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International Malaria Colloquium, Dec 2010

Current issues in the management of malaria elimination and control

Community case management for malaria

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Africa Technical Director

RESEARCH

PREVENTION

DIAGNOSIS

TREATMENT

BETTER HEALTH

Outline

- Introduce community case management (CCM)
- Some lessons learned implementing CCM
- Overview of integrated community case management (ICCM)
- Some early lessons learned implementing ICCM
- Some opportunities
- Some challenges
- Summary

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What do we mean?

Community case management for malaria (CCM)

- An approach to deliver *malaria treatment* closer to the household
- Examples include
  - Home management of malaria (HMM)
  - Home-based management of fever (HBMF)
- Key assumptions that the malaria treatment
  - Is appropriate for the definition of a case
  - Is appropriate for the target group
  - Is safe and acceptable in the hands of the community-based agent

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What is the rationale?

To improve access to appropriate and complete treatment (& diagnosis)

- Poor access to facility-based health care
  - limited functionality and geographical access
- Significant proportion of malaria treatment obtained from private health providers & vendors
  - quality of treatments not ascertained, incomplete dosing, acceptability

To promote referral to health facilities

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Home-based management of fever

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Essential components of HMM

- i) effective communication for behaviour change to enable caregivers to recognise malaria illness and take appropriate action
- ii) community-based agents have knowledge & skills to manage (diagnosis and treatment) malaria illness
- iii) availability & access to effective good quality pre-packed malaria treatment
- iv) good mechanisms for supervision and monitoring of community activities

Were, W. (2004). Bringing malaria management closer to the home. World Health Organisation.

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Main CCM models

- Community delivery system
  - built on Home-based agents e.g. community medicine distributors
  - built on Facility-based agents e.g. extension health workers
- Community based agents
  - Volunteers (some allowances given)
  - Salaried
- Case management approach
  - Presumptive treatment
  - Parasitological diagnosis and treatment

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Community Health Workers

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Lessons Learned

- If not properly planned this approach can easily go wrong
- Essential components sometimes not taken into consideration during planning and implementation
- Misleadingly perceived as an alternative to facility-based access
- Performance of community-based agents is not adequately understood or monitored
- Community involvement is essential but not adequately understood or effectively done

Community case management (CCM) is feasible at scale

Community awareness and engagement can be achieved

Opportunity exists to extend CCM beyond malaria management

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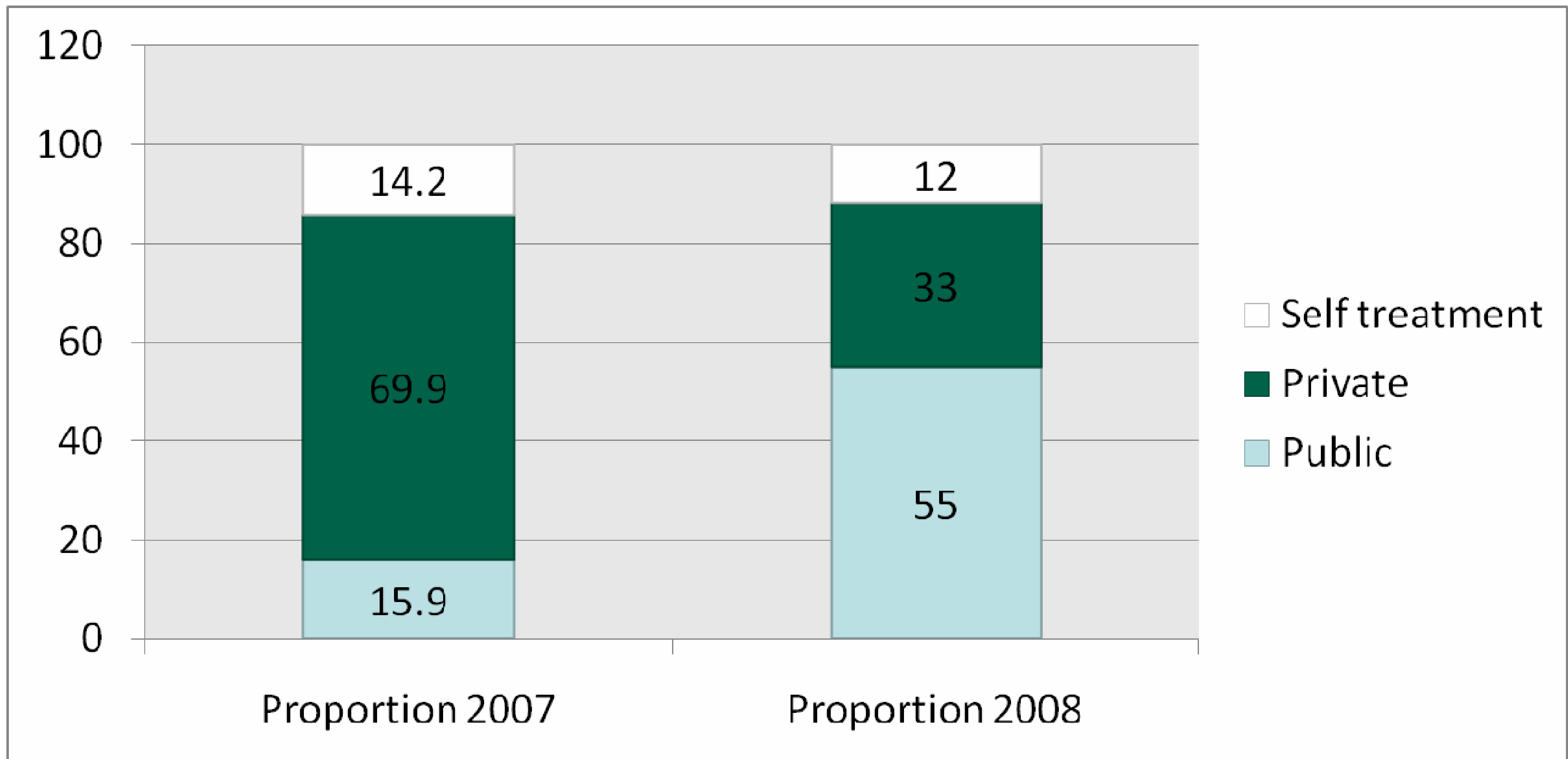
Source of treatment in U5 children, Kiboga District, Uganda (N_{2007}=176, N_{2008}=242)



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Community delivery systems beyond malaria

Integrated CCM (i.e. ICCM)

- Enabling and supporting community-based agents to diagnose & treat common childhood illnesses
  - Malaria
  - Pneumonia and
  - Diarrhoea

  - Other possible add-ons e.g. nutrition, neonatal care, MDA for NTDs, LLIN distribution and hang up.

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WHO estimate that pneumonia kills about 1.5 million children each year

PNEUMONIA
REPORT CARD

TUESDAY, NOVEMBER 9, 2010
EMBARGOED UNTIL NOVEMBER 12, 2010

PREPARED BY THE INTERNATIONAL VACCINE ACCESS CENTER (IVAC)
AT THE JOHNS HOPKINS UNIVERSITY BLOOMBERG SCHOOL OF PUBLIC HEALTH

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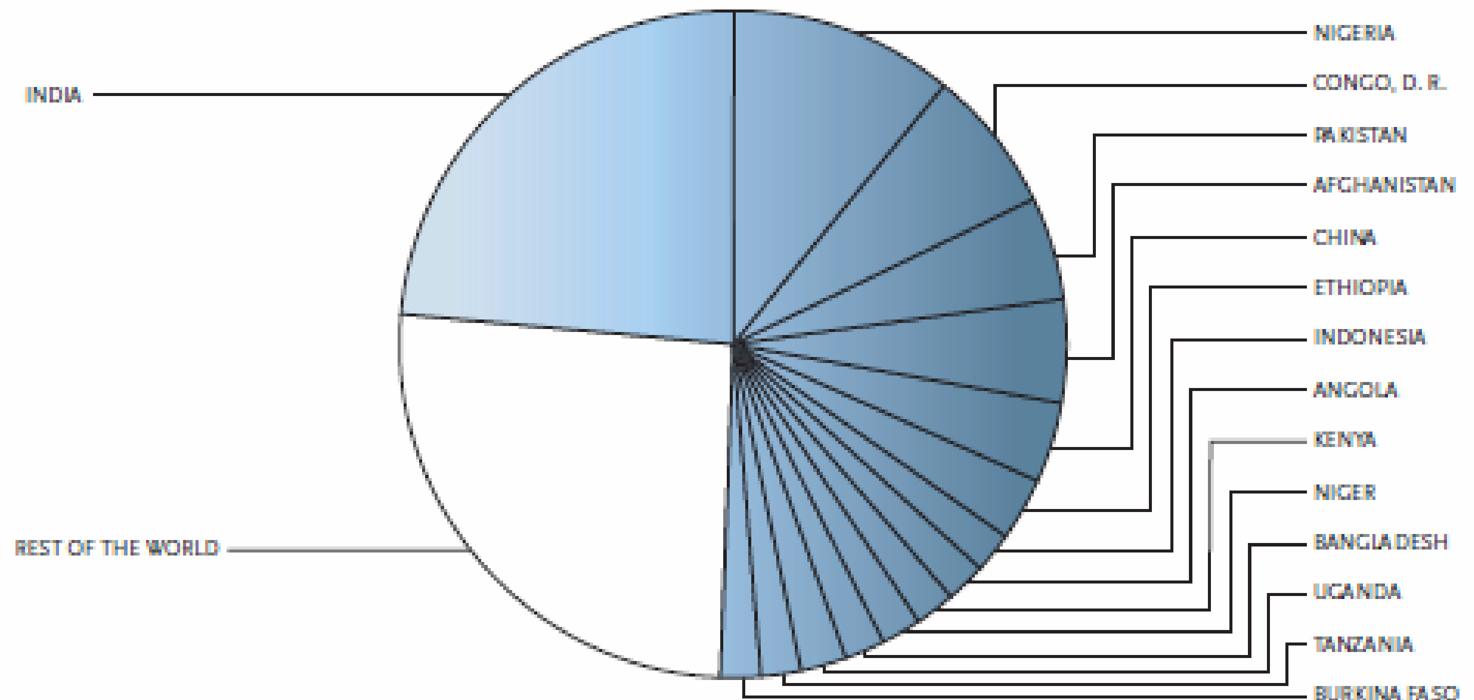

THREE FOURTHS OF ALL WORLDWIDE PNEUMONIA DEATHS AMONG CHILDREN UNDER AGE 5 OCCUR IN THE 15 REPORT CARD COUNTRIES (1.17 MILLION OUT OF A TOTAL 1.575 MILLION DEATHS)

BEGINNING WITH INDIA, COUNTRIES APPEAR CLOCKWISE IN DESCENDING ORDER BY NUMBER OF ANNUAL CHILD PNEUMONIA DEATHS

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By scaling up existing interventions to prevent pneumonia infections, protect children from conditions that increase the risk of pneumonia and treat infections with life-saving antibiotics, we can reduce child pneumonia deaths by two-thirds
WHO & UNICEF

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TREATMENT
PERCENTAGE OF CHILDREN WITH PNEUMONIA WHO ACCESS A CARE FACILITY OR RECEIVE ANTIBIOTICS

100
90 GAPP TARGET
80
70
60
50
40
30
20
10
0

n/a

INDIA
NIGERIA
CONGO, D.R.
PAKISTAN
AFGHANISTAN
CHINA
ETHIOPIA
INDONESIA
ANGOLA
KENYA
NIGER
BANGLADESH
UGANDA
TANZANIA
BURKINA FASO

PERCENTAGE OF CHILDREN WITH PNEUMONIA RECEIVING ANTIBIOTICS
PERCENTAGE OF CHILDREN WITH SUSPECTED PNEUMONIA TAKEN TO A HEALTH FACILITY
COUNTRIES APPEAR FROM LEFT TO RIGHT IN DESCENDING ORDER OF NUMBER BY ANNUAL CHILD PNEUMONIA DEATHS

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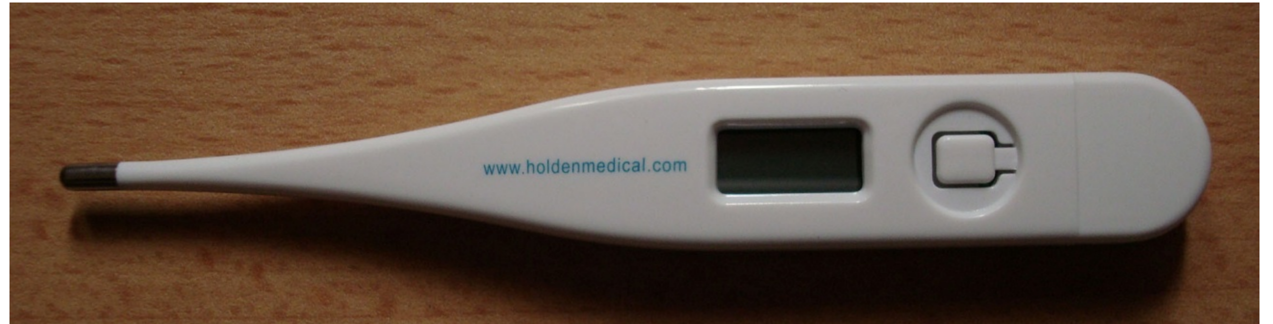
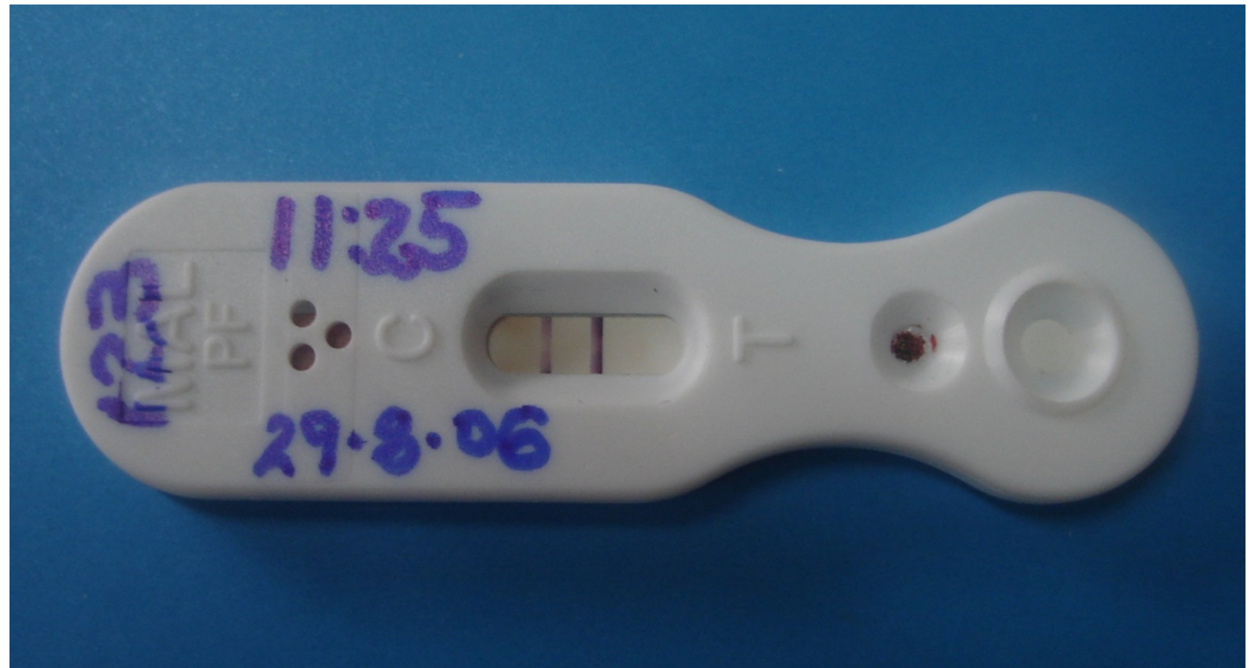
Diagnostic tools





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Referral

- Community referral is an important role of CBAs
  - Detection of severely ill children
  - Detection of other indications for referral
  - Administration of pre-referral treatment

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Recent findings relevant to ICCM

- **Mazumder 2010:** zinc & ORS in under 6 months does result in less acute diarrhoea and ARI (India)
- **Yeboah-Antwi 2010**: ZIMMAPS controlled trial – RDTs+ACTs+Resp Timer+Amoxycillin versus ACTs only (Zambia)
- **Simba 2010**: dilemmas for caregivers to follow referral advice after child receives pre-referral treatment (Tanzania)
- **Bryce 2010**: Accelerated Child Survival & Development Programme in West Africa – low impact, due to poor coverage? (Benin, Ghana, Mali)
- **Ghimire 2010**: community-based programme for diarrhoea and ARIs – more cases reported but less severe (Nepal)

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Some early lessons with ICCM

- Slow process to get established: need to navigate various government structures
  - Approval of integrated interventions – MoH departments (Child health, NMCP)
  - Approval of medicines for use at community level – MoH, Drug regulatory authorities
  - Importation of commodities – Pre-qualification, unit dosed pre-packs
- Often a tension about ownership between NMCP who have experience of implementing CCM/HMM and Child Health Unit of MoH – NMCP can be more powerful due to GF money
- Strong relationship with MoH at all levels is vital for successful implementation

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Some early lessons with ICCM

- Community members regardless of educational level, can be trained to diagnose and treat illnesses – good experience from Southern Sudan
- Difficulty of referring children to health facilities that have less stocks than community-based agents (CBAs) – need to strengthen health facility-based service delivery
- Ensuring that only under 5s receive treatment, difficult for CBAs to refuse treatment for older children
- Community involvement is vital for successful implementation

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Some Opportunities

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inSCALE
Innovations at Scale for Community Access and Lasting Effects

Opportunities: Supervision

In practice supervision is still often administrative, top down, irregular and of poor quality

- **Supportive supervision**: defines objectives and expectations, monitors performance, helps interpret data, provides focused education, helps with planning and problem solving and enhances community participation.

- **Combined supervision approaches are more effective than single strand strategies**: When supervision quality is poor the quantity appears to have no impact on performance.

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inSCALE
Innovations at Scale for Community Access and Lasting Effects

Opportunities: Motivation

Payment is not the only incentive!

- **Identity of the CHW both as an individual and as a member of a group:** The maintenance of positive personal and group identity
- **Goal congruence:** Achieving alignment of worker and program goals is indicative of improved motivation and performance outcomes.
- **Self efficacy of workforce and outcome expectancy:** The belief that they can perform in line with their own, their community's and the program's expectations, with anticipation that a desirable outcome will follow.

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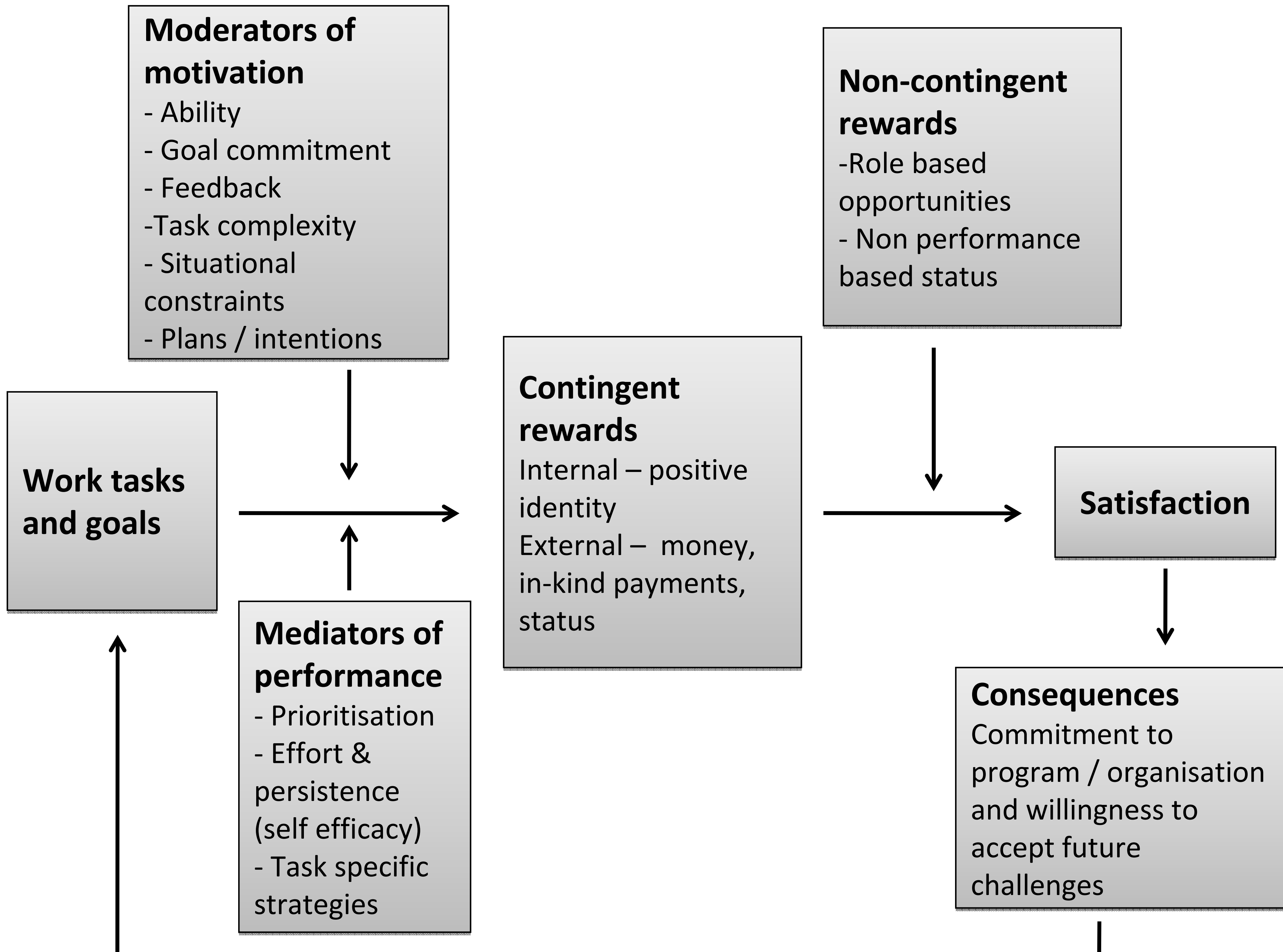
High performance cycle (Latham and Locke, 2002)



Some challenges

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Integration: Can be real hard work

Treat pneumonia

Treat diarrhoea

Treat malaria

Treat eye infection

Distribute ITNs

Treat scabies

Provide MDA

Provide maternal care

Treat cuts

Provide neonatal care

Immunization screening

Malnutrition screening / treatment

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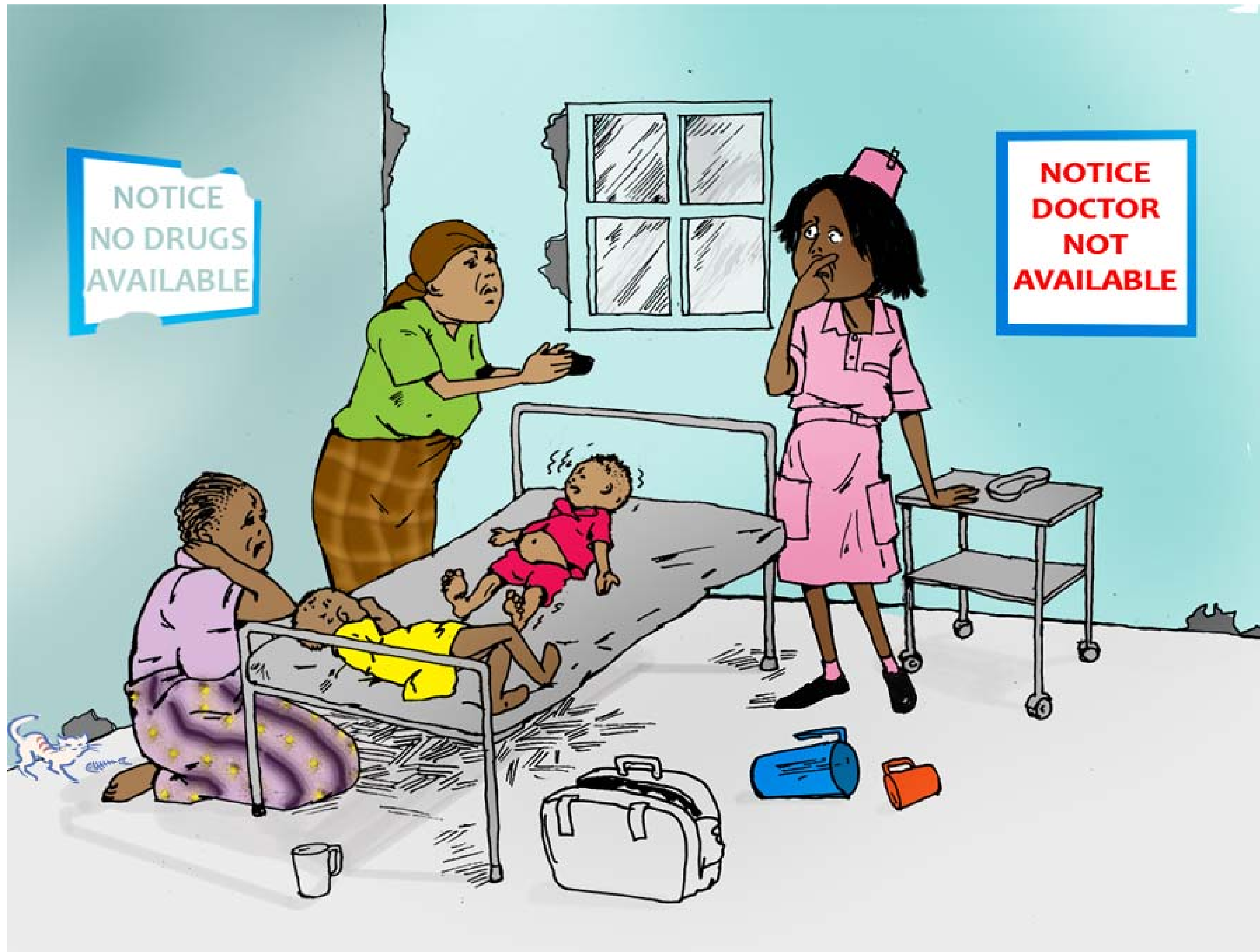
Referral to a weak health system



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Summary

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Keys to success

- Strong relationship with MoH at national and sub-national levels vital for successful implementation
- Community awareness, involvement and ownership are essential
- Capacity building of CBAs should be adequately addressed (knowledge and skills)
- Basic requirements of CBAs should be provided (tools, medicines/supplies and job aids)
- Supportive supervision should be regular and done properly
- Incentives (intrinsic or extrinsic) should be provided
- Avoid irrational integration of interventions: CBA work overload

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Thank You

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