MAXIMISING THE CHILD SURVIVAL POTENTIAL OF INTEGRATED COMMUNITY CASE MANAGEMENT (ICCM) OF CHILDHOOD ILLNESSES BY INCORPORATING COMMUNITY TREATMENT OF ACUTE MALNUTRITION (CMAM).

Concept Note

RATIONALE

According to the World Health Organisation (WHO), pneumonia, diarrhoea and malaria together claim the lives of 3 out of every 10 children who die before the age of 5. Many of these deaths occur in children whose immune systems are already weakened by undernutrition – **nearly half of all deaths among children under 5 are attributable to undernutrition**. The recent Lancet series on Maternal & Child Health estimated that improving the coverage of treatment of severe acute malnutrition (SAM) could save almost half a million lives a year. Currently, estimates of how many children with SAM receive treatment is approximately only 10 to 13% globally and hence, there is a clear need for improvement.

The integrated Community Case Management (iCCM) of childhood illness is a strategy to identify and treat pneumonia, diarrhoea and malaria in a holistic manner in community settings. In most countries, the iCCM protocol (following the UNICEF/WHO package Caring for the Sick Child in the Community) also includes the identification of acute malnutrition. The treatment of severe acute malnutrition, however, continues to be provided at health facilities, but it could benefit from the task shifting approach used by iCCM: all cases are assessed by the CHW, and complicated cases would be referred to the Health Facility. It would just require a few changes to the protocol to make that task shifting possible.

Access to health facilities (e.g. health centres, health posts, clinics) in most parts of Africa and Asia is low, meaning that caregivers are forced to travel long distances to the nearest facility offering care. Whilst there, waiting times can exceed several hours. This issue, coupled with inconsistent quality of care, insecurity and competing priorities, means that **as many as 2 out of 3 caretakers with children affected by SAM simply do not seek care or 'default' (stop attending) after only a few visits**.

Research has shown that the delivery of SAM treatment by Community Health Workers (CHWs) at the community-level can reach over 90% of the affected cases, **almost twice the proportion achieved by facility-based services**. There is also evidence to suggest that the delivery of SAM treatment via CHWs is cost-effective, with the cost per child treated and the Disability Adjusted Life Year (DALY) averted comparable to interventions like immunisation and tuberculosis treatment, which showed a cost benefit of $26 per DALY averted [1].

While the above studies were conducted in optimal conditions with a high level of support and supervision, a recent study conducted by ACF and the Innocent Foundation, attempted to demonstrate the effectiveness of integration within 'normal' settings. This study, conducted in Mali, aimed to further assess the potential of CHWs to support SAM treatment and noted an increase in coverage in the intervention area to 69.9% as opposed to 42.2% in the control area. Moreover, a quality of care study indicated that **70% of SAM cases were treated without any mistakes**.

While these results are encouraging, more research is still required to further build the evidence base for integration. Models need to take into account programmatic considerations, such as ensuring CHWs are not overburdened. Additionally, sensitivity a stronger supervision structure that is sensitive to the likely complications that CHWs will encounter in integrating iCCM and nutrition is required. The

[1] Read the report on this pilot project in Bangladesh

iCCM+SAM treatment intervention would combine SAM treatment into the existing iCCM package and assess this integrated package's impact on the coverage, effectiveness, cost-effectiveness and quality of care. In addition, the intervention will strengthen the delivery of nutrition counselling during illness (including MAM) and recuperation feeding after illnesses (increase BF frequency and diversified complementary feeding).

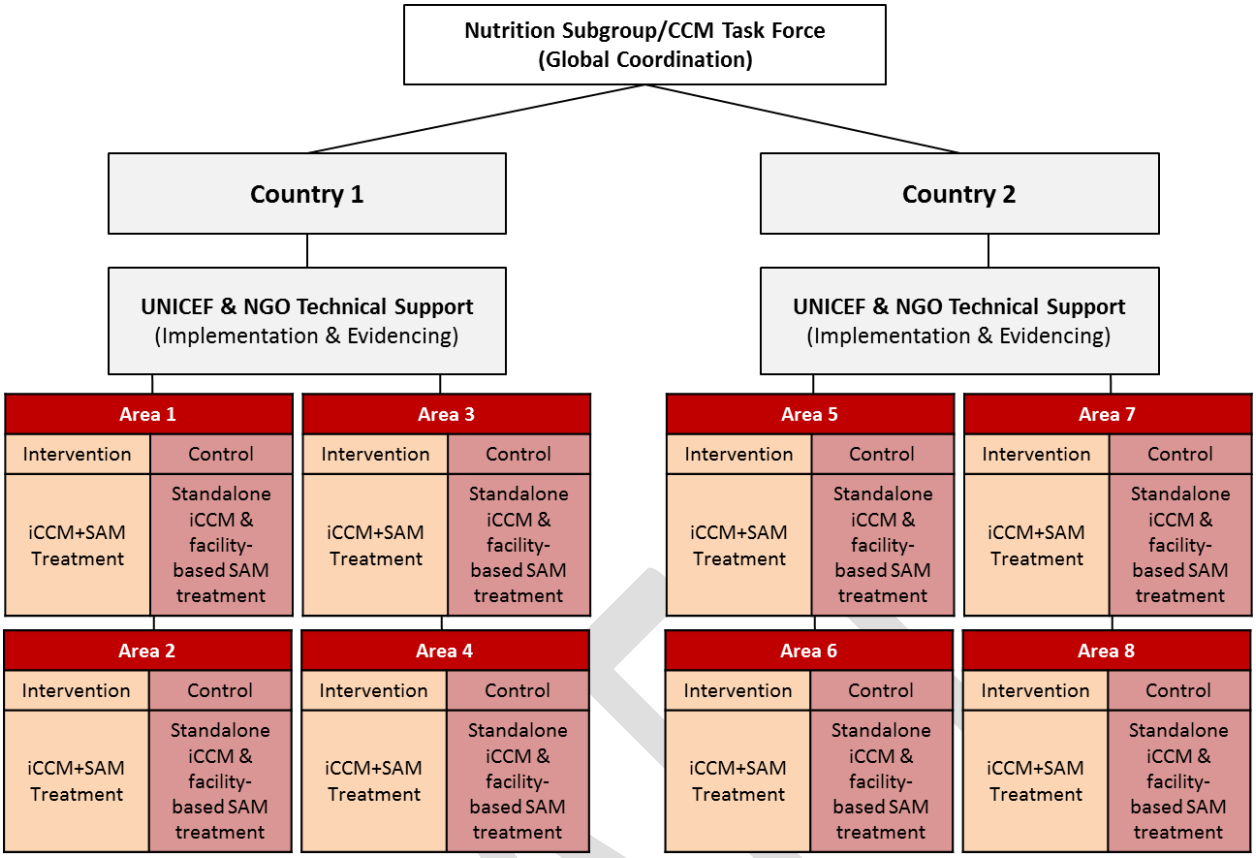
OPERATIONAL MODEL

The proposed iCCM+SAM treatment intervention would be tested in two countries. When additional funds are sourced, more countries will ideally be selected in order to test different, context-specific iCCM models and create a strong evidence base for the integration of iCCM and Nutrition. The selection of countries will be based on an analysis of key criteria including policy environment, existing iCCM and SAM treatment capacity and caseload (see Annex I). Countries that demonstrate a pre-existing interest in the integration of nutrition (and SAM treatment in particular) into iCCM will be prioritised.

In each of the countries, four (4) second-tier administrative areas (e.g. provinces) would be selected to take part in the intervention. In all areas, the intervention would be delivered by the Ministry of Health community health workers already delivering two or more components of the standard iCCM package, working closely with the relevant Nutrition Departments.

UNICEF and partners would provide the technical support and monitoring of interventions (with the iCCM subgroup suggesting monitoring indicators) based on the capacities and needs of each context. The support provided would be carefully designed to; a) ensure optimal use of, and adaptation to, existing health systems and policies; b) reduce external involvement in the implementation of actual activities, whilst; c) providing the necessary means to generate robust and reliable evidence on the performances of the intervention as well as continuing to support and grow Government 'buy in' for service integration. A global coordination and technical advisory group will be set up under the Nutrition Subgroup of the CCM Task Force and technical groups will also be set up in each country of intervention. The initial stages of the RTC will involve evaluating the feasibility and developing the necessary tools for CHW's.

The intervention would run for a 24-month period starting in Q3-Q4 2016.



OBJECTIVES

At a global level, the primary objective of the intervention is **to demonstrate improved child survival through the strengthening and expansion of nutrition activities delivered as part of integrated Community Case Management of childhood illnesses.** A secondary objective is the identification of appropriate support mechanisms for the sustainable implementation of this integrated package by national health systems.

At the national level, the main objective of the intervention is **to increase the uptake of the basic package for childhood illnesses and reduce the costs of SAM treatment. This objective will be achieved through working closely with governments and bringing together Nutrition and Child Health Departments, as well as key stakeholders. At a programmatic level, the objective is to improve the effectiveness, cost-effectiveness and coverage of services for malaria, pneumonia, diarrhoea and the management of severe acute malnutrition.**

Measures of success include:

- Improved cost-efficiency of iCCM+SAM treatment compared to standalone, facility-based SAM treatment and iCCM services.
- Improved coverage of iCCM+SAM treatment compared to standalone, facility-based SAM treatment and iCCM services.
- Acceptable levels in clinical outcomes according to current standards (early identification of SAM cases, cured rates, defaulter rates, death rates, non-responder rates, and average length of stay) of iCCM+SAM treatment compared to standalone, facility-based SAM treatment and iCCM services.

- Improved participant satisfaction of iCCM+SAM treatment compared to standalone, facility-based SAM treatment.
- Development of an evidence-based, effective simplified guidelines and accompanying tools (If literacy is low, this is a must) for an integrated approach to treat diarrhoea, pneumonia, malaria and acute malnutrition.

RESOURCES

The total cost of the intervention is expected to range between US$4-6 million per year per country for a total of three (3) years. The majority of the resources will be allocated to logistics, products and human resources at the country level.
Breakdown of budget:

1. Funding for Activities (e.g. Training of CHWs, training and reporting tool development, Community Mobilisation activities, meetings with government officials and partners, coverage assessments, cost-efficiency evaluation activities, beneficiary satisfaction surveys, etc.)
2. HR Funding (including funding for Technical Advisors, Study Coordinators, Field Staff, Data Collectors, Financial and Administrative Oversight and other operational support costs)
3. Logistical Funding (including flights, accommodation, daily subsistence allowances, IT Equipment, Training material, Anthropometric material, office supplies, RUTF and medicines).

NGO Partners that have raised interests:

- Action Against Hunger (ACF)
- Save the Children
- International Red Cross (ICRC)
- International Medical Corps (IMC)
- Malaria Consortium
- Millennium Development Goals Health Alliance (MDGHA)
- John Snow, Inc (JSI)
- Maternal and Child Survival Programme (MCSP)
- International Rescue Committee (IRC)