



Institutionalising integrated community case management (iCCM) to end preventable child deaths

Technical consultation and country action planning 22-26 July 2019,
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Cover photo:

A Community Health Worker (CHW) counts the respiratory rate of Seril, 4 years-old for diagnosis of pneumonia, as part of the Integrated Community Case Management (iCCM) program under the Wadagi Initiative in Kambayi, Homa Bay, Kenya.

Acronyms and abbreviations

CHW	Community health worker
DHIS	District health information system
DRC	Democratic Republic of the Congo
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GFF	Global Financing Facility
HBHI	High burden high impact
iCCM	Integrated community case management
IMCI	Integrated management of childhood illness
PHC	Primary health care
PMI	President's Malaria Initiative
SDG	Sustainable Development Goal
UHC	Universal health coverage
UNICEF	United Nations Children's Fund

Summary

With the aim of institutionalising integrated community case management (iCCM) in the context of primary health care (PHC) and comprehensive child health programming, the United Nations Children’s Fund (UNICEF) and WHO co-hosted a meeting on 22–26 July 2019. The meeting was organised in two parts: (i) institutionalising iCCM to end preventable child deaths and (ii) implementation of “high burden high impact” (HBHI) approaches and iCCM to accelerate reduction of child mortality from malaria.

The meeting was a dedicated attempt to break down silos between national malaria control programmes and maternal and child health programmes to address challenges to the institutionalising iCCM. It was attended by government officials representing primary health care, maternal and child health and malaria programmes as well as community systems from 14 African countries with high rates of mortality of children under 5 years and a high malaria burden. The meeting was also attended by experts and partners representing 17 technical and funding agencies and WHO and UNICEF staff members from headquarters, regional offices and country offices.

Common challenges were found.

- The absence of national ownership of iCCM compromises the sustainability of implementation and reduces the potential of community interventions to reduce childhood morbidity and mortality in areas where most children are ill or dying.
- Parallel, uncoordinated funding is provided for different components of iCCM, including commodities, systems strengthening and human resources, which hampers implementation, outcomes and impact.
- When community human resources are not part of formal health systems, supported with incentives, or provided mentorship and supervision to sustain motivation, difficulties arise in the delivery of efficient, high-quality services.
- Inadequate supply chain management leads to inconsistent availability and accessibility of diagnostics, medicines, equipment and other essential supplies for use by health workers in communities.

The means for resolving these challenges include the following.

- Funding organisations, including the Global Financing Facility (GFF), the World Bank Group and the President’s Malaria Initiative (PMI), are recognising the importance of strong community platforms for delivering PHC, laying a foundation for investment in integrated service delivery and iCCM.
- National governments are taking greater ownership and accountability to provide services to the poorest and hardest-to-reach populations, including by harmonising and coordinating relevant programmes and increasing domestic resource allocations.
- Initiatives such as the HBHI malaria response are tailoring their guidance to the context of each country to improve the use of data for decision-making and for targeting scarce resources to areas in greatest need.

The participants agreed to 10 recommendations to advance institutionalisation of iCCM (box) and to strengthen the four response elements of the Malaria HBHI initiative.

Recommendations

1. Integrated community case management (iCCM) delivered at scale should be part of the primary health care service package for children. It will support progress towards universal health coverage and ensure a continuum of care, from the community to higher-level facilities through a strong, well-functioning referral system.
2. As an extension of integrated management of childhood illness in facilities, iCCM is relevant for hard-to-reach communities with limited access to health services.
3. iCCM should be fully incorporated into national health policies and health sector development plans, and the strategies and plans of programmes for malaria, child health, community health and others should be used as entry points for harmonised, coordinated activities, as appropriate for the context.
4. Implementation of community health service packages should be overseen by the national community health strategy or sector-specific plan, including, as per WHO's guidelines on community health workers (CHWs)¹: a written contract specifying their roles and responsibilities, working conditions and remuneration; remuneration commensurate with their roles, responsibilities and job requirements; and pre- and in-service training with career development opportunities.
5. The ministry of health should have full responsibility for planning, implementing, monitoring and evaluating iCCM by ensuring coordination among community health, child health and malaria control programmes, including by creating a designated cross-sectoral unit, as appropriate.
6. Resource allocations for the full package necessary to deliver high-quality iCCM should be included in annual national and sub-national health sector budgets. Domestic and external funding should cover all components of iCCM.
7. The supply chain for the full iCCM package should be fully integrated into the national supply management system, with medicines, diagnostics and logistics for community services integrated into the health facility supply management and logistics information system.
8. Interventions to improve quality, including supportive supervision and mentoring of CHWs in designated health facilities, are essential to ensure high-quality iCCM and should be budgeted for and included in district plans.
9. Community engagement is essential for institutionalising iCCM. Community voices and requirements are central to all stages of effective planning and decision-making, selection of CHWs, implementation, oversight, demand and uptake of iCCM. Targeted outreach should be included from the inception of iCCM programme design.
10. iCCM data should be integrated into the health facility information system to allow disaggregated analysis and feedback to CHWs.

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Background

Globally, 5.3 million children under the age of 5 died in 2018, of whom 2.5 million were newborns. Nearly half of all the deaths occurred in sub-Saharan Africa. Worldwide, 52 countries are not on track to achieve child survival target of the Sustainable Development Goals (SDGs) of fewer than 25 deaths per 1000 live births by 2030.²

Pneumonia, diarrhoea and malaria remain the main causes of mortality, accounting for approximately 802 000, 437 000 and 272 000 deaths, respectively, among children under 5 in 2018.^{3,4} Furthermore, it is highly likely that these numbers are underestimated because of the weakness of the health and reporting systems in the countries in which most of the deaths occurred.

Achieving universal health coverage (UHC) and reaching the child health SDG targets will require strong primary health care (PHC) systems, including institutionalisation of community health. Integrated programming in PHC has been shown to be effective in increasing the delivery of essential services in the community, with better coverage of essential interventions and better health outcomes.⁵ Properly trained, supervised and supported community health workers (CHWs) can deliver a range of preventive, promotive and curative health services, increasing access and reducing inequity. WHO has consolidated evidence on optimising CHW programmes and issued guidance on effective policies for the selection, education, management, remuneration, support and role of CHWs.⁶

Since 2012, WHO and UNICEF have recommended integrated community case management (iCCM) of childhood illnesses as a core component of integrated management of childhood illness (IMCI).^{7,8}

By targeting hard-to-reach areas and vulnerable populations, iCCM increases access to life-saving interventions for children with malaria, pneumonia or diarrhoea and promotes rational use of medications, healthy nutrition, timely care-seeking and timely referral to higher levels of care when necessary.

Despite the iCCM Evidence Review Symposium in Accra, Ghana, in 2014⁹ and the meeting on scaling up iCCM in Nairobi, Kenya, in 2016,¹⁰ a WHO-led strategic review of integrated management of childhood and newborn illness in 2016 showed that few countries were implementing well-designed, effective iCCM.¹¹

Nevertheless, considerable progress has been made. To date, over 30 countries have implemented iCCM, usually sub-nationally, with the support of global development partners and especially the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) through allocations for malaria and for resilient, sustainable health systems. Other funding for iCCM comes from UNICEF, WHO, Gavi, the Vaccine Alliance, Global Affairs Canada, the US Agency for International Development, the United Kingdom Department for International Development, the World Bank and the Bill & Melinda Gates Foundation.¹²

An evaluation of iCCM by the GF, UNICEF and WHO in 2018 concluded that, although the iCCM Financing Task Team, established in October 2016, had greatly improved funding allocations for iCCM, financial sustainability is compromised by its reliance on external support from donors and development partners.

Furthermore, despite recommendations from various agencies and conferences, inadequate planning, budgeting and resource mobilisation for the entire iCCM package and insufficient community engagement have meant that many countries that started implementation of the iCCM component of the IMCI strategy have struggled to maintain an acceptable quality of care and coverage, and large portions of the population remain underserved. In addition, operational research for optimising iCCM implementation has not been conducted.¹³ Access to essential commodities and proper inclusion of iCCM in overall community health, PHC and IMCI strategies remain a major challenge in many countries.

There is nevertheless increased recognition of the importance of frontline health systems, of better alignment of resources and partners for national priorities for community health and of building on the 10 principles for institutionalising community health¹⁴ (see Box 1).

Box 1. Principles for institutionalising community health

1. Engage with and empower communities to invest in viable, resilient health with strong links to health and other relevant sectors.
2. Empower communities and civil society to hold the health system accountable.
3. Base community health on recognised frontline health workers, with due incentives.
4. Prioritise populations and areas that are hardest to reach, and implement community health interventions in a comprehensive manner with quality and equitable coverage, guided by national policy and local systems to ensure impact.
5. Ensure sufficient, sustainable financing for community health interventions according to national and international resources, including the private sector, to contribute to reducing financial barriers to health.
6. Reduce inequity in health and gender inequality.
7. Capitalise on community health resources to ensure that populations in humanitarian crises receive essential health care.
8. Invest in inclusive partnerships to leverage and coordinate diverse civil society and private sector groups to support national acceleration plans, and enable communities to shape and support implementation of policies.
9. Integrate community data into the health information system, and invest in innovative technologies to facilitate monitoring and use of data.
10. Use practical and participatory learning and research to identify, sustain and scale up effective community interventions, while providing opportunities for sharing lessons among countries and globally.

Objectives

- To review recent information on PHC in communities, including high-quality, sustainable iCCM of childhood illness and new guidelines for CHWs;
- To refine guiding principles and recommend means for embedding iCCM within community health systems as part of PHC;
- To identify needs and gaps in sustainable financing of iCCM; and
- To review progress, challenges and priorities in order to update national plans for iCCM in the context of recent information, specifically to support to the HBHI response to malaria and broader child health programming, including applications to the GF and other resource mobilisation.

Process

In preparation for the meeting, UNICEF and WHO reviewed the current status of iCCM implementation in the participating countries with their governments and other stakeholders. Published background papers, meeting reports and other material were provided to participants before the meeting. In each session, background information was provided, countries shared their experience, and the group discussed themes relevant to institutionalising iCCM. Group work was organised to define enablers and challenges and to make recommendations on components of health systems for institutionalising iCCM within PHC. During the second part of the meeting, countries defined means to advance iCCM within the malaria HBHI response and to ensure coherent planning and resource mobilisation for iCCM. The report was prepared by the rapporteur and the UNICEF and WHO organising teams and sent it to all participants for comments, which were taken into consideration before finalisation of the report. The presentations and the report (in English and French) can be accessed on the [Child Health Task Force website](#).

Part I.

**Institutionalising
integrated community
case management to
end preventable child
deaths**

1. Setting the stage

Despite substantial progress in reducing deaths among children under 5 during the era of the Millennium Development Goals, many countries have still made insufficient progress in reaching the objectives for child survival. In particular, in 2018, approximately half of the 5.3 million deaths among children under 5 globally occurred in sub-Saharan Africa. Equity must be mainstreamed, as it is the poorest children, mostly in rural households, who are at highest risk of death and are more highly exposed to multiple risks and deprivation that impede their healthy development.

The United Nations Global Strategy for Women's, Children's and Adolescents' Health is comprehensive and equitable and is based on the objectives of "survive, thrive and transform" in a multisectoral approach including nutrition,

education, water, sanitation, hygiene and shelter, which are essential to ensuring health and well-being, reducing inequity and addressing new environmental challenges (Box 2).

To ensure access and an effective, appropriate continuum of care, from primary to specialized levels, timely, high-quality services should be available at all levels, with appropriate inclusion of the private sector. Broader community platforms for their engagement and empowerment are particularly important for PHC and for ensuring nurturing care for children.

Box 2. Strategic shifts in child health programming for "survive, thrive and transform"

1. Extend the predominant focus from survival of children under 5 to programming for the first two decades of life in health, nutrition and a psychosocial and supportive environment.

2. Extend and refocus the "survive" agenda to age-specific high mortality burdens, with greater emphasis on quality, high coverage and equity for vulnerable populations.

3. Increase emphasis on the "thrive" agenda to build children's resilience by nurturing care, early learning and promoting optimal health, growth and development, and by addressing high morbidity burden along the life-course.

4. Adopt multisectoral delivery of comprehensive family, child and adolescent care, services and actions in all health programmes and health-related sectors.

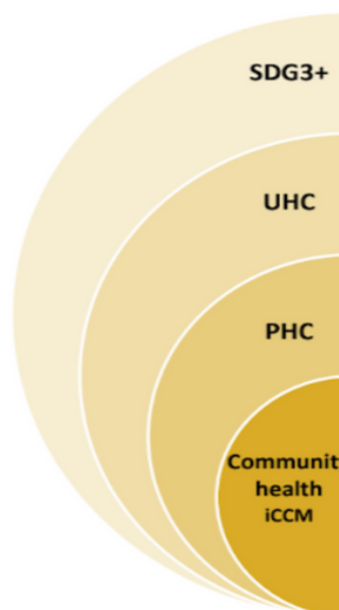
Community PHC to achieve UHC

Investment in community health systems is the basis of PHC, UHC and achievement of the SDGs (Fig. 1, Table 1). This is particularly relevant in sub-Saharan Africa, where the mortality rate of children under 5 remains high because of vulnerability due to humanitarian crises, food insecurity, climate change, forced migration and inadequate health service delivery systems. Further challenges include geographical inaccessibility, weak local governance, verticalisation of interventions, poor-quality services and inadequate community engagement. These problems can be addressed only through a system of integrated, high-quality service, supported by coordinated resource mobilisation for sustainable financing of community health and PHC.

To advance the institutionalisation of community health, 10 key principles were defined at a conference in Johannesburg, South Africa, in 2017 and adopted by about 40 countries (see Box 1). The Community Health Roadmap further raises country-defined priorities for community health to better align partner support and investments in community health.

Table 1. Why, what and how PHC and UHC are important at community level

WHY	WHAT	HOW
<ul style="list-style-type: none"> • Ambitious targets for SDG3 and UHC • High rates of mortality of children under 5 • Decreasing coverage of interventions • Challenging logistics and contexts 	<ul style="list-style-type: none"> • Accelerate progress towards UHC through PHC by investment in strengthening community platforms for integrated service delivery 	<ul style="list-style-type: none"> • Better define needs, opportunities and strategies to improve community service delivery • Institutionalise community service delivery platforms within the PHC system • Support coordinated, sustainable financing for community health



2. Lessons learnt from scaling up integrated community case management

In 2017–2018, the GF, in collaboration with UNICEF and WHO, undertook a systematic review of the literature on iCCM in 18 sub-Saharan African countries to document their experiences of GF-supported iCCM.¹⁵ The GF has provided most of the financial and logistic support for malaria commodities through allocations for malaria and for resilient, sustainable health systems. The lessons learnt and the conclusions of the review are summarised below under nine thematic areas.

2.1 Increase speed, coverage, access and equity

Countries with strong leadership, policy and national partnerships were more successful in scaling up iCCM. The speed of scaling up was increased by use of evidence from pilot studies, as in Ghana, Niger and Rwanda. Successful community PHC programmes were used as a platform for introducing and scaling up iCCM, as in the Democratic Republic of the Congo (DRC), Senegal and Uganda. A competent pool of CHWs who were integrated into the staff structure of the ministry of health and salaried, facilitated recruitment and training of CHWs for iCCM. The extent of scale-up of iCCM in the 18 countries is shown in Table 2.

The United Nations Global Strategy for Women’s, Children’s and Adolescents’ Health is comprehensive and equitable and is based on the objectives of “survive, thrive and transform” in a multisectoral approach including nutrition, education, water, sanitation, hygiene and shelter, which are essential to ensuring health and well-being, reducing inequity and addressing new environmental challenges (Box 2).

To ensure access and an effective, appropriate continuum of care, from primary to specialised levels, timely, high-quality services should be available at all levels, with appropriate inclusion of the private sector. Broader community platforms for their engagement and empowerment are particularly important for PHC and for ensuring nurturing care for children.

Best practice: use of evidence **Malawi** and **Zambia** evaluated their national iCCM programmes and used the results to plan scaling-up and for funding and resource mobilisation.

Table 2. Extent of implementation of iCCM in 18 countries, from GF survey

At scale	Scaling up	Scaling-up and extension to new districts	Extension to new districts, will scale up
<ul style="list-style-type: none"> • Cameroon • Ethiopia • Malawi • Mali • Rwanda • Senegal • Zambia 	<ul style="list-style-type: none"> • Benin • Burkina Faso • Burundi • Sierra Leone 	<ul style="list-style-type: none"> • DRC • Ghana • Niger • South Sudan • Uganda 	<ul style="list-style-type: none"> • Nigeria • Kenya

National scale-up covers all eligible districts, and iCCM scale-up covers all eligible populations with functional iCCM services; extension: introduction of iCCM to new eligible districts.

2.2 Policy, integration, leadership and coordination

Countries that have involved diverse stakeholders such as the human resources department of the ministry of health, the ministry of finance, subnational administrators and community representatives in policy development have been more successful in scaling up iCCM. Technical officers within ministries of health, supported by technical working groups including development partners are important in iCCM policy development and implementation.

2.3 Behaviour change, communication and demand creation

Low use increases the cost of iCCM programmes per capita, affects investments and sustainability and limits reductions in morbidity and mortality rates. The effect of community engagement has not been assessed systematically; however, there appears to be little creation of demand for shifting use of services from the unregulated private sector to trained CHWs. Community incentives must be understood to ensure culturally appropriate mobilisation and systematic creation of demand.

Best practice: Niger holds annual village meetings to assess progress and to celebrate villages, families and individuals as “champions”, “agents of change”, “model mothers” and “model villages” that have been successful. The winners are given soap, mosquito nets or a radio.

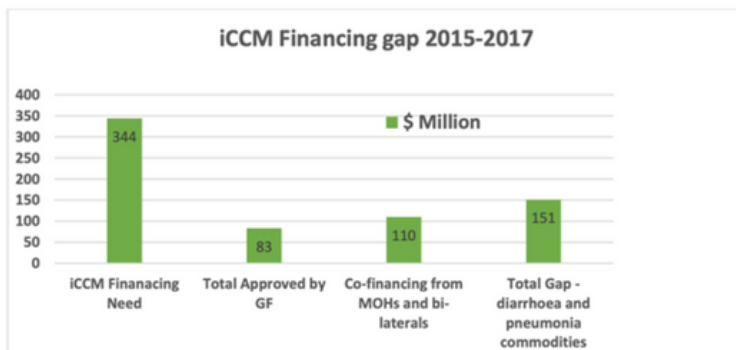
In Rwanda, monthly meetings of about 20 CHW from neighbouring villages for peer support contributed to mobilising communities and households.

2.4 Funding

Between 2012 and 2017, major donors and development partners greatly increased their investments and technical support. The iCCM Financing Task Team was convened in 2014 to support countries in including iCCM in their GF new funding model grants and to facilitate co-financing, which improved funding for iCCM; however, the sustainability of iCCM is jeopardised by dependence on external donors.

Successful measures for resource mobilisation for iCCM include: a detailed gap analyses (e.g. Ghana); domestic funding for components such as CHW remuneration and training with donor funding for programmes and commodities (Ethiopia); flexible funding arrangements in difficult operating environments to secure an uninterrupted supply of iCCM commodities (Burundi, South Sudan); and innovative funding approaches such as the trust fund for reproductive, maternal, newborn and child health. The persisting requirement for resources for procuring commodities to treat diarrhoea and pneumonia is illustrated in Fig. 2.

Factors such as misalignment of timing of funding for non-malaria (pneumonia and diarrhoea) and malaria commodities and gaps in financing the full iCCM package had a negative impact on iCCM extension and coverage. The gap in co-financing non-malaria iCCM components was an issue in Nigeria. Fig. 2 shows the significant gaps in iCCM co-financing of non-malaria commodities in 10 countries.



* Nigeria, DRC, Zambia, Uganda, Ethiopia, Ghana, S. Sudan, Burkina Faso, Malawi and Cote D'Ivoire
Source: iCCM Financing Task Team Consultants

2.5 Human resources: training, incentives and retention

Community health workers should be institutionalised to ensure consistent, uniform remuneration and incentives in order to prevent attrition and sustain motivation. Community involvement in the selection of CHWs increases use of iCCM by increasing trust in and support for CHWs. The placement and case allocation of CHWs can be improved by mapping population density for logistics and supply management. Adherence to training standards, refresher training, incremental training, sustained supportive supervision and mentorship increase the clinical skills and capability of CHWs.

2.6 Supportive supervision and quality assurance

Countries should establish a pool of trained supervisors to ensure an optimal ratio of supervisors to CHWs. Standard checklists may be used to assess the quality of care, supplies, data collection and reporting systematically. Financing and infrastructure, especially transport, for CHWs are vital for motivating them, improving service delivery and identifying barriers to access. Mobile technology allows supervisors and CHWs to plan visits, especially for CHWs who work in remote areas, and also to monitor CHW performance and obtain accurate, timely information about cases and necessary supplies. mHealth strategies should be incorporated into ministry of health systems to support various aspects of engagement.

Use standard checklists to assess:

- provision of the programme package by individual CHWs;
- availability of supplies and logistics for supply and resupply;
- data-tracking, patient register, timeliness and accuracy of reports;
- provision of high-quality iCCM and clinical skills; and
- accountability and recommendations for corrective actions.

2.7 Supply chain management

Increased funding since 2014 improved the availability of iCCM commodities and reduced stock-outs. International partners such as WHO, UNICEF, GF, PMI, the US Agency for International Development, the World Bank and the United Kingdom Department for International Development initiated pooled funding for strengthening procurement and national distribution capacity, warehousing and transport. Variable levels of financing and siloed donors, however, increase the frequency of stock-outs, reducing the quality of care and use of services. Resource mobilisation, quantification and forecasting should therefore be strengthened at both community and health facility level, and all iCCM drugs and supplies should be included in a logistics management information system.

2.8 Service delivery and referral

In countries in which iCCM support systems are integrated into the health system, CHWs can provide higher-quality services. To reduce mortality rates further, referral and counter-referral between CHWs and health facilities should be strengthened; the burden of distance and the costs of accessing referral facilities should be reduced, for example through social insurance schemes (e.g. transport vouchers); and the receiving facility must be well stocked, with sufficient staff trained to treat severe cases with support from the ministry of health and partners. Service delivery and community trust and engagement can be improved by ensuring enough CHWs to meet the iCCM service delivery schedule.

Best practice: Mozambique

UNICEF and the Malaria Consortium support implementation of UPSCALE, an mHealth programme designed to improve the quality of care provision. CHWs are given a mobile device with pre-installed software that supports consultation workflows, patient histories and information on households. CHWs reported feeling better equipped to track families in their communities.

2.9 Monitoring and evaluation

Monitoring and evaluating improvements in iCCM require discussions among implementing partners and the ministry of health to ensure use of a unified approach and agreement on the type of data required at each level. iCCM data should be reported separately from those on IMCI to understand and target each programme. Regular evaluations and review increase the quality of iCCM services.

Main findings of the GF review:

- 14 of the 18 countries have a national policy for iCCM.
- All 18 countries provide some domestic funding for iCCM.
- To institutionalise iCCM, it should be an integral part of national health sector, budget and strategic and operational plans, and parallel systems should be avoided.
- iCCM should be implemented in a functioning health facility.
- The remuneration and workload of CHWs should be optimised.
- Non-malaria commodities should be funded to maximise the impact of iCCM.

Lessons from the Rapid Access Expansion Programme

The Rapid Access Expansion Programme of the WHO Global Malaria Programme implemented between 2012 and 2018, with support from Global Affairs Canada, assisted five African countries (DRC, Malawi, Mozambique, Niger and Nigeria) in increasing access to treatment for common childhood illnesses and thereby contributed to reducing child deaths. In each country, the Programme was implemented under the leadership of the ministry of health, which also chaired iCCM technical committees to provide technical support and programme oversight. In this Programme, 1.49 million children were given access to life-saving treatment for malaria, pneumonia and diarrhoea by training and equipping more than 8200 CHWs in the five countries. The Programme reached its targets in all countries, covering all of Tanganyika Province in DRC, eight districts in Malawi, four provinces in Mozambique, four districts in Niger and two states in Nigeria. In four years of implementation, diagnosis and treatment were provided to over 8.24 million clinical cases of malaria, pneumonia and diarrhoea. The rate of mortality of children under 5 decreased in all six Programme sites by an overall average of 10%.

The Journal of Global Health has published 13 articles on five themes: the impact of iCCM on child mortality, care-seeking and treatment coverage; sustainability; monitoring and health information systems; challenges in mature iCCM programmes; and tools and approaches to improve the quality of care.¹⁶ The lessons learnt from the Rapid Access Expansion Programme are outlined in Box 2.

Box 2. Lessons learnt from the Rapid Access Expansion Programme

The success of the iCCM strategy depends on the availability of trained, supervised CHWs and appropriate supplies in villages in which children fall ill.

Community engagement:

- Community engagement is essential for sustained high-quality implementation.
- Community awareness of iCCM should be raised during the planning stage for effective implementation.

Availability of diagnostics and medicines:

- Effective iCCM requires a reliable, prompt supply of high-quality commodities to CHWs in sufficient quantities.
- Commodity forecasting should be combined with that for similar formulations at health facilities to avoid stock-outs.
- Kit systems should be avoided, and replenishment should be based on consumption.
- Parallel procurement and distribution systems by implementing partners should be avoided.

Supervision to deliver high-quality iCCM services:

- Designated supervisors in a health facility ensure the quality of care, reporting and CHW motivation and are a critical link between CHWs and the health system.
- Ministries must budget and plan for supervision, including transport, refresher training and incentives.
- Implementing partners should not establish parallel supervision systems.

Functional referral system:

- Patients with IMCI danger signs who require inpatient care should be referred by CHWs to facilities with inpatient services.
- Referral facilities should have the capacity to receive and manage cases referred from communities, with trained staff and the necessary diagnostics and medicines.
- Referral facility staff should be involved in CHW training to improve the referral system.

Monitoring and health information system:

- The recording and reporting systems of health facilities and CHWs should be harmonised.
- Parallel reporting systems by implementing partners should be avoided.
- A culture of use of information at all levels of the system, from the community to national level, should be built.

3. Country experiences in scaling up integrated community case management within community health

Ethiopia, Malawi, Niger, Nigeria and Uganda made presentations on their progress in scaling up the health systems components of iCCM. Common challenges were human resources, financing, the role of health facilities, supervision, supply chain, monitoring, health management information systems and community engagement.

3.1 Human resources

The five countries reported insufficient CHWs for the population and lack of a regulatory framework for volunteer workers, which affects supervision and quality of care. All found it difficult to retain and motivate CHWs with financial incentives or professional development, which is often delayed. Some CHWs have a heavy workload, while others (especially volunteers) also have jobs, making it difficult for them to provide high-quality care.

3.2 Financing

The countries cited lack of sustainable domestic resources and frequent dependence on external partners for financing. Domestic funding for iCCM is a priority to ensure sustainability; however, many countries do not have a budget line for iCCM, nor a harmonised, costed implementation plan. Support from different donors for the components of iCCM, from supplies to motivation of CHWs, has hindered implementation of the full iCCM package, often resulting in community case management only for fully funded areas such as malaria.

3.3 Role of health facilities in iCCM implementation

A common challenge is high turnover of trained human resources in health facilities. Nigeria also mentioned frequent strikes of health workers. Other problems include shortages of medicines and supplies and poor coordination between health facilities and CHWs.

3.4 Supervision

The competence for and quality of supervision are inconsistent among and within the countries. CHW supervisors often lack motivation or the means to act. Like CHWs, they often have a high workload, which affects the planned frequency of supervision visits, especially during seasons with high disease transmission (e.g. rainy seasons). Difficult terrain, insecure areas, distance and lack of transport also impede supervisory visits to communities.

3.5 Supply chain

The countries reported that the main challenges were irregular supplies, delays in procurement and replacement and unsustainable sources of commodities from donors. Even when donors (e.g. the GF) finance transport of the integrated package, irregular or off-cycle procurement of non-malaria commodities that are not tracked impedes delivery of the full package.

3.6 Monitoring and health management information system

In all five countries, data are used sub-optimally. Furthermore, data are often entered on paper, which makes them difficult to visualise and use. Further problems are weak feedback to communities, little use of data at any level and multiple reporting systems and tools.

4. Engaging communities

There is no sufficiently robust community engagement model that accounts for multiple entry points. To be robust, it would require recognition of and connection with all levels of power, voice, impact and opportunity for knowledge-sharing and relation-building within and between health systems and communities, and within communities. Box 3 gives a working definition of “high-quality, people-centred community engagement for resilient health service”.

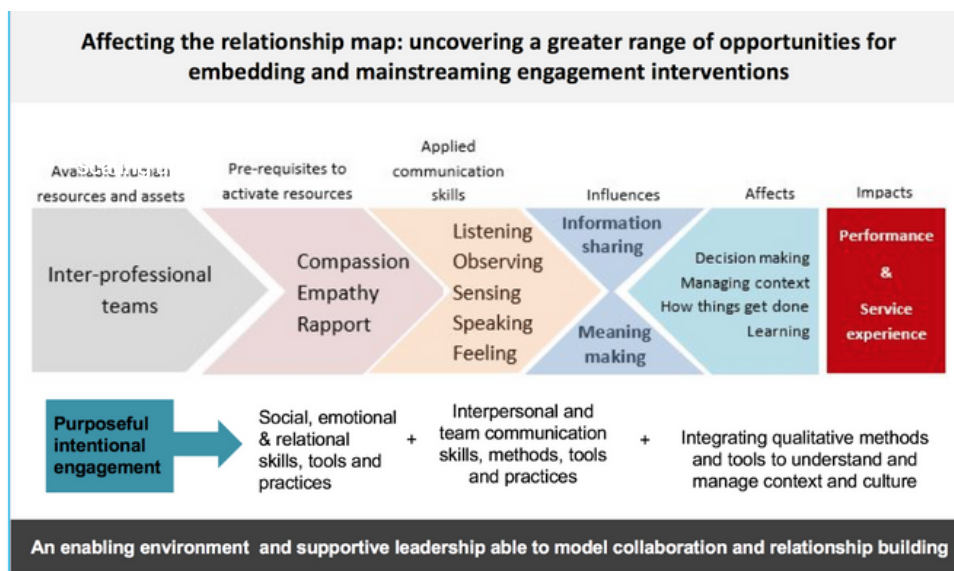
Box 3. Community engagement for high-quality, people-centred, resilient health services

Community engagement involves developing relationships among stakeholders so that they work together to address health-related issues and promote well-being to improve health.

- “Stakeholders” include community members, patients, health professionals and policy-makers.
- “Relationships” should be characterised by respect, trust and purpose.
- “Health-related issues” include public health events such as emergencies.

Most research on community engagement ignores the community of health professionals and focuses on education and information-sharing (Fig. 4) and also ignores emotions and feelings. Insufficient attention has been paid to developing engagement that results in sustainable practices. The role of trauma (such as loss of a child because of poorly trained CHWs, lack of drugs or poor care) has not been sufficiently investigated as a determinant of the quality of community engagement.

Relational feedback at different levels of the health system can be strengthened by combining non-traditional engagements to build trusted, respectful, compassionate relationships among and between service providers and service users and changing the focus from curative, vertical programmes to inclusive, collaborative, coordinated approaches. This requires specific skills, competence and an enabling environment that must be created and managed until it becomes the norm. The WHO community engagement framework for high-quality, integrated, people-centred, resilient health services was prepared in 2017 at a technical workshop on the links between health systems and communities. Collaboration was recommended at all stages, from creation of the framework to data collection and analysis, engagement, intervention, development and intervention.



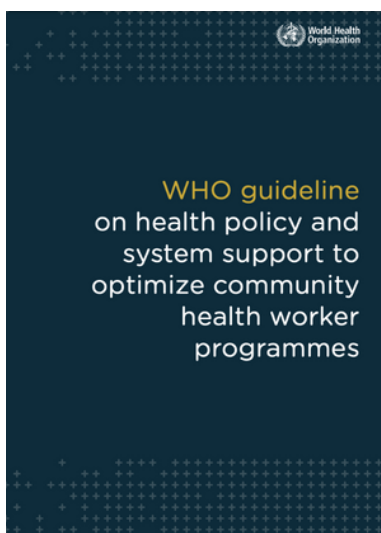
Key findings of an assessment of the community engagement framework in Rwanda were:

- a spectrum of practices in four districts in Kigali;
- the highest incidence of malaria in districts with a top-down model;
- a lower malaria incidence in active communities and the lowest in those with the greatest collaboration;
- discordance between policy-makers for malaria control and elimination and those who implement the practices and procedures;
- no mechanism for sharing lessons and best practices at any level or district;
- CHWs are uniquely situated to serve as liaisons among community members, other stakeholders and malaria programme staff.
- Community engagement is not a means to an end but an intervention in its own right.
- The intent and purpose of community engagement should be defined to determine interventions. A shared view of the different concerns, needs and expectations of communities requires dialogue.
- Strong connections build effective engagement between health systems and communities and others.
- Coordination, collaboration and empowerment are shaped and re-shaped in relationships.
- The role, skills and competence of people involved in engagement in health systems and in communities will be critical in the SDG era.

Community engagement and empowerment in iCCM in Cameroon, Malawi, Mali and Nigeria showed that a uniform approach can ensure the sustainability of community engagement and action, which are often fragmented among districts and regions. Open dialogue is necessary for stronger links among groups that set strategies for malaria control and elimination and those that implement the strategies to overcome discordance between policy and implementation. Such links foster effective engagement between health systems and communities.

5. Guidance on community services

Programmes such as the SDG Action Plan and the Community Health Roadmap ensure that iCCM programmes are implemented as part of broader health workforce, PHC and community health systems, in line with the 2018 WHO guideline on health policy and system support to optimise community health worker programmes. Member States own and have made a collective commitment to support implementation of the guideline, in their contexts, by adopting at the Seventy-second World Health Assembly a resolution that took note of the guideline and its recommendations.¹⁷ These initiatives support countries in strengthening the systems required to deliver high-quality iCCM and IMCI at scale.



WHO guideline on health policy and system support to optimise community health worker programmes

The effectiveness of CHWs in delivering a range of services is confirmed by a growing body of evidence. The challenges include inadequate health systems and community integration, lack of use of best practices and uneven adoption of evidence-based policies. The WHO guideline identifies management systems and strategies for CHW programmes, provides recommendations for scaling up, integrating, optimising design and performance, sustaining effective CHW programmes and filling gaps in policy and system support.

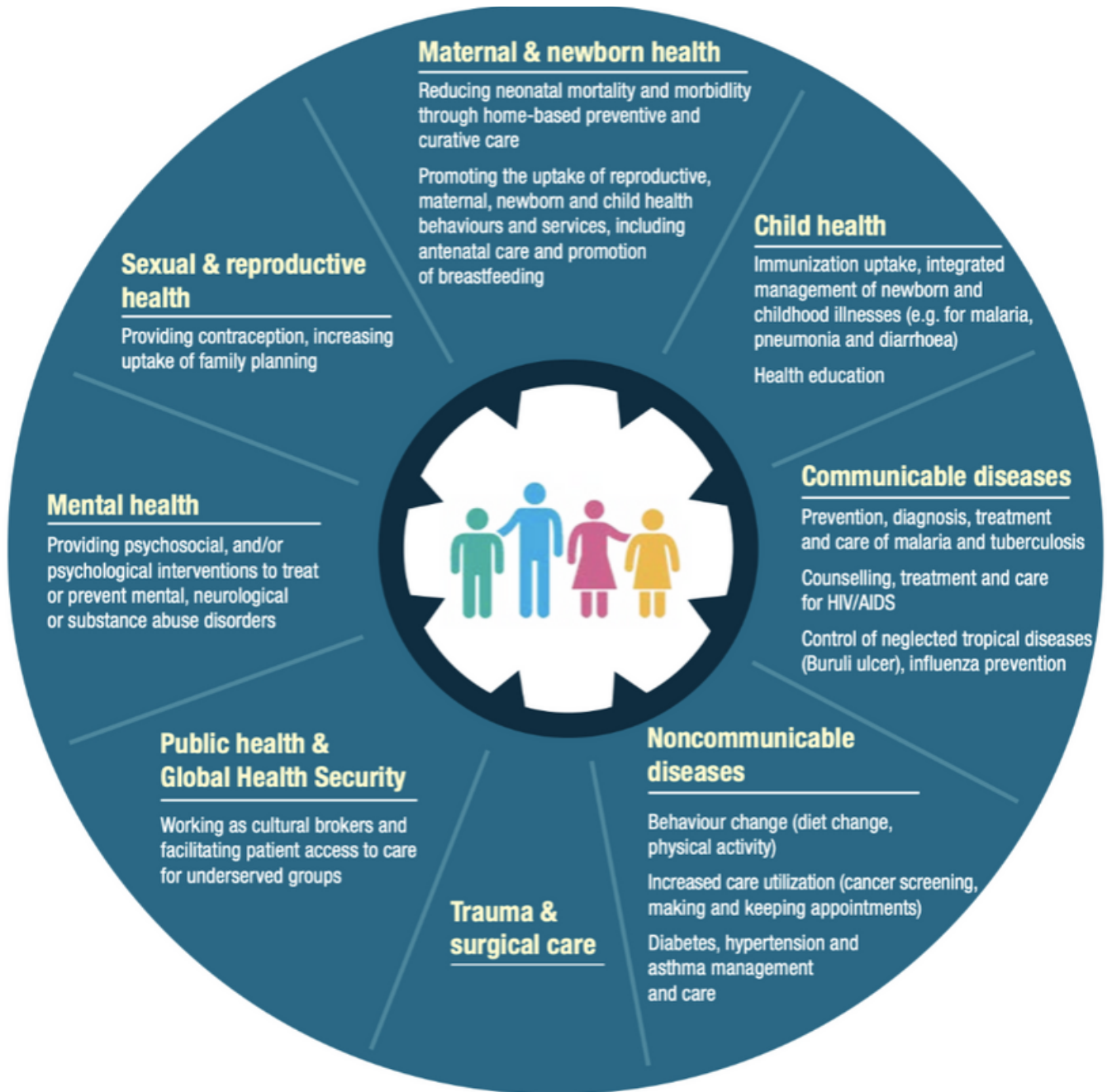
The target audiences of the guideline are national and local policy-makers, planners and managers of health workforce policy, development partners, donors, global health initiatives, researchers, activists, civil society organizations, CHW organizations and CHWs.

The guideline identifies the following enablers of successful implementation:

- Tailor policies for CHWs to the context.
- Consider the rights and perspectives of CHWs.
- Embed CHW programmes in the health system as a diverse, sustainable mix of skills.
- Harness demographic dividends by increasing employment for young people, especially women.
- Fund and invest in CHW programmes as part of the overall health strategy.

The role of CHWs should be defined and enhanced by constantly improving equity, quality of care and patient safety. The responsibilities of CHWs are illustrated in Fig. 5.

Fig. 5. Responsibilities of CHWs





Caring for newborns and children in the community: planning handbook for programme managers and planners

This planning handbook was published in 2015 by WHO and UNICEF in collaboration with the US Agency for International Development, Save the Children and other partners. Its aims were to inform managers and planners about three packages for training and supporting CHWs, their benefits and requirements; to guide them in selecting the best mix of interventions and packages for their countries; and to guide them in deciding on planning and using the packages.



Caring for newborns at home covers:

- promotion of antenatal care and skilled care at birth;
- care in the first week of life;
- identification and referral of newborns with danger signs; and
- special care for low-birth-weight infants.



Caring for the child's healthy growth and development covers:

- care-giving and support for child development; infant and young child feeding;
- prevention of illness; and
- family responses to children's illness.



Caring for the sick child in the community covers:

- referral of children with danger signs and severe acute malnutrition;
- treatment in the community;
- diarrhoea;
- fever (malaria); and
- pneumonia

6. Financing integrated community case management

In all 18 countries evaluated by GF and in other countries, funding was provided by domestic annual allocations, multilateral and bilateral donors and development partners, households through out-of-pocket payments and the private sector. In 2014–2017, there was significantly increased financing for iCCM programmes from donors and development partners: the GF through its new funding model, UNICEF, WHO, the GFF, the Canadian International Development Agency, the US Agency for International Development/PMI, the United Kingdom Department for International Development, the World Bank and the Bill & Melinda Gates Foundation. All levels of iCCM programmes are also supported or implemented by national and international nongovernmental organizations, including planning, financing and logistics for all thematic areas.

Improvements to funding and financial management include national policy changes and financial reforms for scaling up and increasing the geographical coverage of iCCM and ensuring access to treatment of all childhood diseases for children under 5 years. The GF and the PMI have used their congressional mandate to support and train CHWs and integrate logistics; however, elimination of other donors and support for non-malaria commodities has caused inconsistency and friction, impeding scaling up in many countries.

The GF finances most of the essential ingredients of iCCM, such as training for CHWs, malaria commodities in communities, supportive supervision, delivery costs for iCCM commodities and health information systems.

In the new funding model 1 and 2 comprising iCCM commodities and platform, 14% of the US\$ 3.8 billion in funding for malaria was allocated to iCCM in 38 countries, except for non-malaria commodities. The optimal approach to implementation, scale-up and sustainability of GF-supported iCCM programmes is, however, not known. In all 18 countries, iCCM funding comprised domestic allocations and contributions from development partners; however, nearly all these countries struggle to secure funding for implementation of iCCM at scale.

The GFF is a multi-stakeholder partnership for addressing the health and nutrition issues that most affect women, children and adolescents. GFF supports government platforms in which partners plan priorities and mobilise sustainable financing. It funds non-malaria commodities for iCCM that are proposed in investment cases in 36 countries. Country leadership is at the centre of the GFF model. GFF does not replace existing organizations but brings them together to work on clear priorities defined by the countries, on either coordination platforms or platforms established with GFF.

The criteria on which GFF selects countries are:

- disease burden;
- unmet need to ensure sexual and reproductive health and rights;
- income;
- balance of financing and need;
- commitment to increase domestic financing for reproductive, maternal, newborn, child and adolescent health and nutrition;

- commitment to use financing from the World Bank (International Development Association and International Bank for Reconstruction and Development) for reproductive, maternal, newborn, child and adolescent health and nutrition;
- commitment to mobilise complementary financing and/or leverage existing financing;
- commitment to engage private sector resources to improve reproductive, maternal, newborn, child and adolescent health and nutrition outcomes;
- commitment to the “every woman every child” global strategy;
- existing or planned effective, broadly representative country platform;
- one of bottom 30 countries on the human capital index; and
- on the harmonised list of fragile situations in fiscal year 2019.

The PMI is a joint programme between the US Agency for International Development and the US Centers for Disease Control and Prevention, which supports scaling-up of iCCM by funding an integrated platform, including training, supplies, equipment (e.g. medical kits, registers) and supervisory visits. PMI also funds malaria commodities and participates in global discussions on iCCM (like the GF, but with no funding for non-malaria commodities). PMI identified further areas of support, such as strengthening the CHW inventory, operational research, improving community surveillance and data reporting and the toolkit for social and behavioural change. PMI does not provide financing for CHW salaries (Fig. 7).

Fig. 7. PMI support for iCCM

Where PMI Supports iCCM: Advancing Implementation Scale-up

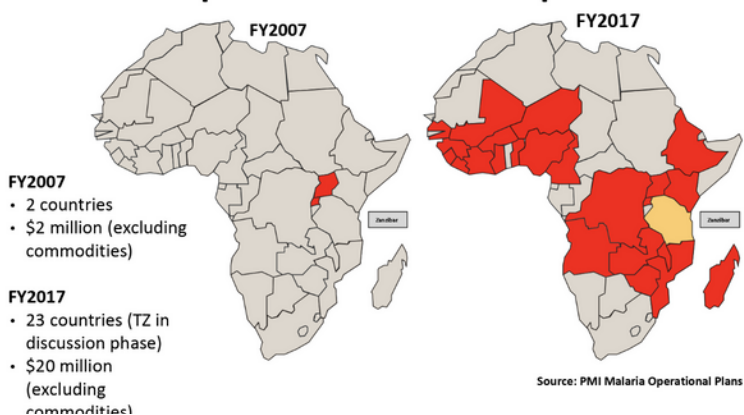
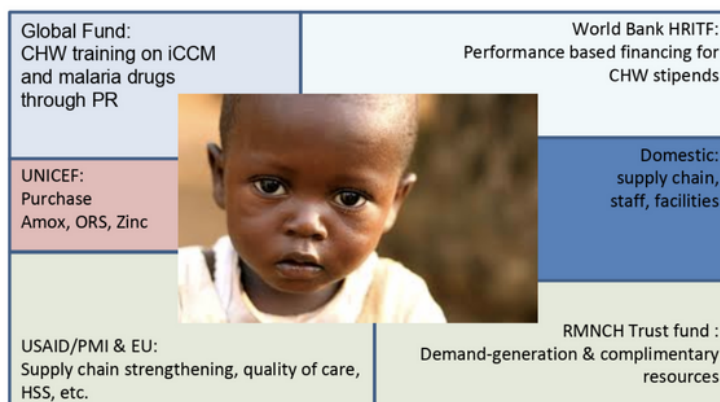


Fig. 8 shows examples of complementary financing and technical resources for iCCM in DRC.



PR, principal recipient; ORS, oral rehydration salts; EU, European Union; HSS, health systems strengthening; HRITF, Health Results Innovation Trust Fund; RMNCH, reproductive, maternal, newborn and child health

The successes in funding include overall financing to strengthen and support CHW activities; geographical and complementary convergence of partners by province to provide the full package; and treatment and care of 1 058 936 cases of simple malaria, 118 780 cases of diarrhoea and 126 773 cases of pneumonia in 2018.

The lessons learnt were that coordination among partners avoids duplication and improves efficiency to make a stronger impact and that regular monitoring improves the quality of care and data. The remaining challenges are to ensure financing for the full package. Funding of more than 90% of programmes by donors creates unsustainability. Further challenges include recovery of capital invested in drugs (free of charge or cost recovery) and maintaining the motivation of the community centre.

In the future, advocacy with governments should be strengthened to provide funding for iCCM in sub-Saharan countries, and funds should be mobilised to complete the package in countries in which only malaria is supported, as, currently, 60% receive only funding for malaria.

Summary

- Most investment in strengthening community systems in iCCM is provided in parallel.
- Countries should set priorities and present them for funding by GFF, GF and others. They therefore require harmonized, coordinated support for preparing a costed operational plan and a gap analysis to show existing and required funding.
- Support to ensure that governments lead the process for effective coordination.
- Improvements in data collection and sharing are vital to convince governments to increase allocation of domestic resources to the main causes of childhood deaths; to ensure equitable targeting of scarce resources to the main priorities; and geographical targeting to ensure proper distribution of commodities according to consumption and need rather than estimates and models.
- The absence of a committed global financing mechanism or dedicated partner for non-malaria commodities hinders scaling-up of iCCM for maximal impact.

Section 7. Procurement and supplies for integrated community case management

Stock-outs of medicines and supplies are a major impediment for implementing iCCM, and they affect the lives of children and undermine the trust of the community in the health system and in CHWs. The most commonly cited reasons for stock-outs are inadequate financing, insufficient or poor-quality data, weak distribution, lack of transport to take commodities to CHWs or for CHWs to pick them up and insufficient CHWs, supervisors and staff at resupply points. Improving recording of stock balances in real time is key for supply chain management and for reducing stock-outs. When there is no government plan for iCCM, accountability for availability and transport of medicines is weakened further, further hindering implementation of the full iCCM package.

A number of donors and partners are trying to improve supply chain management for iCCM, which should be for the integrated package and not just one commodity or one “tracer disease”, which will reduce incentive for integrated planning. Supply chain management for the full iCCM package should thus be central to national management. A functioning supply chain requires financial flow, data flow and product flow, which are interlinked.

Summary

- The supply chain for iCCM should be an integrated part of planning for iCCM as part of the pharmaceutical system.
- iCCM must be part of ministry of health plans to ensure prioritization for presentation to donors.
- Quantification of stocks in the community should not be based on estimated disease incidence, which can lead to under- or over-stocking.
- Health facilities should consider the requirements of CHWs when ordering.
- Finance should be available for the complete package in order to avoid community management of just one disease, which leads to commodity mismanagement and erosion of community trust.
- Cost recovery mechanisms should be implemented.
- Distribution must be ensured to the “last mile”.

Section 8. Recommendations for institutionalizing integrated community case management in the primary health care system

Drawing on evidence, lessons from implementation and best practices, working groups discussed the principles, enablers, hindrances and recommendations for nine health system components relevant to institutionalization of iCCM within PHC:

- coordination and policy-setting
- costing and financing
- human resources
- supply chain management
- service delivery and referral
- community engagement through communication and social mobilization
- supervision
- quality of care
- monitoring, evaluation and health management information systems

The iCCM benchmark framework comprises eight essential health system components for iCCM. As supervision is only one aspect of QA, the WHO–UNICEF planning team decided to consider them separately.

Additional resources used in the discussions included: the WHO guideline on health policy and system support to optimize CHW programmes, the handbook for programme managers and planners in caring for sick newborns and children in the community, the indicator guide for monitoring and evaluating iCCM, the thematic review by the GF of 18 countries and the review of institutionalization of iCCM in routine health systems in low- and middle-income countries.

Below, the outputs of the working group discussions are presented by health system component. A consistent observation during the discussions was that the system components are strongly interrelated.

Coordination and policy-setting

iCCM can be effective for reducing morbidity and mortality from common childhood diseases by improving equity in access to and coverage of PHC. Countries with high mortality of children under 5 should integrate iCCM into national health sector development policies, strategies and plans. To be effective, iCCM must be embedded in overall health system strengthening at district and community levels, with balanced funding.

System component enablers:

1. An up-to-date health sector development plan that prioritises PHC and UHC and the place of community health and private sector engagement, supported by national policy.

2. A comprehensive, coordinated strategy among relevant government departments, including:

- an investment case specifically for community health and iCC
- Maligned national and district strategic and operational plans for maternal, newborn and child health
- bottom-up planning with local actors.

3. Strong government leadership, ownership and resource commitment, e.g.

- focal points for community health and PHC clear budget lines
- legislation to define the roles and responsibilities, selection, certification and remuneration of CHWs
- insurance schemes that cover community health services
- guidelines and tools for community health.

4. Clearly defined mechanisms for coordination of PHC at community, national and decentralized levels, for technical departments, professional bodies, civil society, community leaders and implementation and funding partners.

5. Alignment of iCCM with global initiatives such as the Global Action Plan for SDG3, UHC, PHC and the HBHI approach to accelerate prevention of malaria.

6. Competent, knowledgeable national and district teams to engage health providers, implement policies and make evidence-based, contextualized decisions.

Bottlenecks and challenges

- Lack of accountability at all levels
- Inflexible, asymmetrical funding or investments, such as funding mainly for malaria, and multiple funding channels, which complicate coordination
- High turnover of decision-makers and programme managers, weak district health management and lack of capacity for planning and problem-solving
- No or misaligned standards for provision of community care (e.g. the medicines to be used)

Coordination and policy-setting

Recommendations:

- iCCM should be planned under PHC and in overall health sector development. A national community health policy or strategy should contain clear, official guidelines for recruitment and criteria for implementation of iCCM, especially for hard-to-reach populations to ensure equitable service delivery.
- National policies for different divisions and technical areas should be coherent and, if necessary, updated for community health and iCCM. Community health should be based on multisectoral engagement and community needs. Government-led, multisectoral coordination of community health should be fully functional and linked to other coordination mechanisms such as for specific child health themes. The private sector should support community health and iCCM as much as possible.
- Countries should invest in planning and managerial capacity to ensure high-quality services. They should develop and sustain a critical mass of well-trained health managers for child health.
- Domestic and external funding should be used for system strengthening for malaria, pneumonia and diarrhoea and for provision of care in communities and facilities. Additional funding should be leveraged to strengthen health systems and iCCM.

Costing and financing

Adequate, sustained funding for iCCM requires a clearly defined target population and fully inclusive funding for all iCCM components; a demonstrated impact on goals such as UHC and achievement of SDG3; and demonstrated ability of the government to coordinate diverse funding sources.

System component enablers:

- Costed, well-aligned strategic plans for malaria, community health and child health, including iCCM
- Strong country leadership and coordination of donated resources, including collaboration with relevant government ministries such as for planning and finance
- Leadership at higher levels in donor agencies to promote coordination among programmes.

Bottlenecks and challenges

National prioritization and coordination

- Weak harmonisation and coordination of resources and resource mobilisation. A national financing strategy is required that covers all strategies, such as wider PHC and more human resources for health.
- Lack of harmonised costing tools for community health ensure that every component (supply chain, commodities, supervision, monitoring and evaluation, training) is accounted and sufficiently available (e.g. costing tool).
- In decentralised health systems, national entities cannot influence the prioritisation of resources at sub-national levels.

Donor prioritization and alignment

- Donor agencies may prioritize different programmes, which are not always aligned with country planning and budgeting cycles.
- There is lack of harmonization and coordination among donors for funding iCCM.
- Incomplete financing of iCCM and lack of co-financing for non-malaria commodities to complement GF investments in malaria and health systems strengthening
- Limited engagement with the corporate sector for financing iCCM.

Costing and financing

Recommendations:

Ensure that:

- iCCM stakeholders in the ministry of health (e.g. sub-national and community PHC) are engaged in the development and costing of national strategies;
- iCCM is included in national costing and annual sector budgeting, with specific budget lines;
- annual health programme planning and budgeting for decentralised levels include all the elements for operationalising iCCM.

Development partners should provide technical assistance and support to build capacity.

Government

- Explore use of investment cases facilitated by GFF to strengthen country institutional capacity to drive strategy and coordinate partners.
- Take advantage of effective established coordinating mechanisms (e.g. malaria partnership, country coordinating mechanism) to strengthen national resource coordination for iCCM.
- Ministry of health to map funding and track expenditure regularly to ensure accountability and coordinate donors with regular commitment and dialogue.
- Solve competing priorities by building a case for increased national budget allocation for health, with a clear statement of the impact of investments in iCCM. Governments can support this by including iCCM in advocacy for PHC and UHC at higher levels within the ministry of health.

Donor agencies

- Donors should be actively engaged in national and sub-national planning and align their funding priorities and cycles with government priorities and budget cycles.
- To promote institutionalization and sustainability, donors should coordinate iCCM funding with the ministry of health and support its iCCM implementation plan, instead of funding projects for specific diseases or locations.

Human resources

CHWs who deliver iCCM services should be integrated into interdisciplinary primary care teams and accounted for in multisectoral policies, strategies, budgets and plans for human resources for health.

System component enablers:

- A policy, strategy and vision for national human resources for health that recognises, standardises and supports the community health workforce functionality.
- Use CHWs to deliver PHC as part of multisectoral, interdisciplinary teams, with clear definition and allocation of resources based on an investment case.
- Involve multisectoral partners, government, civil society and the private sector.
- Ensure rational, respectful engagement of CHWs, with appropriate selection, roles, community engagement, equity and personal safety (in emergency contexts) in relevant services for target populations according to their needs and the tasks to be performed.
- Appropriate motivation of CHWs, including recognition by and accountability to the community.

Bottlenecks and challenges

- CHWs are not always recognised or institutionalised in policy and planning.
- Resources for CHWs are not budgeted, and there is no investment case.
- The same labour standards are not applied to CHWs, even when they are working full-time (including safety).
- CHWs sometimes experience task overload, especially with extension of their role and large population groups.
- Lack of recognition and motivation, which contribute to high attrition rates.

Recommendations

- Devise plans and legislation according to the global CHW guideline recommendations to account for the evolving roles of CHWs (full time, part time, volunteers) and changing health needs of the community, while ensuring appropriate workload, compensation and support.
- Prepare cohesive national training strategies, preferably in partnership with national training institutions to standardize the training curriculum, certification and delivery.
- Innovations in iCCM to ensure quality care include better job aids, coordinated field visits, job aids in local languages, supportive supervision and quality checklists.
- Link community engagement to human resources for health: ministry of health to deploy, motivate, remunerate and recognize CHWs. Robust community engagement and ownership in the selection of CHWs, commitment to promote services, enhanced recognition of services, encouragement of communities to solve challenges like stock-outs.

Supply chain management

The supply chain for iCCM is an extension of the national system, but may require revision, redesign, reinforcement and adaptation to each country, including opportunities for the private sector, high-quality data and investment in tools and processes for data management. Supply chain staff should be an integral part of community health programmes.

System component enablers:

- A functional logistics management information system
- Provision of data for planning, quantification, procurement and timely distribution of iCCM commodities
- Interaction with the health management information system for epidemiological data
- Platforms for adequate, aligned, sustainable financing for supplies and supply chain.

Bottlenecks and challenges

- Poor use of data for quantification, procurement, distribution, re-supply of essential drugs and other supplies for iCCM in both health facilities and to CHWs and weak data system for logistics and supply chain management.
- Misalignment of funding cycles and procurement cycles and delayed disbursement of funds.
- Quantification in health facilities or districts may not reflect requirements for iCCM commodities. Irregular distribution of essential drugs and supplies for iCCM, and insufficient distribution planning in regions, districts and health facilities.
- Challenges in transporting essential drugs and supplies for iCCM, particularly to hard-to-reach areas.
- Inadequate capacity of CHWs and health facility workers to manage community medicines and supplies.

In governance, lack of policy harmonization; misalignment of policy and availability of commodities; weak coordination of partners and vertical donor funding of projects and programmes; dysfunctional cost recovery for services that are not charged, e.g. delayed or no reimbursement from the government for services and commodities used for children under 5.

Recommendations

- Redesign the logistics system according to a situation analysis, and map multisectoral actors, community programmes and interventions according to “what, who owns, who manages, who pays” Account for roles and responsibilities in accountability, management, financing and implementation.
- For a logistics management information system: timely collection, analysis and use of community data by investing in digital tools for effective forecasting and planning for procurement and health facility and community resupply. Logistics management information systems should ensure that disaggregated community data and commodities are included.

Service delivery and referral

iCCM consists of delivering a continuum of care, from the community to health facilities and referral facilities, ensuring the quality of treatment in the community.

System component enablers:

- Community engagement comprising both sensitization and active involvement improves the quality of CHW care.
- Compliance with standards for selecting and training CHWs and continuous retraining to increase their knowledge and skills (e.g. regular supportive supervision by health facility workers, peer supervision, group supervision in meetings of CHWs at health facilities and mentoring programmes)
- Ensure the availability of medicines, supplies and equipment.
- Improve basic health facilities to provide high-quality referral care, and support CHWs in referral.
- Lack of adherence of caretakers to recommended treatment, e.g. when a family considers that a child should have recovered sooner and seeks care from a traditional healer or other person who is not medically trained, or stops treatment too early when they consider that the child is better and need not complete treatment, which can have serious consequences, such as drug resistance.
- Suboptimal compliance of caretakers for referral, e.g. because of ineffective links between CHWs and referral centres, lack of appreciation of need due to inadequate communication by CHWs, costs of transport, treatment and care at referral facilities or little decision-making power of women.
- Limited capacity to manage referrals, due mainly to lack of skills, outdated treatment protocols and lack of appropriate, adequate equipment and medicines.

Bottlenecks and challenges

- Suboptimal care-seeking due to lack of awareness, poor-quality care (perceived or real) by CHWs and other social, economic and cultural barriers, such as limited decision-making power of women, negative perception of CHWs.
- CHWs do not manage children according to standard case protocols because of non-compliance with selection criteria, lack of tools and job aids, no or minimal supportive supervision, poor-quality training, heavy workload or little motivation.

Service delivery and referral

Recommendations

- Active community engagement at all stages of programme planning and implementation; better quality of care at community level; and active surveillance and delivery of care (e.g. routine visits to high-risk households).
- Community participation to address social economic and cultural barriers, such as establishing a community fund, with small contributions from all members, to be used for transport. Village elders could encourage families to seek referral care.
- Improve the function of CHWs by support and linkage with health facilities for referrals, ensuring provision of appropriate tools and job aids, specifically, a phone connection to the referral facility to alert the manager about arriving patients and to facilitate transport of patients.
- Continuous updating of knowledge and skills through regular supervision and mentoring by health facility staff and supervisors trained in iCCM and IMCI.
- In high-burden areas and remote communities, the competence and skills of CHWs should be strengthened by providing tools, job aids, supportive supervision and mentoring.
- Uninterrupted iCCM supplies throughout the year.
- Referral of children with danger signs and other indications is part of the continuum of care, and referral facilities must have the capacity to manage them fully and provide counter-referral.
- Classification of referral centres according to the severity of disease should be communicated to CHWs and caretakers, so that a child with danger signs is sent directly to a health facility or hospital that can manage the condition and not necessarily to the nearest health facility.

Community engagement, communication and social mobilization

Institutionalization of iCCM requires community engagement at all levels to build and maintain relationships among all iCCM stakeholders and ensure that local communities are involved in planning, implementing and using high-quality iCCM services and interventions in PHC.

System component enablers:

- Well-planned intersectoral, integrated approaches to identify and involve relevant stakeholders
- Community engagement throughout the programme, from data collection to assessment, prioritization, design, implementation, monitoring and evaluation.
- Set community and provider priorities, and reconcile them collaboratively.
- Build awareness, and strengthen relationships among providers and stakeholders.
- Collaboration among community leaders and policy-makers.
- Build trust by mutual follow-through and follow-up, including supportive supervision.
- Community considers that it “owns” initiatives and activities.
- Build the confidence, initiative and capacity of those involved in community engagement to use relevant, timely strategies, and advocate for and raise resources.

Bottlenecks and challenges

- Lack of prioritisation or a coherent policy statement and dialogue on community engagement for iCCM in programmes, including no clear definition of “community”
- Lack of systematic strategy development, resource mobilization, execution and

monitoring of community engagement, including its role in strengthening links among health system components, community health programmes, CHWs and the community

- Teaching rather than relationship-building, so that programmes and projects are imposed rather than based on mutual goal-setting, learning and action
- Insufficient advocacy for health service changes to improve access to and experience of iCCM services by communities
- Inadequate representation of communities and civil society organizations during policy-making

Recommendations

- Conduct a consultation to engage and raise awareness of policy-makers on the importance and value of early community engagement, which leads to commitment and action.
- Build technical capacity in community engagement at all levels to support the development, review and adaptation of strategic and operational health plans that include community engagement and are aligned with national community health strategies.
- Develop a community accountability framework to strengthen governance and community ownership.

Supervision

Supportive supervision within PHC is core to high-quality iCCM.

System component enablers:

- Prioritize supervision in budgets and programmes to ensure sustainable iCCM.
- Integrate community health fully into the national PHC system.
- Provide dedicated funding for supervision and training.
- Use high-quality data and monitor performance in supervision.

Bottlenecks and challenges

- Community service delivery is not fully integrated into national PHC, resulting in lack of prioritization of health system components related to iCCM, including supervision.
- Inadequate funding and human resources capacity for iCCM supervision at district, health facility and community level, as iCCM is not prioritized in health budgets, leading to dependence on donors.
- Procurement and training account for most of the cost of iCCM programmes, leaving limited funds for supervision.
- Lack of recognition of good performance and sanctions for poor performance.
- Lack of ownership of an iCCM programme by district health committees when they do not prioritize follow-up of supervision and do not receive regular feedback on the iCCM programme and its supervision

Recommendations

- Institutionalization of community health systems, including ICCM, into PHC:
 - iCCM programmes should be key components of national health strategies to extend access to PHC and integrated across the health system;
 - governments should allocate funding for iCCM and recognize CHWs as a part of the national PHC workforce.
- iCCM should be clearly costed in the child health strategy and implementation plans and used for resource mobilization.
- iCCM programmes should include training and refresher training in integrated management of childhood and newborn illness and iCCM supervision for ICCM supervisors and district health management teams.
- An iCCM investment case should be developed to support advocacy for funding iCCM.
- Promote integrated supervision support, especially with programmes such as immunization.
- Nominate “champions” for iCCM at all levels; recognize good performance, and sanction poor performance in a human resources policy.
- Empower community health committees, with links to supervisors.
- District health committees should “own” iCCM programmes, follow up supervisory action plans and receive feedback data and results of supervision.
- Community data should be fed into national data systems and used to improve supervision.
- iCCM indicators could be included in a district “league table” or dashboard to promote competition and improve performance.

Quality of care

Attainment of the highest quality of community care requires ensuring competent CHWs through training and mentoring, consistent supplies of tools, diagnostics and medicines and supervision and motivation as part of a functional national health system.

System component enablers:

- A joint approach in which CHWs are linked to a functional, supportive health system.
- High-quality training with a simplified, appropriately designed, effective, comprehensive package.
 - For example, in Niger, quality improvement models and regular coordinated meetings with CHWs are used to review and analyse data to identify gaps and find local solutions to improve the quality of care and to give medicines and cash incentives to CHWs.
- Tools for quality, such as simplified checklists for standard care, digital applications (mobile phones with care algorithms) and peer networks for supportive learning and engagement.
- Links to assisted referral mechanisms in the health system and to community resources during training and engagement of the community.
 - For example, in Burkina Faso, an algorithm is reinforced during supervision and mentoring.
 - In Niger, service data are used regularly to identify gaps and to address them during coordination meetings.
 - Malawi has digital decision-making tools and an emergency transport scheme.
 - In Mozambique, interventions have been used to improve communication between CHWs and referral facilities.

Bottlenecks and challenges

- Poor compliance to standard care protocols, coverage and timeliness, due to lack of knowledge and of a standardised CHW training package.
- Harm to patients and wastage of medicines because of lack of age-appropriate packaging and lack of knowledge.
- Delayed referral of severely sick children because of lack of recognition of serious illness.
- Lack of reliable transport and poor capacity of referral facilities to manage referred cases.
- Gaps in skills for patient-centred care and in assessing patients' experience of care and satisfaction.

Quality of care

Recommendations

- Provide and sustain the competence and skills of CHWs, including interpersonal communication and patient-centred care by inclusion in training packages for CHWs and health facility staff.
- Ensure that CHWs complete a course only when they demonstrate defined competence, and include training follow-up at 6 weeks or a time to be fixed.
- Focus training on adhering to protocols, and establish two-way referral protocols that are enforced and rewarded.
- Establish a formal mechanism to assess patients' experience of care.
- Ensure consistent availability of diagnostic and treatment tools, medicines and commodities that are age appropriate and colour coded, such as for amoxicillin, oral rehydration salts and zinc.
- Consider use of electronic decision-support tools for CHWs to improve adherence to algorithms and feedback on performance.

Monitoring and evaluation and health management information systems

Government-led, harmonized, streamlined monitoring and evaluation systems ensure high-quality information for learning and data for action and accountability for sustained improvement of iCCM programming.

System component enablers:

- Strong national health management information systems.
- Functional district health information system (DHIS2) or similar platform and strong capacity to update it, with support from information technology.
- Data visualisation capacity in electronic health information systems.
- Digitised systems for data collection and reporting and strong coordination and ownership of health management information system by the ministry of health (e.g. in Uganda).
- Systemic, institutionalised feedback throughout the system and to CHW level.
- Global guidance and harmonisation of indicators and data elements and agreement of all stakeholders (e.g. Health Data Collaborative consensus).
- Proper training and continuous follow-up to ensure well-trained, supported CHWs who understand the data they collect and why, with CHW supervisors trained in data management and use.
- A harmonised CHW reporting form for iCCM and the other programmes delivered by CHWs; and “champions” for data use at several levels to encourage a culture of data use (also at district and national levels).

Bottlenecks and challenges

- Parallel systems due to reporting systems imposed by donor reporting requirements, which may not be interoperable, with weak coordination and government leadership and lack of integration of community reporting systems with the national health management information system. In Madagascar, for example, there are three different systems, and iCCM is not integrated into the health information system.
- Incomplete, late data: Data entry is not prioritised, or CHWs have limited capacity, weak supervision and limited use of data. CHWs have a heavy reporting burden and no incentive to report, although feedback can be an incentive. Many complex or poorly designed forms, no digitisation or lack of forms, which can lead to duplication.
- Weak data use and evaluation: Limited understanding of use of data at all levels, and few evaluations conducted because they are expensive, there is limited capacity and there is fear of failure or repercussions.
- No harmonisation or standardisation of data elements and indicators: weak ministry of health leadership, largely donor-driven systems and differences in packages. There is also inconsistent terminology (e.g. “acute respiratory infection” in facilities and “pneumonia” in communities). Flexibility and relevance must be maintained by building consensus, which requires commitments of time and resources.

Monitoring and evaluation and health management information systems

- Lack of data on iCCM from the private-for-profit sector: No regulation of the private sector, which operates outside the system. In countries in which commodities are provided only by an external donor, the private sector procures non-quality-assured and/or non-regulated medicines. No incentives for private providers to submit data and reluctance to report on their services. The sector is often not included in training or invited to be part of the system.

Recommendations

- Global guidance on harmonised, standardised indicators of iCCM within a community health management information system; support harmonised health information systems and ensure that the various components are interoperable.
- Global promotion of a learning culture and data use to improve data quality.
- Foster strong government leadership to build consensus on indicators and data elements with all partners and users, and develop and implement a digital strategy or e-governance policies to reduce fragmentation.
- Emphasise monitoring, evaluation and data quality throughout training and supervision by practising recording after case management, and ensure ease of use, e.g. server, connectivity, partnerships with mobile providers.
- Promote and support data use, data verification at all levels, including communities; harmonise and improve forms to reduce duplicative recording and reporting; introduce incentives for CHWs overall and for good data reporting and use.
- Acknowledge that the private sector provides many services, and include private partners in global dialogue and discussions, with a national private sector strategy, with policies and regulations for certification and data reporting.
- Formalise the informal private sector, and introduce reporting mechanisms. At sub-national level, engage the private sector in standardised training to foster willingness to report data.

Part II.

**Implementation of
“high burden high
impact” and integrated
community case
management to
improve child survival**

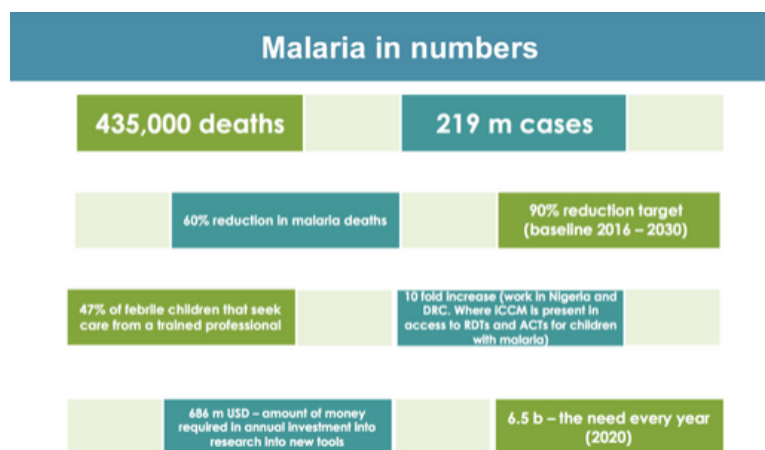
During the second part of the meeting, participants reviewed progress, hindrances and priorities in updating national iCCM implementation plans from recent lessons learnt and the response elements of the HBHI approach to malaria to ensure an impact on mortality of children under 5 in view of the opportunities presented by GF applications and other resource mobilisation.

The principles of the HBHI approach were presented to representatives of malaria and maternal and child health programmes in the 14 African countries at the meeting. Progress made since the launch of the initiative in November 2018 was reviewed and presented, including the results of initial investments in strategic use of information.

HBHI is a holistic approach based on an effective multisectoral response and an effective health system. The four mutually reinforcing response elements result in tangible action to ensure high coverage of evidence-based interventions to reduce mortality and morbidity.

HBHI is guided by the following principles: it is country-owned and country-led, aligned with the WHO Global Technical Strategy for Malaria 2016–2030, the SDGs and national health goals, strategies and priorities. HBHI calls for better-coordinated support from countries and external partners and greater transparency to ensure efficient responses, a commitment from partners to share and analyse data and support for greater mobilisation of domestic and international resources.

Fig. 9. Malaria in numbers

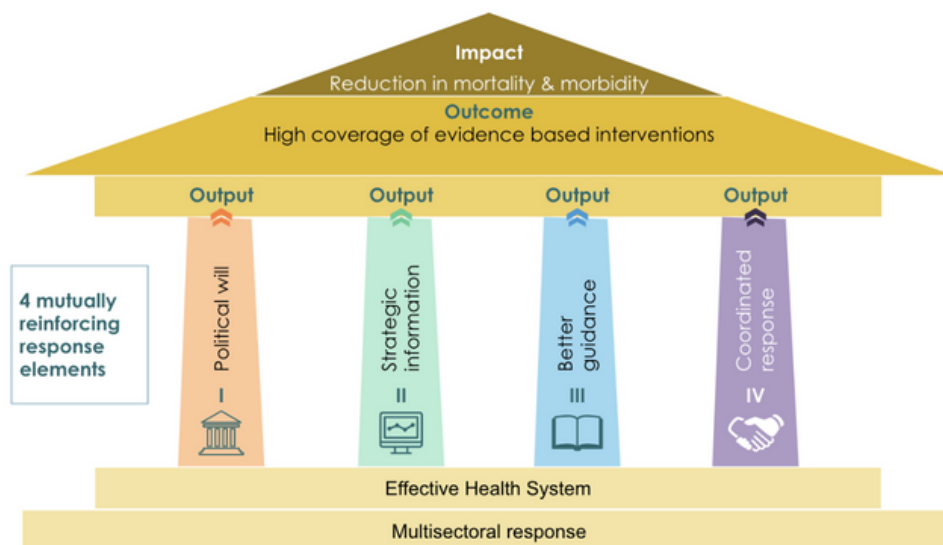


Rationale and response elements of the HBHI approach

The aim of HBHI is to reaffirm commitment and refocus activities, initially in the countries with the highest burden – Burkina Faso, Cameroon, DRC, Ghana, India, Mali, Mozambique, Niger, Nigeria, Uganda and United Republic of Tanzania – to meet the goals of the WHO Global Technical Strategy for Malaria 2016–2030 through four response elements. The burden of malaria represents 70% of global cases and deaths in these countries. The 10 countries with the highest burden reported increased numbers of malaria cases in the previous year, from an estimated 131 000 more cases in Cameroon to 1.3 million additional cases in Nigeria. Only India marked progress in reducing its disease burden, with a 24% decrease since 2016.

The four main response elements in the HBHI are shown in Fig. 10.

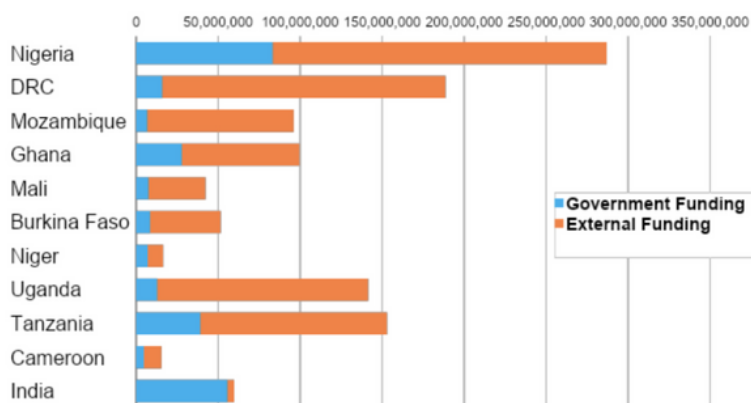
Fig. 10. HBHI elements



1. Political will to reduce malaria deaths

- The approach calls on high-burden countries and global partners to translate their political commitment into resources and tangible actions to save more lives.
- Grassroots initiatives to engage communities, empower people to protect themselves from malaria (e.g. the Zero Malaria Starts with Me campaign) can foster accountability and action.
- The objectives of this pillar are to:
 - empower political structures to ensure political support for malaria and to “leave no one behind”;
 - ensure the accountability of politicians and institutions for commitment and action;
 - translate political will into resources, including funding, by multisectoral resource mobilization;
 - enable active participation of communities in preventing malaria; and
 - ensure more responsive delivery systems that overcome barriers. A major challenge, which was raised consistently during the technical meeting, is turning political commitment into funding (Fig. 11).


Fig. 11. Government and external funding for HBHI in countries




2. Strategic information for impact

With more strategic use of data and information, countries can identify where and how to use the most effective malaria control tools for the greatest impact, rather than a “one size fits all” approach.

Fig. 12. Key areas and objectives of strategic information to ensure an impact of HBHI

Response element II covers 5 key areas 	
Key area / output	Specific objective
a National malaria data repositories: Functioning national malaria data repositories with programme tracking dashboards	<ul style="list-style-type: none"> Centrally assembled and structured existing sub-national geocoded data incl. Demography, administrative data, health system, epidemiology, entomology, efficacy, commodities distribution, intervention coverage, funding (external and domestic), human resources, partnership landscape, documents library, etc.
b Progress review: Country-level malaria situation analysis and review of malaria programs to understand progress and bottlenecks	<ul style="list-style-type: none"> Analysis and review of malaria related data sub-nationally to understand the drivers of progress, the bottlenecks and recommendations for way forward. Note: The analysis should ideally build on the data assembled through the repository, but in some instances may be done in parallel in preparation of the NSP development.
c Analysis of stratification, intervention mixes and prioritization: Data analysis for stratification, optimal intervention mixes and prioritization for NSP development and implementation	<ul style="list-style-type: none"> Analysis of country data to develop sub-national malaria stratification maps and optimum intervention mixes to enhance efficient targeting of resources Revision and costing of the NSP, among other considerations, based on stratification maps and intervention mixes
d Sub-national operational plans: Sub-national operational plans linked to sub-national health plans	<ul style="list-style-type: none"> Sub-national operational plans based on the agreed reprioritization and M&E framework for implementation
e Monitoring and evaluation: Ongoing national and sub-national monitoring and evaluation of programmatic activities (incl. data systems) and impact	<ul style="list-style-type: none"> Adequate NMCP Surveillance, Monitoring and Evaluation Staff High quality malaria-related data Adequate SM&E processes incl. a fully functioning SM&E and operational research TWG

Global Malaria Programme 

The objectives of this pillar are to achieve:

- functioning national malaria data repositories, with programme tracking dashboards;
- analysis of the national malaria situation, review of malaria programmes and research to understand progress and hindrances;
- data analysis for stratification, appropriate combinations of interventions and prioritisation for a national strategic plan and health sector planning and implementation;
- identification of optimal means of delivery;
- sub-national operational plans linked to health plans; and
- continuous sub-national monitoring and evaluation of programme activities (including data systems) and research on impact and implementation.

3. Better guidance, policies and strategies

WHO will use the best evidence to update their global malaria guidelines and ensure that they can easily be adapted by countries to improve their uptake. This will ensure that they are “living documents” and reflect country experience and new tools. High-burden countries will be supported in adapting and adopting the global guidelines according to local settings. They will also be supported in preparing guidance on implementation to ensure uptake and scaling-up of policy.

The objectives of this pillar are to achieve:

- continually updated global guidelines based on the best available evidence, and inclusion of country needs, allowing space for innovation;
- better dissemination and uptake of global policies by adoption and adaptation in countries, including combinations of interventions and priorities;
- guidance for effective, optimal national policies;
- use also at sub-national level; and
- better tracking of policy uptake by countries.

4. A coordinated national malaria response

A key to success is a coordinated health sector response, complemented by other sectors, such as environment, education and agriculture. Alignment of partners with this country-led approach will ensure that scarce resources are used as efficiently as possible.

- clear overview of relevant stakeholders and partners in the country and their financial and technical contributions;
- clear overview of the processes that require coordination and the roles, responsibilities and timelines;
- dedicated structures to ensure systematic coordination; and
- alignment of partner support and funding with a costed national strategic plan and health sector priorities.

To improve reviews of progress, a practical manual for a mid-term review of malaria programmes and strategic plans is available for analysing the following elements at sub-national level:

- expenditure on health and malaria, with a focus on access to care;
- distribution, coverage and use of malaria interventions;
- other determinants of progress in reducing malaria morbidity and deaths of children under 5 from all causes; trends in parasite prevalence, malaria incidence, number of malaria inpatients and deaths of children under 5 from all causes; impact of interventions; and
- challenges and hindrances.

Recommendations for progress in achieving the HBHI response elements

Country teams discussed progress and made recommendations for government and country teams to advance iCCM in each of the HBHI response elements (Annex I).

Conclusions

In part 2 of the meeting, participants concluded that the four response elements of the HBHI approach are relevant for malaria, child health and broader sectoral planning and implementation.

Progress towards SDG target 3.8 on UHC and towards target 3.3 on communicable diseases will require countries to ensure that all people and communities have access to high-quality, safe, acceptable health services.

The definition of UHC implies that more people, especially the poorest and most vulnerable, receive a correct diagnosis and the interventions they need.

The malaria targets can be achieved by improving the capacity of the health system to design and deliver interventions equitably and by addressing the broader social, political, economic and ecological determinants of health.

Delivery of services will depend on countries' health and demography and factors such as health-seeking behaviour, the accessibility and functioning of public health infrastructure, the availability of a private retail sector and community cadres. Governments, as the stewards of health systems, should ensure that services are financially viable, suitable for their context and meet the needs of the population, especially those left furthest behind, by reaching those with the poorest access to effective health interventions and the greatest financial hardship. PHC, which comprises multisectoral policy and action, empowering people and communities and putting primary care and essential public health functions at the core of integrated health services, is the most equitable, efficient, cost-effective, sustainable platform for delivering services for malaria and other health priorities.

At the end of the meeting, countries and partners committed themselves to advance institutionalization of iCCM within PHC and strengthen community health systems by close collaboration among all relevant government programmes and partners for child health, malaria and community health. The upcoming GF process in countries will be an opportunity to continue the discussion, build on lessons learnt and advance iCCM to reach the most vulnerable children with essential curative care.

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Annex I

**Summary tables with
recommendations of
HBHI countries for
scaling up iCCM**

Burkina Faso

Context/status				Recommendations	
Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
<p>Annual statement on community health</p> <p>CHW motivation integrated in local authority budgets</p> <p>Creation of a local development fund</p> <p>National community health forum and general states</p> <p>Quantification of oral rehydration salts, zinc and amoxicillin by quantification committee for artemisinin-based combination therapy and other inputs</p>	<p>Scaling-up mHealth (benefits and inputs)</p> <p>Dashboards developed at all levels</p> <p>Assessment of workload of Community Behaviour Change workers</p> <p>Evaluation of impact</p>	<p>Revise the profile of the Community Behaviour Change workers</p> <p>Guide to orient local communities on of CHW package</p> <p>Plan for passage to budgeted scale</p> <p>Workshop to disseminate strategic plan</p>	<p>Revitalize regional committees</p> <p>Contracts between CHWs and communities</p>	<p>Oral rehydration salts, zinc and amoxicillin integrated in quantification and monitoring committee for artemisinin-based combination therapy and inputs from other programmes</p> <p>Prepare a budgeted scaling-up plan</p>	<p>Financial accompaniment</p> <p>Alignment of partners with national plans</p> <p>Make tools, documents and recommendations available to countries in a synchronized way in French and English</p> <p>Resource mobilization</p>

Cameroon

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Prioritize areas with high child mortality</p> <p>Write a letter to a senior authority to advocate for public commitment to reducing national child mortality</p> <p>Identify champions at all levels</p> <p>Develop an advocacy strategy with an action plan</p> <p>Organize an event to increase political interest in child health, and launch a national communication campaign</p> <p>Integrated approach for child health and malaria:</p> <p>Map partners and resources for child health</p> <p>Develop an investment record on community based interventions (ISDC)</p> <p>Develop the ISDC national strategic plan</p> <p>Invest in service delivery, including iCCM (human resources, commodities and operations):</p> <p>Develop ISDC training curricula</p>	<p>Surveillance of iCCM, tracking progress, outcome and impact:</p> <p>Evaluate community health activities</p> <p>Strengthen system for collecting, analysing and transmitting community data.</p> <p>Integrate community data into DHIS2</p> <p>Use of routine health facility and community data on disease trends and commodity tracking:</p> <p>Set up data warehouse on iCCM</p> <p>Provide incentives collecting high-quality data on the DHIS2 platform by health district</p> <p>Strengthen ability of data focal points to analyse data on the DHIS2 platform</p> <p>Organize data validation workshops at all levels</p> <p>Audit data quality</p> <p>Set up a data analysis platform on iCCM</p> <p>Other sources of data:</p> <p>Create an</p>	<p>Policy issues (existence and use):</p> <p>Elaborate standard operating procedures for process safety management, including cost recovery and ordering of amoxicillin, oral rehydration salts and zinc</p> <p>Define supply chain management system for all levels</p> <p>Lengthen training duration from 10 days and include practical sessions</p> <p>Integration into national health sector development plan:</p> <p>Include ISDC on agenda of the thematic group on child health</p> <p>Operationalize working groups on regional investment</p> <p>Criteria for iCCM prioritization and operationalization</p> <p>Update criteria for prioritization of areas for iCCM ifrom data repository</p> <p>Policy dissemination and use</p>	<p>Leadership and management:</p> <p>Add iCCM to the agenda of joint steering and advocacy monitoring committees for resource mobilization and engagement of stakeholders in partner sectors</p> <p>Joint planning to accelerate reduction of child mortality (human resources, finance, supply chain management, community and health facility referral)</p> <p>Resource allocation for ISDC optimized through GFF investment case</p> <p>Strengthen communication and collaboration among all stakeholders (committees, coordination meetings, circular letters, social media)</p> <p>Improve management of CHW antimalarial activities</p> <p>Alignment of partners</p> <p>Dissemination of national policy to partners</p> <p>Improve</p>	<p>Provide technical assistance to update guidelines, standards and operational standards, conduct reviews and set up data repository</p> <p>Prepare a memorandum for technical and financial partners to support advocacy, with WHO standards documents</p> <p>Generate evidence by HBHI integration and the iCCM approach in four pilot districts</p> <p>Improve operational coordination and alignment of partners</p>	<p>Advocate for an accountability framework at all levels</p>
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<p>for basic human resources</p> <p>Training Institutionalize CHWs and their status Implement actions in the human resources development plan Update CHW mapping</p> <p>Community engagement Approach all structures that collaborate with town halls (e.g. Association of Communes and United Cities of Cameroon), and involve them Form community opinion leaders, heads of households according to sociocultural context Strengthen accountability of political and administrative authorities</p>	<p>implementation research plan to fill information gaps (logistics management information system)</p> <p>Microstratification to target interventions, including iCCM: Conduct national stratification to target iCCM interventions with DHIS2 and multiple indicator cluster surveys</p>	<p>Training, supervision and mentoring for iCCM in health facilities and communities Improve dissemination and uptake of global policies through websites, policy documents and during meetings</p>	<p>operational coordination of partners</p>		
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Chad	
Context/status	Recommendations

Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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Community health strategy 2015–2018 proposed pilot iCCM implementation. UNICEF and Switzerland are supporting a mentoring initiative for iCCM in two districts (Gore and Bessao) for 12 months (ongoing).	The outcomes of the iCCM pilot project will be used to update the national community health strategy. Home management in two regions (Moyen Chari and Mandoul) also at pilot stage. Child-friendly community initiative is promoting community participation and engagement. Suboptimal routine health management information system, lack of logistics management information system. Data collection in project in a parallel system			Evaluation and lessons learnt from pilot project will be used to update community health strategy for next 3 years, including criteria for scaling up community curative services. Establish community health technical working group for planning, resource mobilization, dissemination, implementation, monitoring and evaluation. Strengthen capacity of Ministry of Health to manage and implement the PHC, including community health programmes.	
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DRC

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Analyse gaps in integrated management of severe childhood diseases and maternal health</p> <p>Develop an investment framework to demonstrate gain of investing in child and maternal health</p> <p>Prepare attractive messages from analysis and investment framework to attract political commitment</p> <p>Identify channels and champions to convey messages</p>	<p>Complement community information in DHIS2 with a module for other aspects of child health</p> <p>Improve completeness and quality of community data in DHIS 2.</p> <p>Micro-stratification to determine types of intervention by stratum</p> <p>Strengthen capacity in data analysis at all levels</p> <p>Strengthen operational research to obtain reliable data for decision-making</p>		<p>Improve availability of means for fighting childhood diseases</p> <p>Abolish taxes on means for fighting childhood diseases</p> <p>Promote local producers of means to combat malaria and diarrhoea</p> <p>Establish compensation and retention mechanisms for community workers</p>	<p>Revitalize thematic groups and give them resources to function at all levels</p> <p>Extend private sector thematic group to combat childhood diseases</p> <p>Develop and finance plan for disseminating policies and strategies</p> <p>Establish early warning of risks of disruptions and emergency supply</p> <p>Exempt means for fighting childhood diseases from taxes</p> <p>Institutionalize community relays in the health system</p> <p>Plan compensation for community relays in local and provincial budgets</p> <p>Set up context-specific transport for referral of cases from communities to health centres</p> <p>Support the fight against malaria by allocating counterpart funds according to expected results</p> <p>Establish a national or</p>	<p>Local partners: Work in a consortium to gain political commitment at all levels</p> <p>Organize a joint advocacy mission to the Presidency of the Republic to obtain its commitment</p> <p>Provide technical support to thematic groups</p> <p>Align with the country's policies</p> <p>Strengthen interchangeability of inputs among partners</p> <p>Support government in building capacity for data analysis</p> <p>Support operational research</p> <p>To global partners: Help countries to contextualize guidelines to fight childhood diseases according to realities in the field</p>
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				provincial council for the fight against infant mortality attached to the Presidency of the Republic Revitalize and institutionalize the network of national and provincial parliamentarians for the fight against malaria in the sociocultural commission	
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Ethiopia

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Health extension platform and good political will</p> <p>Plan for optimization of health extension package in preparation</p> <p>Good integration at all levels, particularly health facilities, districts, procurement and supply management, training, planning</p> <p>Prioritization of interventions based on data: prevalence of childhood illnesses e.g. pneumonia, guide for interventions.</p> <p>Concern about sustainable financing for ICCM and ICCM commodities</p> <p>Health extension worker attrition is challenge (expected to be addressed by optimization of package, carrier development)</p> <p>ICCM uptake to be improved through innovative demand creation strategy</p> <p>ICCM training included in</p>	<p>DHIS2 addresses all ICCM components: 95% coverage at health centres</p> <p>Data lost in transition from health management information system to DHIS-2. Retrospective data required.</p> <p>Logistics management information system required for programme managers to quantify stocks in health facilities</p> <p>Microstratification done in health facilities (by morbidity, admission and mortality)</p> <p>Analysis, data use, capacity-building required in districts</p> <p>Implementation research on newborns and young children (enhanced pneumonia diagnosis, serious bacterial infection, Kangaroo mother care, assessment of health extension</p>	<p>Coordination strengthened among directorates in Ministry of Health for maternal, newborn and child health, health extension package, PHC, malaria, disease prevention and control</p> <p>Blanket coverage of ICCM enhanced by community-based newborn care programme</p> <p>Commodity distribution based on consumption and burden. Prioritization for hard-to-reach and high-burden communities requires further analysis and validation.</p> <p>Improvement required for estimation of childhood illness burden (pneumonia, diarrhoea) for drug quantification</p> <p>Lack of incident data on childhood illnesses</p> <p>Health extension workers follow the guidelines well.</p>	<p>Strong Government leadership</p> <p>Joint planning to reduce child mortality</p> <p>Delayed procurement and lack of local production of essential drugs</p> <p>Bottom-up planning</p> <p>Community engagement should be strengthened</p> <p>Good partner alignment</p> <p>More partners required</p>	<p>Coordination among Ministry of Health directorates should be strengthened.</p> <p>Capacity-building in data use and analysis in districts</p> <p>Procurement lead time should be reduced by early planning, simplified bureaucracy, local production of essential drugs</p> <p>Increased partner involvement in technical support and documentation</p> <p>ICCM financing from donors, and increase domestic financing for child health</p> <p>Finalize optimization of health extension package strategy</p> <p>Strengthen PHC linkages</p> <p>Improve ICCM uptake by innovative demand creation strategy and community engagement</p> <p>Improve ICCM quality by quality improvement</p>	
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curriculum and preservice Health extension package to be adapted for pastoral communities	package, ARIDA)			initiative (mHealth, e-community health information system, innovation, mentorship and coaching)	
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Ghana	
Context/status	Recommendations

Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Strong, top-down mandate required for ICCM as a national priority (i.e. from President) to activate stakeholders to support the national child health policy</p> <p>The First Lady to act as a champion for child health to raise awareness of child mortality</p>	<p>National malaria programme to make clear proposal for use of 0.5% of District Assembly Common Fund malaria allocation; presently decided by Director of Public Health (and Director of Family Health; approval by Director-General; engage Director of Policy, Planning, Monitoring and Evaluation; go to districts</p>	<p>Encourage local manufacture of essential iCCM commodities (links to National Health Insurance scheme)</p>	<p>Place local government at the centre</p> <p>Local government partnership for health: district assemblies to support Community-based Health Planning and Services by a 0.5% allocation to malaria, and establish accountability mechanism</p> <p>Additional funds (e.g. 2% Disability Common Fund) could be leveraged to support ICCM</p> <p>Policy translation and guidance: Definition and understanding of iCCM and its relation to Community-based Health Planning and Services must be consistent at national, regional, district and, critically, community levels</p>		<p>Collaboration: WHO and UNICEF should bring partners (GFF, KOICA, JICA, the US Agency for International Development, GF, nongovernmental organizations, etc) together to establish a clear funding plan for Community-based Health Planning and Services (which must include iCCM) to determine what they will fund in iCCM, where, how the funds will be moved and used and how to scale up</p> <p>Recommendation to WHO and donors: lead by example and as an integrated organization for e.g. malaria, child health and PHC</p> <p>Recommendation to GF: review objection to funding non-malaria iCCM commodities</p>
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Mali	
Context/status	Recommendations

Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Ten-year health and social development plan (2014–2023); Free health reform with technical commission</p> <p>Integrated approach to child care (clinical and community levels (ICCM)</p> <p>Strategic plans: Health communication; <i>palu</i></p> <p>Master plan for supply and distribution of medicines and national list of essential medicines.</p> <p>Community engaged health communication</p>	<p>Weekly analysis presented to council of ministers (<i>palu</i>) and corrective action taken</p> <p>DHIS2 stratified to community level</p> <p>Mapping of essential community care</p>	<p>Guides available</p> <p>Dissemination of documents to operational level</p>	<p>Leadership of Health Directorate through health facilities, regulation and community health</p> <p>Technical committee (Ministry of Health and executives of technical and financial partners).</p> <p>Steering committee: Secretary-General Ministry of Health and Social Affairs, central structures, civil society, nongovernmental organizations municipalities, national federation of community health association and technical and financial partners.</p>	<p>Recommendations for Ministry of Health, Government and partners: Improve reporting system: data collection and correct use of health software</p> <p>State commitment to remuneration of CHWs</p> <p>Advocacy to mobile operators for full Internet coverage</p> <p>Organize supervision of agents trained in DHIS2 software</p> <p>Use all possible channels (e.g. meetings) to disseminate documents</p> <p>Seize other opportunities to hold coordination meetings</p> <p>Map stakeholders at all levels</p>	<p>Partners must:</p> <p>Comply with the country's alignment policy. Provide the required support</p>
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Mozambique

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>High child mortality from malaria, diarrhoea, pneumonia, HIV infection, malnutrition. Newborn health prioritized</p> <p>Integrated management of childhood and newborn illness in all health facilities Child health facilities deliver preventive and curative services for malaria.</p> <p>Government investment in human resources and commodities for PHC; however, iCCM mainly donor dependent</p> <p>Community engagement part of health promotion strategy policy, with two approach: engagement to improve PHC services at health facilities and engagement to improve community health. Not sufficiently autonomous and rarely addresses all local problems.</p>	<p>Progress in routine iCCM data collected and used in the health system. Still difficulty in collecting health facility data on pneumonia. Maternal and child health department should incorporate data in the health management information system.</p> <p>Population-based surveys conducted to assess outcomes and impacts</p> <p>Data used to track disease trends and malaria commodities. No tracking for diarrhoea and pneumonia.</p> <p>Surveys and research: health facility survey</p> <p>No micro-stratification at district level. Macro-stratification only for malaria</p>	<p>Guidance on mainstreaming iCCM into CHW policy</p> <p>Integrated into the health policy and national strategic plan</p> <p>iCCM prioritized in areas 8–25 km from health facilities</p> <p>CHW policy disseminated. Prioritization of iCCM should be clarified.</p>	<p>Public health department leads and coordinates PHC intervention at all levels</p> <p>Joint planning at all levels at annual planning meeting</p> <p>Challenges: Human resource planning not linked to service delivery Financing secured through GF, reproductive, maternal, newborn and child health investment case and GFF CHW are not part of health system or public sector payroll Stock-outs of commodities Referral system lacks transport system, tracking of arrivals at health facility, capacity of health facility to manage cases Resources for supervision (human resource, transport, fuel) Partners are aligned with Government.</p>	<p>Finalize policy review for CHWs</p> <p>Ensure data on pneumonia are in health management information system to improve quantification of commodities</p> <p>Optimize iCCM medicines kit to avoid stock-outs</p> <p>Support community committees in improving referral system</p>	<p>Ensure financial support to iCCM to fill all implementation gaps</p> <p>Support resource mobilization to make iCCM a priority in national investments</p> <p>Share experiences of what works and tools</p> <p>Technical assistance to improve procurement and logistics</p>
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Niger

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Insufficient identification of areas with high infant mortality</p> <p>Areas that are difficult to access</p> <p>National strategic plan for community health aligned with health development plan:</p> <p>Integrated package based on child survival plans, ICCM</p> <p>Free care</p> <p>Financial motivation of 10 000 FCFA per month; 50% State and 50% Presidential Task Force</p> <p>Recognition of "relais communautaires" by decree</p> <p>National Strategic Supply Plan: State, Ministry of Finance, UNICEF, PMI, World Bank)</p> <p>Community participation in health committees. Seasonal malaria chemoprevention</p> <p>Relais</p>	<p>Supervision of relais communautaires at all levels</p> <p>Collection and supervision tools</p> <p>Coordination meeting</p> <p>Studies on quality of care</p> <p>Evaluation of impact: 38% reduction in mortality of children under 5 years in RaCE project areas</p> <p>Integration of community epidemiological data into DHSI2</p> <p>Last Demographic and Health Survey in 2012</p> <p>Partial mapping of relais communautaires</p>	<p>National Strategy for Community-based Integrated Health Interventions (2012)</p> <p>National Malaria Control Policy</p> <p>National Community Engagement Strategy</p> <p>iCCM Strategy Scaling Plan (2017–2021)</p> <p>Orientation and Reference Guide on Community Development Relay (2017)</p> <p>National strategic plan for community health being validated</p> <p>ICCM prioritization criteria in national strategic plan for community health</p> <p>National dissemination</p>	<p>Directorships of Organization of Care and of Maternal and Child Health</p> <p>National multisectoral committee for community-based interventions</p> <p>Decentralized health committees</p> <p>Framework for consultation of health sector technical and financial partners on malaria strategic plan at all levels</p> <p>Involvement of technical and financial partners in development of national strategic plan for community health</p> <p>Planning a resource mobilization roundtable</p>	<p>Identify areas with high infant mortality rates</p> <p>Identify areas of difficult access</p> <p>Include HBHI and ICCM in operational plan of the national strategic plan for community health</p> <p>Validate and disseminate national strategic plan for community health</p> <p>Mechanism to motivate relais communautaires</p> <p>Revitalize village health committees</p> <p>Accelerate integration of epidemiological data and community input into DHSI2</p> <p>Strengthen advocacy for HBHI and ICCM funding to Parliament</p> <p>Conduct household surveys</p> <p>Continue mapping relais communautaires</p> <p>Strengthen coordination and alignment of</p>	
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<p>communautaires</p> <p>Institutionalize relais communautaires in communities</p> <p>Provide informal help to relais communautaires</p>				<p>ICCM partners</p> <p>Ensure effective State share of financing motivation of relais communautaires</p> <p>Support organization of the resource mobilization roundtable</p> <p>Support realization of microstratification of ICCM interventions Support completion of household surveys</p>	
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Nigeria

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>iCCM should be an extension of PHC—Ministry of Health iCCM Task Force on Malaria and Reproductive, Maternal, Newborn, Child, Adolescent Health</p> <p>Increase advocacy to State Government for ownership and prioritization of PHC package of interventions including iCCM (Ministry of Health/National Primary Health Care Development)</p> <p>Government to create budget line to ensure consistent iCCM commodities (procurement, distribution and capacity-building)</p> <p>Validate tax on antimalarial and Amoxicillin dispersible tablets: Federal Government</p> <p>Engage private sector for distribution: Ministry of Health, National Primary Health Care Development</p> <p>External technical</p>	<p>Operationalize community health management information system (DHIS2)</p> <p>Scale up community health management information system</p> <p>Use data for planning and decision-making in PHC and community health</p> <p>Identifying areas of need (human resources, access)</p> <p>Prioritize interventions</p> <p>Forecast and quantify commodities</p> <p>External technical assistance required</p>	<p>Policy</p> <p>Better understanding of Community Health Improvement Plan for delivering community health services, including iCCM: Ministry of Health, National Primary Health Care Development</p> <p>State governments to align with the national essential medicines list: Ministry of Health, Food and Drug Services</p> <p>Dissemination and use of policy</p> <p>Disseminate and promote use of national guidelines and tools for iCCM at all levels: Ministry of Health</p>	<p>Community service delivery</p> <p>Draw up costed operational plan for reproductive, maternal, newborn and child health at PHC level: State ministries of health, primary health care development agencies and partners</p> <p>Effective coordination and partnership at all levels (national, state and local government areas)</p> <p>Technical working groups and committees to be functional at all levels</p> <p>Strengthen state and local government leaders' understanding of the concept of iCCM</p> <p>Identify champions at all levels to promote iCCM</p> <p>Regular demands for periodic reports on action plans by higher authorities</p> <p>Mapping of</p>		<p>Work with the country in use of the HBHI approach in child health interventions</p>
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<p>assistance required</p> <p>Investment in service delivery</p> <p>Develop investment case for iCCM (mapping and needs assessment):</p> <p>Ministry of Health, National Primary Health Care Development</p> <p>External technical assistance required</p>			<p>partners in implementing iCCM : subnational to national</p>		
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Sierra Leone

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>President committed to reduce maternal, infant and child mortality and to deliver health care at community level</p> <p>Translation of political will: Free health care initiative Bi-partisan political support Increasing Government contribution: 10% in 2018, 30% in 2019, 50% for 2020</p> <p>Priority evidenced by Government budget line for community health programmes in national health budget</p> <p>Creation of National Medicines Supply Agency as an Act of Parliament</p>	<p>Strong collaboration and reporting: Integration of community health information system into DHIS2</p> <p>Analysis of data: Good analysis of data at central and district levels with access to DHIS2</p> <p>Review of data from district health management team</p> <p>Peripheral health unit in charge of monthly meetings</p> <p>CHW monthly meeting with peripheral health unit</p> <p>Pilot study of digitization of community health data in one district</p> <p>Integration of formal private sector data (limited) into DHIS2</p> <p>Ministry has prioritized integration of DHIS2 and logistics management information system to reduce</p>	<p>Policies coherent and interlinked:</p> <p>National Medium-term Development Plan (2019–2023) National Health Policy National Strategic Plan Reproductive, Maternal, Newborn and Child Health Plan Malaria Control Strategic Plan (2016–2020) National CHW Policy and Strategy (2016–2020) PHC Operational Handbook</p> <p>Strategies are costed</p> <p>Strengthen data use at lower levels</p>	<p>Strong links within and among central and district directorates and programmes</p> <p>Permanent CHW hub within Directorate of Primary Health Care</p> <p>Also at district level with dedicated iCCM/CHW focal points</p> <p>Steering committee at leadership level</p> <p>Discussions and assessments to improve joint planning for various community health activities (CHW hub, HIV infection, tuberculosis, malaria), linked to One Budget, One Plan, One M&E Framework</p> <p>Development Coordination Framework established</p>	<p>Government to absorb CHWs into health workforce</p> <p>All national malaria programmes to ensure inclusion of elimination objectives in national malaria strategic plans</p> <p>Extension of resources and technical support from HBHI to countries outside the HBHI list, especially those that have begun similar processes</p> <p>Technical support with microstratification for optimal targeting of resources</p> <p>Strengthening of regular supervision in peripheral health units and communities (cascade supervision)</p> <p>Government stewardship of digitalization of community health information system and health facility data, with linkage to DHIS2; including</p>	<p>Support strengthening of and alignment with national health information system, including community health information system</p> <p>Recommend better coordination of partners within CHW programme and at directorate level</p>
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	duplication			roadmap Recommend support for consolidation and scaling up of best practices at CHW monthly meetings Strengthen data use at lower levels Ensure alignment of National Health Policy Plan (10 years) with National Medium-term Development Plan Pending revision of many policies with most recent evidence Call for ministries of health to emphasize dissemination and popularization of policies Strengthen guidance and policy for effective referral down to CHW level Support to countries for alignment of global with national policies, with emphasis on operationalization Recommendation for integration of IMCI and iCCM focal points in districts to support overall systems strengthening Policy required to address referral system holistically (from community level) Link Development Cooperation	
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				Framework with service agreements to pool resources	
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Uganda

Context/status	Recommendations
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Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
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<p>Political advocacy strengthened:</p> <p>To improve rationalization of resource allocation and use to equitably target high-burden areas (child morbidity and mortality)</p> <p>Translate political commitment into action</p> <p>Incentives to attract human resources for hard-to-reach, high-burden areas</p> <p>Include CHWs in national health workforce, with appropriate remuneration by the Government</p> <p>Increase domestic resources for iCCM commodities</p> <p>Update the malaria bill to include HBHI and mass action against malaria, and fast track its approval by Parliament to include a malaria fund</p> <p>Use of domestic resources for training, supervision, monitoring and evaluation of iCCM programme</p>	<p>Finalize the malaria data repository</p> <p>Other data should be considered e.g. mortality data from routine systems, functional and geographical access to services, nutrition status, household poverty, refugee and other exclusion factors</p> <p>Disaggregated community data fed into DHIS2 for planning, decision-making and advocacy</p> <p>Data use for evidence-based planning, monitoring and advocacy</p> <p>Regularly update micro-stratification</p> <p>Build capacity for data analysis and use at all levels</p> <p>Review and planning meetings in districts to translate data into action</p> <p>Package information on HBHI and mass action against malaria for advocacy at all levels</p>	<p>Finalize and disseminate community health strategy and framework</p> <p>Align community health strategy and framework with existing health policies and strategies</p> <p>Disseminate policy to every stakeholder to inform decision-making</p> <p>Develop an investment case for ICCM, HBHI and mass action against malaria to plan resource mobilization in line with the health financing strategy</p>	<p>Strengthen coordination, with clear leadership of iCCM in Ministry of Health and districts</p> <p>Incentives to attract human resources to hard-to-reach, high-burden areas</p> <p>Include CHWs in the national health workforce, and Government to remunerate them appropriately</p>	<p>Ministry of Health to:</p> <p>Include CHWs in the national health workforce and remunerate them</p> <p>Provide clear guidance on leadership and coordination of community health programme</p> <p>Secure uninterrupted supply of iCCM commodities</p> <p>Develop iCCM investment case</p> <p>Define Ministry of Health priorities in community health and malaria clearly</p> <p>Office of the Prime Minister to coordinate the multisectoral response to community health</p> <p>Ministry of Finance to allocate more resources to the health sector according to the investment case</p>	<p>Partners to align their support to Ministry of Health priorities and strategies</p> <p>GF to consider funding non-malaria commodities for iCCM</p> <p>GFF to increase resources for national scaling up of iCCM programme</p> <p>The World Bank and GF to increase funding for health systems strengthening, e.g. procurement and supply management, community health systems.</p> <p>United Nations partners to support countries in preparing investment cases for iCCM</p> <p>Joint missions by global partners to countries to advocate for institutionalization of iCCM and increase domestic resources</p> <p>Regional support for malaria programme review</p> <p>Support for the Malaria Elimination Strategic Plan, to include HBI and</p>
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<p>Uganda Parliamentary Forum on Media to engage communities in mass action against malaria and the 22 key family care practices at all levels</p> <p>Religious, cultural and private sector and other sectors to engage in mass action against malaria at community level</p>	<p>Monitoring framework for HBHI to be linked to Reproductive, Maternal, Newborn, Child, Adolescent Health monitoring framework (including process monitoring)</p>				<p>mass action against malaria</p>
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United Republic of Tanzania

Context/status		Recommendations			
Pillar 1. Political will	Pillar 2. Strategic use of information	Pillar 3. Better guidance	Pillar 4. Leadership and coordination	Ministry of health, government	Partners
<p>Finalize the new CHW model for national scaling up</p> <p>Define the package of CHW services, including preventive, promotive and basic curative services.</p> <p>Review policy documents and Implementation guides to align with the new CHW model.</p>	<p>Strengthen newborn and child health technical working sub-groups and the National Technical Advisory Group for coordination of community-based health programmes, including iCCM.</p>	<p>Prioritize villages with no health facilitators and hard-to-reach, remote areas for community health services.</p>	<p>Develop tools for collecting community data, and align with DHIS 2 platform.</p>	<p>Operationalize existing CHWs in line with newly recommended national CHW model with regard to selection, training, service package, supervision and incentives</p> <p>Strengthen community structures (village health carer, village social security, health facility governing board, village executive officer) to support recommended national CHW model.</p> <p>Align community data collection with national health information measurement system and DHIS2 to obtain data on community health and commodities.</p> <p>Link community data on commodities to e-logistics management information systems to track child health commodities.</p>	<p>Ensure integrated support for strategic information, coordination and commodity supplies, building on existing country systems and priorities.</p> <p>Support strengthening of PHC facilities to meet increasing needs of community health systems.</p> <p>Support resource mobilization to fill gaps in funding for child health services such as non-malaria commodities.</p>

Annex II

Agenda

Institutionalising integrated community case management (iCCM) to end preventable child deaths

A technical consultation and country action planning

22-26 July 2019, Elilly International Hotel, Addis Ababa

Agenda

MEETING OBJECTIVES

The objectives of this meeting are to:

1. Review the recent learnings related to implementation of primary health care at community level including integrated community case management of childhood illness with quality and in a sustainable manner, as well as new guidelines on community health workers;
2. Refine guiding principles and develop recommendations for embedding iCCM within community health systems as core to Primary Health Care system.
3. Identify needs and gaps around sustainable financing of iCCM.
4. Review progress, key bottlenecks and priorities to update national iCCM implementation plans in the context of recent learning to guide the High Burden to High Impact response and broader child health programming, as well as Global Fund applications and other resource mobilization efforts.

EXPECTED OUTCOME

1. A set of recommendations for institutionalizing iCCM within the broader community health systems and countries' child health policies and programmes;
2. Draft updated national iCCM implementation plans, including plans for domestic and external financing for PHC at community level

PART I: TECHNICAL MEETING

Monday, 22 July 2019		
8.30–9.00	Registration	
9:00-9:30	Welcome and opening	WR Ethiopia, UNICEF Representative Minister of Health or delegate,
9.30-9.40	Security briefing	WHO Ethiopia
9:40-10.00	Objectives of the meeting and agenda Day 1 – 3	S. Sadruddin
10.00–11.00	Session 1: Child Health Programming the era of the SDGs, PHC and UHC Chair (Day 1): Fred Binka and David Hamer	
10.00-10.20	Child Health and Survival in the SDG era	Wilson Were, WHO
10.20-10.40	Primary Health Care at community level to achieve UHC	Maureen Kerubo Adudans and Rory Nefdt, UNICEF

10.40-11.00	Discussion	
11.00-11.30	Tea/Coffee (Photo?)	
11.30-13.00	Session 2: Lessons learned from scaling up iCCM	
11.30-12.00	Global Fund iCCM Thematic Review of 18 countries <i>Objective: Share key opportunities and challenges</i>	Estifanos Shargie
12.00-12.30	WHO Rapid Access Expansion Programme <i>Objective: Share lessons learned and key challenges from the multi-country iCCM programme</i>	Salim Sadruddin
12.40-13:00	Q&A	
13.00-14.00	Lunch	
14.00 – 15.30	Session 3: Country experiences from scaling up iCCM within community health systems	
14.00 - 14.15	Malawi	MOH
14.15 - 14.30	Ethiopia	MoH
14.30 – 14.45	Nigeria	MoH
14.45-15.00	Q&A	Facilitator (WHO)
15.00-15.15	Niger	MoH
15.15-15.30	Uganda	MoH
15.30-15.45	Q&A	Facilitator (UNICEF)
16.00 – 16.30	Tea/Coffee	
16.30 -17.30	Session 4: Engaging Communities	
16.30-16.50	<i>WHO Community Engagement Framework and experience from Rwanda</i>	Asiya Odugleh-Kolev
16.50-17.30	Moderated panel discussion: The ‘How’ of Community Engagement and empowerment in iCCM	Moderator: Aline Simen Kapeu Panel - DRC - Cameroon - Mali - Angola
16.30 - 17.45	Closing of the day	Rory Nefdt
17.45-18.15	Facilitator’s meeting	WHO/UNICEF/Chair
18.30 – 20.00	Reception	

Tuesday, 23 July 2019

9.00 – 9.15	- Recap of day one - Objectives of the day	Flavia Mpanga
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9.15-11.00	Session 5: Community Based Services – Guidance on Program Planning and Service Delivery Chair (Day 2) : James Tibenderana & Nnenna Ogbulafor	
9.15-9.45	WHO guideline on health policy and system support to optimize community health worker programmes Q&A	Catherine Kane
9.45-10.00		Moderator
10.00-10.30	Introduction to Planning Handbook for Program Managers and Planners	Samira Aboubaker
10.30 – 10.45	Q&A	
10.45 – 11.05	Tea/Coffee	
11.05 – 12.00	Session 6: Financing iCCM	Moderator: Valentina Buj
11.05– 11.45	1. Brief introductory talk by moderator 2. Estifanos Shargie (5 min) Financing aspects from Global Fund iCCM Thematic Review 2. Panel [5 min each]: lessons learned, key considerations moving ahead	<ul style="list-style-type: none"> - USAID: Patricia Jodrey - PMI/CDC: Lauren Lewis - Global Fund: Marcos Patino Mayer (via VC) - GFF: John Borrazzo - BMGF: Diana Measham/Abigail Pratt - DRC MOH - MoH Ethiopia
11.45 – 12.15	Discussion	
12.15 – 13.00	Session 7: Procurement and supplies for iCCM	Moderator: Jane Briggs
12.15-12.30	15 min presentation: <ul style="list-style-type: none"> - Supply chain to the last mile literature review and country case studies - Review of supply chain challenges in 24 WCAR countries 	Karin Kallander Aline Simen Kapeu
12.30-13.00	30 min Panel and discussion	GHSC Program Cameroon Burkina Faso Uganda Malawi
13.00 – 14.00	Lunch	
14.00 – 16.00	Group work: Defining guiding principles and recommendations for institutionalizing iCCM in the Primary Health Care System Introduction: Summary of key successes and challenges presented up to now by thematic area <i>[provided by rapporteur]</i> <i>Group work A: discussion on bottlenecks / challenges pertaining to the specific system component as per presentations and country experience</i> 9 working groups 1. Coordination and policy setting 2. Costing and Financing 3. Human Resources	Introduction: Salim and Maureen

	<ul style="list-style-type: none"> 4. Supply Chain Management 5. Service Delivery and Referral 6. Community Engagement (communication and social mobilization) 7. Supervision 8. Quality of Care 9. Monitoring and Evaluation and Health Management Information Systems 	
During group work	Tea/Coffee (flexible during group work)	
16.00 – 17.30	Plenary – feedback from the groups: key issues/challenges for each health system component around ‘institutionalizing iCCM’	Eric Swedberg
	Closing of day 2	
17.30-18.00	Meeting Facilitator’s meeting	WHO/UNICEF/Chair
Wednesday, 24 July 2019		
8.30 – 9.00	Recap of Day 2 Introduction of Day 3 Chair : Shamim Qazi and Jessicah Nsungwa Sabiiti	Teshome Desta
9.00 – 11.00	<i>Group work B: Developing recommendations for institutionalizing iCCM</i> <i>Each group develops a mission statement and recommendations for institutionalizing the health system component in the Primary Health Care system</i>	Salim and Maureen
Flexible during group work	Tea/Coffee	
11.00 – 13.00	Plenary – Reporting by groups, discussion and agreement on the mission statement and recommendations	Andrea Bosman
13.00 – 14.00	Lunch	
14.00-15.00	<i>Group work C: Draft recommendations</i>	
		Rapporteur
15.30-16.00	Closing: part 1 of meeting	Andrea Bosman/Rory Nefdt
16.00-16.30	Facilitator’s meeting	WHO/UNICEF/Chair

PART II:

Implementation of High Burden High Impact (HBHI) approaches and integrated Community Case Management (iCCM) to accelerate reduction of child mortality Country Planning for Malaria High Burden Countries

Thursday, 25 July 2019

Section 1: High Burden High Impact Response – Getting back high burden countries on track to achieve Global Technical Strategy for Malaria 2016–2030 targets

Chairs: A Kalu and Rory Nefdt

9:00 - 9:20	Welcoming remarks	WR/Pedro Alonso
9:20 - 9:30	Objectives and agenda	Kalu Akpaka

9:30 - 10:00	Background and introduction to High Burden High Impact response (the rationale, the response elements and the need to act now)	Pedro Alonso
10:00-10:30	Country engagement and operationalization of HBHI	Maru Aregawi
10:30-11:00	Coffee Break	
11:00-13:00	<p>Country updates on planning, convening and implementation of the HBHI approaches, follow-up activities, best practices and challenges</p> <p>(**presentations from countries that have conducted HBHI meetings or have advanced activities, 15 minutes each)</p> <p>Burkina Faso**</p> <p>Mali</p> <p>Cameroon **</p> <p>Niger</p> <p>DRC</p> <p>Ghana**</p> <p>Mozambique</p> <p>Nigeria**</p> <p>Tanzania**</p> <p>Uganda**</p>	NMCPs/Country representatives
13:00 – 14:00	Lunch	
14:00-15:00	Discussion	
15:00-16:00	<p>Early progress/status of implementing the strategic use of information (response element 2).</p> <ul style="list-style-type: none"> ○ Malaria repository database in countries ○ Stratification (macro and micro-stratification) ○ Impact analysis ○ Analysis of Geographic Access to health services and distribution of mortality in the African region <p>Discussion</p>	Abdisalan Noor
16:00-16:30	Coffee break	
16:30-17:30	<p>Early progress/status of implementing HBHI response element 1, 3 and 4</p> <ul style="list-style-type: none"> ○ Political will (response element 1) ○ Better guidance (response element 3) ○ Coordination (response element 4) <p>Discussion</p>	Maru/Alastair Peter Olumese Alastair/Melanie
17:30-18:30	Ways forward to improve HBHI processes and accelerate follow-up activities	
18:30	Close of Day	

Friday, 26 July 2019

Section 2 - Scale-up of iCCM in HBHI countries to accelerate reduction of malaria mortality

Chairs: Fred Binka and Andrea Bosman

9:00 - 9:10	Recap of day 4	Spes/Lynda
9:10 - 9:20	Summary of the discussion of sources and mechanisms for funding of iCCM.	Valentina Buj
<p>Country level planning for optimization of iCCM to accelerate mortality reduction in settings with high transmission, limited resources and limited access to services in-light of the HBHI concepts and priority outcomes (key pathways, deliverables, timeline and implementers, risks and mitigation strategies).</p>		
9:20 - 9:30	Guidance on country planning group work (the partners and 10 countries spread across the 4 groups)	Maru
9:30 - 13:00 Working coffee 10.30:11.00	<ul style="list-style-type: none"> • Group 1. Policy, prioritization of high mortality areas for iCCM <ul style="list-style-type: none"> ○ Policy ○ Criteria for iCCM prioritization of areas and operationalization • Group 2. Leadership and Coordination <ul style="list-style-type: none"> ○ Human resources for iCCM (CHWs-profiling, remunerations and sustaining services) ○ Financial arrangements (including Gov) ○ Leadership and Management • Group 3. Service delivery-continuum of care and quality: <ul style="list-style-type: none"> ○ Community & Health Facility ○ Referral facility and referral system ○ Supply Chain Management • Group 4. Surveillance of iCCM, tracking progress, outcome & impact <ul style="list-style-type: none"> ○ Indicators, methods, tools ○ Use of routine health facilities (outpatient consultations, hospitalisation/severe diseases, hospital deaths) ○ Population or community-based survey ○ Implementers 	
13:00-14:00	Lunch	
14:00-16:00	Plenary presentation by four groups	A. Kalu
16:00-16:40	Discussion	
16:40-17:00	Brief remarks by key partners	GF, PMI, UNICEF, Other
16:40-17:00	Coffee break	
17:00-17:30	Summary and recommendations	Pedro Alonso
17:30	Close of day	

17:30-18:00

Meeting of facilitators

WHO/UNICEF/GF/PMI and other partners

