Technical consultation on institutionalizing Integrated Community Case Management to end preventable child deaths

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Globally in 2017, 5.4 million children under the age of 5 died (1). Nearly half of these deaths occurred in sub-Saharan Africa. Pneumonia, diarrhoea and malaria remain the main causes of deaths among children aged 1–59 months. Overall, 52 countries are not on track to achieve the child survival target set by the Sustainable Development Goals (SDGs) of less than 25 deaths per 1000 live births by 2030.

Integrated programming approaches implemented at the primary health care (PHC) level have been shown to improve outcomes for key causes of child death, with delivery of key interventions at community level having a particularly strong impact (2). Achieving universal health coverage (UHC) and reaching the child health-related SDG targets will require strong PHC systems and the institutionalization of community health systems.

Community health workers (CHWs) can effectively deliver a range of preventive, promotive and curative health services, contributing to increased access and reduction in inequities. A recent WHO guideline (3) has consolidated evidence on optimizing CHW programmes through the identification of effective policy options for selection, education, management, remuneration, system support and community engagement.

Since 2012, WHO and UNICEF have recommended Integrated Community Case Management (iCCM) of childhood illness as a community-level component of a comprehensive strategy for Integrated Management of Newborn and Childhood Illness (IMNCI) (4). By targeting hard-to-reach, vulnerable populations and supporting extension of the formal health system to the community level, iCCM increases access to life-saving interventions for malaria, pneumonia and diarrhoea, and promotes rational use of medications, home care, immunization and use of insecticide-treated bed nets (ITNs). To date, over 30 countries have implemented iCCM – mostly at the subnational level – with the support of global development partners, including substantial investments from the Global Fund to Fight AIDS, Tuberculosis and Malaria and the RMNCH Trust Fund through the malaria and Resilient and Sustainable Systems for Health (RSSH) allocations.

Lessons learned have shown that effective iCCM implementation requires district health systems and PHC facilities with the capacity to support the delivery of quality child health services within the health facility and at community level. Despite recommendations from the 2014 Accra iCCM Evidence Review Symposium (5), many countries that initially implemented the iCCM component of the IMNCI strategy are struggling to maintain an acceptable quality of care and coverage, and large portions of the population remain underserved. Adequate planning, budgeting and resource mobilization for all iCCM components, including essential commodities, remain a major challenge in many of these countries, as does the proper inclusion of iCCM in the overall community health systems and IMNCI strategy.
One of the key findings of the 2016 IMNCI strategic review was the lack of prioritization of the community component alongside capacity-building of facility health workers (6).

Despite these challenges, there is increased recognition of the importance of frontline health systems and the need for better alignment of resources and partners around country-led priorities for community health, building on the 10 critical principles for institutionalizing community health (7).

With the aim of promoting the institutionalization of iCCM within PHC systems and comprehensive child health programming, WHO and UNICEF co-organized the Technical Consultation on “Institutionalizing Integrated Community Case Management to end preventable child deaths” from 22 to 26 July 2019 in Addis Ababa, Ethiopia. The meeting consisted of two connected parts: 1) “Institutionalizing iCCM to end preventable child deaths” and 2) “Implementation of malaria ‘High burden to high impact’ (HBHI) approaches and iCCM to accelerate reduction of child mortality”.

The meeting brought together over 140 participants, including ministry officials representing maternal and child health and malaria programmes as well as PHC/community systems from 14 African countries with high under-5 mortality and high malaria burden. Technical experts and partners representing 17 technical and funding agencies also participated. The consultation was the first global iCCM meeting to purposively bring together representatives of national malaria control programmes (NMCPs) and representatives of maternal and child health (MCH) programmes from all participating countries, as well as representatives of agencies engaged in both malaria and MCH.

The objectives of the Technical Consultation were to:

- review recent lessons drawn from the implementation of primary health care (PHC) at the community level, particularly related to iCCM of childhood illness, in the light of new WHO guidelines on community health workers;
- develop recommendations for embedding iCCM within community health systems at the core of the PHC system;
- identify needs and gaps for sustainable financing of iCCM;
- review progress, key bottlenecks and priorities to inform national iCCM implementation plans in the context of recent learning in order to guide the malaria High Burden to High Impact response and broader child health programming and inform Global Fund applications and other resource mobilization efforts.

In preparation for the meeting, the following key documents were shared with participants: i) WHO guideline on health policy and system support to optimize community health worker programmes; ii) WHO/UNICEF planning handbook for programme managers and planners: Caring for newborns and children in the community; iii) USAID/MCHIP indicator guide for monitoring and evaluating Integrated Community Case Management; iv) Journal of Global Health 2019 RAcE supplement (http://www.jogh.org/col-race.htm) (8); v) The Global Fund 18-country thematic review of iCCM as part of its portfolio supporting malaria programmes and health systems strengthening.

The report of the Technical Consultation is under preparation, and the main conclusions and recommendations can be summarised as follows:

- iCCM is an effective strategy to reduce morbidity and mortality of common childhood diseases by improving equity in access and coverage of primary health care. Countries with a high burden of under-five mortality should integrate iCCM in national health policies, strategies and national health sector development plans.

- A national community health policy/strategy should be in place, containing clear, official guidelines for recruitment, job description, motivation of community health workers, as well as clear criteria for implementing iCCM with focus on hardest to reach populations.
• Adequate and sustained funding for iCCM depends upon clearly defined targeted population need and fully inclusive costing, beyond funding of “non-malaria commodities”. It requires demonstrated ability of governments to coordinate diverse funding sources to support iCCM.

• To promote institutionalization and sustainability, funding agencies should coordinate iCCM funding with ministries of health and support ministries of health’s iCCM implementation plan, instead of funding isolated projects in different parts of the country.

• iCCM is a key component of a functional PHC system, ensuring continuum of care from community to health facilities and referral facilities, delivering quality of care at all levels, including at referral facility to manage severely ill children referred from the community.

• Attaining the highest level of quality of care at community level is dependent on competent community health workers empowered through training and mentoring, consistent supplies of tools, diagnostics and medicines, with motivation and supervision support as part of a primary health care system.

• The supply chain for iCCM should be fully integrated in the existing national supply management system, and iCCM medicines and diagnostics should be part of health facility and district level quantification, procurement and distribution.

• Supportive supervision of CHWs from the nearest health facilities is core to quality iCCM and needs to be budgeted and included in district implementation plans. District Management Teams should promote integrated supervision.

• Government led, harmonized, streamlined monitoring and evaluation systems need to include quality information and data from community activities, to guide action at local level, ensure accountability and sustained improvement of iCCM programming.

• Community engagement is key to institutionalization of iCCM. Local communities are central to planning, implementing and up-take of quality ICCM services.

The second part of the consultation focused on implementation of the HBHI approaches and iCCM to accelerate reduction of child mortality in Africa. The participants worked in 13 country teams to develop country plans for optimization of iCCM to accelerate child mortality reduction in settings with high transmission, limited resources and limited access to health care services. The discussion and deliberations of each country delegations were framed according to the four HBHI response elements (or pillars): 1) Political will to reduce malaria mortality; 2) Strategic use of information, 3) Better guidance, strategies and policies; 4) Coordinated action at country level. The participants raised strong concerns for the limited financial support for procurement of non-malaria commodities of iCCM, namely amoxicillin and ORS+Zinc, compromising the effectiveness of iCCM programmes in reducing child mortality. The immediate next steps following the Technical Consultation are:

• to finalize the meeting report and recommendations for institutionalizing iCCM and scaling up iCCM as part of the HBHI approach led by WHO and the RBM Partnership to End Malaria;

• to update the 2012 UNICEF iCCM joint statement, ensuring wide dissemination, policy adoption and implementation;

• to develop an iCCM district operational manual based on best practices and lessons learnt.
References


