Lessons Learned Document

Thematic Area	Impact and outcome evaluations
Description	This Lessons Learned document reviews recent experience evaluating and attributing changes in coverage of pneumonia, malaria and diarrhea treatments to iCCM programmes
Organizations documenting Lessons Learned	UNICEF and Save the Children

Background

Evaluations of iCCM programmes should assess to what extent iCCM contributes to an overall increase in access, coverage and timeliness of treatment, providing important information on how to improve the programmes. To do so evaluations require theories of change, clear evaluation questions, appropriate designs, units of analysis reflective of the geographic area of implementation, robust methods and multiple sources of high-quality programme and contextual data reflective of the periods before, during and after implementation.

It is generally assumed by programme managers and researchers alike that iCCM programme performance follows a theory of change and that certain characteristics of programmes are associated with higher treatment rates and therefore higher coverage. Particular attention has been given to appropriate training, adequate supervision and sufficient medicines and supplies. However other characteristics may also impact treatment rates, including the ratio of CHWs to children, the geographic distribution of CHWs, whether CHWs are paid, whether CHWs are from the community in which they work, whether user fees are charged, quality of services, demand generating activities, active case finding and the overall functioning of the health care system. Unfortunately, most evaluations have not accounted for all of these characteristics. And where they have been measured, they have not been measured in a standardized way. As a result, little is known about the relative importance of these characteristics to treatment rates and coverage.

Process for documentation

The review team first conducted a search of published literature on the outcome of iCCM programmes. Although there were several evaluations in the Asia region, there were few in Africa. We therefore contacted the key international organizations working on iCCM and universities known to be involved in evaluating iCCM in order to create a list of all iCCM evaluations undertaken in Africa since 2000. We identified 22 evaluations. We asked the principal investigator of each evaluation to complete a standardized excel spreadsheet on the characteristics of their evaluation and the programmes being evaluated. We reviewed the reported information on the following themes: theories of change, clear evaluation questions, appropriate designs, units of analysis reflective of the geographic area of implementation, robust methods and multiple sources of high-quality programme and contextual data reflective of the periods before, during and after implementation.

Strategies that worked well

The following characteristics were generally present in evaluations that were successful in attributing changes in access or coverage to iCCM programmes.

- **The programme and evaluation was based on a theory of change** or another conceptual model outlining a causal pathway through which activities within the programme were expected to bring about the desired changes.
- **Clear evaluation question** (e.g. impact of iCCM on coverage of all three diseases, impact of iCCM on timeliness of treatment).
- Depending on the evaluation question, **designs with comparison areas not implementing iCCM were useful if the comparison area was similar to the intervention area**, truly had no iCCM activities being implemented and contextual information and monitoring data were collected along with baseline and endline survey data. However, given rapid scale-up efforts in many countries, other designs (such as step-wedge, pre/post, evaluation platform, realist evaluations) might be more appropriate.
- **Multiple sources of data were used,** including:
    - Baseline and endline household surveys;
    - Routine monitoring data using standardized forms from CHWs and supervisors;
    - Routine monitoring data from health facilities in the same area as the iCCM programme to better understand how iCCM impacted facility treatments;
    - Quantitative survey data from CHWs and supervisors to validate routine data;
    - Qualitative data from CHWs, supervisors, caretakers and health facility staff to assess the acceptability and barriers to receipt of treatment; and
    - Contextual data on factors that could affect programme performance or the outcome of the programme such as disease outbreaks, civil unrest, national disasters, stock-outs of key commodities and other health programmes serving the same community.
- **Data collected was reflective of the unit of analysis,** with respect to:
    - iCCM programme area - Household surveys were collected in the sub-areas in which iCCM was taking place and not just the larger geographic health unit (e.g. if only hard-to-reach areas in a district are covered by iCCM, survey data from the entire district must be able to be disaggregated to provide information from the sub-areas covered by iCCM). The same is true for routine monitoring data.
    - Source of treatment – both surveys and routine data had information on the source of treatment (e.g. facility versus CHW) so that these can be disaggregated in the analysis.
- **Data was of high quality and reliable** (e.g. data collectors were trained, collection instruments tested and revised, information was not missing).
- **Data was representative of the time period before and during implementation**, allowing for the endline to take place after sufficient time for implementation.

Strategies that did not work well

The following characteristics were often present in evaluations that were not successful in attributing changes in access or coverage to iCCM programmes.

- **There was no pre-conceived evaluation plan.**
- **The design was not appropriate for the evaluation question.** In some evaluations comparison areas were not similar to intervention areas. In other evaluations the data collected was not specific to the sub-area covered by iCCM. There were some studies that jumped directly to mortality measurement with no collection of coverage data.
- **Using a comparison area that had partial iCCM (CHWs treating two illnesses) or CHWs treating one illness**. This was not useful to answer the question of the impact of full iCCM.
- **Lack of a full set of multiple data sources**. Some evaluations did not have routine monitoring data from health facilities, nor qualitative/contextual data. In particular information on why persons

were not accessing services is important to understand low utilization rates in some programmes.

- **Definitions and interpretation of some indicators varied across studies**. In particular the definition of stock-outs, and how supervision rates were measured varied across evaluations.
- **The numerator and denominator used to assess coverage were defined differently across studies,** especially in relation to the proportion that received treatment from CHWs.
- **The endline evaluation was conducted when the programme was not fully implemented**. Some evaluations were conducted when the programme had been in place for less than a year.

Lessons Learned

Evaluations of iCCM programmes in the African region were designed to answer a variety of questions other than the effect of iCCM on treatment coverage. These studies used different methods and analyzed and collected key indicators differently. Some were completed prior to full implementation of iCCM and were of varying quality. As a result, it is difficult to draw definitive conclusions across the programmes. We were, however, able to identify a number of lessons learned:

- There must be a **clear evaluation plan**, including a very specific question to be answered, prior to starting an iCCM programme.
- **Definitions of indicators, numerators and denominators should be standardized** across studies and should be clearly documented when writing up the evaluation results.
- **Baseline and endline coverage measurements** based on household surveys should be conducted in those areas under evaluation and have information specific to the sub-area in which iCCM is taking place.
- Allowing time for **full programme implementation** (at least a year) is necessary prior to completing an endline analysis.
- **Comparison areas should only be used when there exists similar intervention and non-intervention areas and if the full set of data can be collected in both.** Other types of study designs, such a step wedge, using counterfactuals, and pre- and post- implementation can be considered based on the evaluation question.
- **Validating the coverage indicators** in households surveys used in these evaluations to determine if they accurately reflect coverage of iCCM is important (e.g. is two-week recall sufficient, are respondents clear who is a CHW).
- **Contextual data** must be collected to understand programme outcomes.
- Data to understand **why services are not being used** must be part of the evaluation.
- **Experienced investigators** with quantitative and qualitative skills should be part of the evaluation team.
- Although evaluation by external partners is important, it must be done **collaboratively** with implementing partners to be able to gather all the sources of data needed for a complete evaluation.
- Given the rapidly changing environment in health care in Africa, **evaluations may need to be modified mid-way to adjust to the changes.**
- More evaluations in Africa need to be conducted and published. The **newest evaluations** in Africa need to be published in the peer reviewed literature
- There should be at least one **standardized multi-country evaluation** conducted in the African region.
- Once there is at least one multi-country evaluation in Africa and some additional country-specific evaluations, iCCM programmes should **focus on monitoring** to ensure the programme attributes are consistent with what has been found in the evaluations.