200/1 ratio (as per MOH criteria and actual)
- 18 – 65 years, ability to read and write, residing in the community, respected by community, preferably women, selected by the community, interested
- Training:
  - Pre-service: not applicable
  - In-service: 6 days, trained at LGA level, classroom and clinical practice
- Deployment of CHWs – MOH led, volunteers
- Modalities for incentivization – monetary (transport allowance) but consideration of non-monetary incentives
- Commodities / equipment – ACTs, ORS/Zinc, Amx DT, Respiratory timers, MUAC tape, medicine box/bag.
- Attrition rate (12256 trained vs 11654 working – December 2018)

Challenges

- Non-standardized incentives
- Lack of regulatory framework for the volunteer cadres
- Attrition
- Literacy
- Cultural influences on CHW selection

FINANCING/COSTING

Status

- iCCM costing exercise conducted for two states
- The country does not have a costed iCCM implementation plan but captured in the 2019 work plan
- Source of iCCM funding – External (Donor)
  - ✔ CHWs salaries – not applicable
  - ✔ Training - yes
  - ✔ Medicines (malaria and non-malaria) and supplies (Donor)
- If mainly donor funded, plans for increasing domestic funding – Basic Health Care Provision Fund, Saving One Million Lives P4R initiative

Challenges

- No budgetary line specific for iCCM (captured in the general RMNCAH budget line)
- Late and inadequate release of appropriated funds

Efforts made to address the challenges

- Proportionate distribution of allocation to programmes
- Continued advocacy to Legislative for early budget appraisal, approval and release

HEALTH FACILITY ROLE IN ICCM IMPLEMENTATION

- Role CHW linked health facility play in support of CCM implementation – Supervision, Mentoring, Commodity stock management, data management
- Readiness of referral facilities is assessed prior to introducing CCM through mapping to identify functional PHCs and conduct of SARA at inception
- Quality of care at referral facilities assessed at inception of project – hence IMCI training

Challenges

Health facility: human resource shortage, poor provider skills, shortage of medicines and supplies, difficult terrain and distance from community, incessant health workers strike

Referral facility: difficult terrain and distance from community, payment for services and drugs, incessant health workers strike

SUPERVISION

- CHWs are supervised by HWs from the linked health facilities
- Supervisors are trained in iCCM supervision skills
- Supervisors are incentivized (transportation allowance)
- Supervisors visit CHWs in their communities monthly to observe CHW at work, conduct inventory of stock and check registers. Also hold group review meetings in the health facilities and encourage peer-to-peer learning among CHWs
- Supervisors themselves are supervised by the LGA Health Dept monthly & MOH quarterly

Challenges

- Increased work load on supervisors which affects frequency of visits
- Transportation allowances borne by implementing partners and stops with exit of partners
- Low motivation
- Poor quality of supervision ?? Supervision skills
- Difficult terrains discourage regular supervision

SUPPLY CHAIN MANAGEMENT

- CHW requirement quantified separately
- CHWs supplies procured separately
- Use MOH storage and distribution system
- CHWs are replenished using the pull system during the monthly review meetings

Challenges

- Unsustainable source of commodities(donor-dependent)
- Procurement is not central
- Frequent stock out of commodities especially the non-malaria commodities
- Poor storage facilities

MONITORING AND HMIS

- Community HMIS developed and piloted but yet to become operational
- Data not yet being routinely sent to the national level
- DQA done in pilot states only, supervisors review registers and support CHWs to identify and correct mistakes during supervision
- No structured mechanism for use of CCM data for program improvement at all levels (national, district, community) yet

Challenges

- Data not yet feeding into the NHMIS
- Monitoring visits still largely donor-dependent
- Poor data quality
- Data entry is paper-based
- Routine iCCM data analysis and use yet to be institutionalized at all levels

COMMUNITY ENGAGEMENT

- Challenges with one national community engagement strategy (community engagement frameworks available for individual programmes – eg, immunization)
- Communities are engaged in:
  - CHW selection
  - CHW incentivization & support
  - CHW supervision

Challenges

- Top-down planning for iCCM programmes
- Limited budgetary allocation for the implementation of community engagement strategies
- Weak data feedback loops to community level

Community support – CORPs acknowledged by the community

Type of support	Estimated cost (NGN)	No of CORPs
Farm support Labour & inputs	30,879,450	302
Financial assistance	6,269,900	433
Cost of Houses constructed	4,279,800	12
Logistics support	496,650	47
Support for wedding	183,050	6
Bicycle and motorbikes for CORPS	350,700	6
Total	42,459,550	

BEST PRACTICE:

Commodity Insurance Scheme for ICCM commodities in Kebbi State

-Two LGAs In Kebbi State involved (Jega (6 communities)and Bagudo(2 communities) LGAs)

-Following challenges with commodity supplies

-Community members now contribute a Hundred Naira(50 pence) to buy drugs (under supervision) and keep in the custody of the CORPs and is access by caregivers and parents of sick children.

-Total Contributions by the different communities ranges from 50- 120 USD

-This is more cheaper when compare with the money they spend on transport to go to the nearest health facility which is atleast 5km away.

THANK YOU