World Health Organization

Malaria

Rapid Access Expansion Programme in Nigeria

April 2018

High rates of preventable child mortality

WHO country profiles on neonatal and child health

There continue to be pronounced disparities in terms of health outcomes and access to health services, and under-5 mortality rates in rural areas are consistently higher than in urban areas. A dearth of human resources for health in rural areas contributes to these discrepancies.

Delivering treatment for childhood diseases in remote areas

Led by the Ministry of Health of Nigeria, the RAcE Programme was launched in November 2013 in Abia and Niger States and ended in October 2017. The aim of the Programme was to deliver and monitor integrated community case management (iCCM) services in rural communities in hard to-reach areas.

This involved recruiting community health workers – known as community-oriented resource persons or CORPs – who live and work in the communities. The CORPs were trained to diagnose and treat children, using RAcE-provided commodities, including acute respiratory infection timers, rapid diagnostic tests, medicines and oral rehydration solution. The community-oriented resource persons were supervised and mentored by community health extension workers (CHEWs) based at the primary health care centres. This system supported CORPs case management skills, as well as data collection and reporting needs.

The RAcE programme pioneered iCCM implementation in the country to the extent that its activities led to the adoption of national guidelines for iCCM implementation.

Better services and fewer child deaths

A final evaluation conducted by ICF International for the period of 2013-2016 demonstrated that an estimated 2,469 under-5 lives were saved by malaria, pneumonia and diarrhoea treatment; an estimated 967 lives were saved in Abia State and 1,274 lives were saved in Niger State by treatment from a relais; and a 12% reduction in under-5 mortality in Abia State and a 14.5% reduction in under-5 mortality in Niger State.

Partners

In Niger State, Malaria Consortium was the main sub-recipient of the WHO grant. Malaria Consortium, WHO, local authorities, traditional structures and the Federation of Muslim Women in Nigeria supported the State Ministry of Health and the Niger State Primary Health Care Development Agency in introducing and monitoring iCCM services in hard-to-reach areas in 6 local government areas for the first time.

ICF International provided support for strengthening improving data quality and conducting baseline and end line surveys.

The partners supported the state and federal ministries of health in:

- effecting state and nationwide policy change;
- developing guidelines and plans for state and nationwide iCCM scale-up;
- recruiting, training and motivating community-oriented resource persons and their supervisors;
- mobilizing communities to create demand for iCCM services;
- incorporating iCCM into the Reproductive, Maternal, Newborn, and Child Health plus Neonatal (RMNCH+N) strategy document;
- strengthening reporting and data quality; and
- improving the procurement and distribution of iCCM commodities.

A prominent element of RAcE Programme success in Nigeria was the strong federal and state collaboration, as well as intergovernmental coordination through the Maternal, Neonatal, and Child Health Programme, the National Malaria Elimination Programme, and the Primary Health Care Development Agency.

In the communities

Community-oriented resource persons are volunteers selected by the community who must be able to read and write. Under the RAcE Programme, CORPs participate in 6 days of iCCM training. They receive an incentive of approximately 20 dollars that supports transport costs. Community health extension workers who supervise the CORPs provide services at the health facility level.

By training and supporting people who live in the communities, RAcE increased accessibility for caregivers who previously had to travel long distances, supported accurate diagnosis and correct treatment, and augments acceptance by community members. Mobilization activities, undertaken with the support and advice of women’s, religious and community leader groups, increased uptake of care-seeking and augment CORPs credibility.

Consultation with community groups resulted in local, simplified and non-technical language to deliver information about the Programme to caregivers, as well as participatory learning. The social mobilization initiative increased acceptability and reception by key stakeholders among community leaders, women leaders and gatekeepers to create an enabling environment. During special bi-monthly sensitization weeks, particularly in remote farming communities, CORPs actively sought sick children to provide service.

Challenges

Long distances often led to infrequent supervisory contact. To increase the frequency and quality of supervision, the RAcE programme evaluated a peer-supervision model. As well, RAcE staff recommended adjustments to the supervisory visits, counselling CHEWs to embrace the opportunity to counsel through live evaluation of CORPs activities, rather than through case scenarios.

The financial incentive provided to CORPs was seen by some as sub-optimal, and as a result, CORPs often left to pursue better livelihoods elsewhere. Communities were being encouraged to support their CORPs in order to motivate them to remain in their posts.

RAcE-supported operational research

An evaluation of the management of chest indrawing pneumonia with oral amoxicillin in children aged 2-59 months of age by CORPs was conducted in Niger State. Results are expected in spring 2018.

Policy changes

To receive the RAcE Programme grant, the Federal Ministry of Health established the national iCCM task force and sub-committees, developed national guidelines on iCCM, and updated relevant policies and strategies to incorporate iCCM into national policy. For example, through the adoption of task shifting and task sharing for essential health care services, national policy now allows CORPs to giver amoxicillin to children under 5.

National guides and training manuals on capacity building for iCCM service provision, data management, supervision and evaluation also were developed.

Nigeria established a strong iCCM coordination platform led by the Federal Ministry of Health iCCM task force. The involvement of multiple development partners in this platform made way for consensus on implementation of iCCM within existing health system structure and scale-up in Nigeria. The task force held regular meetings and established partner-led subcommittees on implementation (WHO), monitoring and evaluation (USAID), and resource mobilization (UNICEF).

At the state level, strong engagement with the State Ministry of Health led to functional iCCM state steering committees in Abia and Niger including local government area chair persons. The RAcE approach has proven the value of government leadership at national, regional and local areas in programme implementation.

Beyond Abia and Niger States, WHO supported efforts, including transferring lessons learned from the RAcE Programme, to implement iCCM in humanitarian and emergency settings in the north east of Nigeria.

The RAcE Programme in numbers

Catchment population	Catchment under-five population	CHW trained*	CHW active*	Total cumulative cases treated*

The RAcE Programme in numbers

2 432 457 people in hard-to-reach areas	407 057 children under five	3155	2681	• 782 004 malaria cases • 389 733 diarrhoea cases • 234 311 pneumonia cases

* Since the start of the Programme
Data April 2018