WHO Technical Consultation on Institutionalizing integrated community case management (iCCM) to end preventable child deaths

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Presentation Outline

• Background
  • Burden of malaria, pneumonia and diarrhea
  • Child mortality in HBHI countries in Africa
  • iCCM programs to ensure UHC in remote settings

• Meeting Objectives

• Review of recent guidance and lessons learnt
  • WHO guideline on health policy and system support to optimize CHW programmes
  • WHO/UNICEF Planning Handbook for Programme Managers and Planners: Caring for newborns and children in the community
  • Results WHO/GMP Rapid Access Expansion (RAcE) Project in 5 African countries
  • The Global Fund 18-country thematic review of iCCM to support malaria programmes and health system strengthening

• Key highlights and conclusions

• Next steps
Burden of malaria, pneumonia and diarrhoea

- Globally, 5.4 million children <5 years of age died in 2017\(^1\), with estimated 266,000 deaths from malaria\(^2\)
- Nearly half of U5 deaths occurred in sub-Saharan Africa
- Pneumonia, diarrhea and malaria remain the main causes of the deaths in children 2-59 months of age
- Coverage of life saving interventions, especially in sub-Saharan Africa is still low due to inaccessible or poor quality of care

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## U5 mortality in the 10 high burden African countries

<table>
<thead>
<tr>
<th>Countries</th>
<th>Number of U-5 deaths</th>
<th>Number and % of U-5 deaths - malaria</th>
<th>Number and % of U-5 deaths - pneumonia</th>
<th>Number and % of U-5 deaths - diarrhoea</th>
<th>Number and % of U-5 deaths due to all 3 conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nigeria</td>
<td>869,879</td>
<td>92,699 (10.7)</td>
<td>140,520 (16.2)</td>
<td>74,785 (8.6)</td>
<td>308,004 (35.5)</td>
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<tr>
<td>DRC</td>
<td>303,618</td>
<td>39,001 (12.8)</td>
<td>39,718 (13.1)</td>
<td>32,902 (10.8)</td>
<td>111,621 (36.7)</td>
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<tr>
<td>Tanzania</td>
<td>110,330</td>
<td>6416 (5.8)</td>
<td>17,624 (16)</td>
<td>9,441 (8.6)</td>
<td>33,481 (30.4)</td>
</tr>
<tr>
<td>Niger</td>
<td>84,058</td>
<td>14,399 (17.1)</td>
<td>16,132 (19.2)</td>
<td>7,995 (9.5)</td>
<td>38,526 (45.8)</td>
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<tr>
<td>Mozambique</td>
<td>80,907</td>
<td>9,442 (11.7)</td>
<td>10,833 (13.4)</td>
<td>5,742 (7.2)</td>
<td>26,017 (32.3)</td>
</tr>
<tr>
<td>Uganda</td>
<td>79,481</td>
<td>5,992 (7.5)</td>
<td>14,578 (18.3)</td>
<td>6,997 (8.8)</td>
<td>27,567 (34.7)</td>
</tr>
<tr>
<td>Mali</td>
<td>78,212</td>
<td>20,044 (25.6)</td>
<td>11,026 (14)</td>
<td>7,052 (9)</td>
<td>38,122 (48.6)</td>
</tr>
<tr>
<td>Cameroon</td>
<td>70,028</td>
<td>6,678 (9.5)</td>
<td>10,448 (15)</td>
<td>6,884 (9.8)</td>
<td>24,010 (34.3)</td>
</tr>
<tr>
<td>Burkina Faso</td>
<td>58,525</td>
<td>14,641 (25)</td>
<td>7,527 (13)</td>
<td>4,593 (7.8)</td>
<td>26,761 (45.8)</td>
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<tr>
<td>Ghana</td>
<td>44,338</td>
<td>5,607 (12)</td>
<td>6,038 (13.6)</td>
<td>3,249 (7.3)</td>
<td>14,894 (33.6)</td>
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1. UN Inter-agency Group for Child Mortality Estimation (2016)
2. Estimates generated by the WHO and Maternal and Child Epidemiology Estimation Group (MCEE)

In 2016 **649,003 deaths** in under-five deaths were due to the three conditions in these 10 African countries: **47% (308,004) of deaths were in Nigeria alone and 65% (419,625) in DRC and Nigeria combined.**

Global Malaria Programme
Integrated Community Case Management (iCCM)

• iCCM is a proven strategy for improving access to care, and reducing inequities and mortality from malaria, pneumonia and diarrhea\(^1\)

• Over 30 countries have implemented iCCM with development partner support, especially Global Fund

• Many countries struggle to maintain an acceptable level of quality of care and coverage despite recommendations from the 2014 Accra iCCM Evidence Review Symposium and the 2016 Scaling up iCCM meeting in Nairobi

• Adequate planning, budgeting and resource mobilization for all iCCM components remain a major challenge, as well as proper integration of iCCM in PHC

• 2016 IMCI strategic review also showed lack of prioritization of the community component

Objectives of the meeting:

1. Review recent lessons drawn from the implementation of primary health care at the community level, particularly related to integrated community case management of childhood illness (iCCM), taking into account the new WHO guidelines on community health workers;

2. Develop recommendations for embedding iCCM within community health systems as the core of the PHC system;

3. Identify needs and gaps for sustainable financing of iCCM;

4. Review progress, key bottlenecks and priorities to inform national iCCM implementation plans 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.
Meeting participants

The meeting brought together over 140 participants:

- Country delegations with WHO, UNICEF staff and Ministry officials from maternal and child health (MCH) and malaria programs (NMCP) as well as community systems from 14 African countries with high under five mortality, including high malaria burden.

- Technical experts and partners representing 17 technical and funding agencies.

- First global iCCM meeting that purposely brought together representatives from both NMCP and MCH programs of all participating countries as well representatives of agencies engaged in both malaria and MCH.
Recent guidance and lessons learnt

- WHO guideline on health policy and system support to optimize community health worker programmes
- Implementation research results and programme learning from WHO/GMP Rapid Access Expansion (RAcE) Programme implemented in 5 sub-Saharan African countries
- The Global Fund 18-country thematic review of iCCM as part of their portfolio supporting malaria programmes as well as health system strengthening
New WHO CHW guidelines - 2018

• This guideline aims to support countries in designing, implementing, evaluating and sustaining effective CHW programmes

• The policy recommendations in the guideline were developed using WHO methodology to appraise the state-of-the-art evidence, taking into account feasibility and acceptability of the recommended policy options.

• Using a health system approach, the guidelines provide recommendations in relation to CHW:
  • selection, education and certification;
  • management and supervision; and
  • integration and support by health systems and communities.
The WHO guidelines support institutionalization of iCCM with three strong recommendations:

- remunerating CHWs for their work with a financial package commensurate with the job demands, complexity, number of hours, training and roles that they undertake;

- providing paid CHWs with a written agreement specifying role and responsibilities, working conditions, remuneration and workers’ rights;

- adopting the following community engagement strategies in the context of CHW programs: pre-program consultation with community leaders; community participation in CHW selection; monitoring of CHWs; selection and priority setting of CHW activities; support to community-based structures; involvement of community representatives in decision-making, problem solving, planning and budgeting processes.
Planning Handbook for Programme Managers

• **Inform** managers and planners about the three community-based packages, their benefits and requirements, for caring for newborns and children in the community:
  1. Caring for Newborn at Home
  2. Caring for the Child’s Healthy Growth and Development
  3. Caring for the Sick Child in the Community

• Guide managers in **selecting** the best mix of community-based interventions and packages to expand or add in their country

• Guide managers through key issues and decisions in planning and implementing the packages in the context of current country activities
RAcE achievement and key lessons learned

- RAcE iCCM project implemented on large scale in DRC, Malawi, Mozambique, Niger and Nigeria in 2013-2017, with over 8’500 CHWs providing care to 1.5 million children
- Major impact on child mortality in DRC, Niger and Nigeria in RAcE supported districts and provinces
- Lessons learnt:
  - iCCM relies on availability of a trained, supplied and supervised CHW in the village when a child falls ill
  - Community engagement is key for quality implementation and sustainability
  - Community and health facility quantification for medicines and diagnostics should be combined to avoid stock-outs
  - Parallel supply management system by partners are disruptive
  - Supervision from the nearest health facility contributes to quality of care, reporting, CHW motivation, connecting the CHWs to the health system
  - Functional referral to inpatient facilities is essential to manage severely ill children seeking care in the community
  - CHW data flow should be integrated in the health facility health management information system
1. Evidence of Impact: iCCM as a strategy to save lives of children aged under five
2. Integrated community case management: Planning for sustainability in five African countries
3. Effect of community-based interventions on improving access to treatment for sick under-five children in Niger State, Nigeria
4. Improving access to appropriate case management for common childhood illnesses in hard-to-reach areas of Abia State, Nigeria
5. Community engagement and mobilization of local resources to support integrated community case management of childhood illnesses in Niger State, Nigeria
6. iCCM Data Quality: An approach to assessing iCCM reporting systems and data quality in 5 African countries
8. Achievements and challenges of implementation in a mature iCCM program: Malawi Case Study
9. Home visits by community health workers for pregnant mothers and newborns: coverage plateau in Malawi
10. Barriers on the pathway to survival for children dying from treatable illnesses in Inhambane province, Mozambique
11. Testing a simplified tool and training package to improve integrated community case management in Tanganyika province, Democratic Republic of The Congo
12. A mixed-methods quasi-experimental evaluation of a mobile health application and quality of care in the integrated community case management program in Malawi
13. Clinical evaluation of the use of an mHealth intervention on quality of care provided by community health workers in southwest Niger

http://www.jogh.org/current.htm
Review of experiences of iCCM implementation in 18 countries supported by the Global Fund to rollout iCCM in sub-Saharan Africa

Major challenges in scale-up

• Weaknesses in sustainable financing and integration of iCCM into national health system
• Lack of an program/institution in charge of iCCM coordination
• In few countries CHWs are institutionalized and part of the healthcare system and many countries have unpaid or volunteer CHWs
• Poor supervision due to shortage of staff at health facilities, weak links between CHWs and health facilities and limited dedicated funds
• Non-integrated iCCM supply chain, poor data on iCCM commodity consumption, and inadequate funding for pneumonia and diarrhea commodities
• Parallel community information systems supported by partners
### Global Fund funding of iCCM in Africa

<table>
<thead>
<tr>
<th>Malaria intervention Areas</th>
<th>NFM</th>
<th>NFM2</th>
<th>Grand Total</th>
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<tbody>
<tr>
<td>Integrated community case management (iCCM)</td>
<td>149,633,261</td>
<td>134,325,000</td>
<td>283,958,261</td>
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<tr>
<td>Case management</td>
<td>1,058,024,343</td>
<td>801,745,645</td>
<td>1,859,769,988</td>
</tr>
<tr>
<td><strong>Total (Malaria)</strong></td>
<td>3,597,205,727</td>
<td>3,040,556,810</td>
<td>6,637,762,537</td>
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</tbody>
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- iCCM by Case Management: 14% (NFM), 17% (NFM2)
- iCCM by total Malaria Portfolio: 4% (NFM), 4% (NFM2)

#### iCCM Financing gap 2015-2017

- iCCM Financing Need: 344 Million
- Total Approved by GF: 83 Million
- Co-financing from MOHs and bilaterals: 110 Million
- Total Gap - diarrhoea and pneumonia commodities: 151 Million

* Nigeria, DRC, Zambia, Uganda, Ethiopia, Ghana, S. Sudan, Burkina Faso, Malawi and Cote D’Ivoire
### Nine working groups (modified iCCM health systems benchmark matrix)

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<table>
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<tbody>
<tr>
<td>1</td>
<td>Coordination and policy setting</td>
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<tr>
<td>2</td>
<td>Costing and Financing</td>
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<tr>
<td>3</td>
<td>Human Resources</td>
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<tr>
<td>4</td>
<td>Supply Chain Management</td>
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<tr>
<td>5</td>
<td>Service Delivery and Referral</td>
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<tr>
<td>6</td>
<td>Community Engagement (communication and social mobilization)</td>
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<tr>
<td>7</td>
<td>Supervision</td>
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<tr>
<td>8</td>
<td>Quality of Care</td>
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<tr>
<td>9</td>
<td>Monitoring and Evaluation and Health Management Information Systems</td>
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</table>

**Group work (step 1): discussion on bottlenecks / challenges pertaining to the specific system component based on country experiences**

**Group work (step 2): develop recommendations for institutionalizing iCCM in relation to the above health system component**
Key highlights and conclusions

• Planning for iCCM should take place under the umbrella of primary health care and overall health sector development
  • 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.

• Domestic and external funding should be targeted at system strengthening, with an inclusive focus on malaria, pneumonia and diarrhea as well as community and facility based provision of care

• iCCM should be included in the national costing exercise and the annual health sector budgeting processes, with specific budget lines

• To promote institutionalization and sustainability, donors should coordinate iCCM funding with MOH and support MOH’s iCCM implementation plan, instead of funding disease or site-specific projects
Key highlights and conclusions (cont’d)

- iCCM commodities should be integral part of health facility and district level quantification
- Supportive supervision of CHWs as part of primary health care system is core to quality iCCM and needs to be budgeted and included in district implementation plans
- iCCM requires continuum of care from community-first level health facility-referral facility, having capacity to fully manage referred children
- Community engagement is key to institutionalization of iCCM: local communities are central for effective planning, implementing and up-take of quality ICCM services
- The training of CHWs should not be considered complete until demonstration of defined competencies with post training follow-up (time to be fixed as per area context) as part of training programme
iCCM in the context of HBHI response

- The high-burden malaria countries contribute an estimated 151 million cases of malaria and 266,000 under-five deaths, 10 in Africa (Burkina Faso, Cameroon, DRC, Ghana, Mali, Mozambique, Niger, Nigeria, Uganda and Tanzania) and India. Of particular concern is the increase of malaria with 3.5 million more cases in 2017 compared to previous year, among the 10 highest burden African countries.

- These countries are also amongst the highest contributors to U5MR and also have some of the highest rates of pneumonia, and diarrhea deaths.

- iCCM provides simplified guidance and tools for management of febrile illness that may be due to pneumonia and diarrhea in children where malaria has been excluded or those with co-morbidities.

- iCCM allows identification and referral of children with severe illness with broader potential impact on child mortality.
Prioritization exercise for HBHI response

- NMCP, MCH, WHO, UNICEF representatives from 10 African HBHI countries plus Angola, Chad, Ethiopia and Sierra Leone, and representatives from additional 17 technical and funding agencies working in 14 country teams

- After presentation and discussion of HBHI response, each country team discussed priority areas for scaling-up iCCM to accelerate reduction in malaria mortality based on the following 4 HBHI Pillars:
  - Pillar 1: Political will to reduce malaria deaths
  - Pillar 2: Strategic information to drive impact
  - Pillar 3: Better guidance, policies and strategies
  - Pillar 4: A coordinated national response

- Developed recommendations for identified priority areas for Ministry of Health, funding agencies and implementing partners
Next Steps

- Finalization of meeting report and recommendations for institutionalizing iCCM and HBHI response
- Updating of WHO/UNICEF 2012 Joint Statement on iCCM
- Development of iCCM District Operational Manual

VISION
IMPLEMENTING iCCM TO SAVE CHILDREN’S LIVES
AND GET OFF THE 10+1 LIST!
Many thanks for your kind attention