USAID
FROM THE AMERICAN PEOPLE

COMMUNITY CASE MANAGEMENT (CCM) OF CHILDHOOD ILLNESSES

IMPROVING THE HEALTH OF THE MOST VULNERALBLE CHILDREN

Dr. Emmanuel Wansi
Senior Technical Advisor
BASICS—Basic Support for Institutionalizing Child Survival
and
Eric Swedberg, MPH
Senior Director, Child Health & Nutrition
Save the Children

March 11, 2009

PRESENTATION OVERVIEW

1. Context
2. How CCM was implemented
3. Progress to-date
4. Lessons learned
5. The way forward

USAID
FROM THE AMERICAN PEOPLE

CONTEXT

- BACKGROUND
- MILESTONES

USAID
FROM THE AMERICAN PEOPLE

CONTEXT

BACKGROUND

BACKGROUND

- Characteristics of CCM/CBT in USAID/BASICS' implementation approach:
  - Focus on pneumonia treatment, but integrated with malaria, diarrhea, as well as nutritional status
  - CHWs treat non-complicated cases and refer severe cases
  - CHWs are unpaid volunteers
  - No active case finding occurs, but home visits are used to follow up cases
  - CHWs operate from home or in a structure built by community
- USAID/BASICS' mission is to develop or identify good practices and work with countries to take them to scale

BACKGROUND

- USAID/BASICS' current involvement in CCM began in March 2002 (Before the June 2002 Stockholm meeting and before the project had a mandate to do CCM).

Period	Countries Planned	Countries Implementing with BASICS inputs
1994-1999 (BASICS I)	0	0
1999-2004 (BASICS II)	0	2
2004-2009 (BASICS III)	10	12

- Prior to 2002, the project focused on behavior change in C-IMCI, though still participating in a major advocacy activity that had considerable impact on CCM.

USAID
FROM THE AMERICAN PEOPLE

CONTEXT

MILESTONES

MILESTONES

- January 2001—With the CORE Group, co-sponsored a workshop (in Baltimore) on “Reaching Communities for Child Health.” This established community care as one of the 3 elements in the HH/C-IMCI framework.
- March 2002—Held a regional workshop in Mbour, Senegal on C-IMCI, including discussion of CCM of pneumonia (ARI).
- May 2002—Participants in a Senegal workshop to review DMCI survey results noted that antibiotics were already attainable through certain sources in communities and recommended a study to determine the feasibility of cotrimoxazole management by community volunteers to treat ARI.
- June 2002—Partners at the Stockholm meeting express support for the Senegal initiative.

MILESTONES

- January 2003—Workshop held in Arlington to develop a protocol for the Senegal CCM (of ARI) feasibility study.
- March 2003—Field implementation began in Senegal.
- June 2004—A review of results from Senegal results in a recommendation for program expansion, with approval given by the MOH in 2005.
- December 2005 — integrated CCM training begins in DR Congo.
- March 2006—Sub-regional workshop on CCM of pneumonia held in Senegal
- February 2007—first training of Madagascar CHWs in integrated CCM.
- October 2007—International workshop on integrated CCM held in DR Congo.
- December 2007—Volunteers trained in integrated CCM in Rwanda
- August 2008—International workshop on integrated CCM held in Madagascar.

USAID
FROM THE AMERICAN PEOPLE

HOW CCM WAS IMPLEMENTED

- POLICY & STRUCTURAL BARRIERS
- LEVERAGING
- COLLABORATION
- APPROACHES AND TOOLS

USAID
FROM THE AMERICAN PEOPLE

HOW CCM WAS IMPLEMENTED

POLICY & STRUCTURAL BARRIERS

POLICY & STRUCTURAL BARRIERS

ISSUE

- Resistance to the use of antibiotics by Community Health Workers (to treat pneumonia).
- Few countries have policies on the use of antibiotics by Community Health Workers.
- Policy change can be slow and energy-consuming, and can delay implementation when disagreement arises, which is often the case with CCM.

POLICY & STRUCTURAL BARRIERS

CONFRONTING POLICY BARRIERS

- USAID/BASICS did not target a written policy, but instead sought to achieve "irreversible changes" in program implementation through adoption of key documents linked to nationwide CCM programming by cabinet-level MOH representatives and key officials. A validation process, including key interested ministerial departments, paved the way to MOH adoption.

The key question was: Will you support CCM if we can show you that it will work in your country?

USAID/BASICS' systematic approach included the vision of going to scale from the outset.

POLICY & STRUCTURAL BARRIERS

KEY QUESTIONS FOR INTRODUCING CCM

- Where does the new intervention fit within the MOH?
- How does one get MOH decision makers at various levels to support CCM?
- What needs to be done to maximize the chances of success for an activity that requires 1-2 years for introduction in an environment of constant personnel change?
  - There were up to 4 changes of the Minister of Health in DR Congo, Madagascar, and Senegal within 3 years
  - … and up to 3 changes of the Director of Health/In-charge of CCM in Senegal, Madagascar, DR Congo,.

POLICY & STRUCTURAL BARRIERS

USING EXISTING STRUCTURES

- The IMCI working group is a best-fit for the introduction of CCM
  - An IMCI working group, chaired by the MOH General Secretary, existed in all countries

- IMCI programs can be used to introduce CCM within C-IMCI
  - The task force concept is built into IMCI and is thus easy to put in place for CCM
  - The weakness of C-IMCI in getting sick children to treatment was recognized and served as a rallying factor
  - The C-IMCI framework by NGOs and USAID/BASICS was a strong advocacy piece

POLICY & STRUCTURAL BARRIERS

ADVOCACY

- Initiation trigger
  - Direct actions through presentations and discussions: Senegal, DR Congo, Madagascar
  - Interest expressed by countries (Rwanda)
  - Partners' actions in countries: UNICEF (Benin); Save the Children (Nicaragua); CARE (Cambodia)
- Key arguments
  - Feasibility study: Senegal, Benin, Cambodia
  - Initial phase: DR Congo, Madagascar, Rwanda
- Strategy
  - MOH in the driver seat from the outset
  - A national vision at the start – standardization and ownership at all levels

POLICY & STRUCTURAL BARRIERS

USAID/BASICS ACTIONS TO MAXIMIZE SUCCESS

- Created a sub-working group/task group
  - Membership: leadership of the Secretary General, key directors with potential roles in CCM (health, pharmacy, communication, statistics), and CCM Partners (UNICEF, WHO, USAID, USAID bilateral, MOH bilaterals & participating NGOs)
  - Roles: overseeing and guiding the process, validating products, ensuring compliance with MOH directives, and taking ownership.

POLICY & STRUCTURAL BARRIERS

USAID/BASICS ACTIONS TO MAXIMIZE SUCCESS (cont.)

- Set up a small technical group
  - Composed of 6-8 members: MOH child health or IMCI officers, and representatives of key implementers (USAID/BASICS, UNICEF, NGO, WHO)
  - Roles: draft materials, test materials and approaches, propose a field implementation plan, and support expansion in regions/provinces and districts

- Facilitated MOH-Partner coordination

POLICY & STRUCTURAL BARRIERS

OBSERVATIONS

- A sub-working group
  - TASK force have been successful, meeting on occasions
  - Madagascar: Task force has become a Child Survival Senior Committee taking up all C/S activities
  - DRC & Senegal, validated all documents, recommended expansion and ensured some level of coordination
  - Cambodia: currently being set up

POLICY & STRUCTURAL BARRIERS

OBSERVATIONS (cont.)

- Technical group
  - Function with 2-3 members except during meetings
  - Key to material development and follow up in the field

- Partner coordination
  - Important in time of problems
  - Active in major events for mobilizing resources
  - Crucial for planning

POLICY & STRUCTURAL BARRIERS

KEY POINTS

The development of the "how to" can build support and readiness for expansion.

The approach and structures have moved implementation from introduction to expansion in DR Congo, Madagascar, Senegal

USAID

FROM THE AMERICAN PEOPLE

HOW CCM WAS IMPLEMENTED

LEVERAGING

LEVERAGING

Leveraging has been a critical aspect of USAID/BASICS' work because…

- Funding for initial development is often hard-to-find because often not budgeted
- At best, USAID/BASICS funding covers limited field implementation
- Partner budgets are under-funded because they are based on BCC experience
- Partners usually support limited areas within a few districts
- Most government budgets do not fund CCM

LEVERAGING

COUNTRIES	DR CONGO	RWANDA	MADAGASCAR	SENEGAL	CAMBODIA	BENIN
PARTNERS	•UNICEF • GTZ • WHO • MSH • IRC • CRS • HNI •CCISD/ PARS School of public health •malaria control program •SANRU •AXxes partners	•UNICEF •Twubakane •MSH •IRC • Concern Worldwide •World Relief •Malaria program •PMI	•UNICEF •WHO •Santénet •MCDI	•UNICEF •WHO •MSH •CCF •AFricare •WV	•UNICEF •WHO •CARE •Racha •Rach	•UNICEF

LEVERAGING

APPROACH

- Meetings and joint planning
- Direct contact with partners and sustained follow-up
- MOH contacts, with USAID/BASICS playing “broker” role
- Spontaneous adherence of NGOs
- USAID-directed funding to NGOs

LEVERAGING

ADVANTAGES

- Build on each strength (UNICEF for equipment and drugs and support to central level, WHO for support to Central level and norms; NGOs and other for district/regional support)
- Take advantage of planning cycle
- Link with complimentary interventions: zinc, malaria, BCC, FP
- Build on common interest : CCM international conference, results
- Close monitoring in unfavorable situation: DRC case

LEVERAGING

FACILITATING FACTORS

- USAID/BASICS Reputation built on its experience
- Good personal relationship, key factor in recruiting country team leaders
- Sustained advocacy
- Good relationships with partners' headquarters
- Advocacy within the CORE GROUP and by CSHGP and USAID

USAID
FROM THE AMERICAN PEOPLE

HOW CCM WAS IMPLEMENTED

COLLABORATION

CORE & PVOs

CORE Group fosters collaborative learning and action to advance the effectiveness and scale of community-focused public health practices. Established in 1997, the CORE Group is a membership association of citizen-supported NGOs that work internationally in resource-poor settings to improve the health of mothers, children and communities.

Partners forming a CCM “Community of Practice”

- Facilitate interaction among practitioners
- Share lessons learned
- Collaborate to solve problems
- Advocate to change policies
- Improve technical excellence in approaches
- Pilot and expand programs

Key Activities: How we partnered & what was the result?

1. Global and regional meetings
   - Reaching Communities for Child Health (2001)
   - West Africa Regional Workshop on C-IMCI (2002)
   - West Africa Consultative Meeting on CCM (2005)
   - Madagascar Zinc Introduction
   - Presentations at International Meetings
2. Technical Guidance: CCM Essentials Guide, CCM Indicators
3. Country level support for CCM pilots
   - Nicaragua, Afghanistan, Niger, Ghana
4. Global Working Groups

Background on CORE/PVO Involvement in CCM

- HH/Community IMCI was officially launched at First IMCI Global Review and Coordination Meeting (Santo Domingo, 1997)
- Obvious to CORE and PVOs from the outset that PVOs have important role to play in HH/C-IMCI
- Advocated for more emphasis on:
  - Appropriate management of sick children at household and community levels
  - Sustainability
  - Being strategic in selection of interventions

Initial Steps Working Together

- Organization of meetings and documents on the PVO role in Community Approaches to Child Health (BASICS I)
- Formation of CORE IMCI Working Group which BASICS has collaborated with
- Reaching Communities for Child Health (2001) – developed an implementation framework for a community approach to child health (BASICS II)

HOUSEHOLD & COMMUNITY IMCI
AN IMPLEMENTATION FRAMEWORK
ELEMENT 1
Improving partnerships between health facilities and the communities they serve
CLINIC
ELEMENT 2
Increasing appropriate and accessible health care and information from community-based providers
VILLAGE SHOP
ORS
ELEMENT 3
Integrating promotion of key family practices critical for child health & nutrition
ABC
LOCAL GOVERNMENT
MULTI-SECTORAL PLATFORM
Optimizing a multi-sectoral platform to support sustainable child health & nutrition
design & illustrations: R. Doyle

Advocacy Tool for CCM

- The joint framework document which facilitated the place of CCM within IMCI was shared widely within the NGO community and in international C-IMCI meetings
- Framework created a common vision and a communication tool
- Increased global acceptance of CCM

West Africa Regional Workshop on C-IMCI (2002)

- CORE and BASICS co-sponsored this workshop with both NGOs and MOH participants to share C-IMCI experience including CCM (including Nepal)
- Joint planning and leading the workshop
- Opportunity to advocate for CCM within C-IMCI by sharing the framework and examples of CCM pilots in Mali, Senegal & other countries
- Result: discussions about treatment of pneumonia & prepared the ground for CCM in Senegal

Senegal: CCF Health Post

West Africa Consultative Meeting on CCM of Pneumonia (2005)

- Focused on learning from Senegal experience which was the first of it's kind in W. Africa: research team from Senegal presented their program and the evaluation
- Participants also visited the program and had a chance to see it first hand
- Presentations from UNICEF on Accelerated Program for Child Survival and Development in West Africa
- BASICS presented the CCM work from Benin and DRC.
- Discussion of potential regional activities to introduce CCM in other countries in West Africa.
- **RESULT:** advanced CCM in Niger and Togo through AWARE

Madagascar Zinc Introduction – Opportunity for CCM

- In 2005 a country assessment for the introduction of zinc in the management of diarrhea took place
- During this assessment stakeholders recognized the value of expanding CCM for diarrhea
- Opportunity to discuss and begin planning for an integrated community case management approach including antibiotics for pneumonia

CCM Essentials Guide

Contributors:

- In consultation with WHO, UNICEF, and USAID led by steering committee from CORE Group, Save the Children and USAID/BASICS with many other partners

Audience:

- NGO Program Managers & MOH Counterparts at the district level
- Central-level MOH planners & others interested in developing large scale CCM programs

Partnership has led to a longer process but hopefully a higher quality product!

Indicators and Tools to Introduce CCM in Countries

- **Monitoring**: Indicators, Register, Monthly Summary…
- **Supervision**: CHW Core Competencies, Checklists for Supervising CHWs and Supervisors, Case Scenarios…
- **Job Aids**: Case Management Flowcharts, Counseling Cards, Reminder Cards…
- **Training**: Operations Manual, Training Manual ("WHO-Plus") for CHW and Supervisor…
- **Formative Research and Planning**: Treatment Ratios, Activity Levels…
- **Newborn**: Indicators, Surveillance and Treatment Register, Work Load…

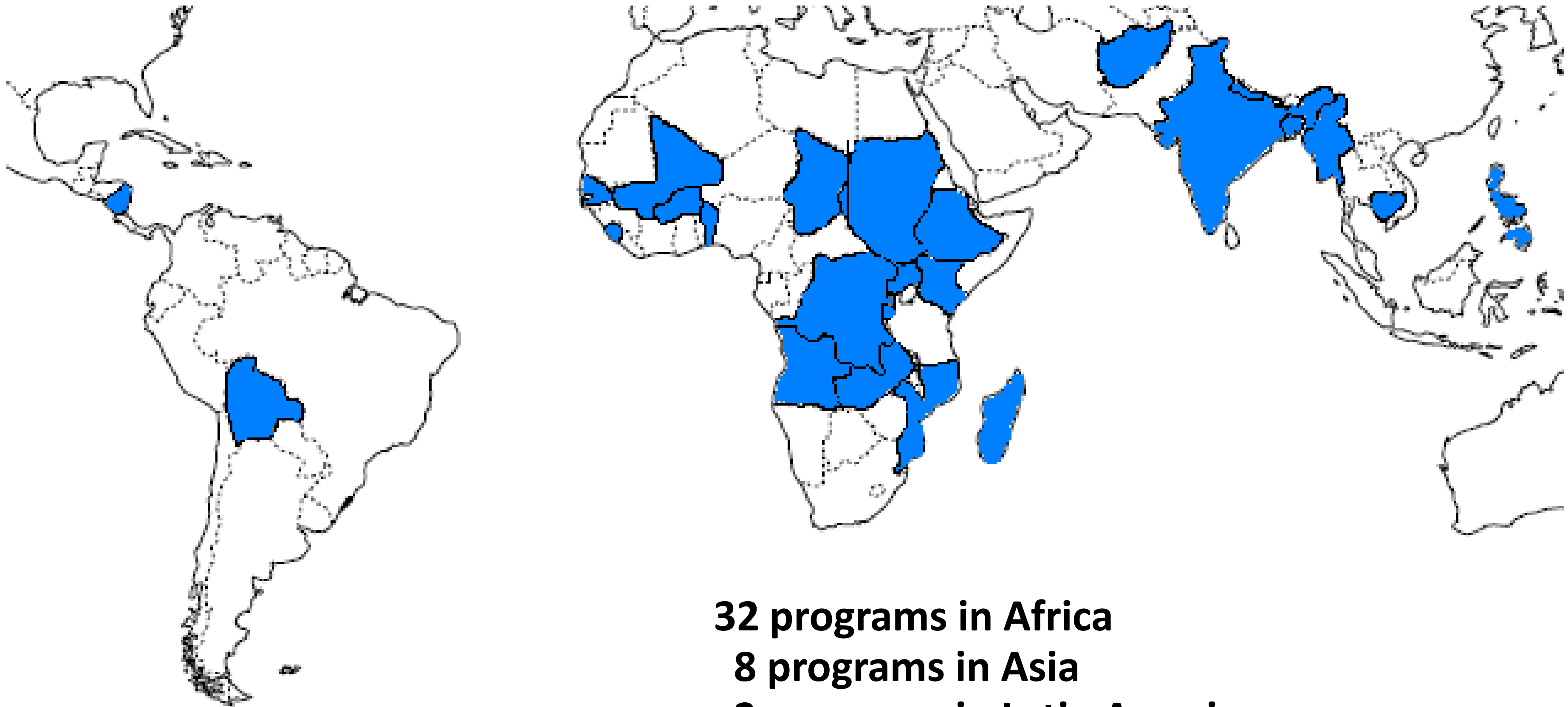
Country support for CCM: Nicaragua

- Financial support from and technical discussion with USAID/BASICS for an SC-led effort
- Pilot-tested in category “C” communities (15,000) in 4 municipalities in León Dept.
- Replicated to 13 more municipalities in 3 more departments (106,000).
- Policy changed: CCM for “C” communities.
- Complete set of MINSA tools developed.
- Adding newborn sepsis and malaria.
- Nicaragua experience informs other efforts in region:
  - Guatemala MINSA supporting CCM in Ixil.
  - Dominican Republic (just starting)

Global Working Groups (BASICS & PVOs)

- Global Action Plan for Pneumonia (GAPP)
  - "Tipping Point" CCM/pneumonia survey
- CCM Task Force
  - Country mapping
  - Tools review
- CCM Operations Research Group
  - Prioritized OR questions
  - Developing tools for 12 case studies

PVO CCM projects: ‘98-‘08



32 programs in Africa
8 programs in Asia
3 programs in Latin America

USAID
FROM THE AMERICAN PEOPLE

HOW CCM WAS IMPLEMENTED

APPROACHES AND TOOLS

MAIN STEPS

- Advocacy
- Setting up a task force and working group to lead the process
- Developing and updating guidelines and tools
- Addressing logistics needs
- Identifying sites and community health workers
- Training
- Conducting post-training support and supervision, including the use of data for decision making/monitoring
- Mobilizing/educating communities
- Reviewing or evaluating early-phase implementation
- Scaling up

APPROACHES AND TOOLS

TOOLS DEVELOPED IN EACH COUNTRY

- Implementation guideline
- Facilitators training manual
- District and health center staff manual
- CHW manual (Set of tools used by CHW)
- Computer application

PROGRESS TO DATE

- GLOBAL LEVEL
- COUNTRY LEVEL

USAID
FROM THE AMERICAN PEOPLE

PROGRESS TO DATE

GLOBAL LEVEL

PROGRESS TO DATE

CCM CONFERENCES

- Objectives
  - share experiences
  - support expansion decisions by countries
  - build network of CCM implementers
- Evolution
  - from a BASICS/UNICEF event in Senegal (2005) → 8 partners in DRC (2007) → an international event with 22 participating countries in Madagascar (2008)
  - The key note address was delivered by an MOH Secretary General in Senegal → the Minister of Health in DR Congo → the Prime Minister in Madagascar.
  - Now being institutionalized through UNICEF, WHO and other partners funding and participation
- Possible Future Directions
  - Multiple focused meetings on specific agenda items
  - Multiple decentralized/regional meetings

PROGRESS TO DATE

CCM COMMON INDICATORS

- Development of common indicators for CCM
  - Stimulate quality measurements across project
  - Promote experience sharing
  - Allow comparisons in order to identify most efficient practices

- History
  - Initiated during Senegal workshop in 2006
  - Reviewed in DRC in 2007
  - Discussed in Madagascar 2008

- GAPP has taken over this activity and work is in progress.

PROGRESS TO DATE

OTHER ACTIVITIES

- *CCM Essentials*
  - USAID/BASICS is one of the key developers of this publication
  - Participated in technical development and funding

- Participant in several global groups
  - GAPP
  - Zinc Task Force Working Group
  - CORE CCM activities

- Review CCM Grants

- Presentations to several forums, including:
  - Universities
  - Global Health Council
  - International meetings

PROGRESS TO DATE

COUNTRY LEVEL

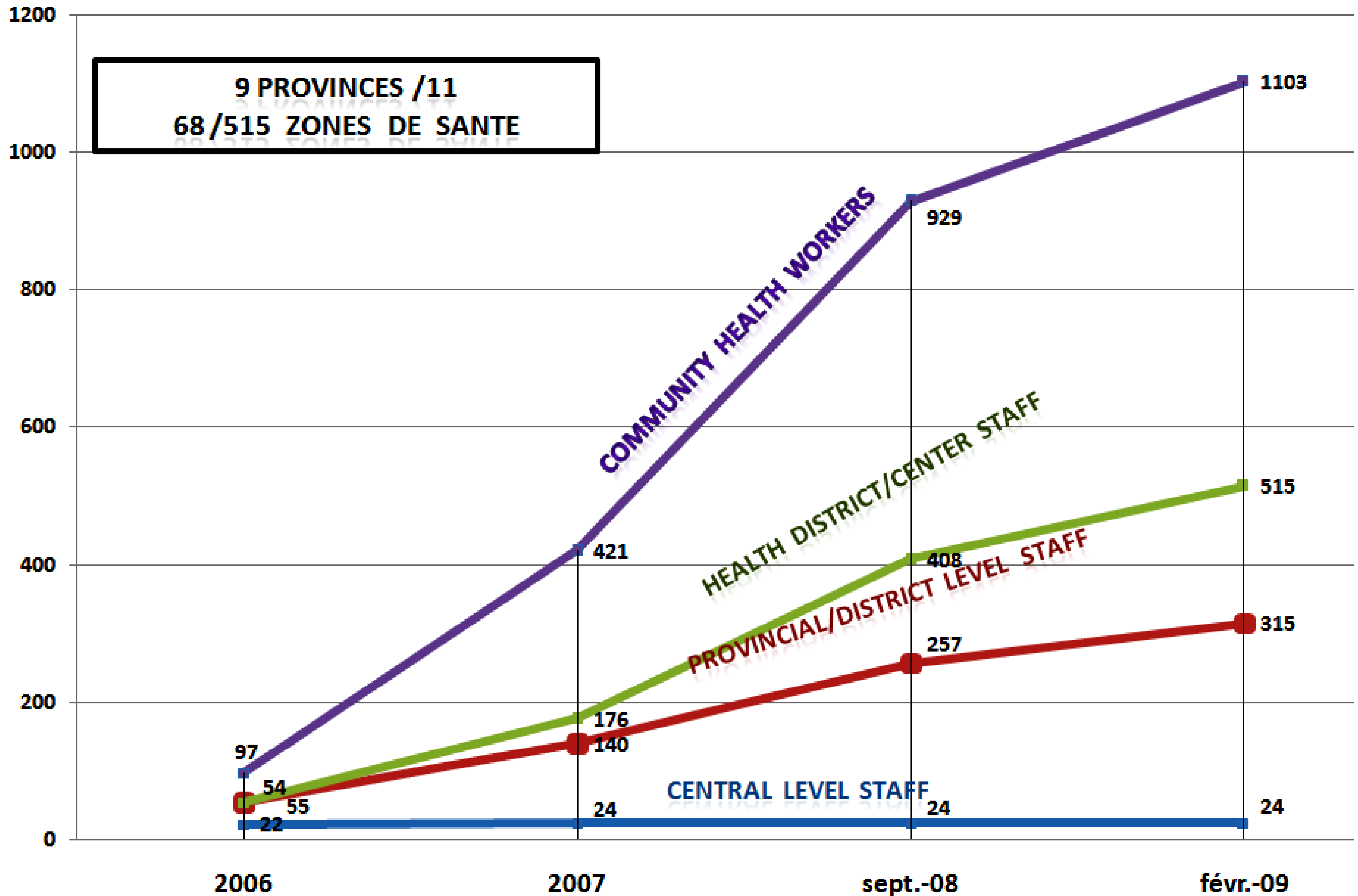
Countries by stage

STAGE	COUNTRIES
Advocacy (with positive response)	Chad, Malawi, Liberia
Introduction	Benin, Cambodia
Expansion	Senegal, DR Congo, Madagascar, Rwanda
Expansion by partners (with USAID/BASICS support)	Nicaragua, Niger, Afghanistan

Building human resource capacity to expand CCM

Country	Provinces/Regions		Districts		Community HW trained
	Total	Training Pool	Total	Covered	total
DR Congo	11	9	517	69	1103
Madagascar	22	9	111	21	907
Senegal	On going expansion in 37 districts information not available				
Rwanda	-	-	30	7	3000+

Capacity building at central, midlevel, periphery and community levels-DRC



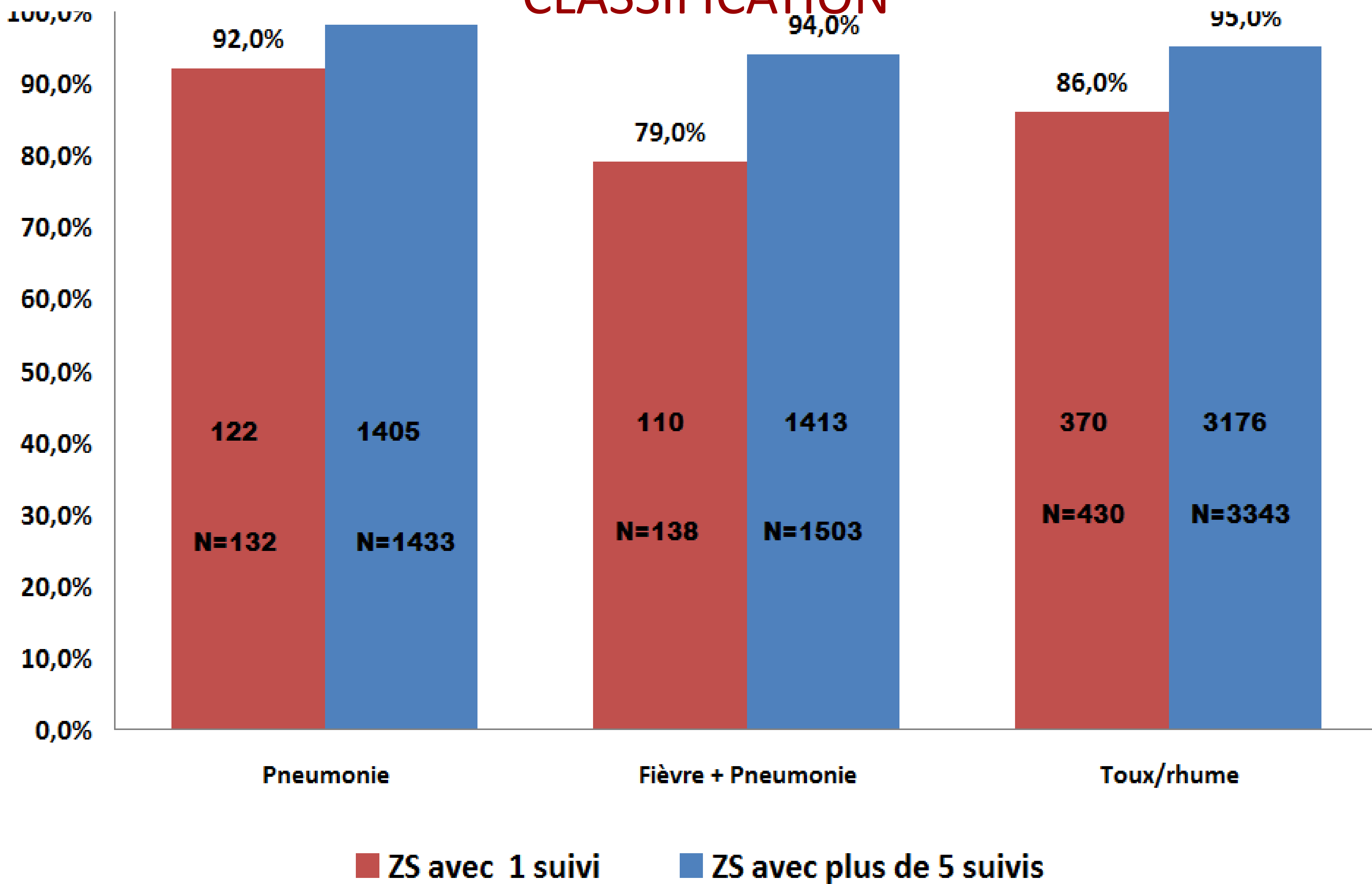
Tools development

COUNTRY	IMPLEMENATION GUIDELINES	FACILIATATORS ' MANUAL	CHW SUPPORT TOOLS	CHW MANUAL	APPLICATION
DR Congo	✓	✓	✓	✓	✓
Madagascar	✓	✓	✓	✓	✓
Senegal	✓	✓	✓	✓	✓
Rwanda	✓	✓	✓	✓	

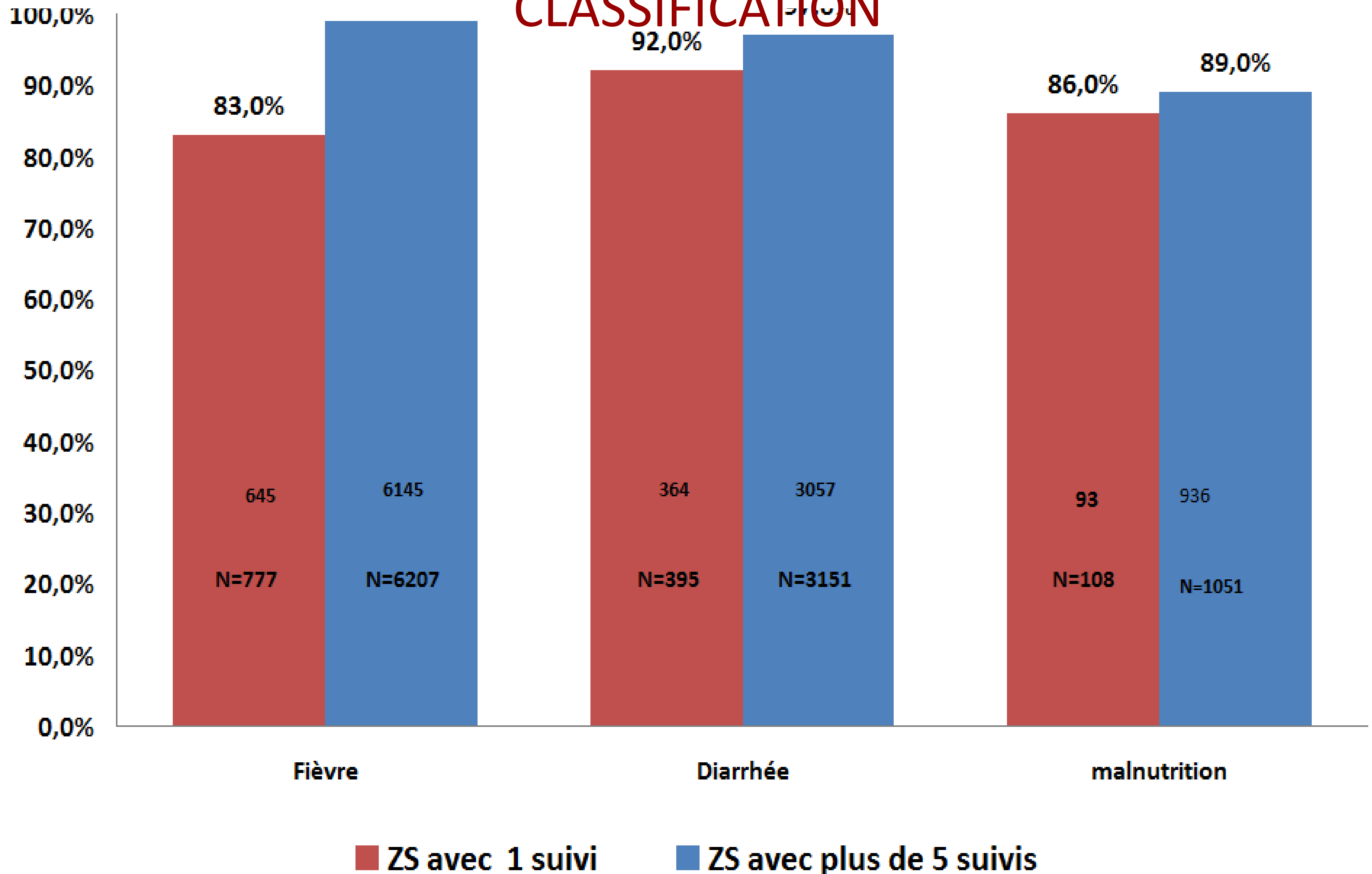
Senegal: Appropriateness of community health worker actions, based on classification of pneumonia and the correct treatment option, using reconstituted patient forms (phase I only)

	Number of cases classified	Action taken		
		Home care (no antibiotics)	Cotrimoxazole	Referral
Cough/cold (Green)	18	16 (88.9%)	1 (5.6%)	1 (5.6%)
Simple pneumonia (Yellow)	192	3 (1.6%)	187 (97.4%)	2 (1.0%)
Severe pneumonia (Red)	10	19 (8.6%)	188 (85.5%)	13 (5.9%)

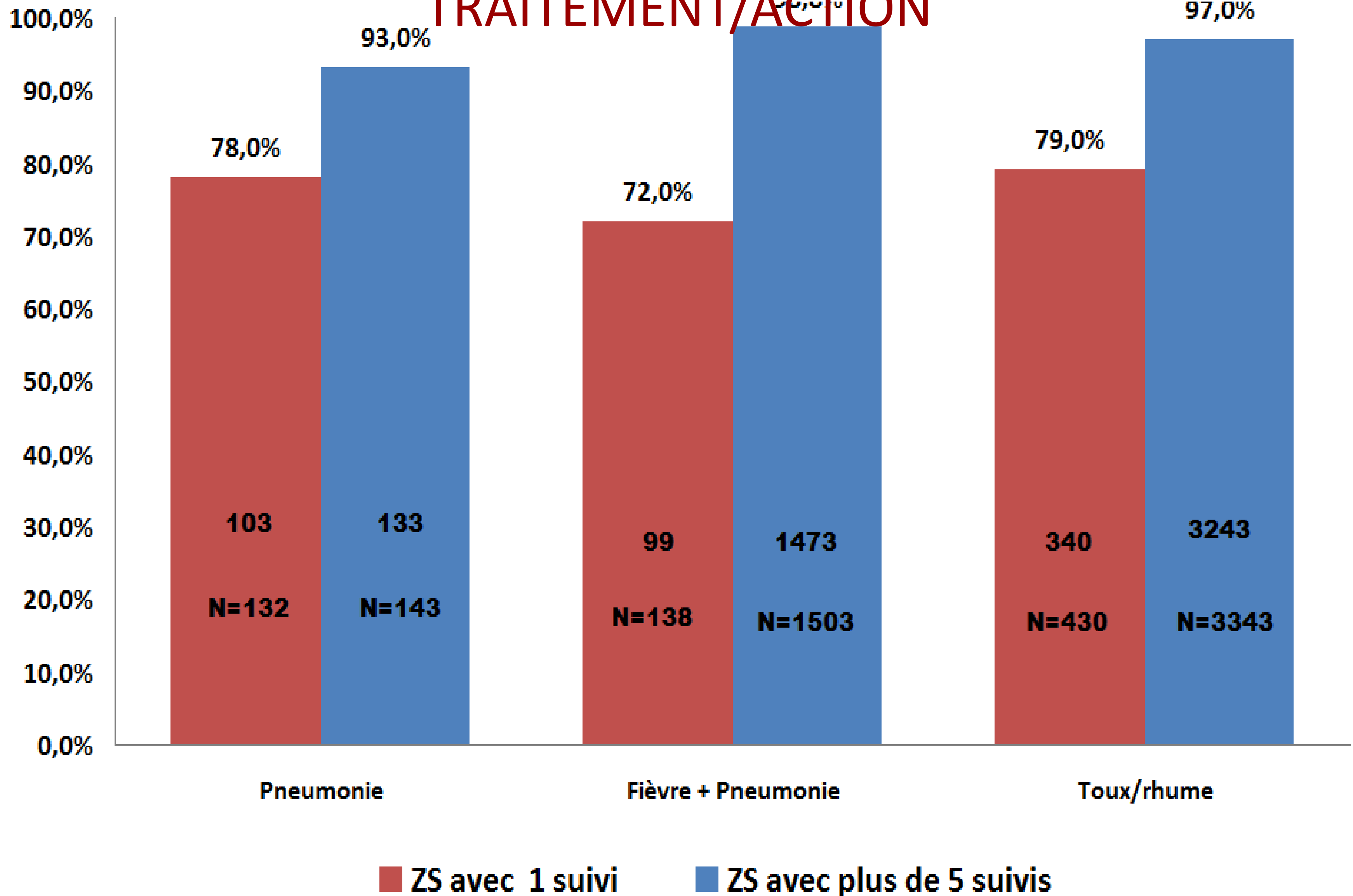
Comparaison
(1) CONCORDANCE ENTRE SIGNES/SYMPTOMES ET CLASSIFICATION

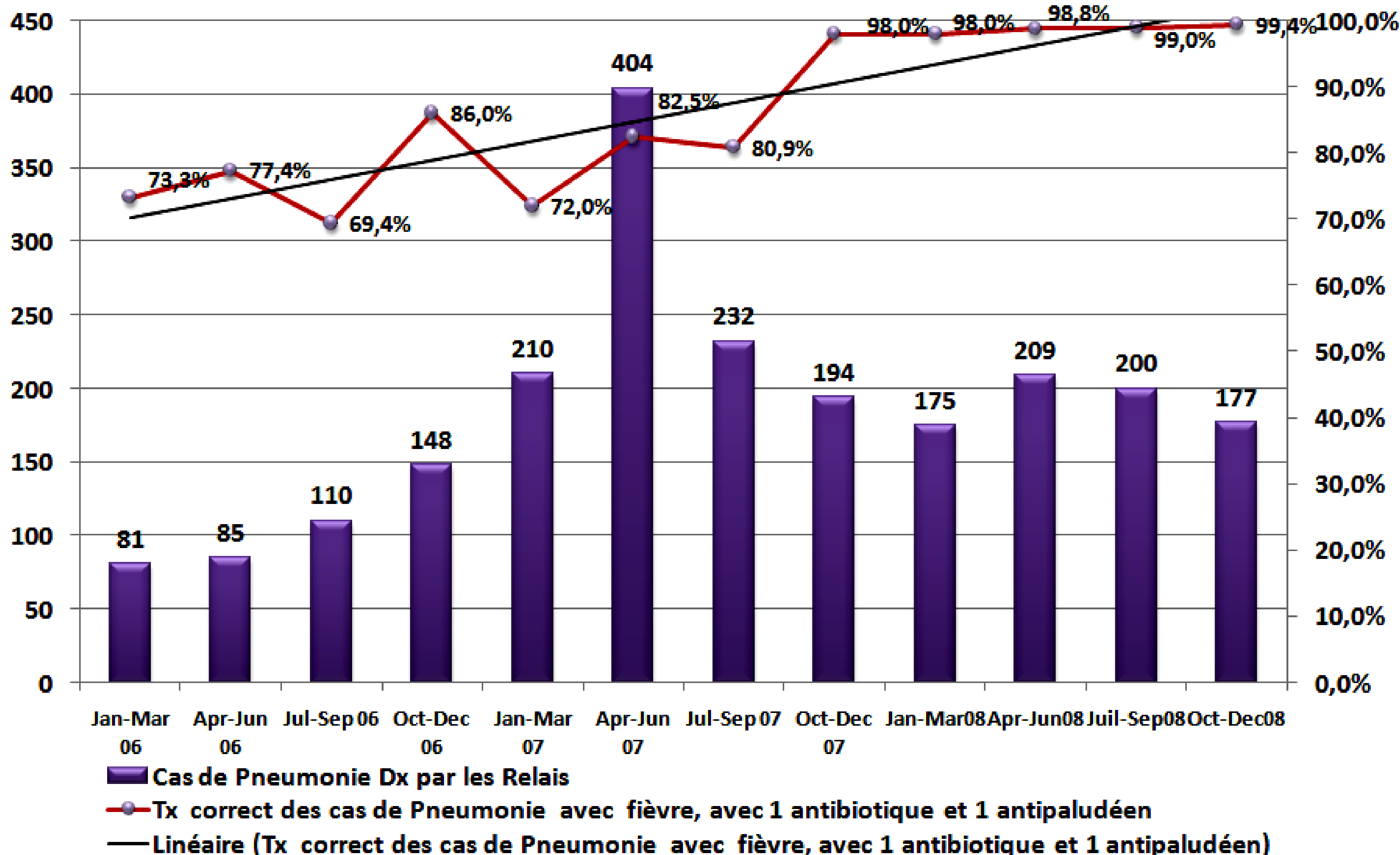


Comparaison
(1) (SUITE) CONCORDANCE ENTRE SIGNES/SYMPTOMES ET CLASSIFICATION



Comparaison
(2) CONCORDANCE ENTRE CLASSIFICATION ET TRAITEMENT/ACTION




Traitement des cas classés Pneumonie avec fièvre, avec antibiotique et 1 antipaludéen
Par les Relais ayant bénéficiés d'au moins 4 suivi post-formation
450
400
350
300
250
200
150
100
50
0
100,0%
90,0%
80,0%
70,0%
60,0%
50,0%
40,0%
30,0%
20,0%
10,0%
0,0%
81
85
110
148
210
404
232
194
175
209
200
177
73,3%
77,4%
69,4%
86,0%
72,0%
82,5%
80,9%
98,0%
98,0%
98,8%
99,0%
99,4%
Jan-Mar 06
Apr-Jun 06
Jul-Sep 06
Oct-Dec 06
Jan-Mar 07
Apr-Jun 07
Jul-Sep 07
Oct-Dec 07
Jan-Mar08
Apr-Jun08
Juil-Sep08
Oct-Dec08
Cas de Pneumonie Dx par les Relais
Tx correct des cas de Pneumonie avec fièvre, avec 1 antibiotique et 1 antipaludéen
Linéaire (Tx correct des cas de Pneumonie avec fièvre, avec 1 antibiotique et 1 antipaludéen)

USAID
FROM THE AMERICAN PEOPLE

LESSONS LEARNED

LESSONS LEARNED

- Identify champions for CCM within the Ministry of Health and support them to introduce CCM
- Leveraging/promoting collaboration to maximize expertise and resources for greater impact
- There is a balance between having too many partners and the speed of implementation
- Partners level of implementation should be compatible with MOH capacity to take over

USAID
FROM THE AMERICAN PEOPLE

THE WAY FORWARD

THE WAY FORWARD

- Use malaria, HIV/AIDs and newborn health programming opportunities to promote CCM and integrate as appropriate
- GAPP should collaborate with other global efforts such as RBM to promote integrated CCM
- Building on increased momentum for CCM focus coordinated and sustained advocacy effort in resistant countries
- Address implementation challenges through operations research

THE FINAL WORD

CCM is here to stay because the need is significant, and we are just scratching the surface of what this life- saving intervention can do for rural populations in the developing world.