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Maternal and Child Survival Program

The Global Fund New Funding Model:

Lessons from Nigeria on Negotiating the Inclusion of Integrated Community Case Management (iCCM) of Childhood Illness

Final Report

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Abbreviations

ACT	Artemisinin-based combination therapy
CCM	Community case management
CHAI	Clinton Health Access Initiative
CHEW	Community health extension worker
CHW	Community health worker
CORP	Community-oriented resource person
DFH	Department of Family Health
DFID	Department for International Development
FMOH	Federal Ministry of Health
FTT	Financing Task Team
GMP	Global Malaria Program
HMIS	Health management information system
iCCM	Integrated community case management
IMCI	Integrated management of childhood illness
LGA	Local government authority
MDG	Millennium Development Goal
MOH	Ministry of Health
NAFDAC	Nigeria Agency for Food and Drug Administration and Control
NDHS	Nigerian Demographic and Health Surveys
NFM	New Funding Model
NGO	Nongovernmental organization
NMEP	National Malaria Elimination Program
NPHCDA	National Primary Health Care Development Agency
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PHC	Primary health care
PMI	U.S. President's Malaria Initiative
PPMV	Patent and proprietary medicine vendor
PSM	Procurement and supply chain management
RAcE	Rapid Access Expansion Project
RDT	Rapid diagnostic test
SFH	Society for Family Health
SURE-P	Subsidy Reinvestment Program
USAID	United States Agency for International Development
WHO	World Health Organization

Abstract

This case study reviews Nigeria's experience in negotiating the inclusion of integrated community case management (iCCM) into the Global Fund New Funding Model (NFM) concept note for malaria. It explores some of the challenges experienced by and lessons learned from the Nigeria experience, and discusses broader issues related to the process of developing the NFM concept note that includes iCCM. This Nigeria case study is part of a series exploring iCCM integration in four other countries: Ghana; Kenya; Uganda; and Zambia. Their experiences are explored in individual case studies and synthesized in "Leveraging the Global Fund New Funding Model for iCCM Integrated Community Case Management: A Synthesis of Lessons from Five Countries."

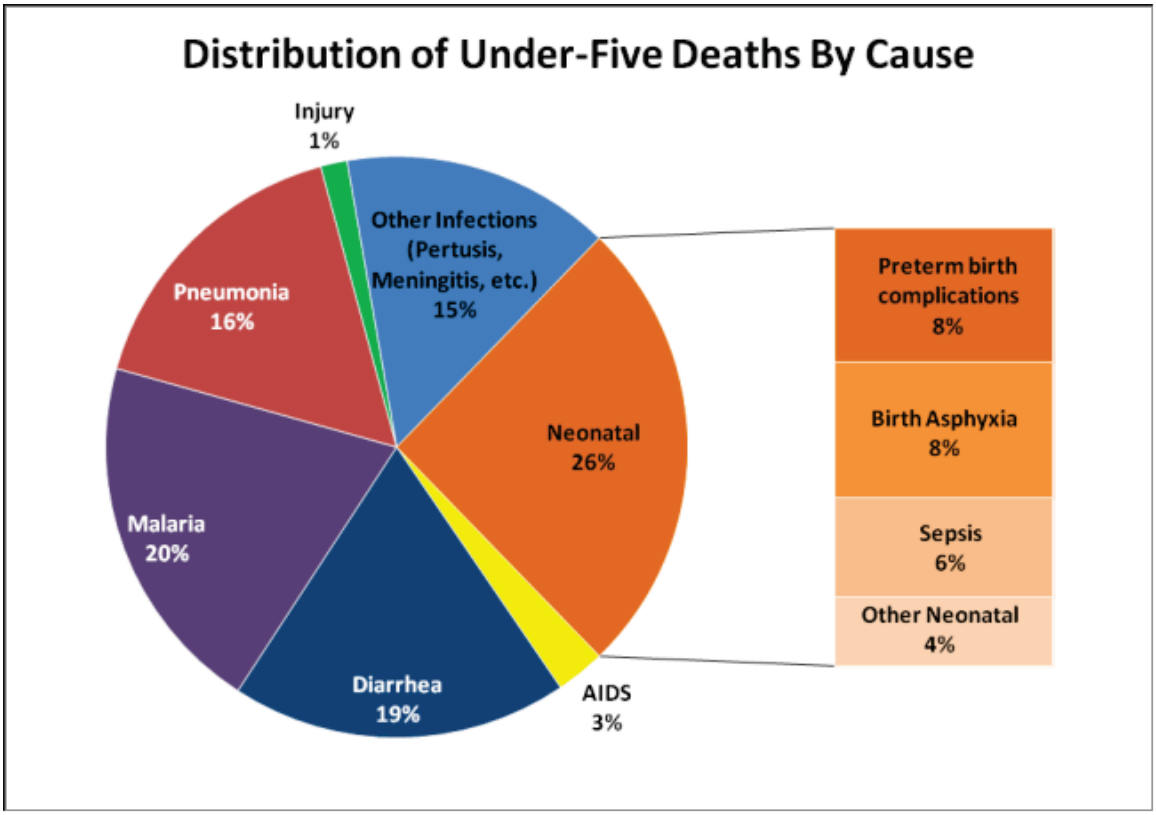
1. Introduction: Nigeria Health Context

Progress on Child Health

Over the last decade, Nigeria has seen improvements in child health. According to the 2013 Nigeria Demographic Health Survey (NDHS), the mortality of children under the age of five years (under-five) declined from 201 deaths per 1,000 live births in 2003 to 128 deaths per 1,000 live births in 2013; infant mortality declined from 100 deaths per 1,000 live births in 2003 to 69 in 2013. Nonetheless, there are huge disparities in mortality rates (Figure 1) across the different regions of the country. In 2011 alone, 756,000 children under-five died in Nigeria, many of them due to preventable and treatable conditions (Federal Ministry of Health 2013). These deaths contributed to 11% of total global deaths of children under-five, placing Nigeria as second on the list of countries with the highest rate of child mortality (IFC International 2014).

The main causes of childhood morbidity and mortality in Nigeria are pneumonia, diarrhea, and malaria; these three are responsible for an estimated 58% of under-five deaths. Yet, the 2011 Multiple Indicator Cluster Survey results show that only 37% of children with diarrhea received oral rehydration salts (ORS) or any form of oral rehydration therapy (ORT) (National Bureau of Statistics 2011). Less than one percent received zinc supplements; only 22% of children with acute respiratory infections received antibiotics; and only six percent of children with malaria received artemisinin combination therapy (ACT)—the recommended and most effective first-line treatment for acute malaria.

Figure 1. Causes of under-five deaths in Nigeria (NDHS 2013)



Note: Nigeria Demographic Health Survey

There are pronounced disparities in health outcomes and access to health services across the geographic regions in Nigeria. Over a ten-year period preceding the 2013 NDHS, mortality rates in urban areas were consistently lower than in rural areas (Table 1). Infant mortality was 43% higher in rural areas (86 deaths per 1,000 live births) than in urban areas (60 deaths per 1,000 live births). There were also zonal disparities: under-five mortality rates ranged from a low of 90 deaths per 1,000 live births in the southwest to a high of 185 deaths per 1,000 live births in the northwest.

A dearth in human resources for health contributes to these urban versus rural differences in mortality rates. Although Nigeria has one of the largest stocks of human resources for health in Africa, "The health workforce is concentrated in urban, tertiary health care service delivery in the southern part of the country, particularly in Lagos" (World Health Organization, 2008). However, as noted by the Ministry of Health (MOH), "Facility-based services alone do not provide adequate access to treatment, especially early in the disease process, as majority of the children are not taken to health facilities or trained health care providers in the event of illness" (Federal Ministry of Health Nigeria 2013, 11).

Table 1. Early childhood mortality rates by regions (deaths per 1,000 live births)

Geographic characteristic	Neonatal mortality	Post neonatal mortality	Infant mortality	Child mortality	Under-Five mortality
Residence					
Urban	34	26	60	42	100
Rural	44	42	86	89	167
Zone					
North-central	35	31	66	36	100
Northeast	43	33	77	90	160
Northwest	44	46	89	105	185
Southeast	37	45	82	54	131
South-south	32	26	58	35	91
Southwest	39	21	61	31	90

Source: Nigeria Demographic Health Survey 2013

Health System Organization

Nigeria, Africa's most populous country (estimated population of 174 million), has a three-tiered public health system. Each tier is associated with a different administrative level of government: federal; state; and local government authority (LGA). The Federal Ministry of Health (FMOH) is responsible for developing policies, strategies, and guidelines, as well as for providing the overall direction for the national health care delivery system. At the state level MOHs provide secondary level of care. LGAs implement primary health care (PHC) services, including immunization.[1] At the federal level, the National Primary Health Care Development Agency (NPHCDA) was established in 1992 to support the promotion and implementation of PHC at the state level through resource mobilization, partnership, and development of community-based systems. The 774 LGAs provide PHC, but are the weakest arm of the health care system (President's Malaria Initiative 2015). There are more than 13,000 PHC facilities nationwide. The federal budget covers tertiary care and disease control programs, including malaria control (the malaria unit is under the Public Health Department of the FMOH). State budgets pay for secondary care and LGA budgets support primary care (President's Malaria Initiative 2015, 14).

[1] http://www.ianphi.org/membercountries/memberinformation/nigeria.html. Accessed October 8, 2015.

Community Services

There are two cadres of community health workers (CHW) in Nigeria: volunteer community-oriented resource persons (CORP) and community health extension workers (CHEW). CORPs are all types of volunteer community-based health workers. CHEWs are paid, community-based health workers who provide extension services to communities, and supervise the CORPs (Management Sciences for Health 2015). CORPs help with community social mobilization to promote child immunization. CORPs receive training to track and undertake postnatal visits within 48 hours of delivery, and track and refer severely malnourished children for nutritional interventions. As part of the malaria elimination program, several organizations, including the World Bank and the United Kingdom's Department for International Development (DFID), have supported the home management of fever by having CORPs perform rapid diagnostic tests (RDTs) and administer ACTs.

The private sector plays an important role in health care in Nigeria: the 2010 Malaria Indicator Survey reported that 57% of those with fever first sought treatment from a chemist or a patent and proprietary medicine vendor (PPMV). However, PPMVs have yet to obtain legal clearance to use RDTs or prescribe amoxicillin to treat pneumonia; thus, case management goes mostly unrecorded and unregulated in the private sector (President's Malaria Initiative 2015).

Key funders for child health include: the Global Fund through UNICEF; the United States Agency for International Development (USAID); the World Bank; World Health Organization (WHO); the Canadian International Development Agency; DFID; and the Clinton Health Access Initiative (CHAI). Key malaria funders include Global Fund, U.S. President's Malaria Initiative (PMI), and the Bill & Melinda Gates Foundation. There is also a growing corporate-sector support for malaria prevention and control from ExxonMobil, Dutch Shell, and the Dangote Foundation.

The Role of iCCM

iCCM is a strategy to extend the case management of childhood illness beyond health facilities so that more children have access to lifesaving treatments to the most common causes of mortality and morbidity.[2] iCCM is an important component of Integrated Management of Childhood Illness (IMCI), which was developed by the WHO in the 1990s. iCCM builds on progress made and lessons learned from the implementation of community-based IMCI, and aims to augment health facility-based case management.

In the iCCM model, CHWs are identified and trained to classify and treat key childhood illnesses, and also to identify children in need of immediate referral.[3] iCCM is an important tool in the toolkit for reducing mortality, especially among marginalized children who otherwise have limited or no access to lifesaving treatments.

Community health serves as a platform for expanding access to case management. The malaria program is using this platform for the community case management (CCM) of malaria. The goal of CCM is to provide prompt diagnosis and effective treatment as an alternative for self-management of fever cases (i.e., for persons with fever who would seek care from entities outside of the traditional health care system, such as pharmacies,

[2] Newborn health and malnutrition are also commonly included in iCCM.

[3] To learn more, see CCM Central and Gove 1997. iCCM is typically delivered by community health workers at the community level, and encompasses the treatment for: (i) childhood pneumonia with antibiotics; (ii) diarrhea with zinc and ORS; and (iii) malaria with artemisinin-based combination therapy. The joint statement on iCCM also supports the identification (but not treatment) of severe acute malnutrition and home visits (but not treatment) for newborns (UNICEF 2012) (see Bennett et al).

informal drug sellers, outlets). The case for tackling the main childhood killers *together*, as part of a common platform, is compelling, for several reasons:

1. Co-infection (of malaria and pneumonia, for example) in children is common.
2. Symptoms of fever, cough/fast breathing, and loose stool can be manifestations of malaria, pneumonia, or diarrhea.
3. Ability to manage non-malarial fever reduces the risk of using anti-malarial treatment for non-malarial diseases.
4. Potentially fatal conditions, such as pneumonia, are often brought to the attention of CHWs first, as they are first-line caregivers.
5. Caregivers sometimes resist referral to a health facility when a CHW cannot manage a condition, which can lead to delayed treatment and worsening conditions. Because of demand and pressure from a caregiver, or because of the need to show competence, a CHW will often give anti-malarial treatment even when the malaria test is negative. Thus, sick children benefit when CHWs are able to detect and treat illnesses in addition to malaria.

iCCM components Supported through the New Funding Model

One mechanism for supporting iCCM inclusion is the Global Fund NFM, which was approved in October 2013. The NFM allows the use of Global Fund money to support activities in addition to the CCM of malaria, such as training CHWs; strengthening supply chain systems; and, if supported by national policies and epidemiological evidence, monitoring and evaluating the CCM of *other* childhood illness (such as diarrhea, pneumonia, malnutrition, etc.).

To support countries to take advantage of the NFM opportunity, members of the global iCCM Task Force established the Financing Task Team (FTT). The Task Force is an association made up of multilateral and bilateral agencies and nongovernmental organizations, and it promotes an integrated community-level management of childhood illnesses. The Task Force's FTT includes UNICEF, USAID, One Million Community Health Worker Campaign, Save the Children, American Red Cross, Maternal and Child Health Integrated Program, CHAI, and the Office of the UN Special Envoy for Financing of the Health Millennium Development Goals (MDG). The FTT ensures that countries received technical assistance to complete iCCM gap analyses and concept notes for the NFM.

As part of this effort, USAID supported technical assistance to five countries, including Nigeria, to develop a Global Fund malaria concept note that includes iCCM.[4] This case study details Nigeria's experience with this process, specifically:

- The degree to which the process between malaria stakeholders and advocates of iCCM, including stakeholders in the Child Health and Community Health Units of the FMOH, was collaborative (and how);
- Factors that enabled or constrained collaboration, as well as inclusion of iCCM in the malaria reprogramming request;
- The outcome of the process and plans for joint implementation; and
- Areas stakeholders would like to see improved in the future to support implementation of integrated programs (malaria/iCCM).

[4] UNICEF also supported technical assistance in 14 countries.

Methods

This case study summarizes information gathered from 15 key informant interviews, which were conducted by the first consultant (the sub-consultant for Nigeria assessment) in Abuja, Nigeria on February 2–9, 2015 (Appendix 1). In addition, this case study summarizes three follow-up interviews conducted via Skype, and the content of email exchanges occurring between April 13–14, 2015 between four others and the task lead consultant. Respondents consisted of a mix of child health and malaria stakeholders from the FMOH, United Nations agencies, implementing nongovernmental organizations (NGOs), and consultants. Literature were also reviewed (see references).

The sub-consultant also participated in the meeting of the global iCCM Task Force on February 3, 2015; about 25 members of the Task Force were in attendance.

Poor quality of data collection and unavailability of some key informants for face-to-face interviews with the sub-consultant made it necessary for the lead consultant to conduct interviews via Skype, and communicate via email to gather additional information. Despite these measures, this report has some limitations, which could not be wholly made up for in follow-up interviews. For example, there were no interviews with representatives from the Global Fund Country Coordinating Mechanism, because these individuals were unavailable to meet with the sub-consultant either by phone or in person.

2. Findings: iCCM in Nigeria

Nigeria has implemented two major iCCM programs. As of November 2013, with support from Canada through the WHO Global Malaria Program (GMP), iCCM is being implemented under the Rapid Access Expansion (RAcE) project in the states of Niger (six out of 25 LGAs) and Abia (15 LGAs).[5] Coverage in these states is approximately 162,000 children in Niger and 202,000 in Abia.[6] In Niger, the program is implemented by the Malaria Consortium. In Abia, iCCM is implemented by the Society for Family Health (SFH), a local affiliate of Population Services International[7], in collaboration with state MOHs and LGAs.

iCCM has also been implemented in the states of Adamawa and Kebbi with the support of UNICEF and NPHCDA, and with funding from the European Union.[8] In Kebbi and Adawama, iCCM is not implemented as a stand-alone project, but rather as part of UNICEF's broader maternal and child health program. The program commenced in May 2013 and will conclude at the end of June 2017; program implementation began January 2014. Initial monitoring results are expected in the second quarter of 2015. Currently, six additional states are under consideration for iCCM implementation. The government of Nigeria is in discussions with partners and seeking donor support.[9]

The iCCM package in Nigeria includes:

- Treatment of diarrhea with zinc and ORS;
- Treatment of pneumonia with amoxicillin;
- Testing for and treatment of malaria with RDTs and ACTs; and
- Referring severe cases, those with danger signs, sick newborns, and severely malnourished children.

Although the use of amoxicillin to treat pneumonia at the community level is part of the national iCCM implementation plan, which was developed by the Department of Family Health (DFH) that is under the FMOH, this policy has yet to be approved by the Essential Drugs Committee of the Nigeria Agency for Food and Drug Administration and Control (NAFDAC). This policy calls for the reclassification of amoxicillin as an over-the-counter drug, which is a subject of an ongoing discussion and advocacy within the FMOH[10] and among relevant Nigerian stakeholders. iCCM will be implemented mainly by CORPs,[11] with supervision provided by CHEWs. The CORPs are closer to communities; there are too few CHEWs to implement iCCM. In this sense, Nigeria resembles similar models assessed in this case study series (Uganda, Zambia). iCCM implementation is reliant on cadres of volunteer health workers who are supervised by paid CHWs, who are usually based in health facilities.

In 2013, as part of the RAcE program support, iCCM national implementation guidelines were created; in February 2014, a Nigerian National iCCM Task Force was inaugurated as the coordinating body. The national iCCM Task Force is a subcommittee of the National Core Technical Committee, coordinating

[5] The RAcE project is funded by Canada for five years to support iCCM in five African countries. The grantee is the malaria program at the WHO, which contracts with NGOs in each country and funds, supervises, and monitors implementation of iCCM.
[6] Interview with Franco Pagnoni. WHO, Geneva. April 14, 2015.
[7] Population Services International operates in Nigeria through its implementing partner, Society for Family Health (SFH), which was founded in 1985 by several eminent Nigerians and Population Services International.
[8] UNICEF, as with RAcE, implements the full iCCM package and measures malnutrition.
[9] Comment from donor stakeholder based in Abuja. April 27, 2015.
[10] Both the Family Health and NAFDA are departments in the FMOH.
[11] The national iCCM implementation plan includes PPMVs in the definition of CORPs, who are targeted to implement iCCM.

maternal/newborn/child health activities. The national Task Force ensures effective coordination of iCCM implementation to build synergy, increase access, and maximize resources and impact. It has broad membership, including representatives from the FMOH, professional associations, and global development agencies.[12] "The Task Force is very large," said one informant. "Everyone is in it, and it's very political. They will form smaller working groups to actually do specific things related to implementation." This Task Force meets quarterly and is housed in the Child Health Unit of the DFH in the FMOH. The Task Force is chaired by the Director of the DFH and co-chaired by the NPHCDA and NMEP; NPHCDA and NMEP are housed within the FMOH (Federal Ministry of Health Nigeria 2013). The national iCCM Task Force has three subcommittees: a monitoring and evaluation subcommittee chaired by USAID; a program implementation subcommittee chaired by the WHO; and a resource mobilization and advocacy subcommittee chaired by UNICEF.

In addition, within the NMEP, there is a focal person for iCCM; and conversely, within the Child Health Unit, there is a focal person for malaria. However, there is no single focal person for coordination of the implementation of iCCM across departments.

According to the FMOH 2013, Nigeria aims to strengthen the capacity of CHEWs and CORPs to properly assess, classify, and treat common childhood illnesses at the community level; ensure a regular and continuous supply of drugs, equipment, and consumables required in the communities for iCCM; and ensure that at least 80% of identified cases with danger signs (as defined by the national iCCM algorithm) are referred to health facilities. To meet these goals, the government and partners will build the capacity of existing community health workers and other community resource persons to: assess, classify, and treat children who have malaria, pneumonia, diarrhea, or malnutrition in the children's homes or within their community; or refer children to health centers.

Nigeria has a supportive policy environment and governance arrangement for implementing iCCM, although the use of amoxicillin at the community level has not yet been approved. Policy documents that support the use of iCCM strategy include the National Child Health Policy, the Integrated Maternal Newborn and Child Health Strategy, Integrated Management of Childhood Illness Strategy, and Community Management of Acute Malnutrition Initiative. These policies have been aligned with within the National Strategic Health Development Plan (2010–1015). Additionally, although iCCM has not been a major component of Nigeria's past malaria policies, the most recent National Malaria Control Strategy (2014–2020) restates the government's commitment to create an environment that enables access to diagnosis and treatment of malaria through the deployment of CHWs in areas that do not have fixed health facilities within a five-kilometer radius of the settlement. In this regard, PMI's 2015 Operational Plan for Nigeria notes the importance of iCCM for expanding access to diagnosis and treatment of malaria in hard-to-reach communities. Finally, other supportive policy documents include iCCM training curriculum, as well as informational, educational, and marketing materials, as well as reporting tools that are used by CORPs and CHEWs. iCCM monitoring tools have been developed and iCCM indicators have been identified to evaluate its integration into the national Health Management Information System (HMIS), once iCCM becomes part of the formal service delivery.

[12] Specific members:

- FMOH: Director, Family Health Department (Chairman); Director, Public Health; Director, Community Services Department-NPHCDA; Director, Sure-P MNCH, NPHCDA; Director, Department of Food and Drug; Director General, NAFDAC; Head, Child Health Division; National Coordinator, National Malaria Elimination Program; Head, Nutrition Division; Head, Health Promotion Division; Desk Officer, Save One Million Lives
- Programme Officers: Four each, Child Health Division, NMCP, NPHCDA
- Professional Associations: President, Paediatric Association of Nigeria**;** President, National Association of Nigeria Nurses and Midwives**;** Registrar, Community Health Practical Board; Nutrition Society of Nigeria; Community Physician Association; Pharmaceutical Council of Nigeria. Institution: Director, Institute of Child Health, University of Nigeria, Enugu Campus.
- Partners: 3 WHO; 3 UNICEF; 1 USAID; 3 SUNmap; 1 PATH2; 1 Save the Children; 1 World Bank; 1 Jhpiego; 1 Canadian International Development Agency; 1CHAI; 1Malaria Consortium; 1SFH; 1USAID T/SHIP.

3. The Process of Developing the Global Fund Concept Note that Negotiated the Inclusion of iCCM

In March 2014, the Global Fund launched the NFM in Nigeria to consolidate funding for the country's existing malaria grants. Global Fund added approximately $316 million to the existing grants, yielding a combined total of $499 million for 2014–2017. The process of developing the Global Fund malaria concept note to integrate iCCM began at the December 2013 launch of the NFM in Nairobi, Kenya and the iCCM Evidence Review Symposium. Attending this meeting, which was held in Accra on March 3–7, 2014, were stakeholders from Nigeria (including representatives from the NMEP and Child Health Units of the FMOH. Informants describe the iCCM Evidence Review Symposium as important for obtaining the malaria stakeholders' buy-in of iCCM integration. One informant said: "It was at that meeting that it became clear to me that malaria will play a role in iCCM implementation in Nigeria. Before then, we saw malaria as a different program."

The development of the concept note had already begun by January 2014, but later that year in late March or early April, with support from UNICEF, two consultants were recruited to work with the Nigeria iCCM Task Force. The consultants' duties included: 1) drafting a document that clarifies the relationship and linkages between iCCM policy and implementation and the National Malaria Strategic Plan; 2) conducting an iCCM program and financial gap analyses; and 3) ensuring that iCCM was included in the Global Fund NFM concept note submission. One consultant responsible for drafting the iCCM narrative for the concept note was hired for about one month, which included spending ten days in Abuja; the other consultant did the gap analysis. The two iCCM consultants acted as liaisons between the Child Health and Malaria Units.

Development of the concept note began with a meeting of a core team responsible for the actual writing (Figure 2). This meeting included the two principal recipients—SFH and the NMEP—and was chaired by the WHO, and led by the NMEP. An iCCM subgroup was also formed and included representatives from Child Health, NMEP, NPHCDA, UNICEF, WHO, PMI, Malaria Consortium, and USAID. During her time in Abuja, the UNICEF consultant responsible for drafting the iCCM narrative in the concept note participated in a meeting with the iCCM subgroup of the Task Force, and held separate meetings with representatives from Child Health, malaria, and the concept note development team.

During meetings throughout April 2014, stakeholders reviewed lessons learned from the iCCM pilots, discussed how to meet the Global Fund criteria for iCCM funding (demonstrable commitment to fund non-malarial commodities in selected states), and discussed how many and in which states to propose supporting iCCM scale-up. There was much discussion about selecting states for iCCM implementation. Before the consultants were hired, a team was already working on iCCM scale-up costs for the concept note in two states. When the iCCM consultants joined, the Global Fund decided that gap analysis should focus on four states. After much back and forth with the iCCM subgroup to determine the criteria for selecting these additional two states, the decision was made to keep to the original number of two states (Table 2).

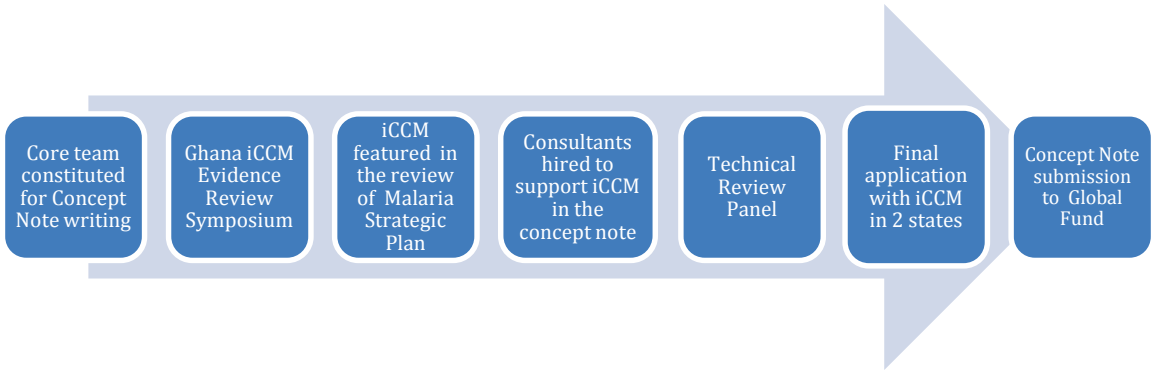
The discussion about the number of states appears to have been driven by several things: a push from Global Fund and the Child Health Unit to increase, if possible, the number of states benefitting from Global Fund iCCM support; and malaria stakeholder reluctance to spread malaria resources too thinly across too many different activities. One iCCM consultant said that collaboration between the Child Health and Malaria

Units was like a, "Marriage of two people who don't want to be married." One department had the technical competency in iCCM (Child Health) and one had the money and profile (Malaria). Of the $499 million allocated by Global Fund, "Something like $167 million was for nets alone," said this consultant. "Plus there was a need to fund drugs, RDTs, everything. So these resources, already allocated by the Global Fund for malaria control, were tight and there was therefore strong competition within malaria sub-elements for those funds. Now, they were supposed to use it to support the platform costs, like training and supervision of more CORPs, for iCCM. It was a hard sell."

In addition, there was a general concern among all stakeholders about procurement of non-malarial commodities, and supporting the procurement of supply chain management (PSM) more generally. PSM activities are fundamental to program performance, and in order to include support for iCCM in the Global Fund concept note, stakeholders had to be assured that other partners would support non-malarial commodities. This issue, in fact, limited the number of states that were recommended for iCCM support in the concept note to two (Table 2), because UNICEF and WHO/RAcE committed to supplying the non-malarial commodities there.

Finally, there were concerns about the availability of necessary human resources for scaling up iCCM, in terms of capacity gaps that would require additional training and intense monitoring and supervision. Some informants also raised concerns about the possibility of the CORPs misusing antibiotics, especially the PPMVs. It was suggested that the latter could be explored through operations research.

Figure 2. Process of developing the malaria Global Fund New Funding Model concept note



Note: Integrated community case management (iCCM)

ICCM Activities Approved

The NMEP submitted the malaria concept note to the Global Fund on June 15, 2014. Following review by the Technical Review Panel, the Global Fund Board approved a final budget in late 2014. The concept note was completed in January 2015, and the grant was signed in April 2015.

The case management and health systems strengthening components of the concept note will support the scale-up of iCCM in two states: Niger (RAcE, 16 LGAs[13]) and Kebbi (UNICEF). The concept note states: "ACTs for facility-based implementation will be distributed to the public and private health facilities, while ACTs for CCM of malaria will be delivered at the community level using iCCM and community case management of malaria approaches in two and 22 states, respectively. The sum of $2,796, 651[14] is allocated

[13] RAcE was approached by NMEP (formally, a letter of request) asking if they could buy ACTs so they could expand in 16 LGAs in Niger, and this has been approved. This means iCCM will be implemented in 25 LGAs in Niger, with only 3 remaining LGAs that need to be covered by the state government.
[14] Updated based on FTT Dashboard (version May 2015).

for iCCM to cover training of CORPs and other health systems strengthening activities, excluding the cost of ACTs" (Global Fund 2014, 23).

Despite the supportive environment for iCCM, Nigeria will continue to implement two-tier case management services. One, as a component of iCCM, and two, as a standalone CCM of malaria. The approach to iCCM is to leverage states that are currently implementing iCCM under the RAcE and UNICEF/European Union projects. On the other hand, according to the concept note, CCM of malaria will be deployed in other states where iCCM is not currently being implemented, in order to accelerate and improve access to malaria treatment (Global Fund 2014, 30). This also means that iCCM can later be expanded to the 22 states that will be implementing CCM of malaria only, depending on the availability of additional funding for training of CORPs, as well as the supply of non-malarial commodities.

In Kebbi, there are 947 hard-to-reach settlements in 21 LGAs; UNICEF iCCM is currently operational in 725 of these settlements. The Global Fund will support scale-up in the remaining settlements. Non-malarial iCCM commodities will be provided by WHO in Niger and UNICEF/European Union in Kebbi, as well as by the state MOHs in both states. NFM funding will also support national and state level quarterly meetings of the iCCM Task Force.

Incentive[15] funding was proposed (but not yet approved as of May 2015) for iCCM in eight additional states: Abia (RAcE); Adamawa (UNICEF); Akwa Ibom; Benue; Katsina; Ogun; Oyo; and Sokoto.

In terms of training, NFM funding will support training for more than 22,000 CORPs in iCCM, which will be implemented through a series of activities from the national to the community levels. At the national level, master trainers will be identified and given orientations or refreshers to support training at the state level. At the state level, iCCM trainers will be identified and trained with the aim of leading the training of the CORPs at the community level. Detailed training roll-out plans have also been developed as part of the finalization of national and state level implementation plans (Global Fund).

Table 2. Summary of funding need, target states and eligible Global Fund gaps for iCCM included in the concept note

Two states included in the country allocation (indicative funding) request			
	2015	**2016**	**Total**
Total iCCM funding needed (excluding ACTs and RDTs but including other iCCM medicines)	$3,783,103	$2,421,641	$6,204,743
Total iCCM funding available (partners and phase II)	$1,645,809	$1,762,283	$3,408,092
iCCM funding through GF NFM	$2,137,294	$659,358	$2,796,651
Eight states included in incentive funding request			
Total iCCM funding needed (excluding ACTs and RDTs but including other iCCM medicines)	$16,543,368	$9,825,766	$26,369,134

[15] "In the new funding model, there are two types of funding available; the country allocation (indicative) amount and incentive funding. The country allocation is derived from an allocation formula for each country and is adjusted based on qualitative criteria. It should represent predictable funding to support countries' prioritized interventions and activities. Incentive funding is a separate reserve of funding that encourages ambitious requests for programs with a potential for increased, quantifiable impact. It is made available, on a competitive basis, to applicants in the same band whose requests are based on robust national strategic plans or a full expression of prioritized demand for strategic interventions, based on a program review." http://www.theglobalfund.org/documents/core/newfundingmodel/Core_NewFundingModel_FAQ_en/ Accessed October 8, 2015

Two states included in the country allocation (indicative funding) request			
	2015	**2016**	**Total**
Total iCCM funding available (partners and phase II)	$6,379,939	$6,645,517	$13,025,456
Final iCCM funding gap	$10,163,429	$3,180,248	$13,343,678

Source: iCCM Gap Analysis 2014

Notes: Artemisinin-based combination therapy (ACT); Global Fund (GF); New Funding Model (NFM); Integrated community case management (iCCM); Rapid diagnostic test (RDT);

4. Implementation Arrangements of iCCM Activities funded through the Global Fund

The two principal recipients, NMEP and SFH, representing the public and private sectors, respectively, were identified by the Country Coordinating Mechanism. Sub-recipients will be state malaria programs and NGOs.[16] During this assessment, both principal recipients were in the process of recruiting sub-recipients and finalizing their implementation plans.

As mentioned earlier, the national implementation plan for iCCM for 2015–2016 was developed in April 2014, and outlines coordination mechanisms, procurement, supply and management, information, reporting flow, and monitoring and evaluation. Nigeria's federal government, through the National iCCM Task Force, will provide direction to states on how to use the national iCCM guidelines, while states will adapt the guidelines to suit the local context. The Nigerian National iCCM Task Force is responsible for coordinating the implementation of iCCM. National, state, and LGA iCCM Task Forces, in conjunction with the Core Technical Committee for maternal, newborn and child health, will coordinate iCCM activities (Appendix 2). UNICEF is facilitating recruitment of a full-time iCCM National Coordinator to be based at the Child Health Unit of the FMOH, where the iCCM secretariat is housed. The iCCM National Coordinator will oversee the implementation of all iCCM-planned activities, including the development of an iCCM strategic plan. To facilitate development of the iCCM strategic plan, funds from the Bill & Melinda Gates Foundation will be used to provide iCCM technical assistance (within the FMOH) for two years.

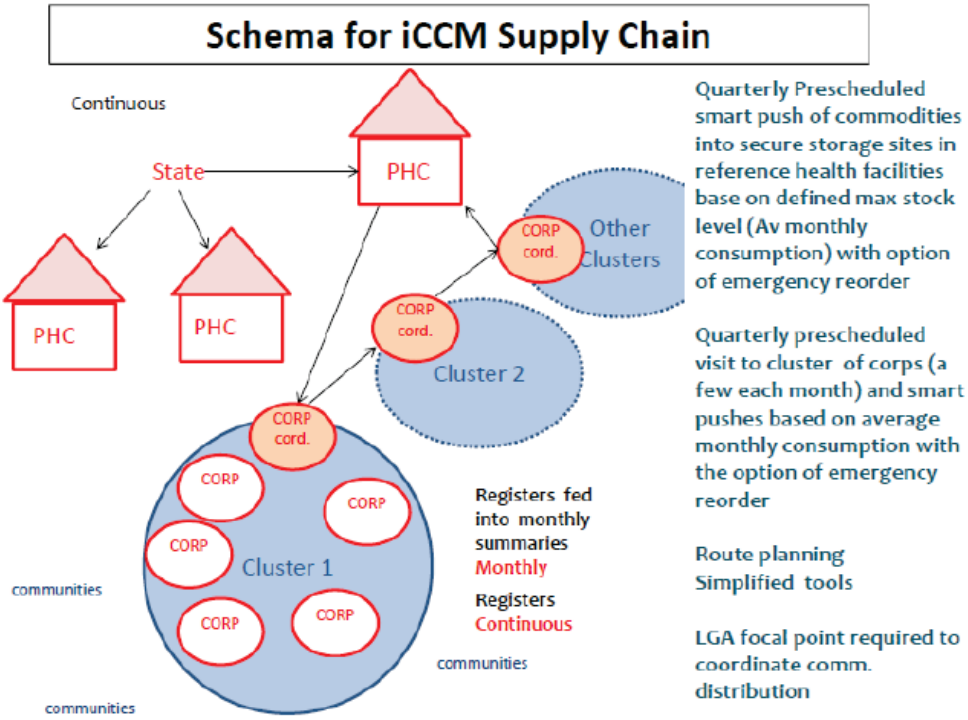
Procurement and Supply Chain Management for Non-Malarial Commodities

Non-malarial commodities will be relocated from the Federal Central Medical Stores to the State Central Medical Stores, where they will be managed by the state-level manager for Roll Back Malaria. From there, they will be transported directly to the health facilities, circumventing the LGAs. However, in the state of Kebbi, distribution of non-malarial commodities will follow the existing structure: state will distribute to LGA; LGA will distribute to health facilities; and health facilities will distribute to the community.

From the health facilities to the CORPs, the iCCM drug supply chain will follow the same scheme that is planned for the six LGAs in Niger that are already supported by the WHO/RAcE project (Figure 3). The UNICEF model is similar, but has in place CHEWs as supervisors, not the CORPs coordinator. Ten CORPs within a given ward will report to one CHEW supervisor (nine CORPs in the case of Kebbi). The CHEW supervisor's role is to actively monitor, support, and supervise the CORPs on a daily basis, and report back to the health facility in charge.

[16] The NGO sub-recipients are yet to be identified. At the time of this assessment, both PRs had publicized requests for expressions of interest.

Figure 3. Schema for iCCM supply chain



Source: Malaria Consortium

Note: local government authority (LGA); primary health care (PHC)

Monitoring and Reporting

A review of the Global Fund NFM's iCCM implementation plan shows that the two principal recipients will have overall responsibility for reporting to the Global Fund. iCCM monitoring and reporting will be aligned with the National HMIS. Specifically, CHEWs and CORPs will report their activities in the CHEW/CORPs iCCM Register and the iCCM Quarterly Report. Each quarter, this information will be compiled and summarized at the health facility level, and subsequently entered into the National HMIS. The MOH will then share this information with key partners, including the two principal recipients and the Global Fund.

Information on commodity requirements will be reported by the CORPs and the PHC facilities. Quantifications based on the combined needs of the CORPs and facilities will be forwarded to the district; the district will transmit this information to the National Medical Stores via the electronic Logistics Management Information System. National Medical Stores will then supply the drugs/commodities as requested.

As much as possible, reporting will be streamlined across multiple donors. For instance, due to the co-funded nature of iCCM in the state of Niger (support from both the Global Fund and WHO/RAcE), stakeholders believe that reporting needs to be channeled through the HMIS to not double the burden.

Areas Where More Support Is Needed

During a February 2015 National iCCM Task Force meeting, partners presented project updates from the four iCCM pilot states. Some of the challenges reported were: the identification of eligible communities; delays in procurement of non-malarial medicines and commodities; and concerns about CHEWs and CORPs dispensing antibiotics. The states of Adamawa and Kebbi reported delays in training trainers, non-availability of materials for training, shortage of human resources for iCCM at lower levels, and security challenges in northeastern Nigeria. The issue of health worker strikes is common to all states, and will affect training and supportive supervision of CORPs.

Among the lessons learned, Task Force members reported that:

- Behavior change communication activities have resulted in strong support from the states, LGAs, and communities.
- Most PHC facilities are not fully functional to receive referrals from the communities.
- Definition of hard-to-reach communities includes not only physical barriers (i.e., outside a 5 km radius of a health center), but also socioeconomic barriers.
- States reported the need for a simpler and concise CORPs training manual.
- The involvement of members of the Ward Development Committees, both as CORPs and drug keepers, was identified as good practice and was noted as contributing to the project's success thus far
- More exploration is needed on the use of incentives to motivate CORPs to do iCCM.

In addition, moving ahead, informants noted the need to strengthen governance and leadership structures responsible for iCCM implementation. For example, one informant said of the Task Force: "Child Health knows it is responsible for iCCM and the Task Force has a structure for pie sharing. The problem is the doing, 'boots on the ground.'" The Task Force is relatively new, and it will take time to develop the systems and routines for decision-making around iCCM.

Another concern is ensuring the capacity of the health workforce to implement iCCM. The caliber of CORPs needed to implement iCCM is different from what was required to implement CCM of malaria only. One informant noted that some CORPs who currently implement CCM for malaria will not be able to implement iCCM. Another informant echoed this point, noting that one of the biggest challenges ahead will be, "The capacity of less-educated CORPs for comprehension of training materials." This is supported by partners, like SFH, who noted that capability to implement iCCM is stronger among PPMVs, who are entrepreneurs with a basic- or secondary-level education. Non-PPMV CORPs in remote areas are less likely to have completed basic-level education. Regarding non-malarial commodities, there may be opportunities to leverage funds from other programs. For example, the Subsidy Reinvestment Program (SURE-P) purchases commodities relevant to iCCM. (Nigeria dedicates debt-relief funds to the SURE-P to accelerate achievement of health-related MDGs to reduce child and maternal mortality in states where iCCM has been prioritized.) In Kebbie state, zinc tablets have been provided to the state by SURE-P. There may be other opportunities to leverage other programs in this way.

The evolving role of the private sector was also noted as an important area for the government to address. Said one informant: "Public-private partnership, especially with PPMVs, is critical to iCCM success. There is a need to update their knowledge and skills, but this should be done in line with government standards and following due process. All partners working with PPMVs should ensure they work with Pharmaceutical Council of Nigeria-licensed ones. Evidence is critical for policy decision."

In this regard, PMI is helping fund a nine-month pilot study of PPMVs scheduled to start in September 2015. This study will have intervention and control arms focusing on PPMVs and their corresponding catchment areas. Training in iCCM will be provided to the PPMVs and a waiver is being sought in order to permit use of RDTs and ACTs in the intervention sites. If this pilot study yields encouraging results (e.g., appropriate distribution of an ACT based on a positive RDT, and referral of RDT-negative fever), then the next intended step would be to advocate for the revision of regulations that would permit PPMVs to diagnose, treat, or refer non-severe febrile disease as appropriate (President's Malaria Initiative 2015).

5. Analysis—What Worked and What Didn't?

What Worked Well?

A number of factors enabled the successful integration of iCCM into the Nigeria Global Fund malaria concept note. Stakeholders noted that the long-standing partnership between UNICEF and the Global Fund, and the recent global cooperative agreement to better coordinate efforts to reduce the burden of HIV, tuberculosis, malaria, and improve maternal and child health, catalyzed development partners to accept iCCM. Informants also cited the historically good relationships between the Global Fund (which was in favor of iCCM integration, as evidenced by the suggestion to include more states) and the NMEP in Nigeria, and the strong NMEP partnership with Roll Back Malaria. These relationships and the strong high-level leadership among global partners for integration provided the pressure and incentive to integrate iCCM. "Going in, I thought it was a given that iCCM would be included," said one informant who participated in concept note negotiations. "It didn't occur to anyone that it wasn't an option. It was viewed positively as a good opportunity." In Nigeria, this translated into an active collaboration between WHO, UNICEF, FMOH, PMI, USAID and the Malaria Consortium for integrating iCCM in the concept note. One informant reported: "Several consultative meetings were held with the right people and there was continuous consultation and dialogue throughout the process between key stakeholders in government, civil society, and the private sector. The core team drafting the concept note always fed back to a larger stakeholder group for their comments. This promoted ownership and participation. Because the iCCM concept is new to Nigeria, development partners taking the lead provided needed direction." The Child Health Unit specifically reported satisfaction with the level of consultations it experienced in developing the concept note, noting that no major decisions were made without their involvement throughout the process of writing the concept note.

It also helped that malaria stakeholders had, to some extent, been sensitized to iCCM because of the RAcE and UNICEF projects, and saw the value of iCCM. One informant remarked, "Integration is desirable because 60 percent of ACTs are going to unconfirmed malaria cases." Thus, malaria stakeholders saw value in iCCM, both as a means to avoid wasting ACTs and to reduce morbidity in children who are negative for malaria, but nonetheless in need of care and treatment. As one informant noted, "Malaria stakeholders [in Nigeria] are quite open to iCCM."

Informants also noted that the consultants hired to support the concept note development process were helpful in further sensitizing stakeholders to the benefits of iCCM, and supporting the iCCM concept note subgroup with doing the gap analysis and iCCM implementation strategy. Furthermore, iCCM informants noted that the gap analysis and investment case were useful advocacy tools in negotiating with malaria colleagues, and provided, for the first time, comprehensive costs for iCCM services. As noted by a representative from the Child Health Unit: "Before, there has not been a gap analysis to determine the actual cost of iCCM services and that is a gap in planning, budgeting, and advocacy." Work on costing is ongoing: consultants in the United States have worked on a costing template for iCCM, which the national iCCM Task Force is using to develop investment cases for advocating iCCM to states.[17]

What Didn't Work Well?

There are a number of interrelated factors that posed challenges to integrating the iCCM. One relates to the power dynamics between child health and malaria stakeholders. Malaria has traditionally been managed

[17] Personal communication with Abuja-based informant on April 27, 2015.

vertically, like HIV, separate from the rest of the health system. Historically, malaria has received more funding and visibility among donors than child health. Malaria also has a more defined structure for decision-making compared with the DFH, which houses the Child Health Unit. Because the NFM model requires malaria stakeholders to agree to share limited funds with iCCM, malaria stakeholders in Nigeria, as in other countries, were somewhat reluctant about iCCM. Thus, advocacy was needed to explain the benefits of the iCCM approach to malaria stakeholders. Yet the international consultants hired by UNICEF were the main iCCM proponents in the concept note development process. They were involved for a short time only and then left the country. Yet they—as opposed to a permanent staff member from the Child Health Unit—were responsible for advocating iCCM. Though the iCCM Task Force existed, it never met in the ten-day window when the iCCM consultants were in Abuja.

The consultants hired by UNICEF also began late in the concept note development process. The two consultants initially briefed with the iCCM subgroup on April 23, despite the fact that the subgroup had met twice before; there was only one additional debrief meeting scheduled for April 29, and it was with the lead consultant who developed the iCCM strategy. By then, the consultant who conducted the gap analysis and costing had moved on after submitting his work to the lead, and therefore, was not available to answer questions about costing formulas, etc., from the team who was writing the concept note. One respondent lamented that, "From this point on, the consultant handed over the costing component of the iCCM gap analysis to Ministry people, through the lead consultant for integration, and had no more input in the process. And since different actors were asking many questions about the costing formula for the investment case, and the initial lack of clarity about ownership of iCCM within the national structure loomed large, different actors were doing different things and synergy was lacking." Another informant echoes this view that the technical assistance needed to be extended: "Much of the grey areas about costing formula would have been clarified if the same consultants that supported iCCM gap analysis had followed through with the concept note writing." Stakeholders suggested streamlining this process in the future, and noted that the consultant who conducts gap analysis should also support the concept note team with actually writing the portions of the concept note that include iCCM-malaria integration.[18] The lack of a full-time iCCM focal person from the Child Health Unit to lead and manage the process was also noted as a constraint.

One informant noted that moving from CCM to iCCM meant considering in which health facilities to implement differently. In the Global Fund Round Seven,[19] 15 health facilities received Global Fund support in every supported LGA. The choice of health facilities was not made from an equity perspective, as one informant noted: "Some wards had no Global Fund-supported health facilities while others had more than one." In this model, CORPs supported by the Global Fund for CCM were concentrated in communities near these health facilities. With iCCM, the focus is on equity and reaching the hardest to reach, which requires ensuring activities are spread across wards and in communities that lack access to facilities.

Finally, a member of the concept note core writing team described the Global Fund NFM process as overly complex: "The initial concept note templates introduced by the Global Fund to guide the concept note writing were new and too complex, so there was a lot of back and forth to really get at what the Global Fund wanted. Also, there were too many documents for the core team to review within a short time." A lack of consistency at meetings of the concept note core team also slowed efforts, because organizations kept sending

[18] The NMEP led the concept note development process. The final concept note could only be accessed during the assessment from the NMEP, which included the iCCM implementation plan for the approved states. Neither the consultant hired by UNICEF to conduct the gap analysis nor the CH unit knew exactly how much funds had been allocated to iCCM in the proposal.

[19] Before the Global Fund NFM, funding was based on "Rounds" in response to call for applications.

"available" staff to meetings. The new entrants often struggled to understand the context before being able to make meaningful contributions.

Despite the success of achieving Global Fund support for iCCM platform costs in two states in Nigeria, integration remains a challenge. "A challenge looking ahead," said one informant, "is that the Global Fund grant supports implementation of both CCM in some places and iCCM in others. This is not really integration."

6. Conclusion & Recommendations

Nigeria was able to integrate iCCM into their Global Fund malaria concept note. The National iCCM Task Force proposed ten states, but the approval is for the scale-up in two states where iCCM is already being implemented, and where there is demonstrable commitment for provision of non-malarial commodities by government and development partners (UNICEF and WHO). From this assessment, some recommendations have emerged for the country and the global partners involved in supporting integration of iCCM into Global Fund NFM.

Country-Specific Recommendations

1. As iCCM is scaled up with Global Fund support, invest in operations research and disseminate emerging lessons and promising practices in: iCCM/malaria integration; use of volunteer CORPs versus the PPMVs; approaches to providing skill-building for CORPs who have different levels of education; and improving programming and cultivating buy-in among stakeholders.
2. Continue to pursue and secure clear commitments from government and partners on the procurement of non-malarial commodities and supplies to ensure provision of the full iCCM package.
3. Strengthen the role of the Task Force and its subgroups, and prioritize recruitment of a national focal person for iCCM who can work across both child health and malaria.
4. Assist states and LGAs to create iCCM task forces to coordinate and monitor the implementation of iCCM.
5. To ensure successful iCCM implementation, state-level staff should be assigned to monitor the iCCM product supply chain closely, and alert appropriate authorities about the low stock of an item.
6. Share the gap analysis report. Use the report to inform all stakeholders about the cost of implementing iCCM and to identify resource mobilization strategies to fill the gap.

Recommendations to Global Partners

1. Global Fund instructions could be less complicated and decisions made clearer, earlier to reduce gray areas and fatigue on country teams.
2. Donors that fund technical assistance should consider the value of continuity in the integration process—from gap analysis to proposal development to program planning to program implementation—while also remembering that international technical assistance cannot substitute for effective local leadership for iCCM.
3. Continue to advocate for Global Fund to support procurement of non-malarial commodities and supplies to ensure provision of the full iCCM package.

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Appendix 1: Individuals Interviewed or Contacted for Interviews

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[*]Contacted for follow-up questions, but did not receive a response.

[†]Contacted for follow-up questions, but did not receive a response. This person was interviewed by both the lead and sub-consultant.

[‡]These persons were interviewed by the lead consultant (i.e., these stakeholders were not interviewed by the sub-consultant). Among these interviews, Femi and Ogbulafor were very short email correspondences; thus, it was really only Franco, Kemi, and Obinna who provided helpful additional information.

Appendix 2: Institutional Arrangement for Current iCCM Implementation Plan

Institution	Terms of reference find and insert	Leadership	Milestones as of January 2015
National iCCM Task Force	• Provide strategic guidance, monitoring, and oversight at all levels of implementation • Develop a framework for iCCM implementation by aligning the key components—service delivery, procurement and supply chain management, and monitoring and evaluation • Undertake capacity building and behaviour change communication • Provide support to states to develop implementation plans and tools • Organize high profile advocacy activities • Mobilize resources and support for iCCM	Chair: Department of Family Health, FMOH Co-Chairs: NPHDA and NMEP Secretariats, Child Health Unit	• Adopted iCCM strategy in 2010 • Inaugurated national iCCM Task Force in February 2014 • Coordinated full implementation of iCCM in 4 states: Abia and Niger for the Rapid Access Expansion project (RAcE) with support from WHO; and Kebbi and Adamawa with support from UNICEF/Global Fund/European Union • Produced and circulated iCCM national implementation plan • Produced health workers training manual that includes a facilitator guide and job aids • Integrated monitoring tools and indicators have been into the national HMIS • Produced supervisor's manual • Produced essential commodities for iCCM (engagement, certification, production) locally: dispersible zinc and amoxicillin tablets; chlorhexidine gel for cord care

Institution	Terms of reference find and insert	Leadership	Milestones as of January 2015
Project Implementation and Support Subcommittee	• Develop the decision tree manual • Coordinate state roll-out • Develop iCCM-IMNCH implementation plan • Conduct situation analysis and needs assessment for implementation of the IMNCH strategy • Build capacity for program management and service delivery • Plan for operational research • Conduct partners and resource mapping and financial gap analysis • Address any other priorities as identified by iCCM task force	WHO	• Ensured that the Malaria Consortium presents the sample decision tree document • Set up task group for adaptation of the decision tree document • Ensured that activities in Abia (RAcE/SFH) and Niger (RAcE/MC/Global Fund) are ongoing • Ensured that activities in Kebbi (Unicef/Global Fund) are ongoing • Concluded following the completion of the IP, Advocacy kit, and other documents in the ICC toolkit • Drafted implementation plan • Ensured TSHIP supports the procurement of technical assistance to finalize document • Documented need for situation analysis documented; required resources • Developed training manuals • Completed ICCM training toolkit • Completed supervisor's manual that is currently in use in states implementing iCCM • Relocated OR to monitoring and evaluation SC • Requested support from MSH to develop national ICCM gap analysis; completed fraction during the Global Fund grant application

Institution	Terms of reference find and insert	Leadership	Milestones as of January 2015
Advocacy, Communication, and Resource Mobilization Subcommittee	• Develop advocacy and communication plan • Adopt/adapt existing tools to organize high profile advocacy activities • Mobilize additional resources for iCCM implementation • Facilitate BCC for iCCM activities • Investment plan • Address any other priorities as identified by iCCM task force	UNICEF	• Drafted advocacy/communication plan-CHAI • Drafted concept note for mobilizing resources in Nigeria • Considered two options for developing investment case: State by state data collection and costing—similar to MSH costing of Abia and Niger (more costly, may take longer, will need to link with impact); and MBB and LiST tools (shorter time, less direct costs, links costs and benefits) • Shared draft of advocacy/ communication kits (shared by SFH) • Procured additional resources for ICCM from BMGF ($1.4 million) for an ICCM scale-up in at least one state • Set up technical assistance ICCM task force (some of the recruitment on course
Monitoring, Evaluation, and Quality Assurance Subcommittee		USAID	

Notes: Clinton Health Access Initiative (CHAI), Federal Ministry of Health (FMOH), Global Fund (GF), Integrated community case management (iCCM), Integrated maternal, newborn and child health (IMNCH), Lives Saved Tool (LiST), marginal budgeting for bottlenecks tool (MBB), Malaria Consortium (MC), Management Sciences for Health (MSH), National Malaria Elimination Program (NMEP), National Primary Health Care Development Agency (NPHCDA), Operations Research (OR), Rapid Access Expansion Project (RAcE), supply chain (SC), Society for Family Health (SFH), (TSHIP), World Health Organization (WHO)