# Toolkit for iCCM Institutionalization

**iCCM Subgroup Meeting**

**12 January 2022**

PMI Impact Malaria is the flagship global service delivery project of the U.S. President's Malaria Initiative (PMI)

Photo credit: Mwangi Kirubi, PMI Impact Malaria

# AGENDA

- Definition of Institutionalization
- Institutionalization Framework
- Next Steps for Toolkit Development

# Overview of Preparatory Phase

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| Conduct landscaping of existing literature and tools | Consult select govt. officials re: experience with existing tools and iCCM institutionalization | Perform critical analysis of existing iCCM tools and identify gaps | Develop framework for describing institutionalization, including draft list of indicators | Assessment of options for toolkit format and dissemination approach |
| Complete | Not Started | In Progress | In Progress | In Progress |

# Definition of Institutionalization

# Key Literature Identified & Reviewed


- Goodman RM, McLeroy KR, Steckler AB, Hoyle RH. **Development of level of institutionalization scales for health promotion programs.** *Health Educ Q.* 1993;20(2):161-178.
- Hodgins S, Quissell K. **Scale-up as if Impact Mattered : Learning and Adaptation as the Essential (often missing) Ingredient**. *SNL Learning Paper, December 2016.*
- Koon AD, Windmeyer L, Bigdeli M, et al**. A scoping review of the uses and institutionalisation of knowledge for health policy in low- and middle-income countries.** Marshalling the Evidence for Health Governance Thematic Working Group Paper, *USAID, November 2017.*
- Krieger MGM, Wenham C, Nacif Pimenta D, et al. **How do community health workers institutionalise: An analysis of Brazil's CHW programme.** *Glob Public Health*. 2021;1-18.
- McGorman L, Marsh DR, Guenther T, et al. **A health systems approach to integrated community case management of childhood illness: methods and tools.** *Am J Trop Med Hyg. 2012;87(5 Suppl):69-76.*
- Maeda A, Harrit M, Mabuchi S, Siadat B, Nagpal S. ***Creating Evidence for Better Health Financing* Decisions : A Strategic Guide for the Institutionalization of National Health Accounts.** *Directions in Development–Human Development;. Washington, DC: World Bank, 2012. https://openknowledge.worldbank.org/handle/10986/13141*
- Nanyonjo A, Counihan H, Siduda SG, Belay K, Sebikaari G, Tibenderana J. **Institutionalization of integrated community case management into national health systems in low- and middle-income countries: a scoping review of the literature.** *Glob Health Action. 2019;12(1):1678283.*
- Silimperi DR, Franco LM, Veldhuyzen van Zanten T, MacAulay C. **A framework for institutionalizing quality assurance.** *Int J Qual Health Care*. 2002;14 Suppl 1:67-73.
- Zida A, Lavis JN, Sewankambo NK, Kouyate B, Ouedraogo S. **Evaluating the Process and Extent of Institutionalization: A Case Study of a Rapid Response Unit for Health Policy in Burkina Faso**. *Int J Health Policy Manag*. 2018;7(1):15-26.

# Definitions of Institutionalization in the Literature

"**Institutions are comprised of regulative, normative, and cultural-cognitive elements** that, together with **associated activities and resources,** provide stability and meaning to social life." [Jepperson, 1991]

**Regulative dimensions** of institutionalization highlight the role of incentives for motivating efficient behavior. **Normative dimensions** of institutionalization occur by increasing commitments of individuals to behave according to established order (identity). **Cultural-cognitive dimensions** of institutionalization entail the conversion of shared beliefs into routines, protocols, language, and other artifacts. [Scott, 2008 via USAID, 2017]

**Institutionalization is a process** that emphasizes this **affinity for stability** and can be simply understood as, "to **infuse with value** beyond the technical requirements of the task at hand." [Selznick, 1957 via USAID, 2017]

Institutionalization is the **process by which a set of activities becomes an integral and sustainable part of a formal system.** It can be seen as a **sequence of events leading to "new practices becoming standard practice.**" [Zida et al., 2018]

**Key Themes**

- Ongoing process, but also an eventual state of stability (but not permanence)
- Occurs when practices become integral and routine

# Proposed Definition of Institutionalization for iCCM

**A process by which iCCM becomes an integral, routine and stable part of both community and health systems.**

*"Community Health Workers function at the intersection of two dynamic and overlapping systems – the formal health system and the community."*

Naimoli, J.F., Perry, H.B., Townsend, J.W. *et al.* Strategic partnering to improve community health worker programming and performance: features of a community-health system integrated approach. *Hum Resour Health* **13,** 46 (2015).

# Institutionalization Frameworks

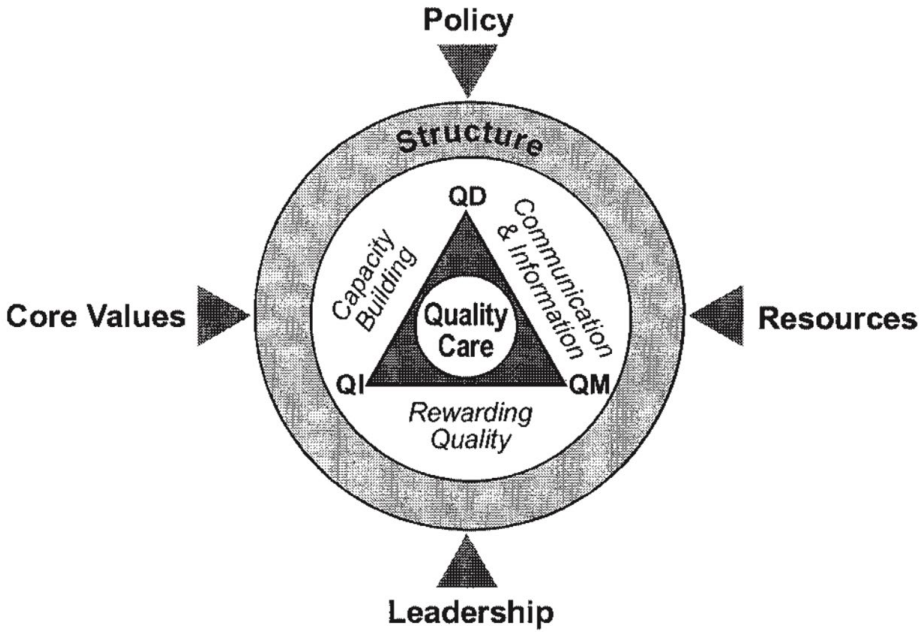
# Institutionalization frameworks in the literature: Goodman et al.

| Dimensions / Subsystems | Passages | Degrees / Routines | Niche Saturation |
|---|---|---|---|
| Production | | | |
| Maintenance | | | |
| Supportive | | | |
| Managerial | | | |

Source: Goodman RM, McLeroy KR, Steckler AB, Hoyle RH. **Development of level of institutionalization scales for health promotion programs.** *Health Educ Q.* 1993;20(2):161-178.

Looks at **dimensions** and **degrees** of institutionalization, but with a **focus on assessment** of institutionalization status.

# Institutionalization frameworks in the literature: Silimperi (part 1)




Describes **the internal enabling environment** (policy, leadership, core values, resources), **the structure** (including delineation of responsibilities and accountability for oversight, coordination and implementation), and **the support functions** (capacity building, communication + information, and rewards/incentives) required to achieve institutionalization.

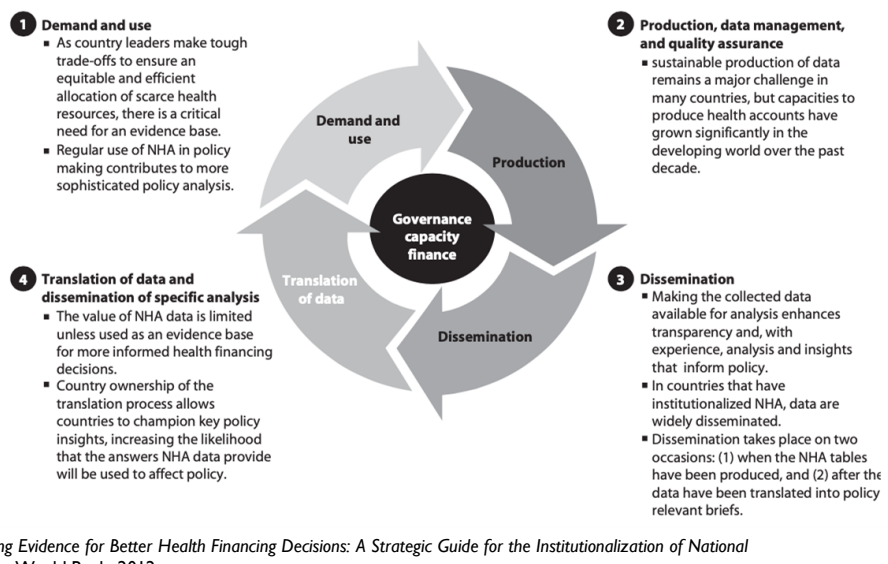
Source: Slimperi D et al. *A framework for institutionalizing quality assurance.* International Journal for Quality in Health Care 2002; Volume 14, Supplement I: 67-73.

# Institutionalization frameworks in the literature: Silimperi (part 2)


Source: Slimperi et al. *A framework for institutionalizing quality assurance.* International Journal for Quality in Health Care 2002; Volume 14, Supplement I: 67-73.

# Institutionalization frameworks in the literature: World Bank & Zida et al.

**Figure 1.3 Framework for Institutionalization of National Health Accounts**




Source: *Creating Evidence for Better Health Financing Decisions: A Strategic Guide for the Institutionalization of National Health Accounts*, World Bank, 2012.

**Table 1** Indicators of policy unit institutionalisation

| Institutionalisation elements | Indicators |
|---|---|
| 1. Existence of an institutional framework (the policy unit's mandate from government) | • Law/regulation providing a mandate for the policy unit<br>• Institutional home identified for the policy unit<br>• Protocols/public norms set out for data or information production |
| 2. Consistent production of data and preparation of reports | • Explicit process designed for data gathering, compilation and transmission for decision-making<br>• Policy unit activities are regular and ongoing<br>• Protocol exists for validating reports<br>• Minimum set of globally agreed data is produced |
| 3. Adequate financial and human resources, and infrastructure capacity to routinely produce and make use of data in policymaking | • The policy unit has an annual plan of action<br>• Government budget is earmarked for the policy unit's activities<br>• Sufficient material and human resources are available for the policy unit's activities<br>• The unit's annual action plan is at least half funded |

Source: based on the World Bank framework [3]

*Zida et al. Health Research Policy and Systems (2017) 15:62*

# Institutionalization frameworks in the literature: Zida et al.

| Institutionalization Phase | Institutionalization Elements | | |
|---|---|---|---|
| | **Existence of an Institutional Framework** | **Consistent Production of Relevant Reports** | **Adequate Resources (HR, financial)** |
| **Awareness** | | | |
| **Experimentation** | | | |
| **Expansion** | | | |
| **Consolidation** | | | |
| **Maturity** | | | |

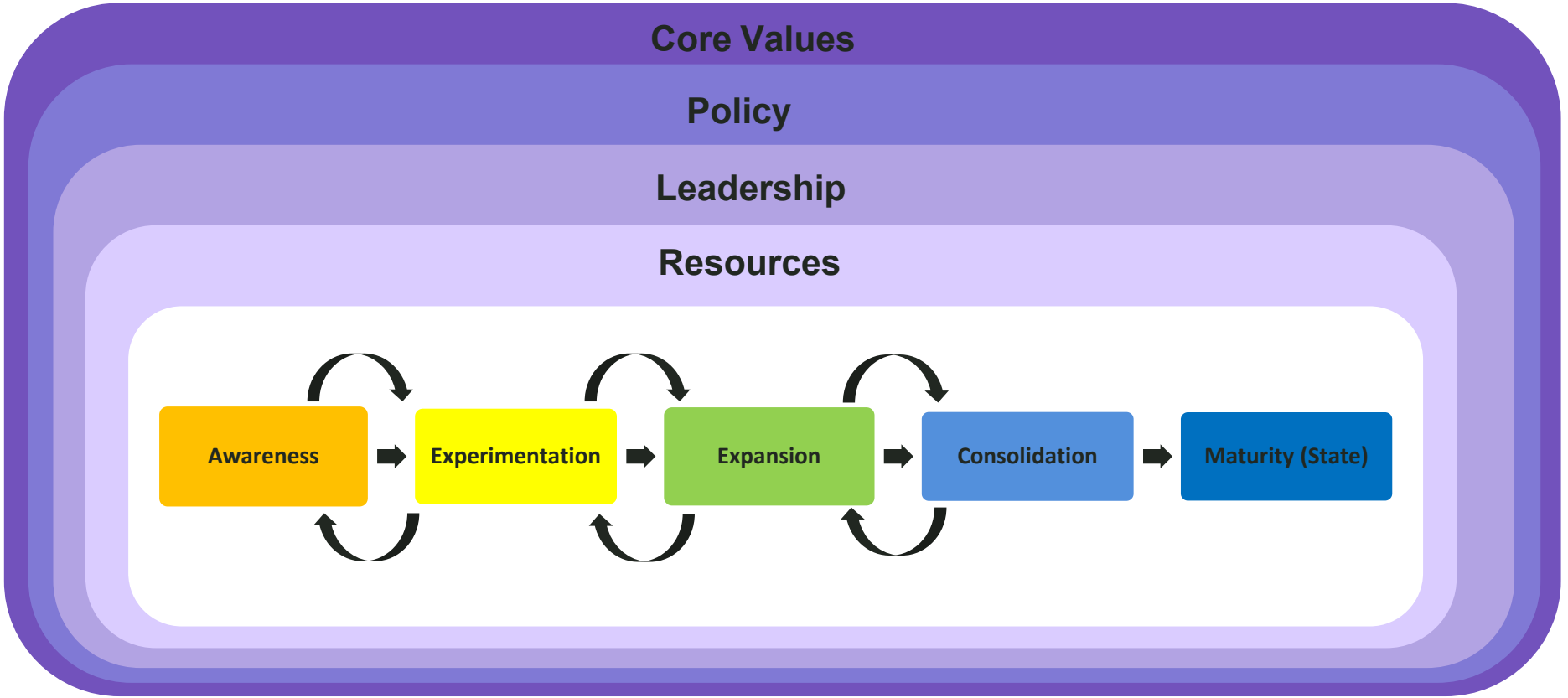
**Combines the essential elements** defined by the World Bank **with the institutionalization phases** defined by Silimperi.

**Missing:** explicit roles of institutional values, culture, and behavioral norms.

Source: Zida et al. *Evaluating the Process and Extent of Institutionalization: A Case Study of a Rapid Response Unit for Health Policy in Burkina Faso.* Int J Health Policy Manag 2018, 7(1), 15-26.

# Proposed Institutionalization Framework for iCCM

# Framework for iCCM Institutionalization



# Descriptions of Enabling Environment Phases

| | Core Values | Policy | Leadership | Resources |
|---|---|---|---|---|
| **Awareness** | Key stakeholders recognize the need for change in approach to improve access to services for management of childhood illness. | Key decision makers are willing to consider new policy options to improve access to services for management of childhood illness. | Key leaders are willing to explore iCCM as a treatment approach. | Human and financial resources are made available from any source (e.g. govt, donor, community, etc.) to review existing evidence and options. |
| **Experiential** | Key stakeholder are convinced of the safety and effectiveness of iCCM. | Key decision makers are willing to allow experimentation with new approaches for management of childhood illness outside existing policy. | Key leaders approve of piloting iCCM for demonstration and learning purposes. | Human and financial resources are made available from any source (e.g. govt, donor, community, etc.) to pilot iCCM. |
| **Expansion** | Key stakeholders apply principles of equity and community partnership to guide decisions in expanding/scaling-up iCCM. | Policies, strategies and guidelines to enable implementation of iCCM across the health system are progressively developed. | Key leaders start to align organizational, unit and individual goals, plans and ways of working to enable the expansion/scale-up iCCM. | Human resource plans and budgets for iCCM activities are developed; efforts to coordinate resources from multiple sources (e.g. govt, donor, community, etc.) commence. |
| **Consolidation** | Principles of equity and community partnership are articulated and reinforced by policies, performance rewards, and leadership behavior (i.e. coalescing as core values). | Policies, strategies and guidelines to implement iCCM across the health system are enacted and progressively operationalized from national to community levels. | Formal roles and accountabilities are designated and widely understood for implementation of iCCM across the health system from national to community levels. | Sufficient human and financial resources are allocated and coordinated to implement iCCM activities at scale, increasingly from annual government budgets (i.e. not reliant on external, short term sources). |
| **Maturity** | Key stakeholders from national to community levels routinely demonstrate understanding and accountability to the core values of equity and community partnership in their day-to-day decisions and actions. | Policies, strategies and guidelines to implement iCCM across the health system are routinely updated and fully operational from national to community levels. | Key leaders and designated staff throughout the health system from national to community levels routinely fulfil their roles for implementation of iCCM. | Sufficient human and financial resources are routinely allocated from annual government budgets and coordinated with all other sources of funds to implement iCCM on a stable long-term basis. |

# Wrap-up & Next Steps

# WRAP-UP & NEXT STEPS

1. **Agreement of Institutionalization Definition**
2. **Agreement of Institutionalization Framework**
3. **Outreach to country stakeholders (when and how)**
4. **Date for sharing preparatory phase report**
5. **Date of next meeting**

# Annex

# State of iCCM Institutionalization

| | iCCM Essential Components | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | **Coordination & Policy** | **Costing & Financing** | **Human Resources** | **Supply Chain Management** | **Service Delivery and Referral** | **Community Engagement, Comms & Social Mobilization** | **Supervision & Quality Assurance** | **M&E/HMIS** |
| **Description of State** | Mechanisms for stakeholder coordination* of primary healthcare including iCCM services exist and function on a routine basis from community to national levels.<br><br>iCCM is an integral part of all relevant national health sector development policies, strategies and plans. | Sufficient resources are routinely allocated from annual government budgets and coordinated with all other funding sources to implement iCCM on a continuous, long-term basis.* | CHWs delivering iCCM services are recognized as integral members* of their community and local primary healthcare team as well as accounted for in multisectoral policies, strategies, budgets and plans for human resources for health. | Coordinated supply chain management system routinely provides sufficient iCCM supplies to CHWs (i.e. no substantial stockout periods). | Diagnosis, treatment and referral between community and facility levels is routinely performed through collaboration of communities, CHWs and facility based health staff.* | Local communities are routinely involved in planning, implementing, using and improving iCCM services as partners in primary healthcare governance. | Supervision of CHWs and quality assurance of iCCM services are integrated into routine responsibilities of relevant primary healthcare team members* and community governance mechanisms.** | Routine monitoring systems are established, utilized, and contribute to national HMIS and are regularly reviewed to inform action for continuous improvement. |
| **Notes** | *Comprised by echnical departments, professional bodies, civil society, community leaders as well as implementation and funding partners. | *i.e. funding not reliant on external, short term donor sources). | *or could refer to "owned" by communities and health system; recognized and supported like any other HRH cadre. | *plan is owned and led by the MoH comes out in the literature, but seems to exclude mixed health systems | *benchmark guidelines include "patient compliance," but should also include initial care-seeking (i.e. demand).<br>*Diagnosis, treatment and referral for iCCM relevant illnesses | *could simplify to just "community engagement," which could include both comms and social mobilization? | *or could be MOH staff, but then excludes mixed health systems/partners<br>**i.e. role of community feedback/ partnership of communities in supervision. | |

Table 1. Integrated Community Case Management Benchmark Framework

| STAGE OF PROGRAM IMPLEMENTATION | | | |
|---|---|---|---|
| | **Advocacy and Planning** | **Pilot and Early Implementation** | **Expansion/Scale-Up** |
| **Component 1: Coordination and Policy Setting** | Mapping of iCCM partners conducted | MOH leadership established to manage unified iCCM | MOH leadership institutionalized to ensure sustainability |
| | Technical advisory group established including community leaders, iCCM champion and CHW representation | | |
| | Needs assessment and situation analysis for package of services conducted | | |
| | Stakeholder meetings held to define roles and discuss current policies | Discussions completed regarding ongoing policy change (where necessary) | Routine stakeholder meetings held to ensure coordination of iCCM partners |
| | National policies and guidelines reviewed | | |
| **Component 2: Costing and Financing** | iCCM costing estimates undertaken based on all service delivery requirements | Financing gap analysis completed | Long-term strategy for sustainability and financial viability developed |
| | Finances for iCCM medicines, supplies and all program costs secured | MOH funding invested in iCCM program | MOH investment in iCCM sustained |
| **Component 3: Human Resources** | Roles of CHWs, communities and referral service providers defined by communities and MOH | Role of and expectations for CHW made clear to communities and referral service providers | Process in place for update and discussion of CHW role/expectations |
| | Criteria for CHW recruitment defined by communities and MOH | CHWs trained, with community and facility participation | Ongoing training provided to update CHWs on new skills, reinforce initial training |
| | Plan for comprehensive CHW training and refresher training developed (modules, training of trainers, M&E) | | |
| | CHW retention strategies, incentive/motivation plan developed | CHW retention strategies, incentive/ motivation plan implemented and made clear to CHW; community plays a role in providing rewards, MOH provides support | CHW retention strategies reviewed and revised as necessary |
| | | | Advancement, promotion, retirement offered to CHWs who express desire |
| **Component 4: Supply chain management** | Appropriate iCCM medicines and supplies consistent with national policies (RDTs where appropriate) included in essential drug list | iCCM medicines and supplies procured consistent with national policies and plan | Stocks of medicines and supplies at all levels of the system monitored (through routine information system and/or supervision) |
| | Quantifications for iCCM medicines and supplies completed | | |
| | Procurement plan for medicines and supplies developed | | |
| | Inventory control, resupply logistic system and standard operating procedures for iCCM developed | Logistics system implemented to maintain quantity and quality of products for iCCM | Inventory control and resupply logistics system for iCCM implemented and adapted based on results of pilot with no substantial stock-out periods |

| STAGE OF PROGRAM IMPLEMENTATION | | | |
|---|---|---|---|
| | **Advocacy and Planning** | **Pilot and Early Implementation** | **Expansion/Scale-Up** |
| **Component 5: Service Delivery and Referral** | Plan for rational use of medicines (and RDTs where appropriate) by CHWs and patients developed | CHWs rationally use medicines and diagnostics to assess, diagnose and treat sick children | Timely receipt of appropriate diagnosis and treatment by CHWs made routine |
| | Guidelines for clinical assessment, diagnosis, management and referral developed | Guidelines reviewed and modified based on pilot | Guidelines regularly reviewed, and modified as needed |
| | Referral and counterreferral system developed | Referral and counter-referral system implemented; community information on location of referral facility clarified; health personnel clear on their referral roles | CHW referral and counterreferral with patient compliance is routine, along with information flow from referral facility back to CHW with returned referral slips |
| **Component 6: Communication and Social Mobilization** | Communication strategies developed, including messaging on prevention and management of community illness for policymakers, local leaders, health providers, CHWs, communities and other target groups | Communication and social mobilization plan implemented | Communication and social mobilization plan and implementation reviewed and refined based on M&E |
| | Communication and social mobilization content developed for CHWs on iCCM and other messages (training materials, job aids, etc.) | Materials and messages to aid CHWs are available | |
| | Materials and messages for iCCM defined, targeting the community and other groups | CHWs dialogue with parents and community members about iCCM and other messages | |
| **Component 7: Supervision and Performance Quality Assurance** | Appropriate supervision checklists and other tools, including those for use of diagnostics, developed | Supervision visit every 1–3 months, includes reports review, data monitoring | CHWs routinely supervised for quality assurance and performance |
| | Supervision plan, including number of visits, supportive supervision roles, self-supervision, etc., established | Supervisor visits community, makes home visits, provides skills coaching to CHWs | Data from reports and community feedback used for problem-solving and coaching |
| | Supervisor trained in supervision and has access to appropriate supervision tools | iCCM supervision included as part of the CHW supervisor's performance review | Yearly evaluation includes individual performance and evaluation of coverage or monitoring data |
| **Component 8: M&E and HMISs** | Monitoring framework for all components of iCCM developed and sources of information identified | Monitoring framework tested and modified as needed | M&E through HMIS data performed to sustain program impact |
| | Standardized registers and reporting documents developed | Registers and reporting documents reviewed | Operations research and external evaluations of iCCM performed as necessary to inform scale-up and sustainability |
| | Indicators and standards for HMISs and iCCM surveys defined | | |
| | Research agenda for iCCM documented and circulated | CHWs, supervisors and M&E staff trained on the new framework, its components and use of data | |

Reference: McGorman L, Marsh D, Guenther T, et al. A health systems approach to integrated community case management of childhood illness: methods and tools. *Am J Trop Med Hyg*. 2012;87(suppl 5):69-76. Note that the iCCM Benchmark Framework is adapted from WHO building blocks for health systems (World Health Organization. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes; WHO's Framework for Action*. 2007. Available at: www.who.int/healthsystems/strategy/everybodys_business.pdf).

Abbreviations: CHW = community-based health worker; HMIS = health management information system; iCCM = integrated Community Case Management; M&E = monitoring and evaluation; MOH = Ministry of Health; RDT = rapid diagnostic test.