Symposium summary and conclusions

Between 3 and 5 March 2014, over 400 individuals from 35 countries in sub-Saharan Africa and 59 international partner organizations gathered in Accra, Ghana for an Integrated Community Case Management (iCCM)[1] Evidence Review Symposium. The objective of the symposium was twofold: first, to review the current state of the art of iCCM implementation by bringing together researchers, donors, government, implementers and partners to review the map of the current landscape and status of evidence in key iCCM programme areas, in order to draw out priorities, lessons and gaps for improving child and maternal-newborn health. Second, to assist African countries to integrate and take action on key frontline iCCM findings presented during the evidence symposium around eight thematic areas:

1. *Coordination, Policy Setting and Scale up*: The current state of iCCM policies in Africa and challenges in development of policy and scale up
2. *Human Resources and Deployment:* Community health worker (CHW) selection, geographic disbursement, motivation and retention
3. *Supervision & Performance Quality Assurance:* Strategies to ensure high quality care including strategies for effective training, use of alternative models for supervision, and the role of mHealth to support and motivate CHWs to provide quality care
4. *Supply Chain Management:* Which systems ensure continuous supply, how best to forecast needs
5. *Costs, and cost effectiveness and financing:* Identifying cost drivers, improving cost effectiveness and the importance of minimizing patient costs
6. *Monitoring, Evaluation and Health Information Systems:* Innovations in monitoring, integrating with health management information systems, using results to drive programmatic decision-making and improvements, evaluation design and methods
7. *Demand generation and social mobilisation:* The relationship between iCCM and care-seeking, treatment utilisation and treatment adherence, effective strategies to generate demand
8. *Impact and outcome evaluations:* Review of 18 iCCM programme studies with coverage or mortality data.

Conclusions

Several lessons are clear based on the evidence were presented and may serve as recommendations for future iCCM implementation, as relevant:

- National government leadership is essential.
- iCCM must be integrated in national health systems and seen as a priority means of delivering care, and embedded as a costed element of national health sector plans, with a clear budget line.
- Integration is key among all health-related programmes at community level (water and sanitation, nutrition, etc.).
- Coordination mechanisms should extend beyond health to include other sectors (e.g., finance).
- Advocacy on the iCCM model is still paramount to its dissemination.
- There is no single model of human resource management for community based interventions. Countries reported having paid or volunteer CHWs, as well as CHWs with significant skills operating in conjunction with volunteers.
- Charging fees decreases utilisation.
- High supervision rates increase quality, utilisation and motivation.

[1] iCCM is a strategy to extend case management of childhood illness beyond health facilities so that more children have access to lifesaving treatments. The iCCM package can differ based on particular contexts, but most commonly includes diarrhoea, pneumonia and malaria, and in some cases newborn health and malnutrition as well. In the iCCM model, community health workers (CHWs) are identified and trained in diagnosis and treatment of key childhood illnesses, and also in identifying children in need of immediate referral (Source: CCM Central, http://ccmcentral.com/about/).

- Having fewer stock outs increases utilisation.
- Providing treatment for malaria, pneumonia and diarrhoea combined increases utilisation of services for each illness.
- Using rapid diagnostic tests (RDTs) decreases malaria and pneumonia treatments suggesting more appropriate antibiotic/antimalarial usage and improved quality of treatment.
- Private public partnerships should be explored as vehicles for iCCM implementation. In addition, iCCM can be used as vehicle for private sector quality improvement in settings where the private sector is an important source of care for children.
- New technologies such as *Rapid SMS, mHealth*, and *mTRAC* can facilitate monitoring and management.
- iCCM programmes must be well documented, periodically reviewed and evaluated in order to guide implementation at scale.

In addition, there were two key messages that emerged from the Symposium:

Increase utilisation of iCCM to be more cost efficient and to ensure maximum impact

- by deploying services to areas of greatest need
- by assessing demand barriers and addressing them through community engagement and mobilisation
- by structuring supervision and management to be affordable and effective
- while maintaining quality of services, continuous supplies and high levels of standardised reporting.

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

- Examine routine data to know if you have been providing high rates of appropriate treatments
- Once your routine data show you are providing high rates of treatment, collect data on coverage and quality, and model mortality based on the Lives Saved Tool (LiST)
- Final evaluations should include data from routine sources, as well as contextual, qualitative, coverage, quality of care and costing data
- Given that we know that iCCM treatments are effective in decreasing mortality, and that there are significant methodological challenges attributing outcomes and impact specifically to iCCM, it is perhaps more critical to conduct operational research that supports programmes to increase treatment rates rather than "impact evaluations of iCCM." It is also important to use routine programme data to track indicators and household surveys (baseline and follow up) to measure care seeking behaviour, source of treatment and timeliness of treatment to assess if these outcomes are moving in the right direction.

The way forward

With 2015 fast approaching, the time for improving iCCM implementation is now. We have effective interventions that respond to the major causes of child mortality and are well packaged for delivery. We have evidence showing that many treatments can be delivered successfully in the community, and now have innovations that facilitate community-based programming, including Rapid Diagnostic Test (RDTs) and mobile technologies. In addition, there are important new opportunities to mobilise resources from domestic as well as external funds (e.g., the Global Fund to Fight AIDS, Tuberculosis and Malaria) and, in many countries, to integrate public private partnerships with government systems.

Following discussions about the opportunities and challenges in their respective countries, participants are poised to work with their colleagues and partners to ensure that iCCM programmes are based on the latest evidence and are most appropriate for, and integrated into, their particular health systems and contexts.

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