Collaborative Action Strategy (CAS) Customization

Rapid CAS Feasibility Assessment for Nigeria

Assessment conducted between April & June 2024 by a team from the HCE Coalition's Program Office (Task Force for Global Health and Camber Collective) in collaboration with the Nigerian F-MOH / NPHCDA

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Executive Summary

Objectives and Methods

This feasibility assessment meant to collaboratively develop a knowledge base to support CAS implementation in Nigeria, mobilising many sources

Primary focus of the assessment

Objectives

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Campaigns	**Partners/Stakeholders**	**Opportunities**	**Recommendations**
Develop a snapshot of the current **state of campaigns, capacities, and resources available** and needed for CAS customization & execution	Identify **current and required partners** for CAS customization and implementation	Identify the risks, challenges, and **opportunities to CAS implementation**	Assess individual CAS recommendation **feasibility and sequencing** in the Nigerian context

Methods

Initial Workshop	Interviews	Document Review
Organised a workshop April 22nd – 23rd 2024 to launch the CAS customisation process. As preparation for that workshop, **validated and verified data on current and past Nigerian health campaigns**	**Conducted in-depth interviews with over 30 key Ministry of Health (MoH), NPHCDA, national and subnational stakeholders and key partners**	**Collected and reviewed strategic documents** related to campaigns to inform this feasibility assessment and augment interviews.

Nigeria Summary: The CAS as a SWAp tool

Nigeria can build on its political momentum with the adoption of the Sector-Wide Approach (SWAp), which the CAS can serve

Nigeria is at a crossroads for health campaigns, and there are critical challenges to overcome

Political Commitment

There is clear commitment at all political levels and within partners in the country towards fewer campaigns, increased campaign efficiency, and integration into the PHC system.

Continuous commitment towards the CAS at the highest-level of government will be critical for its success.

Institutional Knowledge

Nigeria can leverage on its wide government infrastructure, history of improving government collaboration (e.g., PHC Under One Roof), and history of integration.

The country has already demonstrated its potential for campaign integration (e.g. MNCH week; 2022 COVID/Measles/Yellow Fever/Vitamin A/Birth registration campaign).

Near-Term Momentum

Intra- and inter-department norms are changing. A clear first step is to align with the SWAp and foster information sharing (specifically within NPHCDA).

Furthermore, CAS implementation will need to happen in three distinct phases:

1. Develop norms & anchor to the SWAp
2. Gather necessary insights
3. Systematize collaboration

Bandwidth Constraints

Teams are overburdened at all levels (national and subnational). Additional bandwidth must be freed by rationalising and leveraging existing structures in implementing CAS (e.g., merging working groups or limiting duplication).

The SWAp's Resource Mobilisation WG work will help to provide additional bandwidth, but more will be needed.

Polio Integration

Polio represents almost half of all identified campaigns in 2019-2026.

Integration efforts so far rarely included Polio because of different priorities, workforces, methods, etc.

Identifying ways of collaborating more with the Polio campaigns is critical to CAS success.

Collaboration Disincentives

While stakeholders at all levels state a clear fatigue towards the numerous campaigns, there are disincentives to collaboration and integration to overcome (e.g., siloed internal and external working structure; disparate per-diem practices; apprehension towards a perceived decrease in funding or efficiency).

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Overview of support needed

To ensure CAS uptake, teams at all levels must be inspired, engaged and have access to the right level of resources

CAS customization & planning in Nigeria will mandate four kinds of specific support[1]:

	SWAp Integration & Political Will	Subnational & Local Involvement	Flexible & CAS-Relevant Funding	HR / Bandwidth
	Government	*Government*	*Donors/Partners*	*Government & Donors/Partners*
General need	Sitting CAS governance at the right level, and ensuring inclusion within the SWAp and continuous commitment of the highest-level of government is key for CAS uptake and ultimate success	Bottom-up involvement, and regular socialization of state, and community level stakeholders will be needed from the Nigerian government to ensure state and community support for the CAS	International donors and campaign implementers should facilitate a timely release of funding and mitigate counterpart funding delays through embedded flexibility in disease-specific programs budgets or bridge loans	Additional human resources to lead change management efforts is anticipated, implement integrated campaigns (e.g., HEWs)[2], as well as capability building targeting key stakeholders in states
Examples	• Create a CAS specific working group within the SWAp • Continually provide progress updates to Hon. Prof. Pate & depart. heads (e.g., in the final customization workshop)	• Develop subnational/state consultation processes • Invite subnational representatives to final customization workshop • Stand up state level WG	• Donors' country rep to liaise with MoH/NPHCDA identify bridging funding in states with limited counterpart funding, flexibility within current funding, or imbed CAS in upcoming grants[1]	• Free up bandwidth for TA for CAS in embedded teams in MoH/NPHCDA (e.g., CDC, UNICEF) • Set aside capacity building funds • Increase CAS advocacy efforts

1. Additional context and recommendations based on the SWOT analysis are provided on slide 20
2. e.g., with Global Fund, GAVI ; 2. Health Extension Workers

Objectives & Methodology

Feasibility assessment objectives

The rapid feasibility assessment is meant to develop a knowledge base that can support CAS customization, planning, & implementation efforts

Primary focus

1 Campaigns

Develop a snapshot of the current **state of campaigns** (e.g., current and future campaigns), **capacities, and resources available** and needed for CAS customisation & execution

2 Partners/Stakeholders

Identify **current and required partners** for CAS customization and implementation

3 Opportunities

Identify the risks, challenges, and **opportunities to CAS implementation**

4 Recommendations

Assess individual CAS recommendation **feasibility and sequencing** in the Nigerian context

Overview of assessment methods

Initial Workshop

Organised a workshop April 22nd – 23rd 2024 to launch the CAS customisation process in Nigeria and initiate the CAS specific TWG to develop a shared understanding of the CAS and begin the process of adapting the CAS to a Nigerian context.

As preparation for that workshop, **validated and verified data on current and past Nigerian[1] health campaigns** (e.g., cross-checked during interviews and with key Nigerian stakeholders).

Interviews

Conducted in-depth interviews with over 30 key Ministry of Health (MoH), NPHCDA, national and subnational stakeholders and key partners

Interviews were conducted in April-May 2024, notably with:

- Federal MoH teams: NTD, HIV/AIDS, Malaria, Health Promotion, Nutrition
- NPHCDA teams: Disease Control, Nutrition, PHC System Development
- Subnational stakeholders: State Immunization Officers, NPHCDA Zonal Directors, Zonal NTD officers
- Key partners: GAVI, WHO, UNICEF, BMGF, Carter Center, CDC

Document Review

Collected and reviewed strategic documents related to campaigns to inform this feasibility assessment and augment interviews.

Documents reviewed include:

- the Strategy for PHC Revitalisation in Nigeria
- the National Strategic Plan of Action for Nutrition
- Nigeria's National Malaria Strategic Plan 2021-2025
- The NTD Master Plan 2023
- National Polio Emergency Action Plan
- National Gender in Health Policy 21-25

1. Linksbridge's Health Campaigns Intelligence Hub was leveraged

Stakeholder Interviews

We held 45-60 min semi-structured interviews with select health campaign related MOH and NPHCDA departments at the federal and subnational level, and key partners to understand the campaign ecosystem in Nigeria

We would like to thank the over 30 individuals (and organisations) who provided their valuable perspectives during this process, including:

Ministry of Health (MoH)

- *Public Health*
  - *NTD Department*
  - *HIV/AIDS Department*
  - *Malaria Department*
- *Planning, Research, and Statistics*
  - *Health Financing*
- *Family Planning*
  - *Health Promotion Department*
- *Nutrition*
  - *Nutrition Department*

National Primary Health Care Development Agency (NPHCDA)

Diseases Control Department

- *Non-Polio SIAs Unit*
- *Outbreak Response Unit*
- *Polio Emergency Operations Centre (EOC)*
- *Nutrition Department*
- *Finance Department*
- *PHC Systems Development (incl. PHC Under One Roof PHC System)*
- *Financing*
- *Community Health Services Department (incl. MNCH week)*

Subnational NPHCDA & MoH

- *Zonal NPHCDA & MoH Directors in NWZ, NEZ, NCZ, SSZ, SEZ, & SWZ*
- *State Immunization Officers, NTDs, and / or Malaria in Kano, Adamawa, Kwara, Bayelsa, & Imo States*

Partners

- *GAVI*
- *Carter Center (Nigeria)*
- *BMGF (Nigeria)*
- *UNICEF (Nigeria)*
- *US CDC Office (Nigeria)*
- *WHO (Nigeria)*

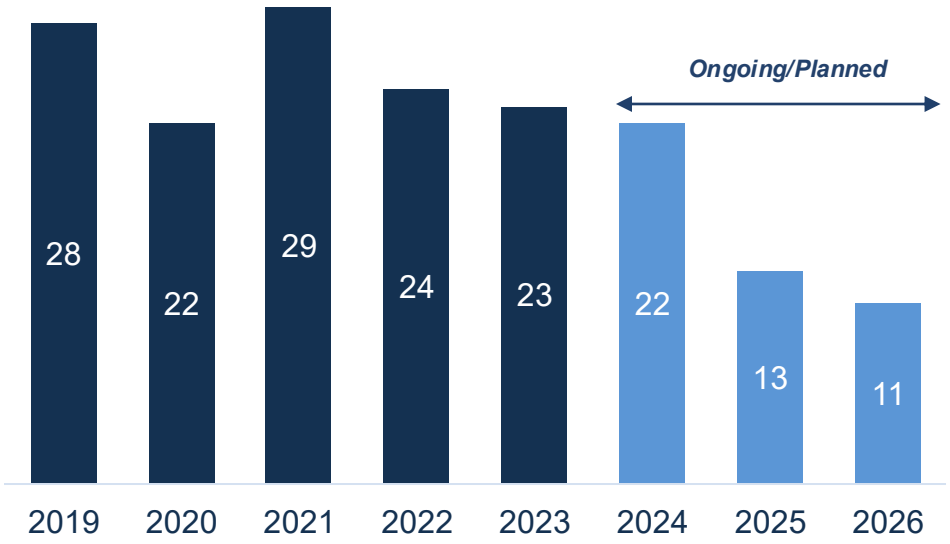
Campaign Overview

How many and where do campaigns happen in Nigeria?

There is a steady number of campaigns in the country, that are implemented in all states

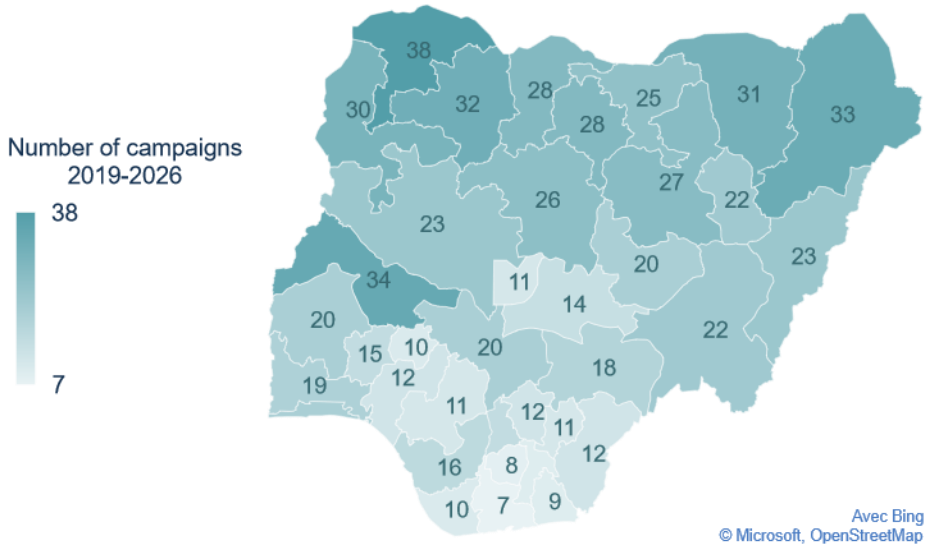
Number of campaigns identified in Nigeria since 2019[1]

n=172 identified campaigns in 2019-2026[2]



State specific campaigns between 2019 and 2026[2]

Out of 172 identified campaigns in 2019-2026, (n=) 110 are not nationwide and occur in one or more states



- *Collecting data is challenging but on **average Nigeria conducted 25 campaigns per year between 2019 and 2023.***
- *About a third of campaigns (55 out of 172) are nationwide. When they are state-specific, the **Northern States** (e.g. Sokoto, Borno, Zamfara) and **Kwara** are the most concerned.*

Campaign burden is a country-wide phenomenon with more than 20 campaigns per year in Nigeria since 2019

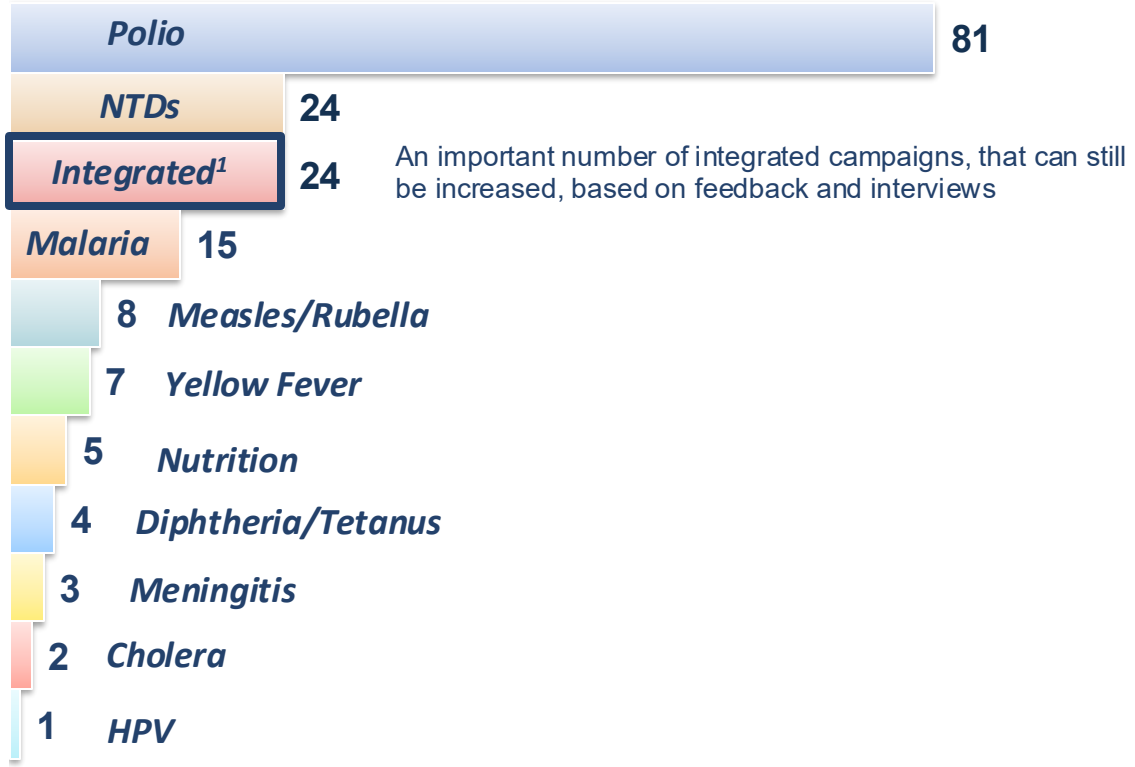
1. All data is reported to and collated by Linksbridge SPC from global health partners. Data pulled from the Health Campaign Intelligence Hub on April 2, 2024
2. Data includes already identified planned campaigns for 2024 and 2025 in light blue

What types of campaigns occur in Nigeria?

Nigeria is affected by all major campaign domains, with Polio representing the clear majority of campaigns between 2019-2026

Number Of Health Campaigns By Type in 2019-2026

n=172



- The greatest number of identified campaigns between 2019 and 2016 were for **Polio** and **NTDs** (e.g., LF, STH, Schisto). Malaria, Measles, Yellow Fever and Nutrition campaigns are regularly undertaken as well.
  - Critically, given recommendation 1b in the CAS (i.e., identifying campaigns for increased collaboration / integration), Polio campaigns are implemented house-to-house in 2-3 days and can be undertaken by community volunteers.
  - Immunization campaigns are usually fixed post and concerned with cold chain management, while MDAs often take place in schools with volunteers.
- While co-funding exists, most **campaigns are funded by partners**
  - Immunization campaigns are largely funded through GAVI, Malaria campaigns through Global Fund and PMI; NTD campaigns by the Carter Center, End Fund or HKI.
  - Nutrition, as an MoH department, has dedicated government funding.

Integrated campaigns[2] do already occur in Nigeria. Including Polio campaigns in that approach will be key to achieve a reduction in overall interventions and reduce campaign fatigue.

1. Integrated campaigns in this graph are campaigns co-delivering interventions from at least two distinct disease domains (e.g., Measles/Nutrition/STH or COVID-19/HPV). Different NTDs treated through one campaigns were not considered as "integrated".
2. Note that integration is a spectrum and can be ranging from campaign calendar sharing to full co-delivery.

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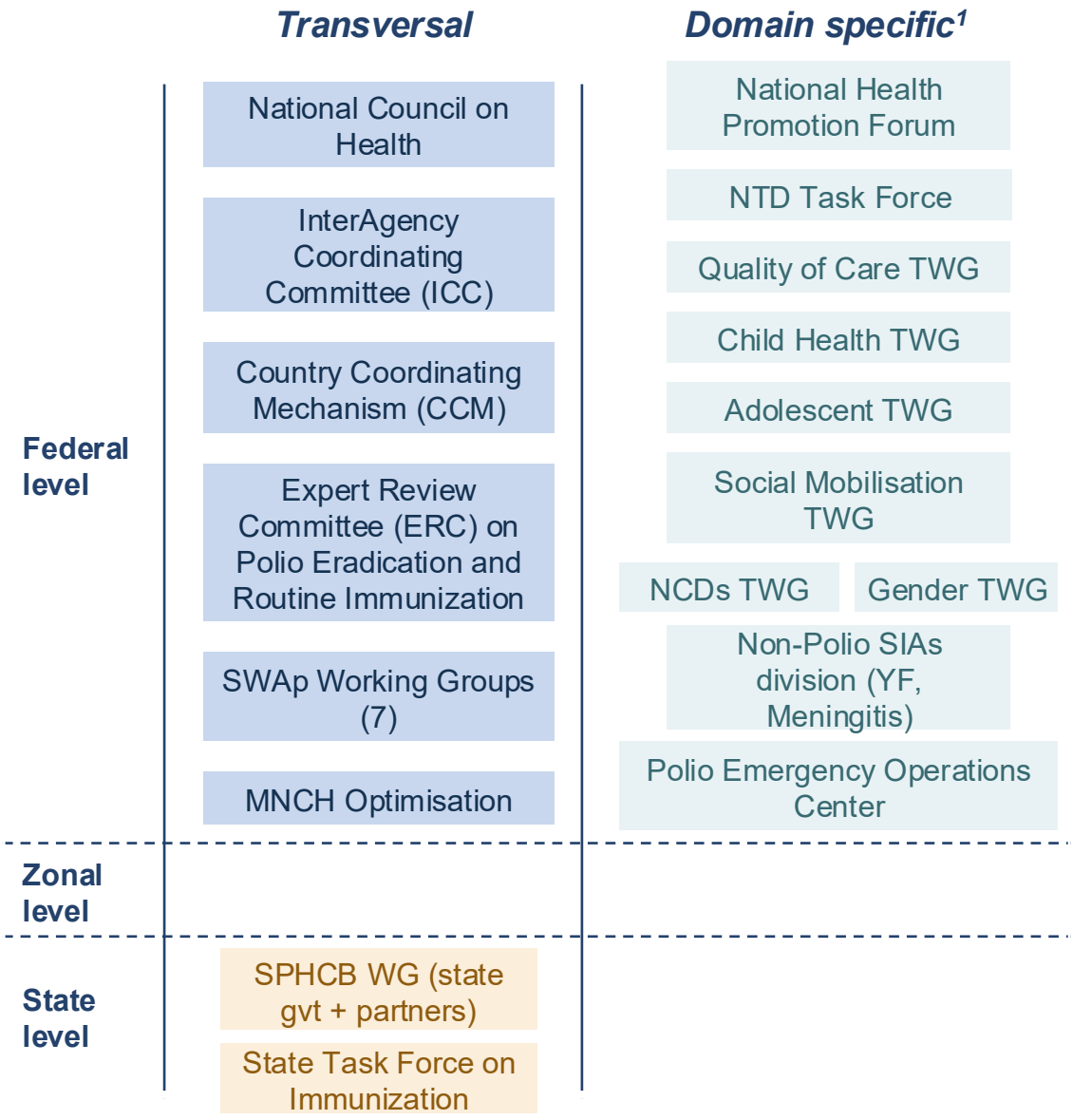
Key Stakeholders

Actors are involved in campaigns at all levels

	Administration	Key Partners	Health Care System
Federal level	***National Council on Health***	MoF, Budget & Planning	RTI, WHO, UNICEF	Specialized Hospital
	Federal Ministry of Health	N-CDC	USAID, GAVI, End Fund	
	N-Malaria Eradication Prg, DP&C, HSP&D, Finance	NHIA	Hellen Keller Int., CHAI, The Carter Center	
	National Primary HealthCare Development Agency (NPHCDA)	NAFDAC	IFRC, BMGF, CDC	
	CHS, DCI, PHCSD, PRS, L&HC, F&A, A&C			
Zonal level	NPHCDA Zonal Coordination			
State level	State Ministry of Health		AFENET, Sightsavers, Sydani, Solina, Mitosath	General Hospitals
	State Primary Health Care Development Board (SPHCB)			Primary Hospitals
Local Gvt level	Local Government Health Authority (LGHA)			
	Development Committee			Health Centers
	Facility Management Committee			
	Wards			Health Extension Workers
	Communities			

Technical working groups & committees

There is a large number of coordinating bodies including donors/partners & national stakeholders that can be involved in campaign integration



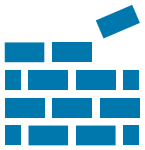
- These bodies are tasked with coordinating public health matters at a strategic level and **are not campaign focused** *(except Non-Polio SIAs NPHCDA Division)*.
  - For the CAS to be successful**, a campaign-specific coordination mechanism is needed.** CAS is best nested as a SWAp WG.[2]
  - Furthermore, the Nigerian government will need to **decide which relevant groups[1] to involve in the CAS and how**
- Most of these coordinating bodies **sit at the federal level**, and states structures vary.
  - Given the importance of states in campaign implementation, **specific engagement of these structures will be needed** to ensure CAS involvement at the right subnational level.
- **Domain-specific coordinating bodies are many and limit collaboration bandwidth.** Within NPHCDA they include the Non-Polio SIAs division and the Polio Emergency Operations Center.
  - This organisation is reflective of the division between Polio and other campaigns and **NPHCDA norms around information sharing will need to be shifted.**

1. Other technical level groups were identified but not presented here (e.g., National Polio Expert Committee)
2. Should that not be possible, it should nest under a cross-domain transversal WG / committee (i.e.,. beyond immunization).

SWOT Analysis

Strengths

Nigeria's ecosystem is strongly mobilised towards rationalisation of the health system, including campaigns, and can build on demonstrated experience

		Illustrative quotes
 **Political Commitment**	• The **highest level of decision making** (the Hon. Prof. Pate, the National Council on Health) has **committed** to increase collaboration and integration. This commitment is reflected in the **Sector Wide Approach (SWAp)** and its "One Programme, One Budget, One Report, One Conversation" objective. • **All stakeholders interviewed** agree that the high number of campaigns is a burden on the Nigerian health system and **see the value in the CAS / increased integration and their willingness** to participate in additional integration (incl. Polio stakeholders).	*"The biggest thing in Nigeria is the SWAp. We have one of the most known global health leader Prof. Pate. and a huge interest and funding around the SWAp"* *"Integration is the way to go. Too many interventions happen at the same time."* *"The time is now to think of campaign effectiveness more broadly. Now there is stronger appetite for integration from the program teams at the higher level."*
 **Existing Infrastructure for Improved Effectiveness**	• Nigeria has **long-standing priorities that align with** the integration and increased efficiency goals of **the CAS**. for example, Nigeria **increased its efforts** towards PHC strengthening and rationalisation with the **PHC Under One Roof**, the **Health Provision Fund** and the **multiyear plan on immunization**. • While bandwidth is limited, NPHCDA and F-MoH have **highly motivated & dedicated staff** focused on improving health outcomes.	*"PHC Under One Roof started in 2011, to bring primary healthcare under one unique policy. Over the years it has been fine-tuned and now all states are on board."* *"We have a whole lot of motivated and committed staff and team members at national, state and LGA levels"*
 **Integration Experience**	• Nigeria maintains **well established integration practices** including the Maternal, Newborn and Child Health Week (**MNCH Week**), on which to lean for increased integration in the country. • Multiple integrated campaigns have happened in the country at an **increasing pace since COVID-19** (e.g., a COVID/Measles/Yellow Fever/Vitamin A/Birth registration campaign was conducted in 2022)	*"We have tried to integrate campaigns through the MNCH week twice a year. There is potential for even more integration using this platform"* *"We increased integration at the height of the COVID pandemic. June 2022 (COVID/Measles/YF/vitamin a/birth registration) was our biggest integrated campaign"*

Weaknesses

Nigeria's campaign ecosystem is fragmented, with no systematic inclusion of integration at the planning stage and limited information sharing and available resources

		Illustrative quotes
Decentralised & Fragmented Ecosystem	• Nigeria is characterised by a **multiplicity of actors at all levels** (national, zonal, state, LGA) and **decentralised decision making**. • States have **strong agency** and **disparate structures** that necessitate tailor-made plans for socialization / advocacy and campaign implementation. • Campaign stakeholders are **strongly fragmented** and sometimes duplicative (e.g., there are Nutrition depts in F-MoH & NPHCDA).	*"We are members of quite a number of Technical Working Groups and it gets overwhelming."* *"There are too many funding sources. It is cumbersome to manage."*
No Systemic Approach	• **While campaign integration occurs, it is not systematised,** and many opportunities are missed. When it occurs, it happens opportunistically or at the grassroot level, with **little consistency**. • Most programmes **work in siloes**, including within the same organisation (e.g. 3 teams manage campaigns in the disease control unit of NPHCDA). They develop **different ways of working** (planning, implementation methods, reporting templates) which result in a high number of working groups, parallel processes and funding flows. • **Information is seldom shared** with other departments.	*"We don't really know what the others are doing. We stumble upon information when we are members of their working group."* *"It is absolutely critical that a more structured and systemized approach to campaigns and information sharing is developed within the NPHCDA or the CAS will not succeed"* *"The verticalness has negatively impacted the routine service delivery of the health system "*
Limited Resources (HR & Financial)	• Teams and **health workers are overburdened** by numerous campaigns. This affects routine services and limits available bandwidth to initiate integration efforts, all within an HR environment with recruitment/retention difficulties. • **Campaign funding remains limited**, especially at the state level when several international programmes request counterpart funding.	*"All states do not implement the campaigns at the same time due to inadequate resources. Release of counterpart funding is an issue at the state level."* *"Funding is always a problem. There will never be enough money. Even the human resources, the people that provide the services are not really there"*

Opportunities

The political momentum initiated by the SWAp is a unique opportunity to capitalise on Nigeria's institutional knowledge and seize the observed integration moment

Sector Wide Approach Momentum

- The **political momentum** created by the SWAp is recognised by all actors, creating a **unique opportunity for action** towards increased collaboration and integration at all levels.
- CAS should be nested as a **SWAp working group,** liaising with the 4 that can directly contribute to it (i.e., Resource Mobilisation, Health Financing, M&E, HR).

Institutional Memory to Leverage

- Key **moments are clearly identified** as "integration moments": MNCH Week, Nutrition week. They are clear opportunities to lean on and expand for increased integration.
- Institutional knowledge fostered in the **coordination structures put in place in past years** can also be leveraged to benefit the CAS (e.g., PHC Under One Roof approach, Health Provision Fund, Health Promotion media calendar).

Optimal Timing to Increase Integration

- Numerous and fragmented campaigns have led to **widespread campaign fatigue** in the country: for example, 8 vaccination campaigns happened in Kano in Sept-Dec 2023.
- The **moment** is **prone to increased integration** and there is "low hanging fruit" to seize[1].
- All programmes state interest, **including Polio** which has an ambitious end of 2024 eradication target.

Illustrative quotes

"The SWAp is a now or never moment. The priority is to SWApify this CAS."

"Political will is optimal currently with the implementation of the SWAp. The earlier it can be institutionalised, the better."

"With the SWAp, we should be in a position to see things move in Nigeria."

"The MNCH week gets a lot of attention. It is a very good platform to integrate."

"The national level has the organisational capacity to provide guidelines and can leverage partners and technical skills at state level."

"At NPHCDA we have 4 units running parallel campaigns. There is a huge potential for additional coordination/integration."

"We [Polio] want to integrate because it's an opportunity for us to reach our target."

"In Kano, in the last 4 months of 2023 it was literally a campaign per week. […] We could reduce to 2-3 per year."

1. Linksbridge SPC developed an algorithm identifying missed integration opportunities based on: target demographics, start date, and precedence of the intervention pair. 85%(19) of the 21 campaigns identified for 2024 have codelivery potential.

Threats[1]

There are disincentives to collaboration and increased integration at all levels, hindering change in a resource-scarce environment

Limited Financial Incentives

- Multiple stakeholders depend on the **important funding for campaigns** (e.g., federal and state-level public agents, NGOs) and are apprehensive of meaningful change.
- **Grassroot-level workers** compensated through **per-diems** have incentives to continue the status quo.

Perception of a Potential Decrease in Efficiency

- **Stakeholders are concerned and protective of their scope** and have **conflicting priorities** (e.g., Polio's eradication target). This can lead to a **perceived fear** that increased integration will lead to **underperformance** & a reduced effectiveness.
- **Trust and transparency is not institutionalised** among teams, limiting willingness to collaborate and awareness of common targets.

Difficulty Mobilising Resources

- **Mechanisms pushing for change (e.g., SWAp) are in their infancy,** while strong initial efforts will be needed.
- Skilled human resources (e.g., trained vaccinators, project managers) are hard to hire and retain. It **will be challenging for limited teams to find the time additional integration will mandate**.
- International donors have shown limited appetite for basket funding for campaigns and can have **limited flexibility**.
- States have difficulty releasing **counterpart funding** which can cause delays and limit integration.

Illustrative quotes

"Campaigns mean a lot of money. It's an opportunity. For some people, there is an interest in having campaigns."

"There are clear incentives for all low and medium actors to keep the fragmentation. Per diem complement low and often unpaid salaries."

"Everybody wants to protect its own turf. This is a major problem for integrating."

"You're collaborating with people; every member of the team has an agenda. Trust and transparency is needed."

"If care is not taken, these other vertical campaigns will sway us from where the bigger problem lies"

"Even the human resources, the people that provide the services are not really there."

"Funders are supposed to align. From what I think and saw, funders don't want to have a basket funding."

"Release of counterpart funding is an issue at the states. That's another factor that will affect integration."

1. Threats presented here are CAS related. Broader threats identified for campaigns are security and scepticism from communities (incl. religious structures) about health issues (particularly vaccination)

SWOT Double Click: Polio-specific synthesis

While Polio campaigns are currently standalone, they have potential for integration and teams have initiated processes to capitalize on it

Polio campaigns represent almost half of all identified campaigns in 2019-2026. Integration efforts so far rarely included Polio, because of different priorities and targets, funding streams, workforces, and methods[1]

Polio SWOT

Strengths

- **The SWAp (and CAS efforts) is inclusive of all health domains**, including Polio, and rallies all major health stakeholders in Nigeria behind a common coordination goal
- **There is Polio integration experience and institutional knowledge** to anchor (e.g., Polio/COVID-19 campaigns are common) and desire / need from other campaigns to leverage the Polio infrastructure (e.g., security)
- **GPEI funding remains important in the country** (between $50M and 100M annually between 2017 and 2020) and could be leveraged, if appropriately flexible, for CAS implementation

Weaknesses

- OPV Polio has a specific delivery methods. Alongside bed net distribution, it is one of the only house-to-house campaign mobilising non-health workers. The oral vaccine used in Nigeria is hard to integrate with injectables used by non-Polio SIAs.
- Polio campaigns in Nigeria are **mainly outbreak responses and difficult to anticipate**
- The **ambitious 2024 eradication of Polio target does not allow for any efficiency decrease**, and might be incompatible with integration objectives
- **Polio teams do not regularly share information with the MoH (and within NPHCDA)** and integration procedures are unsystematized and still unclear
- **There is limited visibility on future funding** (incl. government funding – e.g., no budget line at state level for counterpart funding (as for other campaigns)

Opportunities

- The **moment is right for Polio integration**. The eradication target is 2024, stakeholders (e.g., NPHCDA team) show willingness, & related processes are under development (e.g., Polio transition committee, NPHCDA coordination meeting with non-Polio SIAs, information sharing Excel file).
- **Integrated campaigns w/ Measles are planned for end 2024** and integration w/ bed nets distribution is currently being considered
- While integration with immunization (non-Polio) can be restrictive given different delivery methods, **there are opportunities for other house-to house-campaigns (e.g., WASH, Nutrition) and other 'low-hanging fruit'** forms of collaboration (e.g., training)

Threats

- The **main threat to integration is funding and procurement**. Integration with non-Polio SIAs depends on the end of the current global shortage of IPV Polio vaccines (injectable)
- **Priorities, timing & target incompatibilities between campaigns** can lead to limited participation of Polio teams in CAS efforts and little integration
- **Structural challenges** (e.g. security, accountability) exist for all campaigns but are more acutely problematic for Polio given targets / geographies

Next steps

Short term

1. **Leverage Polio impending goals and related timeline to raise awareness of CAS efforts & their relevance for Polio**
2. **Systematise info sharing with non-Polio SIAs, as recently initiated in NPHCDA (e.g., coordination meetings, Excel file)**
3. **Ensure Polio participation in CAS activities (e.g., TWG sub-group meetings, customization workshop, implementation plan develop.)**

Long term

1. **Include Polio immunization in routine PHC system**
2. **Advocate for an increase in government contribution and dedicated budget lines for counterpart funding from states**
3. ***Where possible (*and appropriate*), leverage the use of IPV to systematically co-deliver, where appropriate, with other immunizations / domains**

1. Polio campaigns are implemented house-to-house by community volunteers, contrary to immunisation (health workers in a fixed post for cold chain). Polio campaigns generally last for 4 days after training and can be planned and carried out in 10-15 days.

Overview of Practical Next Steps Based on the SWOT Analysis

In addition to implementing the CAS recommendations, there are clear next steps (in 2024) that Nigeria can take to leverage its strengths, capitalize on its opportunities, mitigate weaknesses, and counter its threats

Strengths

1 Political Commitment

Provide frequent progress updates on CAS status to the Minister of Health, the Director of Public Health, the ED of NPHCDA, and the Director of Disease Control & Prevention, as well as regular touch points with the relevant departments

2 Infrastructure for Improved Effectiveness

Don't reinvent the socialisation / outreach, and implementation process for subnational stakeholders. Leverage the integrated services approach used for the PHC Under-One Roof and CHIPS[1] program (under the CHS Department[2])

3 Integration Experience

Capitalise on momentum to integrate 'low-hanging fruit' in the near-term. Integrate campaigns in 2024 (e.g., Measles, Polio) with obvious integration overlap

Weaknesses

4 Decentralized & Fragmented Ecosystem

Invite subnational representatives into CAS customisation efforts (e.g., finalisation workshop, implementation plan development) and develop a state-level working group

5 No Systemic Approach

Create a standing policy and norm that all relevant MoH / NPHCDA departments share campaign information with each other on a recurring (e.g., monthly) basis

6 Limited Resources (HR & Financial)

Government should request, were feasible, additional HEW and CAS-related TA planning and implementation support and / or budget (given the likely need for more additional bandwidth during CAS implementation)

Opportunities

7 Sector-Wide Approach momentum

Add a CAS-specific TWG underneath the SWAp and mobilise relevant existing core working groups (i.e., Resource Mobilisation, Health Financing, M&E, HR)

8 Institutional Memory

Leverage MNCH week(s) and identify what additional campaigns can be added to this platform. Work towards 1 highly integrated campaign per quarter, where feasible

9 Optimal Timing

Leverage Polios impending goals and related timeline to raise awareness of CAS efforts (and their link to Polio's priorities), and increase their participation in CAS activities

Threats

10 Limited Financial Incentives

Develop a 1–2-page document outlining the incentives (financial or otherwise) for collaboration at different levels and for different domains and identify answers to doubts.

11 Perceived Efficiency Decrease

Leverage emerging norm shifts in information sharing between departments to build trust, and outline clear steps for joint MERLA processes and defining collective & cross domain success during implementation

12 Difficulty Mobilising Resources

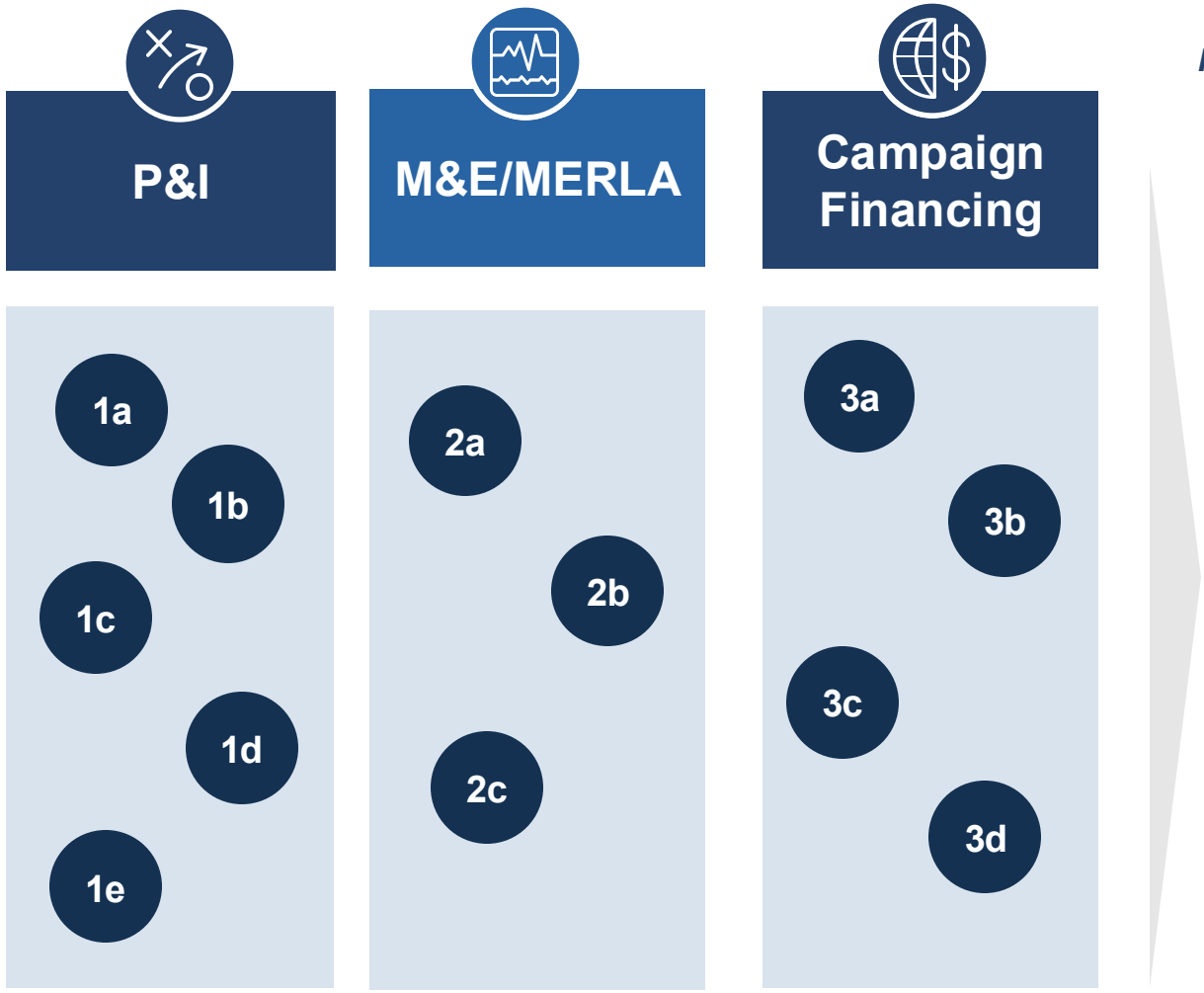
Government (alongside partners) should request CAS-related flexibility within current funding (reprogramming) or embed it in upcoming grants (e.g., with Global Fund, GAVI)

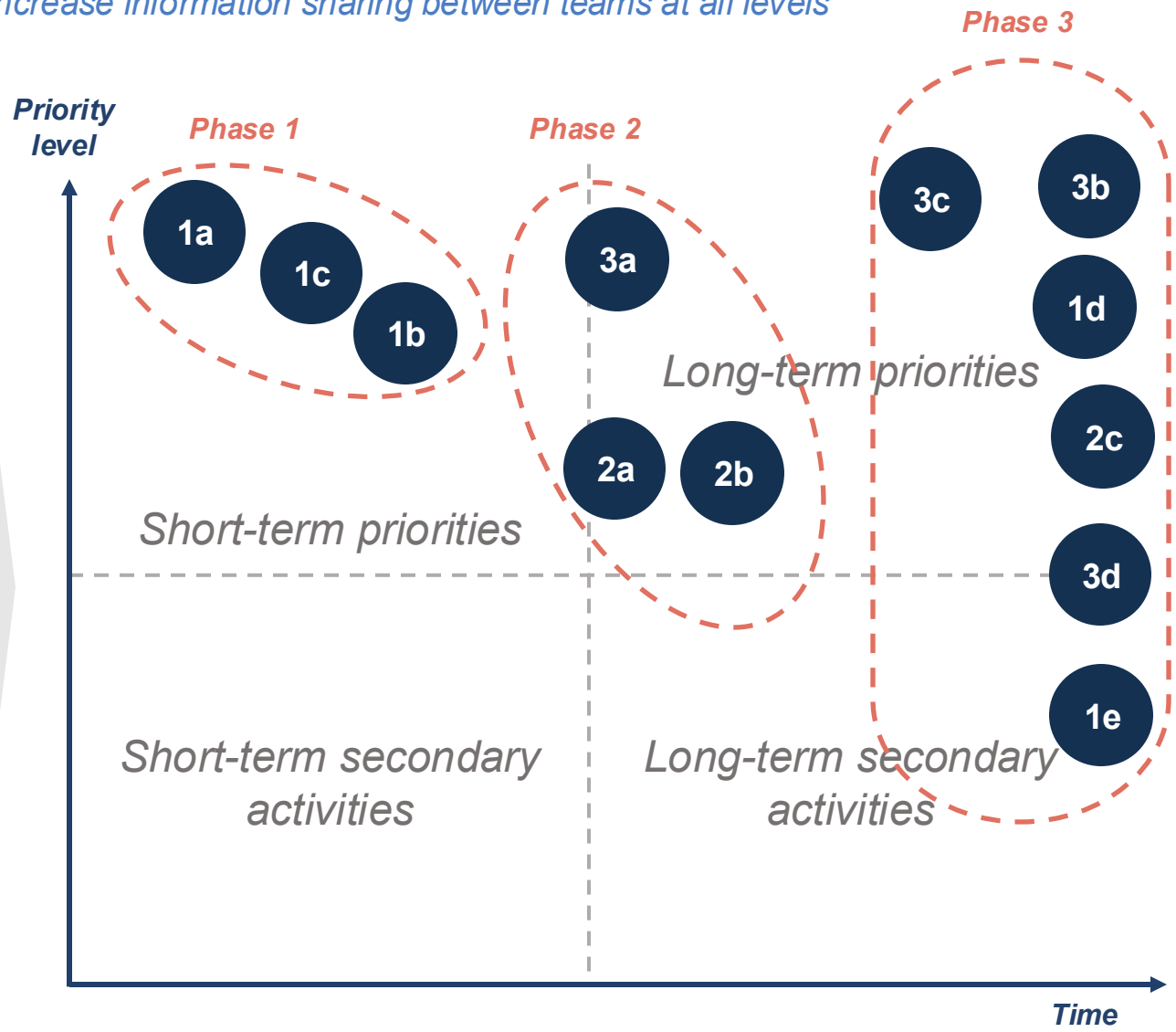
1. Community Health Influencers, Promoters and Services (CHIPS); 2. Community Health Services
2. Additional suggested tangible approach: Donors' country rep to liaise with MoH/NPHCDA to study the feasibility of bridging funding in states with limited counterpart funding

CAS Recommendation Sequencing

Sequencing of CAS recommendations (1/2)

Based on feedback from interviewed stakeholders across domains, planning recommendations are the most salient in the short term, with a clear first step being to clarify governance within the SWAp and increase information sharing between teams at all levels





MERLA: Monitoring, evaluation, research, leaning, and adaption

See Appendix for full title of Recommendations

Sequencing of CAS recommendations

In Nigeria, the implementation of the CAS recommendations will need to happen in three distinct phases: 1. Anchor to the SWAp; 2. Develop norms and gather necessary insights; 3. Systematise collaboration/integration in the country

Q2 2024 – Q3 2024*

Phase 1: **Anchor**

1a 1b 1c

Identify the CAS's place within the SWAp & socialise CAS with key teams (Polio) and sub-nationally

Develop information sharing norms between agencies, (i.e., MoH & NPHCDA), departments, & partners

Operationalise Linksbridge's mapping (as a tangible, collective initial step) to share campaign information and identify what campaigns can be integrated

Q3 2024– Q1 2025*

Phase 2: **Initiate**

2a 2b 3a

Align MERLA plan and processes across departments, partners, and domains

Develop a comprehensive understanding of campaign funding across domains and partners

Q1 2025 and beyond*

Phase 3: **Systematise**

1d 1e 2c 3b 3c 3d

Harmonise funding practices, operations, & logistics

Systematically communicate & coordinate across domains, partners, and campaigns

Anchor to SWAp momentum & develop norms

Gather the necessary insights for proper national scaling

Make campaign collaboration/integration systematic in Nigeria

*Anticipated timing to be tested with TWG

CAS Customization & Planning Timeline

2024 Customization & Implementation Process

Initial next steps will be to bring stakeholders together into a steering committee and build a common vision for CAS

Standing up National Steering Committee & TWGs

- Drafting of Terms of Reference
- Drafting of a customization template
- Organization of an initial workshop
- Formation of TWGs (and sub-groups) for customization

Subnational implementation

- Subnational consultation and state socialization
- Initiation of state-level steering committees

May | June | July | August | September | October | November | December | 2025

CAS Customization

- 2-3 pages per recommendation
- Country-specific background section
- Adoption by MoH by the end of July

Implementation Plan

- In-depth description of necessary steps for implementation
- GANTT Chart
- Dates/Milestones
- Cost
- Responsibility

Appendix

Assessment Limitations

This feasibility analysis is subject to some limitations due to stakeholders interviewed, data availability and limited subnational cross-referencing. It should be used as a first step into CAS customisation for Nigeria and pave the way for additional work with national partners.

Stakeholders

- All key national stakeholders were interviewed as part of the feasibility assessment.
- Some **national offices from international partners** (e.g. USAID, Global Fund) were contacted but **not available** for an in-depth interviews. Their views are not reflected here. We remain available for any comment/request for modifications from them.

Data

- This assessment was undertaken using **limited available data**. Specifically, there is no comprehensive view of campaigns in Nigeria and **no shared calendar** to validate the Health Campaign Intelligence Hub (HCIH) data used.
- Similarly, some **strategies** were not available to consultants drafting this assessment (e.g., SWAp, Immunisation) nor **consolidated data on campaign funding** at country level.

Subnational level

- Subnational inputs were included in this assessment through interviews with the State Immunization Officers and NPHCDA Zonal Directors.
- **Subnational data on campaigns** is critically important but **challenging to acquire** given the way campaigns are run in Nigeria and implemented by states. The analysis presented here (specifically on non-national campaigns) should be cross-checked with state-level stakeholders.

Documents

Through the feasibility assessment process, we were able to acquire and review health campaign related documents via the MoH / NPHCDA and key partners

List of Documents Reviewed

- ***[NPHCDA] NCDC Strategy & Implementation Plan*** *(2023-2027)*
- ***National Gender in Health Policy*** *(2021-2025)*
- ***National Policy on Maternal, Infant, and Young Child Nutrition in Nigeria*** *(2021)*
- ***National Strategy on Maternal, Infant, and Young Child Nutrition*** *(2022)*
- ***Implementation Guidelines for Primary Health Care Under One Roof*** *(2022)*
- ***National Strategic Plan of Action for Nutrition*** *(2021-2025)*
- ***National Adolescents & Young People Implementation Plan*** *(2021-2025)*
- ***National Child Health Policy*** *(2018 & 2022)*
- ***NTD Nigeria Multi-Year Master Plan*** *(2015 -2020 & 2023-2027)*
- ***Nigeria Immunization Financing Assessment*** *(World Bank; 2018)*
- ***National Strategy for Immunisation & PHC System Strengthening*** *(2018-2028)*
- ***NPHCDA Primary Health Care Under One Roof Scorecard 6*** *(2022)*
- ***National Polio Emergency Action Plan*** *(2023)*
- ***The Revised Ward: Health System Strategy*** *(2023)*
- ***Primary Health Care Transformation Agenda*** *(2023-2030)*
- ***National Guidelines for the Prevention & Control of Micronutrient Deficiencies in Nigeria*** *(2021)*
- ***Health Sector Recommendations for Nutrition Indicators Collected Nationally in Nigeria*** *(2022)*
- ***National Health Promotion Policy*** *(2019)*

Gaps

(Documents that were requested but not acquired)

- ***Sector-Wide Approach (SWAp)***
- ***Malaria Strategic Plan*** *(or similar strategy)*

Overview of Questions

Examples from the interview guide

A. Campaign & Organization / Department Overview	• What role does your organization play in health campaigns in Nigeria? How long has this type of support (e.g., funding) beenoccuring?
	  ○ Are your organizational plans for support likely to be the same in the next 3-5 years or change? If they are to change how and why?
	• Are the campaigns that you support integrated (e.g., planning and or co-delivered) with other campaigns and / or the PHC system?
	• From your perspective, what is needed / what steps could be taken to better integrate campaigns through the MoH and / or intothe PHC system?
	• How is your support funded? Does the funding you provide (if any) get funneled through the MOH?
	  ○ What % of the funding is public (i.e., coming from the MOH or state government)? Is this likely to change?

B. Opportunities, Strengths, Challenges & Risks	• In terms of collaborative and/or integrated campaign planning or implementation, what has worked well (e.g., strengths) and what has not? Please explain?
	  ○ When there has been success in collaborating or integration, what factors facilitated success?
	• What are likely to be the biggest challenges and opporunties for Polio campaigns?
	• What do you view as the major opportunities for CAS implementation? In other words, what are you hoping or expecting the CASto achieve in your country (in the short term – 1-2 years – and in the longer term)?
	• As you think about the successful implementation of the CAS, where do you envision capacity constraints or challenges (national and / or subnational level)
	  ○ What do you view as the major risk(s) to CAS implementation?
	• What support and resources would be needed to overcome those constraints and challenges

C. Rec.-specific	• Of the 12 CAS recommendations, which should be implemented in the near term (e.g., this year)? • Which recommendations will take the least amount of time and effort to implement? • Which of the 12 recommendations will require the most effort (or will be the most challenging) to implement and why? • Are there any recommendations that are less relevant to Nigeria? If yes, which ones and why? • In order to reach the intended outcomes of the CAS (more effective and collaborative campaigns), are there topics, activities, or areas that are needed that are not covered within one of the CAS 12 recommendations?
D. Gaps & Needs	As you look at the CAS, what support (e.g., who) and resources are likely needed for the CAS and each recommendation? • Is there flexible funding or support that could be used to fill these gaps?
E. Partners	• Who should be part of the technical working groups (TWGs) for CAS customization? • Which departments and partners need to be consulted, socialized, and sensitized?

12 Recommendations were Developed to Enhance Country-Level Impact and Coordination

The CAS recommendations are intended to be **adaptable** and **flexible**, allowing for country specific decision-making. All recommendations will require **joint effort between countries, global funders and implementers**, with specific recommendations targeting funders (e.g., campaign finance), implementers (e.g., 1d), and MOHs (e.g., 1a).

Planning & Implementation

Rec #1a
Establish or leverage an existing multi-sectoral, cross-campaign National Coordination Body

Rec #1b
Identify campaigns and domains for collaboration and integration

Rec #1c
Develop a multi-year, cross-campaign workplan and schedule for campaigns

Rec #1d
Harmonize tools and operations (e.g., logistics, supply chain, microplanning) across campaigns

Rec #1e
Develop a coordinated and effective approach to enable active community engagement at all levels and phases

M&E/MERLA[1]

Rec #2a
Within countries, develop a coordinated and collaborative cross-campaign MERLA strategy

Rec #2b
Aligned with the coordinated country MERLA strategy, improve the ability of campaign implementers and partners to identify, measure, utilize, and share data on campaign effectiveness

Rec #2c
At the global level, develop a Learning Platform and a MERLA framework as a practical guidance to countries and global stakeholders

Campaign Financing

Rec #3a
Create a comprehensive view of campaign financing at the country level

Rec #3b
Take incremental steps toward harmonizing and aligning campaign financing

Rec #3c
Harmonize and align incentive payment modalities and rates across campaigns

Rec #3d
Advance government role in campaign financing

1. Monitoring, evaluation, research, leaning, and adaption