



a decade in communicable disease control and child health

# ICCM in practice – lessons learnt from a participatory evaluation across three African countries (South Sudan, Uganda, Zambia)

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## Specific objectives

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- Gather experiences, lessons learnt and best (fit) practices
- Effectively document our implementation models and processes in practice
- Promote participant learning and capacity building in evaluation methodologies
- Effectively disseminate these experiences for the purpose of wider learning on approaches for improving feasibility, acceptability and effectiveness in the delivery of services using an integrated community platform
- Develop case studies

# Methods

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- *A participatory evaluation approach* - exact methodologies are developed by those involved in implementing the programme within a specific setting
- Similar evaluation scope developed from one original thematic framework
- Similar methods selected:
  - Beneficiary assessment
  - Stakeholder consultation
  - Case studies



**Deductive**  
**Inductive**



# Scope of enquiry

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1. Central level preparation
2. Sub-national level introduction and start up
3. CHW recruitment and selection
4. Training and capacity building
5. Support supervision
6. Routine data collection
7. Commodities and supply chain
8. Community involvement and support
9. Behaviour change communication
10. E-health
11. Management and coordination
12. ICCM integration into the health system
13. Technical scope of ICCM
14. Evaluation



# Target groups

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Central	MoH Donors Malaria Consortium Other partners
Sub-national	Sub-national health management team
Health facility	Levels of public health system
Community	CHWs Community leaders Beneficiaries

# Preliminary findings



# CHW recruitment and selection

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- Selection process mostly followed national level guidelines
- But less democratic approaches to selection occurred in all countries:
  - In some cases, becoming a CHW associated with personal gain, influence, and related to tribal and political affiliations
- Where community reported to be fully involved in selection:
  - Increased utilisation of ICCM services
  - Stronger community support for the CHWs
  - Trust and a greater sense of ownership in the ICCM programme
- Ramifications of less democratic selection:
  - Unqualified CHWs being trained
  - Less community support

# CHW recruitment and selection

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Respondent recommendations:

- Enhanced emphasis on community sensitisation
- Expanded random/targeted monitoring of selection process
- Promotion of importance of adhering to selection criteria
- Little suggestion for revision of guidelines (Uganda: add a max. age limit of 50)

*“When the community is involved it becomes easier for the [CHW] to work with them because they are the ones who have chosen him, it came from them so that is the lesson I have learnt. He is theirs...”*

Health facility in-charge, Hoima, Uganda

# Training and capacity building

- Participatory, practical approaches supported CHW grasp of content and confidence building
- CHWs particularly valued visits to HCs to observe danger signs
- CHWs largely reported tools as useful and appropriate, especially:
  - Videos demonstrating chest in-drawing and convulsions
  - Dolls for rectal artesunate demonstration
  - Sick child job aid “the bible”
- Lower literacy presented significant challenge in South Sudan



*“...we take them to health centers that have children admitted with danger signs so that they are able to see [them]. We also use videos to show them the danger signs... We then allow them to practice and internalise and at the end of the session they give us the feedback so here was not lecture method of teaching.”*

Malaria Consortium Technical Officer

# Training and capacity building

Respondent recommendations:

- Increase training emphasis on:
  - Identifying pneumonia compared with cough
  - Using respiratory timers
  - Completing CHW registers
  - Referral procedures
  - ICCM overlap with newborn care?
- Extend training duration?
- Regular refresher training suggested focused on problem areas
- Training in low literacy settings to include literacy and numeracy skills?



# Supportive supervision

- Where delivered regularly and consistently, supportive supervision reportedly has a positive effect on CHW motivation and performance
- Where weak, CHWs can feel discouraged and alone in addressing challenges
- Home-visits highlighted as particularly beneficial



*“Their supervision helps me to correct my mistakes especially in my storage of drugs at home. I also share experiences with them, they ask me where is this and I reply...all this helps build my confidence.”*

CHW, Buliisa, Uganda

# Supportive supervision

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- Most commonly reported challenges:
  - Availability of funds
  - Time required and availability of staff (workloads)
  - Difficulty in accessing CHWs due to poor roads (especially hard to reach areas and during the rainy season)
  - Weak supervisors (a need for ‘buddying up’)
- Recommended that focus should be on addressing routine challenges rather than revisiting model – emphasis on *regular contact*

*“Supervision is not consistent and when they don’t come to see what we are doing we become demoralised and sometimes when they don’t come we feel that what we are doing is not very important.”*

CHW, Hoima, Uganda

# Routine data collection

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## Quality:

- Mostly reported to be of “acceptable” standard and has improved over time (variations and potential bias here)
- In Uganda and Zambia, inaccuracies in the monthly CHW registers reportedly due to:
  - Poor numeracy skills
  - Lack of sufficient training on the tool
  - CHW forgetting how to effectively use tool
  - Human error (tiredness, busy with other activities)
- In South Sudan, low literacy reported to have effect on data quality



# Routine data collection

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## Completeness:

- Where gaps existed, supervisors tend to consult CHWs (but resultant quality of data unclear)
- In Zambia and Uganda, CHWs cited commodity stock outs as main reason for not completing registers
- Initially no space for community data in HMIS forms - since corrected but amalgamation and integration within HMIS remains challenging

*“ICCM data are not usually part of our reports to the MoH. Our collection tools only goes as far as the health centre”*

Health worker, Zambia

## Collection/submission of data:

- Challenges in funds and transport availability (and distance to HCs, especially in South Sudan)
- Where supervisors do not appear to be available, CHWs more reluctant to submit data

# Routine data collection

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## Usage:

- Across all countries sub-national stakeholders reported a need to strengthen capacity to analyse and use data for review/planning
- But value placed in data demonstrated by range of uses:
  - Summarising cases (incidence proxy) for consideration of possible causes/responses
  - Reviewing general community case load against predicted numbers
  - Comparing cases with diagnosis and treatment data (i.e. ACTs and RDTs) to explore CHW performance
  - Drug and supply quantification, surplus supplies, stock outs

*“For ICCM yes somehow, when we receive the reports we look at how the drugs have been used, we also draw graphs and if its reducing that means they are actually treating, we also look at the turn up in case there are many children then there is a problem in that particular village.”*

Health worker, Uganda

# Routine data collection

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Respondent recommendations:

- Enhanced emphasis in training/ refresher training
- Address routine support supervision and data collection/submission challenges (and explore integration of these activities if not already)
- Strengthen and regular capacity building
- Enhance value CHWs place on data



# Commodities and supply chain

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## Supply chain:

- Aims of integration into public sector supply chain conflicted in practice with need to get comprehensive package commodities fast to lower levels (Uganda and Zambia)
- Exchange of ICCM and National Medical Store supplies as needed (Zambia)
- In South Sudan, a need to deliver commodities direct to communities

## Stock outs:

- Periods of stock outs widely reported across each country
- CHWs and communities widely agreed that stock outs negatively impact community perceptions of ICCM and also CHWs
- (Unsubstantiated) suggestions across all countries of CHWs selling drugs
- Significant impact on workload (more patients during stock outs)

# Commodities and supply chain

- Drug acceptability appeared to be universally high
- RDT acceptability good from start and grew further in time
  - In Uganda and Zambia, some concerns over alternative uses for blood (i.e. HIV testing, “satanic” purposes)
- Respondent recommendations:
  - Increase in quantities
  - More frequent deliveries
  - Regularity - circulation of drug delivery schedule
  - Link commodity distribution with data submission
  - Improve quantification over time
  - Mixed views on integration in NMS/ separate partner delivery



# Community involvement and support

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Commonly reported that beneficiaries have embraced ICCM:

- Reduction in long distances for seeking care most commonly mentioned factor
- Decline in cases reported
- Trust in CHWs has increased over time

Utilisation reported to be generally high:

- But impacted negatively by stock outs, inappropriate CHW behaviour
- CHW workloads varied between “manageable” and “heavy”

Community support to CHWs:

- Supportive community leadership makes a big difference
- CHW attrition reportedly due to absence of financial incentives and weak community support

# Community involvement and support

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- Key barriers to referral include:
  - May not realise severity of the child`s illness
  - Cost, distance and transport
  - Long waiting times at health facilities
  - Cultural beliefs around cause of illness and treatment required
  - Language barriers
  - Stock outs at health facilities (perceived, actual)
  - Negative attitudes of health facility staff
  - “Laziness, procrastination, stubbornness”



# Community involvement and support

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Respondent recommendations:

- More sensitisation on the role communities can play in supporting ICCM

*“...attrition among CHWs does happen in our community because some of them feel that they are not receiving enough support from the community; especially during farming season. They are failing to provide for their families since they spend much of their time providing health care services to the community at the expense of their families.”*

Community leader, Zambia

# Behaviour change communication

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- Role of community leaders cited as key across countries
- Where implemented, community dialogues viewed as successful

*“Where these community dialogues have been at first you could find that they had bushes around and faeces were scattered around the toilets but during the dialogue, [CHWs] talk about diarrhea and proper use of latrines, proper disposal...so today you find that people have changed- they can construct toilets and use them well and can maintain children’s faeces.”*

Health facility in-charge, Buliisa, Uganda

Community level respondents reported value in BCC activities, specifically:

- Promoting use of CHWs
- Boosting CHW motivation
- Encouraging trust in western/biomedicine

Respondent recommendations:

- More, and more regularly, utilising community structures

# Learning

- Qualitative studies can offer a valuable contribution in understanding the ‘hows’ of implementation, and implications for improved feasibility and acceptability of ICCM in practice
- Participatory methodologies enable scope of research enquiry to be context specific
- Community support to ICCM and CHWs is necessary for sustained health benefits
- A sharp focus must be maintained on capacity building and ‘enabling’ of the public health system



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[www.malariaconsortium.org](http://www.malariaconsortium.org)

Thank you



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