iCCM, CHWs & Malnutrition: Inter-Agency Roundtable

London, UK

May 12th & 13th 2014

Meeting Report

GLOSSARY

ACF	Action Against Hunger
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
GAM	Global Acute Malnutrition
iCCM	Integrated Community Case Management
IMC	International Medical Corps
IRC	International Rescue Committee
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MC	Malaria Consortium
MoH	Ministry of Health
PSI	Population Services International
RUTF/ RUSF	Ready to Use Therapeutic/Supplementary Food
SAM	Severe Acute Malnutrition
SC	Save the Children
WV	World Vision

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INTRODUCTION

On May 12th and 13th 2014, ACF and Save the Children co-sponsored an informal round-table to discuss the potential linkages between iCCM, CHWs and Malnutrition. The meeting brought together a group of organisations with prior experience in iCCM, CMAM and the delivery of SAM treatment at community-level. They included Malaria Consortium, International Medical Corps (IMC), International Rescue Committee (IRC), Population Services International (PSI) and World Vision. The meeting was designed to showcase operational experiences and to outline areas for further collaboration and research. The participants identified a set of specific expectations for the meeting, including (but not limited to):

- Exploring the potential of integrating SAM & MAM treatment and IYCF into iCCM
- Managing expectations of the iCCM and CMAM models
- Building partnerships and communicate effectively our experience and research on ICCM and CMAM integration
- Building an action plan for the next global ICCM symposium
- Bring together ongoing discussions in Europe and the US on this subject

Introductory presentations by **Saul Guerrero (ACF)** and **Zaeem Ul Haq (SC)** helped to situate the discussions within the broader strengths, weaknesses, opportunities and challenges currently facing CMAM and iCCM. The presentations made a number of key points, including:

- The 2013 Lancet series on maternal and child health has highlighted the importance of nutrition within the global health community, strengthening the evidence base and increased interest to include nutrition in future agendas.
- According to the evidence review at the recent ICCM symposium, UNICEF presented the state of implementation of CCM programmes across SSA. The findings showed 33 countries reporting to be implementing CCM of malnutrition.
- However, the extent to which these 33 programmes are actually implementing nutrition through CHWs and how effectively it has been integrated as part of the ICCM programme and health systems is questionable.
- CMAM is often misunderstood to mean the delivery of SAM/MAM treatment at community-level. In reality, these services are currently being delivered at health facility level, and remain in many cases out of reach for many of those who need it. .
- The iCCM model raises important questions in nutrition about the potential decentralisation of SAM/MAM treatment to the community.
- There is the potential to use nutrition and ICCM integrated models as an effective mechanism for reducing child morbidity and mortality, yet the current (and somewhat limited) research has shown major context specific barriers and issues scaling-up in country[1].

The meeting was seen as an opportunity to review some of the experiences in bringing the treatment of SAM/MAM and iCCM/CHWs closer together.

REVIEW OF FIELD EXPERIENCES

A total of 6 case-studies were presented during the meeting. These included past/future operational research, recently concluded interventions and ongoing programmes.

Chloe Puett presented findings from research on integrated CCM SAM in Bangladesh with Save the Children/Tufts University

- 89% coverage achieved, one of the highest achieved in any integrated program
- 89% of CHWs achieved >90% error-free case management of SAM cases, according to a supervisory checklist
- CHW proximity promoted early presentation, less complicated cases
- Community satisfaction and participation were due to:
  - CHWs were a familiar, trusted source of information and treatment
  - CHWs reinforced program awareness, access, compliance
- Integrating SAM into CHWs CCM increased workload by 3 hours/week however the increased workload did not result in poor performance (on other curative and preventive tasks)
- Cost effectiveness was comparable to other child survival interventions and had low cost burden to households.

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Emily Keane presented Save the Children's ICCM and malnutrition, what are the opportunities? This included feeding of the sick child and findings from a formative assessment for Lady Health workers to treat SAM in Pakistan

- Different nutrition interventions will be appropriate in different contexts- 6 of the 11 evidence based interventions identified in the 2013 Maternal and Child Nutrition Lancet Series could be considered and in various 'bundles' of interventions (IYCF, management of SAM and MAM, micronutrients)
- Overall perception about the CHWs has been supported by all the stakeholders, but full integration of health system at all levels is required for successful service delivery.
- Overall workload of CHWs needs to be considered: CHWs would also need guidance for proper time management so that other programmes / service delivery does not suffer.
- Appropriate incentives for CHWs should be considered for this additional workload.
- While proper identification and treatment of sick children is increased through ICCM, nutritional counselling, especially optimal feeding during illness and recovery is not adequately emphasized during treatment and follow-up.
- The ICCM model should capitalize further on illness as an important "moment of opportunity" for nutrition counselling (IYCF) and potentially other interventions.

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Helen Counihan presented Malaria Consortium's experience from South Sudan on the key outcomes and lessons learnt on integrating CMAM & ICCM

- Coupling ICCM and nutrition programming has real potential for impact on U5 morbidity and mortality.
- In the context of South Sudan where the majority of Community Health Workers who deliver ICCM are illiterate, treatment for SAM is delivered by another cadre of CHWs based outside of Health Facilities. ICCM CHWs deliver screening and referral of SAM and follow up on SAM cases
- Additional challenges to integration included: Poor IYCF practices due to lack of family structures particularly among refugees and returnees.
- Major concern with stock outs of RUTF affecting quality of programme delivery.
- Poor ability to adapt to the context, when the situations change to emergency settings and rapid increase in demands.

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Casie Tesfai (IRC) shared her experience of CMAM and ICCM integration in South Sudan.

- In South Sudan, when the iCCM model was adapted to accommodate SAM treatment (that required literacy), there were issues regarding the peer-supervisors time allocation and supply chain/delivery to treat SAM;
- In order to improve coverage of SAM, treatment should be integrated into iCCM and part of the treatment algorithm so it is the 4th condition treated at home. Peer-supervisors can then

focus on quality of data collection and increasing CHWs quality of care (which is the iCCM model).

- CMAM is currently facility based, not community based.
- IRC's iCCM model in South Sudan relies on a dense penetration of female illiterate CHW's to treat diarrhea, malaria and pneumonia at the home level, where each CHW covers only 50 HH's. IRC believes that this is the key to overcome the challenges of RUTF delivery and storage as each CHW would only be responsible for treating up to about 5 children with SAM.
- To do this, IRC believes that the CMAM protocol should be simplified for use by illiterate CHW's just as the IMCI protocol was simplified for iCCM.
- There was debate from participants around whether it is possible to simplify the CMAM protocol sufficiently so that illiterate CHWs could deliver services directly 'at the door step' of communities. IRC suggested that this should be piloted and compared to the model currently being used in S Sudan which use different literate CHWs for SAM treatment at the facility level.

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Sarah Morgan presented World Vision's experience with CHWs and CMAM delivery in emergency response in Angola.

- Close proximity of CHWs to communities - Long standing relationship with community meant they were able to support and monitor on a frequent basis.
- Good community mobilization strategy using Traditional Village and Church Leaders as focal points.
- Gender Imbalance - CHWs were mainly male and there were issues regarding the use of female CHWs when working on breast feeding and general IYCF practices.
- Adherence to international treatment protocols - Policy did not allow CHAs to dispense routine meds, not all children with SAM went to a health facility for a complete check-up, quantity of RUTF given was standardised rather than being based on weight of the child as in most protocols.
- Reporting and M&E systems complex and needed revisions after initial roll out.
- Poor supply chain and significant stock-outs of RUTF/RUSF.
- Incentives not properly planned - project proposal didn't allow for sufficient incentives providing only work tools which were not always appropriate (e.g. bicycles).
- Expectations of integration and handover too high – particularly the time required for the process.

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Jose Luis Alvarez (ACF) presented ACFs planned research on the delivery of SAM treatment by CHWs in Pakistan and Mali (2014 – 2017).

- Pakistan and Mali were chosen based on various factors (safety, access, health system, etc.)
- Funding of the programme may have limitations in access because Mali will have 'treatment for fee' mechanism.
- The research in both country are separate and not carried out for comparison between models.

In Pakistan the pilot will be conducted in partnership with the Aga Khan University

The case-studies helped to highlight six key messages

1. CHWs can deliver a high quality of care for acute malnutrition
2. Adding treatment for acute malnutrition does not necessarily affect the quality of other services
3. CCM with treatment for acute malnutrition can be cost-effective
4. CHW supervision is essential

5. CMAM protocols/tools can be simplified and need to be shared more widely
6. Supply chain is a fundamental aspect of present and future implementation

The presentations also identified a wide range of crucial questions/evidence gaps. These include:

1. **Literacy:** How do we adapt training/programmes according to literacy levels?
2. **Population Density**: how does it affect results? Design? Implementation? What is the optimal human resource deployment? How do we deliver different elements through different cadres?
3. **Motivation**: How long can we sustain motivation? What are the factors the affect motivation?
4. **Policy Environment**: What is the minimum in terms of policy involvement (or environment?)
5. **Supply management**: what are the options?
6. **Supervision**: What is the optimal level of supervision/ support?
7. **Community Engagement**: How do we foster adequate levels of community participation?
8. **Protocols:** Does CMAM protocols need to be simplified/ aligned with ICCM? What would it look like?
9. **Nutrition Packages**: What bundles of interventions should be delivered and in what order? Which aspect of nutrition (e.g. IYCF, MAM, SAM) are appropriate in each context? How can we promote continuity of care?
10. **Health Systems**: What are the lessons about Health System Strengthening that we can take into ICCM?

THE WAY FORWARD

The participating agencies agreed to the following Statement of Intent:

NUTRITION SHOULD BE EFFECTIVELY INTEGRATED INTO ICCM.

- **We know that poor nutrition underlies morbidity and mortality in children under-five.**
- **We believe that prevention/ treatment of malnutrition as part of ICCM, maximises the outcomes for child health/survival and development.**
- **We believe that community-based delivery of nutrition and health services is the best way to improve access and coverage of these services**
- **We acknowledge that integration will require adaptation to context-specific opportunities and challenges.**
- **We will work towards building and sharing the evidence base for effective service delivery in different contexts and use this to influence policy and practices of stakeholders.**

The participating agencies recognise that a number of variables and factors can impact on the way nutrition and iCCM can be integrated in each context. These variables include (in no particular order):

Community: Power, Dynamics, Information, Interventions and Healthy Behaviours
Stakeholders: Donors, NGO, UN Agencies, Academic and Research Partners
Demographic: Sedentary, Rural, Urban

Access: Road, Geography, Security, Population Density
Supply Chain: Health, Nutrition (Production and Delivery of RUTF)
Literary/Numeracy Rates
Levels of Malnutrition/Causes of Malnutrition
Health System Strength: health system analysis “building blocks”
CHW: Type, Pay, Management, Density
Policy Environment: Nutrition, iCCM
Implementation: iCCM Maturity, Longevity
Funding: Nutrition, iCCM

The participating agencies acknowledge that the integration of nutrition into iCCM will require greater understanding of these variables and the success of iCCM/nutrition programmes in adapting to them. Whilst future research and evidence in these areas is therefore required, the participating agencies agreed that a review of all relevant experiences in iCCM and Nutrition is the top priority. The following next steps were agreed upon:

1. Develop a Terms of Reference for the review of relevant experiences
2. Explore potential funding opportunities to cover the costs of the review of relevant experiences
3. Use the findings of the review to
    a. Identify further areas of research and opportunities for inter-agency collaboration
    b. Identify common advocacy messages on the integration of nutrition and iCCM
4. Create an online repository of relevant documents accessible to all
5. Schedule a follow-up meeting (Q4 2014) to present the findings of the review to a wider group including key stakeholders and iCCM/Health colleagues from within the participating organisations

Annex 2: Timetable

Day One – Monday, May 12th - *Where We Are*

When	What	Whom
09:00 - 09:15	**WELCOME & INTRODUCTION** • Who we are, Why are we here & *Where we work (iCCM/Malnutrition)	Saul Guerrero **ACF**
09:15 – 09:30	**EXPECTATIONS**	Alex Rees **Save the Children**
09:30 - 10:00	**CMAM – and iCCM could fit in** • Where is CMAM at present? What opportunities could iCCM offer? What are the potential challenges?	Saul Guerrero **ACF**
10:00 – 10:30	**ICCM – and how CMAM/Nutrition could fit in** • Where is iCCM at present? What must we consider when exploring the addition of malnutrition? Potential Challenges and Opportunities	Zaeem Ul Haq **Save the Children**
10:30 – 10:45	*Break*	
10:45 – 11:30 (40 min presentation, 5 min reflections)	**Save the Children/Tufts University Experience with Community Case Management of SAM in Bangladesh** • Key Outcomes and Lessons Learned	Chloe Puett **ACF**
11:30 – 12:15 (40 min presentation, 5 min reflections)	**Key learnings from work and research conducted in ICCM and malnutrition** • Pakistan, Bangladesh and more **ICCM and malnutrition – CMAM and beyond**	Emily Keane **Save the Children**
12:15 – 13.00 (40 min presentation, 5 min reflections)	**Malaria Consortium's Experience with iCCM & CMAM in South Sudan** • Key Outcomes and Lessons Learned	Helen Counihan & Prudence Hamade **Malaria Consortium**
13.00-13.45	*Lunch Break*	
13:45 – 15:30 (40 min presentation, 5 min reflections)	**IRC's experience with iCCM, and CMAM integration in South Sudan** • Key research questions & lessons learned	Casie Tesfai **IRC**
15:30 – 16:15 (40 min presentation, 5 min reflections)	**World Visions Experience with CHWs and CMAM delivery in Angola**	Sarah Morgan & Polly Walker **World Vision**
16:15 – 17:00	***Group Work:* SWOT Analysis for ICCM and Nutrition (with coffee)**	Saul Guerrero / Emily Keane **ACF / Save the Children**
17:00 – 17:15	**Wrap Up**	Saul Guerrero **ACF**

DAY TWO - TUESDAY 13TH- *Where Do We to Go?*

When	What	Whom
09:00-09:15	**Recap from Day 1 and Outline Day 2**	Zaeem Ul Haq **Save the Children**
09:15 – 10:00	**Planned Research: Delivery of SAM Treatment by CHWs in Pakistan & Mali (2014-2017)** • Key research questions, Methodology/Expected Outcomes	Jose Luis Alvarez **ACF**
09:00 – 10:00	**TRENDS, RISKS & GAPS IN KNOWLEDGE** • What conclusions can we draw from existing/planned work in this area? • What evidence do we have and how strong is this evidence? • What are the key gaps in knowledge and what questions must be prioritised?	Saul Guerrero / Emily Keane **ACF / Save the Children**
10:00 – 11:15	**DEFINING THE INITIATIVE** • What is the aim and nature of the initiative? • What should we aim to do in the context of the iCCM Community? (e.g. is a Task Force/Working Group looking at iCCM & Malnutrition needed? Can we establish such group? To what aim?)	Saul Guerrero / Zaeem Ul Haq **ACF / Save the Children**
11:15 – 11:30	*Break*	
11:30 -13:00	***Group Work:* WORKING EXTERNALLY: PARTNERSHIPS, COORDINATION & FUNDING** • *Which partners/types of partnerships should be explored? • *Which models for collaborative implementation, learning and advocacy can we draw from? • How can we create the right (and adequately resourced) architecture for exploring these issues further? • *What funding opportunities are there which are relevant?	Saul Guerrero / Paula Valentine **ACF / Save the Children**
13:00 – 14:00	*Lunch Break*	
14:00 – 15:30	**ACTION PLANNING MOVING FORWARD** • Outcomes, roles and responsibilities • Milestones	Saul Guerrero / Zaeem Ul Haq **ACF / Save the Children**
15:30 – 15:45	*Break*	
15:45 – 16:00	**WRAP UP**	Saul Guerrero **ACF**