Action Points to Include in Country Plan

What are our key action points?

- Task Force should…
  - Develop framework and then all of the specific plans under that (e.g. BCC, PSM)
  - Create workgroups – BCC, PSM, M&E etc to put together each specific plan
  - Do commodity quantification and gap analysis
  - Drive resolution of policy bottlenecks on regulation
- Meetings & dissemination
  - Task Force should meet and move quickly
  - Arrange a national advocacy and sensitization meeting –
  - Share memo on iCCM during state level and national council on health
- Organizing structures
  - Needs to be a replication of iCCM task force at state level
  - Needs to be a system for coordinating TA and a TA plan overall

What additional resources are required to support these action points?

- TA to support gap analysis and strategy development

Action Points to Include in Country Plan

What are our next steps as a country to implement these next steps?

- Task Force should meet as soon as possible to review recommendations and move forward on next steps
- Convene and advocate with local partners
- Speak with state councils on health and national councils on health
- Gap analysis needs to begin as soon as possible

SUPERVISION & QUALITY

iCCM 2014

Key points from break out session

- Supervision very challenging. Peer group supervision can be helpful for overcoming these challenges.
- **Tools**: Need to revise the integrative supportive supervision tool – will expand the community tool to make sure we integrate
- Important to build capacity for supervision – doing a landscape analysis around supervision models, create a framework for supervision
- Monitoring of supervision: data doesn't tell the whole story. Critical that there are checks on quality as well.
- Performance management
    - CHEWs and CORPs – should consider motivating them differently
        - Mali unable to sustain motivation because there was no strong package
        - Non-monetary incentives - Mobile phone, sugar
    - Need to think about costs of non-monetary incentives
- Training
    - Need to spend time on training – training manuals, other guides, but need to be field tested
    - Job aid use emphasized

DEMAND & SOCIAL MOBILIZATION

iCCM 2014

Key points from break out session

- Contradiction between national and global treatment guidelines – need to harmonize
- Sensitization at community level
  - KOLs first
  - Having the community select the community volunteers who will participate
  - Sensitizing the community about iCCM
  - Want to encourage consistency of messaging across diversity of country – find right mechanism for that
- Layers of committees
- Need to use ward development committees
- Gray areas in understanding drivers of coverage – measurement of demand
- Community question and how you collect your data…important.
  - Reporting and getting commodity – demand and supply get linked
  - Need to link to the ward development committee
- What should be the role of health educators in this system?
- **Key recommendation**: need to align on data collection and dissemination – for ward development commission

Innovations

Key points from break out session

- Deploying mHealth systems very important for iCCM
- Should consider RapidSMS as a tool – but consider whether financially sustainable
- Phase approaches –
    - mHealth not key intervention, could put in phase 2 – major telecom sector in Nigeria
    - Worked as a team to ensure that iCCM fed as an indicator into health systems
    - Quality of data
    - Training of staff at level of community critical – needs to be high quality data input into the system

SUPPLY CHAIN MANAGEMENT

Key points from break out session

- National medicines coordination mechanism – engage with CTC
- Most critical product now is dispersible amoxicillin – need to create a bridge while supply is being scaled up
- Issue of stock won't be the bottlenecks
- Procurement issue needs to be well-articulated at the beginning
- Need to get from store to end user
- States have key role in scaling up iCCM
- State and local government supposed to develop an implementation plan – think about how
- Create a standard model for how malaria, zinc/ORS, amoxC will come together

POLICY

Core topics covered

- Costing needs to be done to inform policy
- Feasibility study also important part of policy creation – understanding contextual factors, understanding pilot structure; understand at a strategy level what is feasible
- Political will
    - How best do we get financial will to drive this process? MOF – needs to be on board. Is MOF in Nigeria part of the discussion? How do we get funds released
    - Critical to involve Nigeria's new iCCM Task Force
- Implementation
    - Critical tipping point for iCCM when there is a state-level implementation plan
- Local evidence required to make policies
    - Should present findings at National Council on Health
    - Involve academia – easier to generate evidence
- iCCM Task Force should coordinate with RMNCH sub-groups as well as essential medicines committee

COST & COST-EFFECTIVENESS

Key points from break out session

- Cost effectiveness: important that utilization is high – each CHW needs to cover many people
- Gap analysis: need to do a proper gap analysis so from the beginning you know what you are faced with
- “Gross vs net” For costing, important to look at existing structures
    - Some places need to budget for full amounts, others it will be shared costing
    - Other things like equipment and supervision you will share costs
- Supervision and management are major cost drivers – need to think about what this will mean for Nigeria
- Implementation plan needs to have a costing framework, also have the M&EE plan, BCC plan, etc
- Need to do a long term costing plan – need to think about how fast we want to do scale up
- Over time as health sytem improves, CHWs will be replaced – what will we do with them?
- People with expertise need to help us think through these key questions

PRIVATE SECTOR

iCCM 2014

Key points from break out session

- Need to think about training of PPMVs – are they able to come as CORPs
- Private sector – 60% of service provision from PPMVs
    - Need to factor into our new iCCM training or we'll only do about 25% of coverage
- Referenced to Uganda project shared in session
    - Drug shop provider – changed from a problem for iCCM to becoming part of iCCM system – part of solution
    - Private vendors never stocked out – can be inculcated into system as part of supply chain
    - Could work, provided we link up drug shops to the broader iCCM system
- Regulation a big challenge – discuss these and support elimination of bottlenecks
    - E.g. can't give out Amoxicillin, can't do RDT
- Need to take advantage of the private sector as much as possible – behaviors can be changed to part of the answer
    - Preliminary results will come from operational research – helpful for Task Force
- Need to involve public regulatory structures in iCCM deployment
- Rate limiting bottleneck for iCCM in Nigeria will be around regulation – need a framework for rollout, need to map out who the major stakeholders are
- Supply chain coordination mechanism should feed into iCCM Task Force
    - Essential medicines scale up committee should briefly