COUNTDOWN
Calling time on Neglected Tropical Diseases

Nigeria Situational Analysis | Brief 3

Human Resource Constraints Affecting Community Directed Treatment for Neglected Tropical Diseases: A challenging model for Nigeria's frontline workers

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The COU**NTD**OWN project conducted an NTD situational analysis between February and April 2017 in Kaduna and Ogun States, Nigeria. The study consists of a literature review, a policy review and a qualitative component. Findings were triangulated and synthesised into key outcomes, presented in this series of 4 briefs. This brief presents findings of the situation analysis relating to the management of human resources and support for frontline health implementers in the NTD elimination programme.

A participatory workshop with CDDs in Kaduna State, Nigeria

Community Drug Distributors (CDDs) and teachers are the frontline implementers of many NTD control and elimination strategies, particularly mass administration of medicines (MAM), also called mass drug administration. Data suggests there are over 10,000 CDDs and teachers involved in MAM just in Kaduna and Ogun States, in Nigeria. These volunteer workers are an essential link between health services and endemic communities. They play a role not only in medicine administration itself, but also in the critical activity of community engagement.

Key Messages

- The process of selection of Community Directed Distributors (CDDs) varies between communities. Challenges emerge where traditional community directed approaches are not followed. For example, when CDDs are selected by health centre officials there is a decline in community ownership which leads to a lack of community desire to incentivise CDDs, who may become demotivated and disengaged.

- CDD attrition is affected by other health programmes that provide financial incentives for community workers. Consequently, there are shortages of available CDDs in some areas.

- Training of frontline workers is cascaded. The duration of training is thought to be short and the programme lacks standardised training manuals that address complex treatment cases.

- In many cases, only one teacher per school is selected and trained to deliver deworming. In theory, the training is cascaded to other teachers. However, teachers have misperceptions of the incentives paid to the trained teacher, which leads to their disengagement with the programme. This results in overburdening the only trained teacher and compromises his/her effectiveness.

- A lack of motivation among teachers involved in deworming is a programme bottleneck. Most teachers interviewed felt that deworming was an extra responsibility rather than a mandatory task and they wanted to be remunerated accordingly.

The recruitment, training, and retention of frontline implementers is key to the success, sustainability and quality of the NTD programme and its ability to meet disease control and elimination goals.

Key Findings

Inadequate training of frontline implementers

There are national guidelines on the training and re-training of frontline health implementers. For both CDDs and teachers, training and re-training occurs annually and should be cascaded down from state to community/school. All CDDs should receive training and at least two teachers from each school, based on the school population, should be selected for training in the implementation areas[1].

CDDs in both states reported that the duration of the training (one day) was too short to fully understand the content and requirements of the job. CDDs reported confusion about treatment protocols for rare scenarios, such as determining dosages for people with disabilities or those unable to stand by a dose pole. CDDs also reported that trainers did not provide standardised responses to their questions about complex scenarios, ultimately resulting in inadequate treatment of those groups.

Frontline health facility staff reported similar issues, stating that the short training duration made them feel overwhelmed and affected the quality of training being passed on to the implementers (CDDs and teachers). They also felt this compromised their ability to be able to provide supportive supervision. Finally, teachers noted a lack of training manuals that they could refer to during programme implementation and in one case, teachers were given drugs to distribute without training.

Insufficient teachers are trained for MAM in schools. In Ogun State, only one or two teachers are selected per school, and in Kaduna only the head teacher is invited to training. As the cascade training within schools is often unsuccessful, the workload of treating children often falls only to trained teachers.

'then the limited cooperation among the teachers….in my group we discussed that some teachers did not cooperate with the teachers that went for the training. They said that since two of them went for the training, the two should administer the drug for all the pupils. Which is not…which was not going well'

Participatory meeting with Teachers, Abeokuta North LGA, Ogun State

The Community Directed Intervention model is not fully implemented, which affects CDDs

The NTD programme in Nigeria draws heavily on the Community Directed Intervention (CDI) model originally developed within the onchocerciasis control programme. The cornerstone of CDI is that communities decide when, where and how to distribute medicines. They use participatory meetings to select their own volunteers (CDDs) and are encouraged to provide incentives (financial or non-financial) at their discretion to these volunteers. Key informants, CDDs, and frontline health facility staff pointed out that the CDI model was no longer working in this way in Nigeria. The CDD selection is predominantly done by the village head or by frontline health facility staff. This change in approach was explained by the lack of time and resources to conduct participatory meetings, the need to quickly replace CDDs who were not available, and difficulties in identifying people willing to volunteer for the programme.

Lack of community participation in CDD selection led to a reduction in community ownership of the programme - in some cases CDDs were selected from other communities - and consequently, their acceptance by the community was problematic. This was particularly prominent in Ogun State which does not have a long history of CDI.

'CDDs should be selected within their community because if community people do not recognize the CDD giving them the medicine they may not accept the drugs thinking it is something else'

Participatory meeting with Frontline Heath Facility staff, Ikara LGA, Kaduna State

Disengagement of the target communities from the selection of CDDs and poor knowledge of the CDI model resulted in a widespread perception that CDDs are incentivised by the government, as they are for the polio campaign. As a result, some communities decided to stop incentivising CDDs, who were left without any remuneration for their efforts. CDDs reported feeling demotivated and preferred to engage in other health programmes. **Some longstanding CDDs reported that while incentives were decreasing, their workload was increasing,** with CDDs being required to cover larger areas and more challenging contexts (such as geographically and socially isolated communities), and to deliver medicines more frequently as the NTD programme integrated and expanded. For example, in some communities, CDDs distribute ivermectin and albendazole and two weeks later distribute praziquantel. This leads to fewer individuals volunteering for the CDD role, while those who volunteer feel demotivated and disengaged.

'I came to be CDD over 19 years ago…I have continued to do the work because of the confidence the community has placed on me in selecting me. Other people who joined before have left the work and looked for something more lucrative to do…in the past people used to give me money when I go to distribution, they may also invite me to eat with them if they are eating or help me with my farm work on a dedicated day, but these days that is not so'

Participatory meeting with CDDs, Igabi LGA, Kaduna State

'I have said it before that an 'empty mouth does not make noise'. And our CDDs are not happy to work with us again because of no pay'

Participatory meeting with Frontline Health Facility Staff, Ijebu East LGA, Ogun State

Teachers feel they are inadequately compensated for MAM

Teachers involved in the deworming programme reported that treating school children was stressful and considered it to be extra work without extra payment. They expected some form of remuneration to encourage them; some teachers reported being demotivated despite their overall willingness to distribute the drugs. This issue was particularly evident in Ogun State, where only a few teachers per school were involved in MAM. Teachers attending the training for MAM received only a transportation allowance, although other teachers and the community believed they were paid. This undermined the cascade training in schools because other teachers believed those who were trained should share their incentives or bear the full responsibility for deworming. The initially trained teachers received little or no support from colleagues and wanted more health workers to be engaged in the administration of drugs**. A few teachers also felt that MAM should be the responsibility of health workers, not educators.** This view was particularly common in the areas where teachers were involved in community engagement activities or where they had to manage side effects, which was critical in the distribution of praziquantel.

'You see, some of us we want to participate in this thing, there should be provision for us. Because, going to the school, we have voluminous work in the school and you will involve us again in this type of thing…Even before we attend to our wives and husbands, the work is so much that there should be remuneration to encourage us on the job and make us happy'

Participatory meeting with teachers, Ijebu East LGA, Ogun State

Reference

1. The ratio of CDD to population in Nigeria is stated as follows: At least two persons should be selected by each community of 200 persons. (Federal Ministry of Health Nigeria. 2015. Training of Trainers Manual for FLHF workers, on NTD control and elimination. Federal Ministry of Health: Abuja).

Recommendations

This situational analysis highlights several challenges in the implementation of CDI and training of volunteers who play a vital role in enabling the community to access medicines. The training courses were thought to be too short and lack information on the management of complex situations. The number of teachers trained for deworming is insufficient and there are problems with cascading the training to other staff. Both CDDs and teachers feel that they are not appropriately incentivised for their efforts; many teachers believe that the administration of drugs lies outside their role, while CDDs are not incentivised by communities who are disengaged from their selection. These frontline implementers are central to the success and sustainability of the NTD programme in Nigeria; therefore, the following critical activities are recommended to ensure their continued engagement:

1. Explore the most effective approaches for re-engaging CDDs, teachers, and their communities with the NTD programme in different contexts. This may involve returning to the original CDI model, where the community is involved in the appointment and remuneration of CDDs; or it may involve the development of alternative strategies for the community level.

2. Research the cost implications of different incentive packages (financial and non-financial) for frontline implementers and how the provision of incentives would fit with the current and future NTD programme implementation.

3. Review the existing training materials for inclusion of different treatment scenarios and update them where necessary. A variety of treatment scenarios should be prioritised during training, monitoring, and supervision of CDDs, and the length of training should also be reviewed.

4. Provide basic training materials to all frontline implementers. More detailed reference materials should also be available in health facilities and schools to assist frontline staff in managing complex cases and supervision.

5. Increase the number of teachers trained for MAM, improve transparency of teacher selection and encourage annual rotation for attending the training.

6. Research to better understand the exact scope of work and activities completed by CDDs and teachers, to ascertain the costs of the work they do with the NTD programme in terms of time and lost wages. Specific thought should be given to the point at which a task shifts from a volunteer position to a salaried job.

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