Lessons Learned Document

Thematic Area	Coordination, policy setting and scale up
Description	This Lessons Learned document presents a summary of the development of effective policy to launch, scale up and sustain iCCM programmes, along with key challenges and the relationship of iCCM policy to other health policies.
Organizations documenting Lessons Learned	UNICEF and Johns Hopkins Bloomberg School of Public Health (JHSPH)

Background

Policy development and implementation of iCCM has become common in sub-Saharan Africa. Most African countries now have iCCM policies for malaria and diarrhoea, and an increasing number have iCCM pneumonia policies. Very few countries, however, have iCCM policies for newborn care. Most iCCM implementation has involved significant funding and support from external development partners.

Process for documentation

The main source that informed the documentation of lessons learned on the development of iCCM policy was a series of country case studies. These were qualitative retrospective case studies on iCCM policy, drawing from document reviews, semi-structured interviews and in-country validation workshops. The case studies were conducted in Burkina Faso, Kenya, Malawi, Mali, Mozambique and Niger by a consortium of researchers led by JHSPH and funded by USAID-TRAction and UNICEF. These countries were purposively selected to reflect maximum variation in iCCM policy status, sub-regions within Africa, and CHW models. A further study, also involving document review and in-depth interviews, was undertaken, looking at global actors in iCCM policy. A synthesis of the main findings of the case studies can be found in:

Bennett S. George A. Rodriguez D, Shearer J, Diallo B, Konate M, Dalglish S, Juma PA, Namakhoma I, Banda H, Chilundo B, Mariano A, Cliff J. *Policy challenges facing integrated community case management in sub-Saharan Africa.* (Manuscript submitted for publication)

A cross-sectional, quantitative survey of iCCM policy formulation and implementation in countries in sub-Saharan Africa was undertaken by UNICEF in 2013, building on previous surveys of iCCM. This survey, whose findings are shortly to be published in the *Journal of Global Health* (www.jogh.org), was used to help consider the generalizability of the findings of the case studies.

Strategies that worked well

The following factors have promoted the development of effective policy to facilitate the implementation of iCCM.

- **External funding** to provide resources for the implementation of iCCM policy (for example, by financing drugs and/or a paid CHW workforce) has been crucial for successful policy development, with the promise of such external funding itself a key stimulus for policy formulation.
- **Political commitment to the Millennium Development Goals (MDGs)**, and concern about the

rate of progress to meet them, has motivated countries to develop policy to implement iCCM, recognizing that existing strategies to achieve MDG 4 were not producing sufficiently rapid progress.

- **Evidence** has played a key role in persuading decision-makers in countries of the need to construct iCCM policy. Different types of evidence have played different roles. Country-based evidence has been used to understand the major challenges. Research evidence has been used to identify and prioritize interventions. Global organizations, such as UN agencies and international NGOs, have played a major role in disseminating and promoting evidence.
- The **nature and history of the existing health system** has influenced the speed at which iCCM policy has been developed and implemented. Countries with strong existing CHW cadres, and with a history of adopting a primary health care approach, have been able to develop and implement iCCM policy more rapidly.

Strategies that did not work well

The following factors have proved obstacles to the development of effective policy for iCCM.

- **High-level policy champions of iCCM have been rare and not all key stakeholders have been engaged.** Policy development has usually been driven by technical officers within Ministries of Health. Communities themselves have often not been sufficiently involved in policy formulation, although it should not be assumed that communities are necessarily supportive of iCCM. Ministries of Finance have also been absent, despite the challenges of funding.
- **Global influences on iCCM policy have not always been coherent**, with sometimes-conflicting views between agencies and omission of some key stakeholders. This has also occurred at the national level.
- **Other stakeholders have resisted granting prescribing rights to CHWs to deliver iCCM** in some countries, with physician groups being most prominent in doing so.
- **Integration across iCCM conditions has proved variable**. Countries with well-funded, vertical programmes (for example, for malaria) have sometimes faced greater difficulties in achieving integration.
- **Policy-maker doubts about the transferability of evidence** of iCCM effectiveness from other countries, **and limited local iCCM evidence**, has sometimes delayed policy.
- **Development of newborn iCCM policy has lagged significantly** compared to other iCCM activities, with treatment for neonatal sepsis and resuscitation remaining at the facility level in most African countries. This slower progress is due to newborn care's link to maternal care (and therefore different policy groups in most countries), and concerns about CHWs' ability to provide adequate and appropriate care.

Lessons Learned

The development of policy for iCCM is an incremental process, and rarely does it involve a stand-alone policy. Higher-level policy documents often vary in their explicit reference to CHWs or components of iCCM; programme documents and training guidelines are generally more consistent. The development of higher-level policy frameworks for iCCM has not always preceded lower-level implementation guidelines. Countries have often understood iCCM policy to build on the legacy of Integrated Management of Childhood Illness (IMCI), however global partners have not always framed iCCM as an extension or continuation of IMCI.

Policy challenges for the implementation of iCCM often involve **cross-cutting barriers** to policy for health systems in general, such as **lack of political priority and insufficient funding**. Individual countries also face challenges in relation to specific policy aspects of iCCM, in particular CHWs and

supply chain issues. iCCM was developed as a global strategy, but each country has had to consider how best to introduce iCCM in its specific policy environment, institutional structures and health system.

The sustainability of iCCM policy and implementation remains a key issue, even in countries where significant progress has been made. Ministries of Health have played a key role, but in most countries external partners continue to provide the bulk of funding and often have a major role in policy development and implementation. The major costs for iCCM are for CHW salaries and for purchase of drugs and other commodities. **Concerns about funding are the major factor in discouraging development of iCCM policy in many countries**, as well as threatening progress in countries that have adopted iCCM policy. Discussions about iCCM policy need to be "mainstreamed" into health system policy dialogue and discussions about the health workforce, rather than continuing to exist as a separate activity funded and championed by external partners.

The increasing momentum to move towards universal health coverage in many countries, with increasing domestic fiscal resources for health services, provides an opportunity to place **iCCM as a core, cost-effective strategy to increase coverage of health services in an equitable manner**. Doing so will also require consideration on how to accommodate iCCM to differences across countries in the existing structures of health systems.