Summary of Symposium

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iCCM 2014
Integrated Community Case Management (iCCM):
Evidence Review Symposium
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Overview

- Clarifications
- Important Lessons Learned
- Key Messages

MORTALITY CLARIFICATIONS

Mortality Measurement

- Further explanation of mortality analysis

- We collected raw data from as many recent studies that we could but we could not include some studies

Mortality Data We Collected

Burkina Faso	✓	South Sudan	Rejected - quality
Cameroon	✓	Uganda – Central	✓
Ethiopia	✓	Uganda – Eastern	✓
Ghana	✓	Uganda - Western	✓
Sierra Leone – IRC (Kono)	Not included due to different method	Zambia	✓
Sierra Leone - UNICEF	✓		

Design of the Studies & Results

Country	Design	Number of intervention district	Number of comparison district	**Mortality measurement**	**Sample size endline survey (#HHs)**	**DD mortality Incidence rate ratio and 95%CI**
Burkina Faso	Quasi-experimental	19	19	DSS	-	0.95 (0.57, 1.59)
Cameroon	Quasi-experimental	2	1	Census with FBH	18,177	1.05 (0.85,1.29)
Ethiopia	RCT	16	15	Survey with FBH	28,000	0.85 (0.62, 1.18)
Ghana	RCT	39	38	DSS	-	0.24 (0.06,0.96)
Sierra Leone	Quasi-experimental	2	2	Survey with FBH	6,000	0.79 (0.41, 1.51)
Uganda (Central)	Quasi-experimental	8	3	Survey with FBH	8,000	0.70 (0.18, 2.78)
Uganda (Western)	Quasi-experimental	9	3	Survey with FBH	8,000	0.66 (0.32, 1.40)
Zambia	Quasi-experimental	4	3	Survey with FBH	8,000	1.45 (0.86, 2.46)

Mortality Measurement

- Some studies were not testing iCCM* but another community delivery model
  - Treated all fevers with ACT and antibiotic
  - Treated only two illnesses

Let's remove those

*iCCM defined as CHWs assessing symptoms and, in some cases using RDTs, then providing appropriate treatment for diarrhea, pneumonia and malaria (if malaria is present in community)

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Mortality Measurement

- Some studies did not have appropriate comparison areas
  - were not comparing iCCM to no iCCM but rather CHWs treating two illnesses compared to treating three
  - Or comparison area was very different demographically, socioeconomically to intervention district

Lets remove those

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Mortality Measurement

- Some studies were conducted before two years being at scale – Remember it takes time to reach scale and you need to be at scale for awhile before you will see impact.

Let's remove those

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Mortality Measurement

- There are no studies remaining

- Unfortunately, due often to donor requirements we spent a lot of energy and time and money on trying to measure mortality impact when we should have first been concentrating on scaling up, ensuring quality of service, increasing demand, assessing costs, and conducting process evaluations

Recommendation

- Because these treatments have been proven effective the mortality impact should be equivalent to the treatment effectiveness if most of the children with these illnesses in the targeted areas are treated.
- So we need to do routine monitoring and process evaluation to improve treatment rates

IMPORTANT LESSONS LEARNED

Important lessons learnt

- Government leadership is essential
- iCCM must be a national priority, well embedded in national health sector plan, and costed with a clear budget provision
- There is no single model of human resource management for community based interventions - programs that pay CHWs or use volunteers can work, provided there is clear leadership and support
- Charging fees decreased utilization

Important lessons learnt

- High supervision rate increased utilization
- Fewer stock outs increased utilization
- Providing treatments for 3 illnesses actually increases utilization for each illness
- Using RDTs decreased malaria and pneumonia treatments suggesting improved quality of treatment
- Implementation has to be at scale (80% of targeted CHWs trained and deployed) for a duration of a year or more, in order to achieve high rates of utilization

Important lessons learnt

- Community programs must be well documented, periodically reviewed and evaluated in order to guide the implementation at scale

KEY MESSAGES

Key Messages

INCREASE UTILIZATION OF iCCM TO BE COST EFFICIENT AND ENSURE MAXIMUM IMPACT!

- By deploying to areas of greatest need
- By assessing demand barriers and addressing them
- While maintaining quality of services, continuous supplies and high levels of standardized reporting
- Community engagement and mobilization

Key Messages

USE ROUTINE REPORTING DATA TO ASSESS PROGRESS AND ONLY CONDUCT ENDLINE EVALUATIONS OF IMPACT AFTER BEING AT SCALE WITH HIGH UTILIZATION FOR OVER 1 - 2 YEARS

- By examining routine data you will know whether or not you have been providing high rates of appropriate treatments
- Once your routine data show you are providing high rates of treatment you can collect data on coverage and model mortality based on LiST
- Final evaluations should include data from routine, contextual, qualitative, coverage, costing.
- Given the large sample sizes to assess mortality, the expertise required to do this properly, the costs, the time you need to wait before assessing mortality and the fact we know these treatments are effective we need to re-consider the need to conduct such studies in individual countries.

WAY FOWARD

- iCCM is a cost-effective strategy that should be embedded in strategies towards achieving universal health coverage
- There are important opportunities to mobilize resources from domestic as well as external funds
- Integration with government systems and public private partnership is essential to maximize impact
- Exchange between countries and partners remains essential to learn about innovations that will offer guidance for scaling-up and relief of bottlenecks.

Overall messages from the symposium

- We have effective interventions that respond to the major causes of child mortality and are well packaged for delivery

- Children present with multiple symptoms and therefore **integrated** case management is a must

- **Integrated case management of common childhood illnesses can saves lives and improve quality of care**

THANKS

SESSION HIGHLIGHTS

Policy

- Champions play major role to bridge gap between policy and implementation
  - Resistant stakeholders e.g. medical associations
- Policy discussions for iCCM need to be at highest political levels,
  - Go beyond technical MoH discussion to include Ministries of Finance and other sectors
- Fit iCCM to existing health system
  - Need for evidence in local setting
- Better coordination of iCCM activities between different levels of health system required
- Sustainable financing key concern
- Development partners should better align iCCM support and financing with other linked agendas e.g. UHC

Supply Chain Management

Community health supply chains work best when:

- **Product flow**, **data flow** and **effective people** approaches are considered together when designing CH supply chains
- Base CHW resupply on demand using consumption data,
- Use data consistently for decision making; mHealth systems offer timely, accurate access to data
- Facilitate **teamwork** and **motivate** staff across all levels of the supply chain
- Leadership is needed to ensure product availability at CHW level
- Overall supply chain system can be functional and provide products at adequate levels

Costing and Cost Effectiveness

- iCCM treatment costs are expected to change as programs mature; as utilization increases, costs per treatment decrease, and services become more cost-effective
- Increasing access in hard to reach areas with lower density means that demand may be small, and costs may be higher
- Key drivers of cost effectiveness are numbers of patients; number of CHWs and time spent; and amount and cost of training, supervision and management
- In addition to supply side costs (in particular, availability of medicines), it is critical to consider demand side and patient costs for iCCM
- Expand costing to look at cost per outcome to make the results more meaningful

Quality Assurance

- Use adult-focused and participatory training approaches and job aids key to building skills of CHWs
- Collaborate with MoH and other stakeholders to develop harmonised, context-specific iCCM training materials
- Training is the first step – maintain CHW skills and motivation including the use of supervision and refresher training
- Routine supervision data not reliable to assess quality but still important to maintain contact with and motivation of CHWs
- Use alternative supervision models such as peer support groups and quality improvement teams including community members
- mHealth approaches might improve supervision, motivation and quality

Human Resources and Deployment

- Long term sustainability of personnel is a challenge (volunteer or paid)
- Importance of integration into existing health budgets and structures
- Balancing act between coverage, quality and sustained services
- Spatial analysis can improve cost-effective distribution and deployment of CHWs
- Private sector/entrepreneur approach as a promising mechanism for sustainability and impact, as a compliment to the public sector

Demand and Social Mobilization

- Supply and demand are critical to the success of iCCM programs
- Financial barriers (e.g. user fees) negatively affect demand
- Involve communities in selecting CHWs; make them aware of what CHWs can do; make sure CHWs are available locally
- Diagnostic tools (RDTs) and pre-packaged medicines (with pictures, if possible) can improve caregiver acceptance of treatment plan and adherence
- Social mobilization efforts should include dialogue, engage different stakeholders; consider/address social norms
- There are evidence gaps (including how CHW gender impacts demand) that need to be assessed

Monitoring and Evaluation

Monitoring:

- Capture qualitative, contextual and costing information
- Validate and improve quality of all data sources
- Integrate iCCM data into national HMIS & prioritize (keep it simple! No parallel systems!)
- Make use of appropriate use of technology
- Use simple, visual data outputs to facilitate understanding and use of data

Evaluation:

- Triangulate data sources
- Evaluation designs must be participatory, flexible, adapted to country context and decision-making needs, and allow adequate time for implementation

Private

- In many countries, more people go to the private sector than the public sector
- The private sector has the larger market share in antimalarials, but the quality is generally unregulated and poor
- For example, engaging drug shop owners by training them in proper care increased appropriate diagnosis and treatment and increased referrals
- Need increased discussion, knowledge and research on the role of and integration of the private sector into national iCCM strategy

Innovations

- Innovations like Mhealth can be a helpful resource to improve supply, training, supervision, motivations, monitoring and evaluation.
- It needs to be user centered, simple, designed with end users in mind and Invest in evaluation and capacity building.
- Challenges with lack of electricity supply in remote areas (solar power solutions can improve that in near future)
- Transport innovations still needed to improve outreach of more distant locations and improve equity

Community based newborn health

- Evidence shown that home visits by community health workers during pregnancy and in the postnatal period improve essential care practices, increase coverage of skilled care at birth, and save lives

- Home visits create trust of families in the CHW which in turn may facilitate utilization of CHW services for sick children

- WHO and UNICEF have developed training materials on Caring for the Newborn at home which include promotion and support activities as well as identification of sick newborns for timely care seeking and referral to a health facility

- **Where the iCCM platform is functional, it is useful to include home visits in the menu of tasks for CHWs**