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MALARIA

SCALING UP HOME-BASED MANAGEMENT FOR CHILDREN

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BASICS—Basic Support for Institutionalizing Child Survival
September 2, 2009



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THE SITUATION

- About 850,000 children under the age of five die annually due to malaria; 94% of these deaths occur in Sub-Saharan Africa.
- Malaria accounts for 18% of under-five mortality in Sub-Saharan Africa; well above the global average of 8%.



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THE CHALLENGE

- How to reach children in need of preventive and curative malaria services.
- How to provide these services in an efficient and effective manner.

WHAT IS CCM?

- Priority element: Curative therapy for malaria delivered at the community level (through CHWs, HSAs, extension workers)
- Integration*: Curative therapy for malaria, diarrhea, and pneumonia delivered at the community level

** Integration refers to the, "...organization, coordination, and management of multiple activities and resources to ensure the delivery of more efficient and coherent services in relation to cost, output, impact, and use (acceptability)." (WHO, 2006)*



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USAID/BASICS' MALARIA PROGRAM

COUNTRIES	AREAS OF FOCUS
Benin	Malaria CCM
Madagascar	Malaria CCM
Malawi	ITNs, IPTp, prompt treatment
Rwanda	Malaria CCM
Senegal	CCM
Timor-Leste	ITN



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BENIN

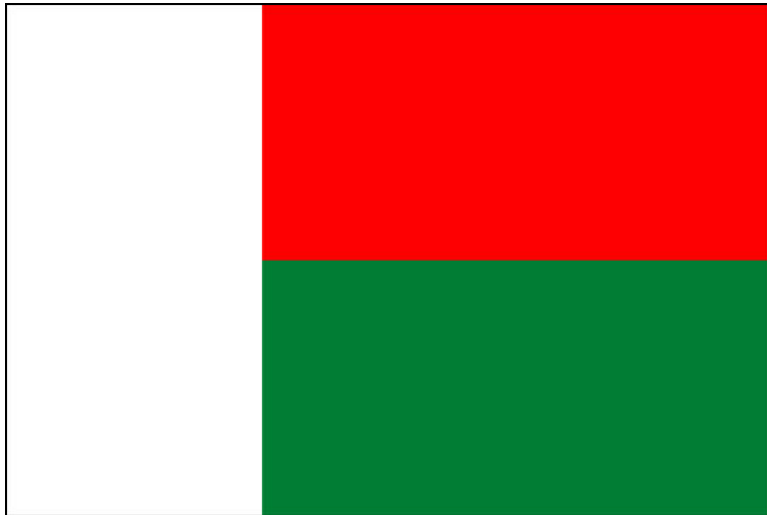


BASICS beginning efforts in 5 Health Zones to implement CCM-Malaria, as well as diarrhea, nutrition, and, hopefully, ARI.



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MADAGASCAR



Previous CCM work undertaken in a number of districts. Collaboration with PMI partners, the Global Fund, and the bilateral to coordinate the implementation of CCM-Malaria in a way that would minimize partner overlapping.



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MALAWI



Through local NGOs, BCC activities to promote prompt treatment, IPTp, and ITN use. Ongoing in 9 out of 28 districts. Some 4,000 Health Surveillance Assistants will be trained in CCM.



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RWANDA



Assist the National Malaria Control Program, in collaboration with SPS, in:

- Assessing Home-based management (with and without RDTs)
- Drafting next steps for the integration of RDTs into CCM
- Conducted a study on the nature of RDT referrals to health centers.



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TIMOR-LESTE



Assisted the MOH to distribute ITNs in 5 districts, using a partnership model that linked the public sector and civil society. Evaluation showed about 80% coverage.

**MALAWI
NGO GRANT REVIEW**



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MALARIA GRANT PROGRAM OVERVIEW

- BASICS awarded 6 grants to NGOs to operate in 7/28 districts in June 2008
- Community-level BCC/IEC activities to promote
 - Prompt treatment
 - ITN use
 - IPTp



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PURPOSE OF NGO REVIEW

After 10 months of implementation, ask:

- *What is the added value for malaria prevention and control when NGOs promote BCC/IEC interventions at the community level?*
- *What is the state of collaboration between the NGOs, DHMTs and partners?*
- *Are quality messages being delivered and retained by beneficiaries?*



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REVIEW METHODOLOGY

- Key informant interviews
 - District Health Management Teams (DHMT)
 - NGOs
 - Community Leaders and Health Surveillance Assistants (HSAs)
- Focus group discussion with community members
- Public health talk observations (HSAs and volunteers)
- Exit interviews (health talk attendees, 2x talk)



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OVERVIEW OF RESULTS

- Activities reached communities
- NGOs utilized different strategies to achieve varying degrees of depth versus breadth
- NGOs covered targeted population, but coverage was assessed at Traditional Authority level
- Five of 6 NGOs actively engaged with DHMTs
- Message delivery was good, but needed to be strengthened and cultural barriers addressed

Frequency of Messages Delivered During HSA and Volunteer Public Health Talks

Observation of 93 HSAs and 71 Volunteers

Message	HSA	Volunteer
Benefits of ITN use for children under five	87/93 (94%)	62/70 (89%)
Benefits of ITN use for pregnant women	86/93 (93%)	62/70 (89%)
Benefits of ITN use for PLWHA	19/69 (28%)	19/64 (30%)
Pregnant Women should take SP in order to prevent malaria	80/91 (88%)	62/70 (89%)
SP must be taken twice	70/89 (79%)	46/67 (69%)
LA is the newly recommended drug by the Government of Malawi	87/93 (94%)	65/71 (92%)
LA must be taken twice a day for three days	60/93 (65%)	32/71 (45%)

Frequency of Message Recall Following HSA and Volunteer Public Health Talks

Exit interviews with 336 caretakers

Message	HSA	Volunteer
Benefits of ITN use for children under five	70/87 (81%)	53/62 (86%)
Benefits of ITN use for pregnant women	69/86 (80%)	54/62 (87%)
Pregnant Women should take SP in order to prevent malaria	10/80 (13%)	8/62 (13%)
SP must be taken twice	23/70 (33%)	22/46 (48%)
LA is the newly recommended drug by the Government of Malawi	85/87 (98%)	60/65 (92%)
LA must be taken twice a day for three days	50/60 (83%)	26/32 (81%)



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RECOMMENDATIONS FROM NGO REVIEW

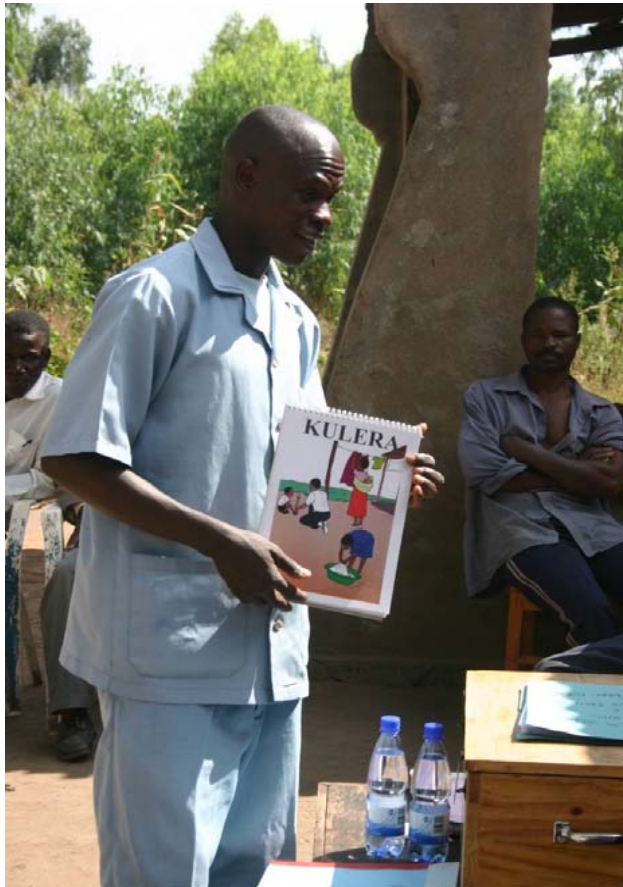
- NGO granting is an effective mechanism to reach communities with malaria BCC messages
- The program should be scaled up to other districts in Malawi
- Grantees require more than one year of funding to achieve behavior change at the community level
- Grantees should emphasize the use of interactive strategies (i.e. household visits and health talks)

CCM IN MALAWI



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VILLAGE CLINICS



- Focus: Managing common childhood illnesses (fever, pneumonia, diarrhea, red eye) using IMCI algorithms.
- Provision of Depo Provera is included in the service package.
- Between July 2008 and August 2009, 450 clinics (across 15 districts) were operationalized.



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VILLAGE CLINICS--CHALLENGES

- Health Surveillance Assistant overload
- Understanding drug requirements and supplying sufficient drugs (logistics)
- Supervision
- M&E systems

RWANDA
HOME-BASED MANAGEMENT
OF MALARIA ASSESSMENT
(WITH AND WITHOUT RDTs)



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OBJECTIVES OF THE ASSESSMENT

- Assess CHW performance according to standards (complete assessment, correct diagnosis [with RDT and without], appropriate referrals, counseling, and treatment)
- Explore community health-seeking behaviors and preferred treatments for young children when they have fever
- Investigate community satisfaction with CHWs and their services, including the use of RDTs



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METHODOLOGY

- Focus group discussions
- In-depth interviews
- Observation
- Exit interview

***CHW practice
related to danger signs***

Interviews and observation of CHWs

Danger Signs	Practice (n=69)
Convulsion	43%
Difficult breathing	45%
Vomiting more than 3 times	74%
Unable to drink and eat	57%
Unconscious	43%
CHW that mentioned all key danger signs	18%

CHW knowledge and practice related to RDTs

Task	Knowledge (n=24)	Practice (n=24)
Check expiration date	71%	63%
Put on gloves	100%	96%
Position kit horizontally	92%	100%
Write identification of person and date on kit	71%	96%
Put drop of buffer in first hole	95%	100%
Disinfect finger and use pipette correctly	96%	92%
Use the pipette correctly	96%	48%
Discard pipette in waste container	71%	78%
Put entire volume of blood in 1st hole	100%	95%
Use kit to insert it in the first hole for 10 minutes	100%	79%
Use pipette to stir and let stand one minute	80%	100%
Use dipstick in 2nd hole for 10 minutes	100%	87%
Take out stick and throw away remains of kit	96%	96%
Interpret test correctly	N/A	91%
Gave PRIMO if test positive	100%	100%
Gave PRIMO if test negative	N/A	25%
Gave PRIMO and referred to HC	92%	14%

RECOMMENDATIONS

- Renew focus on several tasks of case management.
- Strengthen the supervisory system so that supervision of CHWs is more consistent and focused on case management.
- Several issues related to RDTs need re-examination before scale-up.
- Improve specific elements of the pharmaceutical management of the HBM program.
- Revisit the recommendation from the 2006 HBM assessment on motivation and the CHWs.

RWANDA

**Retrospective study of
follow-up on RDT-negative
children**

Evaluation of the Community Health Worker Referral Program for RDT-negative children with fever

Goal: retrospectively examine treatment provided to children with a negative RDT when they are referred to the Health Center, focusing on the following points:

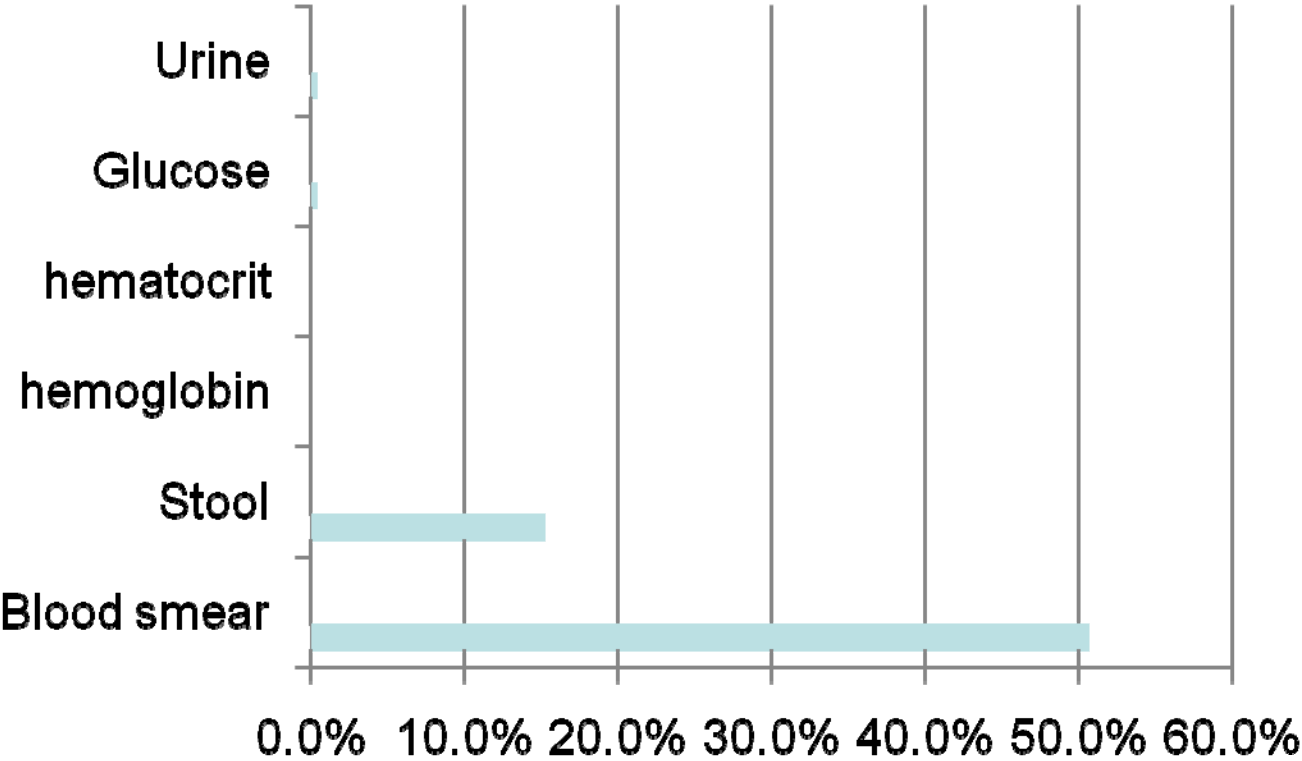
- What treatments were given?
- What tests were administered?
- What were the outcomes?

preliminary findings

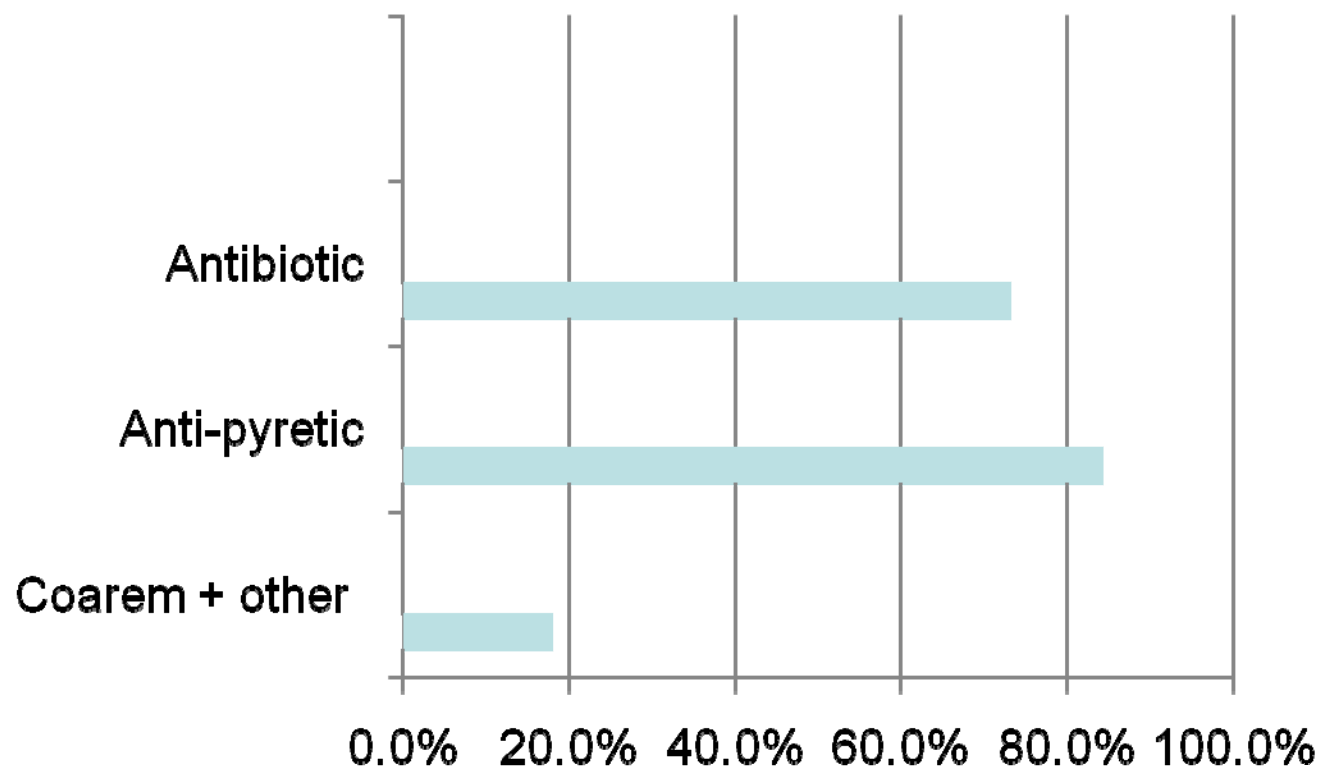
Methods (a retrospective study)

- 551 children with RDT negative identified from all CHW referral records (linked with 4 health centers)
- Examination of health center records for these children based on date, name, and village
- Follow-up at household level to determine survival and, in case of non-survival, symptoms associated with death
- 550 children were still alive; only one child died (from other causes)

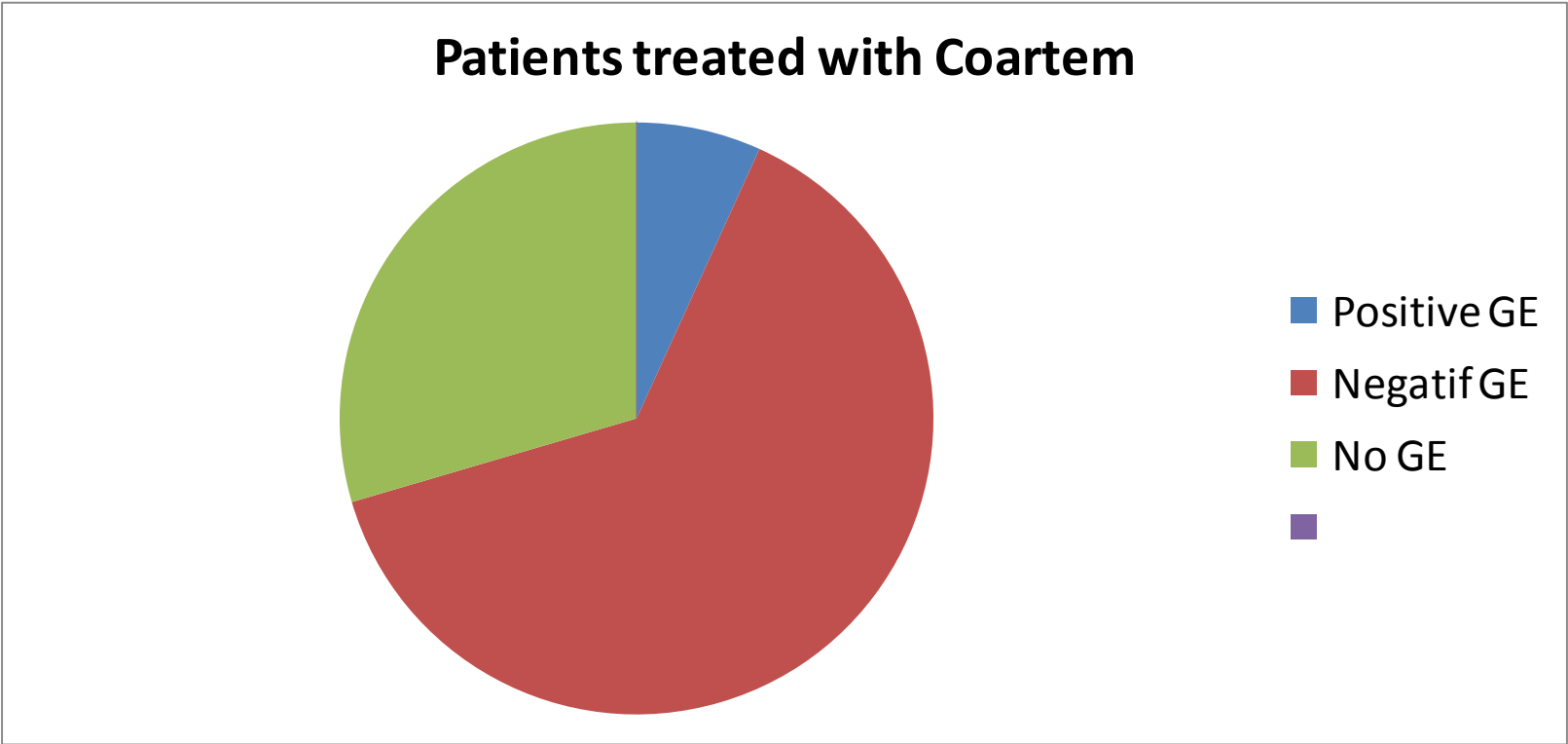
Tests administered to RDT-negative children at health center (n = 551)



Types of treatment given to RDT-negative children at health center (n = 551)



16% (n = 88) of RDT negative children treated at health center with Coartem



Preliminary implications

- What should be the CHW policy for dealing with RDT-negative children at community level?
 - Should they be referred?
 - What is the benefit of these children going to the health center from a family perspective and a public health perspective?
- What should be the policy for handling cases referred from community level with a negative RDT?
 - What guidelines should be developed for health center staff to manage children referred from community level with a negative RDT?

LESSONS LEARNED AND THE WAY FORWARD

LESSONS LEARNED AND THE WAY FORWARD

- The feasibility of CCM-malaria and ICCM depends on endorsement by the MOH and the community, **and a clear system of support** for CCM.
- RDTs at community level are quite feasible, as long as the support system is adequate and clear guidance for follow-up of RDT results is provided
- Scaling up CCM is critical to control malaria and other conditions. It requires a mechanism, such as NGO grants, with clearly defined roles to strengthen collaboration between the public sector and civil society