Strengthening monitoring and evaluation for ICCM: lessons learned and promising innovations

CORE Group Global Health Practitioner Conference, Pre-conference session
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Session organizers:

- Tanya Guenther
- Dyness Kasungami
- Serge Raharison
- Savitha Subramanian

Session objectives

Share experiences and discuss:

- Lessons learned, recommendations and tools emerging from the CCM evidence review
  - How routine monitoring systems have been developed for iCCM and integrated with other systems
  - How data from different sources have successfully been used for decision-making at national and subnational levels
  - How innovative approaches have been developed and applied to improve data quality and use
  - Evaluation design and methods

Session overview

Part 1: Presentations

- Lessons learned, recommendations and tools emerging from the CCM evidence review (*Tanya Guenther*)
- Overview of the CCM Indicator guide (*Dyness Kasungami*)
- Updates to the KPC sick child indicators and questionnaire (*Jennifer Luna*)

Part 2: Panel (Moderated by Serge)

Wrap-up (Dyness)

Lessons learned, recommendations and tools emerging from the CCM evidence review

Symposium summary and conclusions

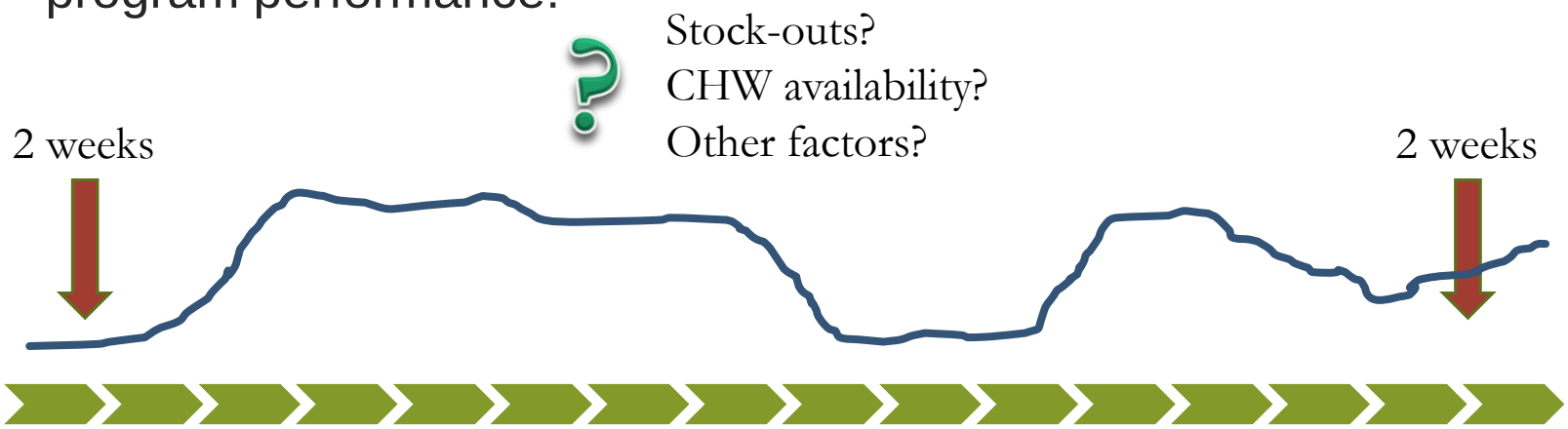
Two key messages emerging from the Symposium:

1. Increase utilization of ICCM to be more cost-effective and ensure maximum impact

2. Use routine reporting data to assess progress and only conduct endline evaluations of impact after being at scale (e.g. at least 80% of providers trained and equipped) with high utilization for at least 1 year

Why routine data for ICCM?

- Children fall ill with CCM conditions frequently (~3.3 episodes of diarrhea, 1.7 episodes of malaria and 0.3 episodes of pneumonia per child per year)
- Health services need to be routinely available and accessible to provide timely and appropriate treatment and save lives
- Household surveys, the current gold standard, fail to fully capture program performance:



Challenges setting up routine data systems for ICCM

- Multiplication of provider data collection points
- Variation in provider capacity
- Weak to non-existent supportive infrastructure
- Multiple donors and implementing partners with their own reporting requirements
- Tendency to impose greater documentation and reporting requirements on CHWs than expected even at HF level
- No ‘one-size-fits-all’ for HOW to implement an effective M&E system

Top 5 lessons learned for Monitoring

1. **Prioritize and minimize indicators:** select those that reflect the determinants for achieving high coverage and are tied to specific targets and actions. Use standardized indicators.

2. **Engage end-users in development of monitoring tools –** keep it simple, design for lowest capacity users, and ensure adequate time for training and testing

3. **Provide simple tools for data visualization and build mechanisms to strengthen capacity for data use and response** by program managers, health workers and CHWs

Top 5 lessons learned for Monitoring

4. **Build in triangulation and data quality audits into M&E plans** from the beginning to guide interpretation of routine data. Focus on small set of indicators tied to action and track follow-up.

5. **Think long-term and scale when introducing mHealth.** Innovations such as rapid SMS for CHW reporting can help improve data availability but must be coordinated through the Ministry of Health and linked to plans for integrating iCCM treatment data into HMIS or other platforms.

Top 5 lessons learned for Evaluation

1. **Final evaluations should include multiple data sources:** routine sources, contextual, qualitative, coverage, quality of care and costing data
2. **Endline coverage surveys should be only conducted <u>when</u> and <u>where</u> program impact can be reasonably expected**. This means:
   - Allow time for program implementation and verify through monitoring data that you have high utilization of treatments from CHWs
   - Sampling approach must focus on areas eligible and targeted for ICCM services and information on ICCM service availability should be collected for each cluster to enable further analysis
3. **Carefully consider use of comparison areas**: should only be used when there are similar intervention and non-intervention areas and full set of data can be collected in both

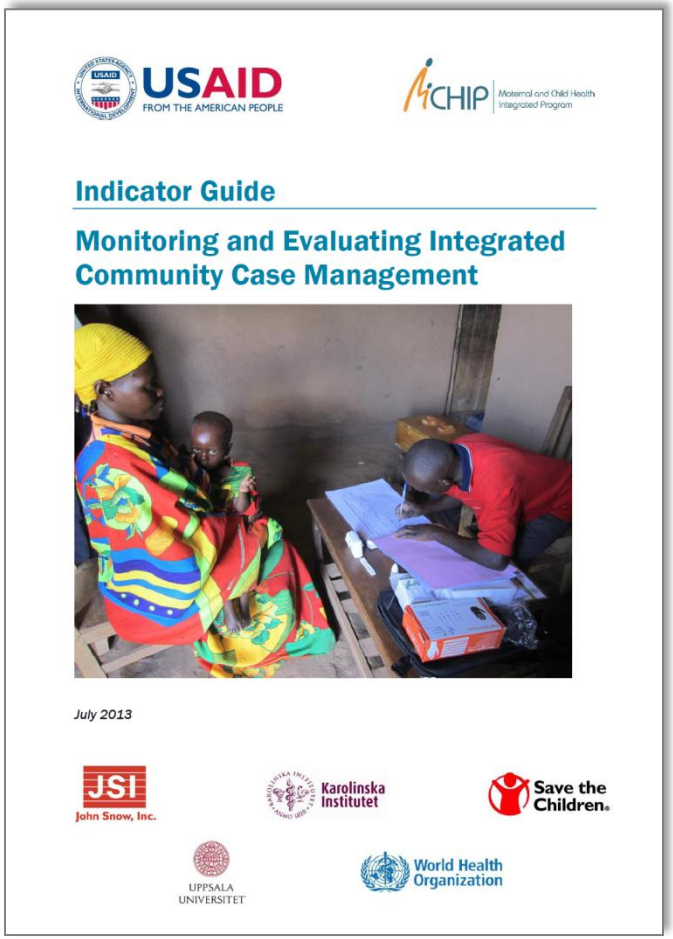
Top 5 lessons learned for Evaluation

4. **Evaluations should be collaborative and flexible–** external evaluators must work closely with implementing partners to understand context and access program data and be open to modifications mid-way
5. As programs scale up, focus can be placed on **operations research and process evaluations** to support programs to increase rates of timely and appropriate treatment

Tools and Resources

- **One page hand-out of M&E tools**
- **CCM evidence review conference materials & presentations: http://iccmsymposium.org/materials**
- **Tools highlighted in this session:**

1. ICCM Indicator Guide
2. Revised KPC indicators and questionnaires for sick child management



Thank-you


1) Number of fever cases treated in children aged 5-59 months by month
2) Number of fast-breathing cases treated in children aged 2-59 months by month
4) Total number of sick child cases treated in children aged 2-59 months by month