SUSTAINABLE HEALTH

World Vision

Community Case Management Toolkit: Tools for Planning and Design

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In Malawi, child health interventions are being carried out by World Vision through Mposa programme in collaboration with other partners working in the health sector. In addition to conducting community meetings, Grinjer Thomas conducts home visits every three months. He also inspects children's weight, checks sanitary facilities, and at times issues medication to children who are sick.

Contents

Abbreviations

ACT	Artemisinin-based combination therapy (for malaria)
ADP	Area development programme
AIDS	Acquired immunodeficiency syndrome
ARI	Acute respiratory infection
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behaviour change communication
CCM	Community case management
CHC	Community health committee
CHW	Community health worker
CHW AIM	Community health worker assessment and improvement matrix
CMAM	Community-based management of acute malnutrition
COMM	Community groups
CVA	Citizen Voice and Action
CWBT	Child well-being target
DME	Design, monitoring and evaluation
DOTS	Directly observed treatment, short-course
DPA	Development Programme Approach
FBO	Faith-based organisation
GIK	Gifts-in-kind
HH	Household
HiB	Haemophilus influenzae type B vaccine
HIV	Human immunodeficiency virus
HMIS	Health management information system
iCCM	Integrated community case management
ICT, ICT4D	Information and communication technology, ICT for development
IDS	Immunisation, deworming and supplementation
IEC	Information, education and communication
IFA	Iron and folic acid
IMCI	Integrated management of childhood illness
INGO	International non-governmental organisation
IPTc	Intermittent preventive treatment of malaria in children
IPTp, IPTi	Intermittent preventive treatment in pregnancy, in infants
ITN/LLINs	Insecticide-treated nets; long-lasting insecticide-treated nets
mHealth	Mobile health
MNCH	Maternal, newborn and child health
MoH	Ministry of health
MUAC	Mid-upper arm circumference
NGO	Non-governmental organisation
NO	National office
ORS	Oral rehydration salts
ORT	Oral rehydration therapy
PCV	Pneumococcal conjugate vaccine

PHC	Primary health care
PHU	Public health unit
PMTCT	Prevention of mother-to-child transmission of HIV
RDT	Rapid diagnostic tests
SAM	Severe acute malnutrition
SBA	Skilled birth attendant
SO	Support office
TA	Technical approach
TB	Tuberculosis
TBA	Trained birth attendant
TTC (ttC)	Timed and targeted counselling
UNICEF	United Nations Fund for Children
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

Introduction

A growing body of evidence supports the fact that community case management (CCM) can reduce childhood deaths from the biggest killers such as pneumonia, diarrhoea, malaria, newborn infections and malnutrition.[1] The approach employs community-based interventions aimed at extending health care and treatment to hard-to-reach areas with poor access.[2] CCM is a strategy to increase access to care and deliver lifesaving treatment for common childhood illnesses. It expands the use of curative interventions, bringing care close to homes where most children under age 5 die from pneumonia, diarrhoea, malaria, newborn infections and malnutrition. It is implemented by trained and supervised community health workers (CHWs) and is linked to local health facilities. CHWs usually work out of their homes, a community centre or local health centre. CCM strategies are focused on training of CHWs in partnership with Ministries of Health (MoH) to assess, classify, treat, counsel, and refer children with signs of infection. CHWs are also trained to educate, counsel and train families to recognise and seek prompt care for danger signs of illness that indicate serious disease.

Successful CCM requires a strong and well-established community management structure as the basic mechanism to achieve expansion of curative services from health centres into the community. The community management structure is essential for improved governance, accountability and basic management of the network of community members involved in CCM. CCM also requires strong and functional links to the formal health structure and to a well-staffed and well-stocked local health centre that is implementing integrated management of childhood illness (IMCI), a facility-based approach initiated by UNICEF and the World Health Organization (WHO).

World Vision (WV) is currently engaged in a wide range of CCM programmes in multiple regions. The principle is to work in partnership with the MoH and other partners and within existing area development programme (ADP) plans and strategies. It complements WV's approach to building community involvement and community structures to provide management, supervision and support to CHWs. WV national offices (NOs) should understand the national government policy and support the rollout of CCM in alignment with new guidelines and in synchrony with other stakeholders, such as CCM-implementing partners, to ensure a consistent and unified CCM approach. In recent years, many governments around the world have begun to adopt CHW policies and health strategies which include CCM as a core approach. It has been recognised that community case management of individual diseases such as diarrhoea, pneumonia and malaria is less effective than an approach that enables CHWs to treat multiple presenting illnesses together. For instance, integrated CCM (iCCM) is promoted as the most effective strategy to reduce child deaths.[3]

Although national governments have plans for iCCM, they have limited capacity to implement and sustain it, and therefore in many contexts iCCM is being delivered through a coalition of multiple stakeholders working together to extend these basic services to communities in a sustainable manner. WV plays a key role in enhancing the community-based aspects of CCM and filling the gaps for MoH. Sustainability and partnership underpin WV's approach to promoting the adoption of iCCM in WV's projects and programmes:

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[1] CORE Group, Save the Children, BASICS and MCHIP, *Community Case Management Essentials: Treating Common Childhood Illnesses in the Community. A Guide for Program Managers.* Washington, D.C, 2012. <http://www.coregroup.org/storage/documents/CCM/CCMEssentialsGuide/ccmbook2012-online.pdf> accessed 26 June 2014.

[2] Bryce, J. et al. 'Reducing child mortality: can public health deliver?' *The Lancet*, Vol. 362, Issue 9378, 159-164. 12 July 2003. <http://www.thelancet.com/series/child-survival> accessed 26 June 2014.

[3] Young, M. et al. *World Health Organization/United Nations Children's Fund Joint Statement on Integrated Community Case Management: An Equity-Focused Strategy to Improve Access to Essential Treatment Services for Children.* WHO and UNICEF, Geneva and New York, 2012. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3748523/pdf/tropmed-87-6.pdf> accessed 26 June 2014.

- *We take a systems-based approach* – Unlike other project models iCCM does not stand alone in the context of a single ADP or grant-based project. For iCCM to be functional it must be adopted as a strategy with a seamless flow from household to health systems, and requires multiple support mechanisms from the local and district health authorities, local government, transport and supply chain systems and the support of community organisations. As such iCCM can be considered a health systems strengthening approach, rather than a project model per se. It is essential that iCCM is viewed within the context of the existing community health system, and that the CCM work feeds into those processes at a local, district and national level.
- *We are evidence-based* – WV aims to adhere to current international standards and guidelines for the delivery of iCCM, as well as to contribute to the evidence base through high quality monitoring and evaluation, and through building research partnerships to improve implementation science.
- *We are partners* – As a health systems strengthening approach, WV cannot work alone in extending iCCM to communities. As multi-stakeholder platforms emerge at national and district levels WV looks to contribute to and promote harmonisation of iCCM among actors to effect strong and sustainable change.
- *We are advocates* – Where iCCM is applied, we seek to leverage our local-level advocacy approaches to address those weaknesses identified in the delivery of iCCM from the household to the health systems, such as supply chain issues, linkages with health services, or strengthening of a sustainable CHW workforce.

CCM contributes to World Vision's 7-11 health strategy

World Vision's Global Health and Nutrition strategy, known as 7-11, is built around delivering evidence-based, cost effective interventions for pregnant women and for children under age 2 that, when taken together, can significantly reduce maternal and child morbidity and mortality. The key interventions are summarised in the table below, and those that are linked to the CCM approach are underlined.

Table 1. 7-11 interventions for maternal, newborn and child health as part of the 7-11 strategy

7 interventions for pregnant women	11 interventions for children under age 2
1. Adequate diet	1. Appropriate breastfeeding
2. Iron and folate supplements	2. Essential newborn care
3. Tetanus toxoid immunisation	3. Hand washing with soap
4. Malaria prevention, <u>treatment access</u> and intermittent preventive treatment	4. Appropriate complementary feeding (6 to 24 months)
5. Health timing and spacing of pregnancy	5. Adequate iron
6. Deworming	6. Vitamin A supplementation
7. Facilitate access to maternal health services: antenatal and postnatal care, skilled birth attendance, prevention of mother to child transmission of HIV, and HIV, TB and sexually transmitted infections screening	7. <u>Oral rehydration therapy, zinc</u>
	8. <u>Prevention and care seeking for malaria</u>
	9. <u>Full immunisation for age</u>
	10. <u>Prevention and care seeking for acute respiratory infection (ARIs)</u>
	11. Deworming (after 12 months of age)

For a complete description of the 7-11 strategy, refer to *The Global Health and Nutrition 7-11 Start-Up Field Guide,* available at wvi.org.

CCM contributes to child well-being

CCM contributes to all of WV's child well-being aspirations, specifically to the aspiration 'children enjoy good health,' and is fundamental to the child well-being targets (CWBTs). High level benefits that CCM has for WV programmes include:

- CWBT 2: Increase in children protected from infection and disease. CCM has a direct impact for children who fall ill due to pneumonia, diarrhoea and malaria, in low access and poorest areas.
- CWBT 3: Increase in children who are well-nourished. Children who get pneumonia, diarrhoea and malaria become malnourished very quickly as the gain made by nutrition interventions can be lost within a few hours.
- CWBT 1: Children report an increased level of well-being. Children who are healthy perform better in life and have a greater sense of well-being.
- WV's Child Health Now initiative goal: reducing preventable deaths due to major killers of children under age 5 by focusing on family and community health, in line with Millennium Development Goals four, five and six, particularly in the poorest and most marginal countries and regions in the world.

Introducing the WV CCM toolkit

This toolkit has been developed building on the rich experience of existing programmes and guidelines. The development of these guidelines entailed a literature review to understand the gaps and needs and a rapid assessment of existing tools, job aids and guidelines by each NO planning to implement CCM or iCCM. The toolkit is a how-to guide to be used for NO policy and strategy, assessment, programme design and planning. It is meant for health managers, at national and ADP levels, to aid in designing and implementing CCM and iCCM of childhood malaria, pneumonia and diarrhoea to achieve child well-being outcomes and targets and to ultimately reduce child morbidity and mortality. Design, monitoring and evaluation (DME) specialists will also find this toolkit useful as many times they are the frontline staff providing assessment and design support to ADPs, yet in many cases they may not have a public health background.

It includes tools for country preparedness, assessment, programme design, monitoring and evaluation and operational tools based on the gaps identified during the rapid assessment phase at each country level. Hence it can be used for new ADPs, ADP redesign and expansion to new geographic areas.

The toolkit includes:

- tools for planning and design
- tools for monitoring and evaluation
- operational tools.

Minimum standards for WV Global Health project models

Project models are intended to be developed based on evidence of a positive impact on specific outcomes. In the process of demonstrating evidence, strict controls are typically enforced on implementation procedure. As good models are scaled up, however, these controls often disappear and implementation procedures are degraded. This might almost be considered a natural effect as models are communicated from their original test sites to multiple implementation contexts. Dilution of implementation integrity is not uncommon through cascading training cycles and is magnified when implementers have little related technical knowledge and experience.

The World Vision International (WVI) Sustainable Health team has both positive and negative examples of project model implementation. It might be said that World Vision's Community-Based Management of Acute Malnutrition (CMAM) and Channels of Hope (CoH) implementations have careful control systems designed to maintain a high level of integrity through implementation standards and technical mentorship. Positive Deviance Hearth (PD-Hearth) and community health workers (CHW) projects, conversely, are chronically poorly implemented due to weak adherence to best practices. This is not solely a WV experience. CHW programming, for example, has historically been found to be highly variable in success, quality and sustainability.

To address the somewhat natural degradation of project model implementation, the WVI Global Health team has developed sets of essential elements and minimum implementation standards for each type of project model. The objective of this effort is to maintain the quality of intervention implementation per best practice recommendations so as to increase the probability of having a positive impact.

What the minimum standards can do

- Describe essential programme design and implementation elements of a project model or approach.
- Provide a benchmark of evidence-based recommended practices against which existing or developing projects can be compared.
- Be shared with partners, such as communities and health authorities, to negotiate minimum qualitative practices and advocate for improved methodologies and policies.
- In evaluation, enable comparison of project outcomes with achievement of best practices in model implementation.
- Reduce risk of poor outcome achievement.

What the minimum standards should not do

- Block programmes: As CHW programming in WV is implemented through partnership approaches between communities and government, in many cases WV will have limited remit to enforce the standards. When a programme element is assessed as weak in a design phase, this can be used to explore and find solutions. Where a solution cannot be found this will not necessarily cause WV to block the programme, but to inform the decisions ultimately made by project managers and technical advisors.
- Set an upper limit: The standards should not be taken as an upper limit for efforts to deliver on a project. Their use is for quality assurance or improvement. They are deliberately set at a minimum level in order to encompass a wide variety of circumstances. Therefore assessment against the standards should not be driven

by compliance, and programme managers should be encouraged to look for ways to surpass the standards in their contexts.

- Inhibit innovation: Where innovation has been well-evaluated and found to be effective, emerging good practices and creative approaches within the context should be shared and achievements recognised.

When should the standards be applied?

During programme design

The standards should be used to inform design teams on essential design elements to plan for. Where check-listing is used during a design phase, each standard can be rated according to feasibility in the context as high, medium and low.

During implementation

Mid project cycle, the standards can be used by any visiting staff. They can be used to frame qualitative inquiry with implementation staff and managers and rated according to the assessment scores. Subsequently, recommended actions for improvement can be made. They can also be used as a self-assessment tool to be completed by implementers during the project cycle. The standards represent a rapid appraisal methodology.

During evaluation

The standards can be examined by project evaluators as a qualitative evaluation tool. Whether implemented only at the end of a project, or in comparison of results over time, standard achievement can be used to describe how effectively a model has been implemented, and this information can be benchmarked with outcome achievement.

During stakeholder orientation

The standards represent a convenient outline for stakeholder orientation, quickly conveying the essential elements of the model. For example, NO senior leaders or support office (SO) programme officers might quickly assimilate the qualitative requirements of model implementation through reviewing the standards.

During research

The implementation standards should be carefully applied in research situations where models are implicated to ensure implementation integrity.

Assessment scores

During assessment, each standard may be attributed a score which is essentially a qualitative summary of achievement assigned subjectively by the reviewer.

Table 2. Scoring each standard

Score	Achievement	Description
0 – Weak	Below minimum standard	Project is currently not achieving the minimum standard for this element, or has excluded the element from implementation
1 – Satisfactory	Achieves minimum standard	Project is applying the minimum standard in this element
2 – Good	Above minimum standard	Project is surpassing the minimum standard in this element
3 – Excellent	Well above minimum standard	Project is surpassing the minimum standard and applies methods or approaches that are superior in achievement to the essential elements (with respect to inputs and processes and not to project outcomes)

Quality standards scoring sheet

Below is an example of how a standards score sheet might appear which could be used to address multiple core models implemented together.

Table 3. Standards score sheet

ADP: **Assessor name:** **Date of assessment:** **Project cycle phase:** (Design, implementation, evaluation)													
Model	**CVA**												
Essential element	1	2	3	4	5								
Assessment scores													
Agreed actions													
Model	**COMM**												
Essential element	A1	A2	B1	C1	C2	C3	C4	D					
Assessment scores													
Agreed actions													
Model	**CHW FUNCTIONALITY**												
Essential element	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Assessment scores														
Agreed actions														
Model	**TTC**												
Essential element	1	2	3	4	5	6	7	8					
Assessment scores													
Agreed actions													

Quality standards for CHW programme models

Aim of the CHW programming standards

Many of the weaknesses in community health worker (CHW) programme delivery are common across countries and regions, based on limited financial and human resources and a lack of clarity around needs and standards amongst different stakeholders. Common weaknesses include insufficient ongoing training, inadequate supervision, lack of supplies and sustainable supply chains, and poor trust relationships between CHWs and health centres and the communities they work for. Significantly, attrition rates are high and motivation amongst CHWs as a voluntary cadre affects programme costs and the effectiveness of interventions. Many activities, such as CCM, benefit from CHWs having years of experience and familiarity with the methods; therefore, retention and motivation strategies are important to ensure long-term commitment and programme quality.

However, the programming standards apply to regional and local application and should be upheld even where MoH guidelines do not necessarily support best practice as yet. WV therefore strives to uphold these standards in its CHW programming, and has identified tools that will enable NOs and ADPs to gauge where they stand and what they ought to do to improve CHW programming in their areas. Guidance is provided on the minimum standards required for every essential element of CHW programming assessed.

CHW principles of practice and harmonised approaches

The principles of partnership with the MoH and local health authorities, and harmonisation with other non-governmental CHW programmes, are at the centre of WV's delivery approach. CHW programmes have often evolved from grassroots origins, resulting in diverse methods being applied by different actors. Many countries are now working towards establishing national standards for training, supervision and reporting, for example. Endorsing these actions at national and regional levels should lead to improved community health systems and country ownership. To this end, WV, in partnership with the CORE Group (www.coregroup.org), developed the CHW Principles of Practice.[4] These principles are embedded within a vision for CHW programmes that aims to work with existing health structures through strong, long-term partnerships in order to deliver consistently high standards of quality implementation, training and support and to enable community health workforces that are sustainable, functional and effective and that can be successfully implemented at scale. Seven principles that guide the essence of WV CHW programming are incorporated into the CHW programming standards. These principles also form part of the WHO framework for harmonized support for CHW programmes.[5]

[4] Walker, P. et al. *CHW Principles of Practice: Guiding principles for non-governmental organizations and their partners for coordinated national scale-up of community health worker programmes*. CORE Group and World Vision International, 2013. <http://www.coregroup.org/storage/Program_Learning/Community_Health_Workers/CHW_Principles_of_Practice_Final.pdf> accessed 26 June 2014.

[5] Sigrun Mogedal, S., Wynd, S. and Afzal, M. *Community Health Workers and Universal Health Coverage: A Framework for Partners' Harmonised Support.* Global Health Workforce Alliance, 2013. <http://www.who.int/workforcealliance/knowledge/resources/frame_partner_support/en/> accessed 26 June 2014.

Box 1: CHW principles of practice

The seven guiding principles
Non-governmental organisations working in CHW programming should endeavour to work with national and regional health authorities and all collaborating partners, understanding that each country will vary in its approach to CHWs, in order to:

1. Advocate for the legitimisation and recognition of appropriate CHW cadres within the formal health system through country policies and initiatives that support registration, accreditation and minimum standards for the role and performance of different cadres.

2. Enable and support country leadership including national or regional coordination bodies developed under a multi-stakeholder approach, empowered to provide oversight in CHW programme implementation across partner organisations, health authorities and communities.

3. Work with and through existing local health services and mechanisms where possible to strengthen them, avoiding the creation of parallel services, methods and supply chains or competitive working practices, while reinforcing the supportive role played by communities.

4. Establish standards and methods for the motivation and support of CHWs which are ethical, non-competitive, sustainable and locally relevant under a unified country policy.

5. Develop minimum standards of needs- and resource-based training and continuing education of specific cadres of CHWs, as well as necessary minimal tools, under an agreed unified system linked to accreditation.

6. Support unified mechanisms for reporting and management of community health worker data that promote consistent quality monitoring and accountability to existing health structures and communities reinforcing local use of data for decision-making.

7. Maximise the NGOs roles in supporting CHW research, developing appropriate low-tech innovations, and judiciously taking to scale evidence-based cost-effective solutions made available in the public domain through partnership approaches.

CHW AIM functionality matrix

The WV CHW programming standards are also based around the USAID Community Health Worker Assessment and Improvement Matrix (CHW AIM),[6] a tool that was developed to help ministries, donors and non-governmental organisations (NGOs) assess and strengthen their CHW programmes to improve their functionality**.** The first step in WV CHW programming is to use the CHW AIM to assess the status of the CHW structures that deliver the various programming models. In many cases, after the CHW AIM assessment it will be found that WV has limited remit to improve specific elements. In such cases, a given functionality score can be viewed as a minimum standard, and higher-level guidance can be sought to improve the element if necessary.

The tool is built around 15 necessary programmatic components derived from evidence-based good practices (Figure 1). It provides a framework for the evaluation of national CHW guidelines as well as their implementation in field sites. The assessment would typically take place during the planning stage of a CHW-centred project or programme as part of project baseline activities, or it would have been conducted at least once by the local or district health

[6] Crigler, L., Hill, K., Furth, R. and Bjerregaard, D. *Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services*. USAID, 2011. <http://www.urc-chs.com/uploads/resourceFiles/Live/CHWAIMToolkitcomplete.pdf> accessed 26 June 2014.

authority within the last two years. The process should involve local or regional stakeholders to identify elements that need strengthening between households, the community and health centres.

Project models that are specifically aimed at CHWs, such as timed and targeted counselling (ttC) and CCM, should aim to have a functional CHW programming structure as a pre-requisite. A functional programme refers not only to the selection, recruitment and training of CHWs, but also to the structures and systems that are necessary to support the CHWs in their work.

It is not enough to train CHWs and set them loose without first ensuring that the essential components of a functional CHW programme are in place. The CHW AIM matrix can be found in the CHW Program Functionality Tool [7]. The tool has scores from zero to three, and each of these scores for the different programmatic elements is explained. In working with different stakeholders in a workshop setting and using validation tools in the field, stakeholders agree on the rating and what needs to be done.

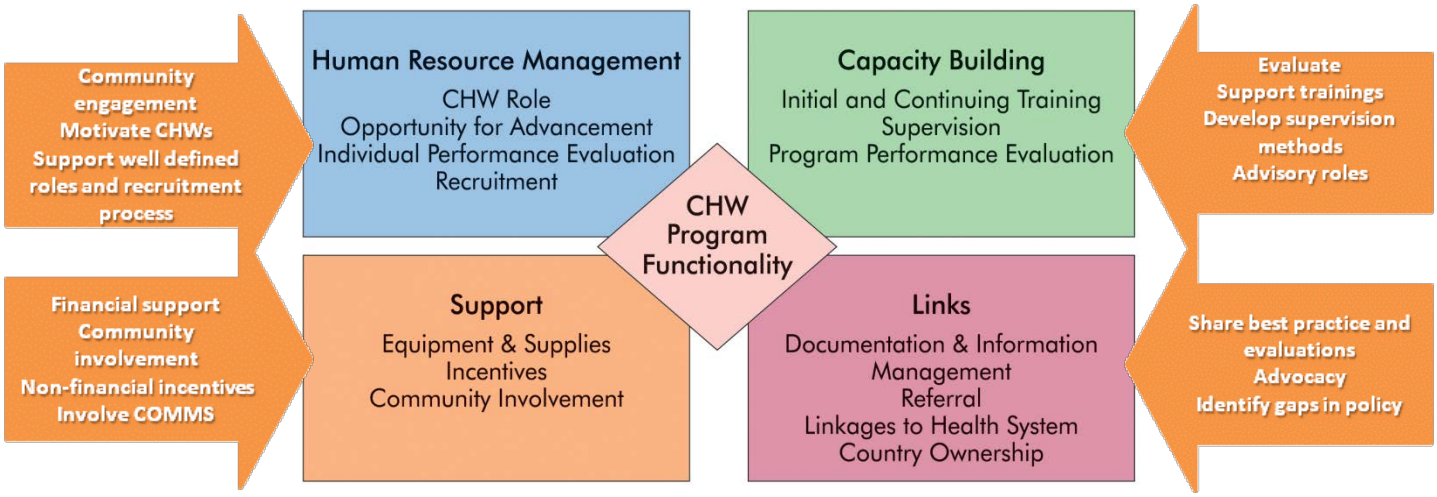


Figure 1. CHW AIM functionality matrix and World Vision support mechanisms: shows the CHW AIM functionality matrix with the 15 functionality elements. The orange arrows show some of the ways in which WV partnership approaches can be used to strengthen the components.

[7]Community Health Worker Assessment and Improvement Matrix (CHW AIM): A Toolkit for Improving CHW Programs and Services http://www.who.int/workforcealliance/knowledge/toolkit/50.pdf

Quality standards for CHW programming

Table 4. CHW programming standards

Essential elements and recommended practices	Minimum standards for implementation
1. CHW functionality assessment is carried out prior to or during the project planning phase.	
Recommended practices: Functionality assessment is conducted at a national level to assess policy environment and guidelines during country readiness process for model expansion (ttC or CCM). CHW AIM tool along with CHW demographic and educational profile information is captured during planning or baselines. The NO should coordinate assessment of current functioning of existing CHW programmes for 15 programme components preferably in collaboration with district health partners.	• CHW functionality assessment conducted as part of project baseline activities (or has been conducted at least once by the local or district health authority within the last two years). • Health authorities engaged in design, implementation and analysis. • Results shared with CHWs, community groups (COMM), local health authorities and the MoH.
2. CHW recruitment process is community-driven, transparent and engages all existing cadres without the creation of new ones.	
Recommended practices: Community members and target beneficiaries are directly involved in recruitment through a democratic process, and empowered to remove and re-elect CHW if deemed unfit. Selection criteria and core competencies are available and transparent to all those involved, and appropriate for country context (culture, language, literacy, gender).	• A minimum CHW AIM score of two or above. • CHW is selected from the chosen community and currently resident there. • Community is directly involved in the recruitment of the CHW, including women.
3. CHW role is designed with clarity, including competencies with agreement of community, CHW, and health system.	
Recommended practices: Process for discussion and update to CHW role is in place. Expectations of CHW regarding time, role, protocol, incentives, supervision and training are clearly documented. Guidelines are aligned to national policies and available to CHW, health staff and community.	• A minimum CHW AIM score of two or above.
4. Initial CHW training is sufficient to prepare them for their role with appropriate time, trainers and practical training.	
Recommended practices: If required by the MoH, standardised basic training modules are to be completed prior to any subsequent training modules. Training is consistent with health facility guidelines and existing policies and local health staff conduct or are involved in training. All records of training should be maintained. practical skills training and support included in all trainings.	• All new training modules only introduced once basic competency based training required by MoH is completed. • Field practical skills training for at least one day. • Programme maintains a record of trainings per individual.

Essential elements and recommended practices	Minimum standards for implementation
5. Ongoing training is planned to ensure necessary revision and skills-building and considers estimated attrition rates.	
Recommended practices: Ongoing training provided to update CHW on new skills, reinforce initial training, and ensure protocol compliance. Replacement rates can be as high as 40 per cent per year and need estimating prior to project. Training is tracked and opportunities offered in a consistent and fair manner to all CHWs. The health facilities are involved in all training events.	• Refresher training plans for at least four days per year throughout the project cycle. • Reselection and attrition rates are predicted at least 10 per cent, and budgeted for 10 per cent retraining of new volunteers per year.
6. Equipment and supplies are available and sufficient to deliver services including medicines, supplies, and job aids.	
Recommended practices: Medicines and materials are channelled through existing supply chains where possible, assure functionality avoiding parallel systems. Medicine supply is linked to supervisory mechanisms, and technically competent staff check and update stocks including expiration dates, quality and inventory to ensure no substantial stock-outs.	• Existing supply chains are utilised and strengthened during project. • Stocks and job aids quality assessed at supervision at least twice per year (as part of supervision).
7. CHW supervisors are trained, equipped and supported to conduct regular supportive supervision with at least 4 contacts per year.	
Recommended practices: Supervisors are trained in supportive supervision methods and have basic supervision tools (checklists) to aid them, and sound technical knowledge. Community, CHW and PHU have clear guidance on supervisor role. **Frequency:** A suitable time frame is established for supervision, with face-to-face contact regularly planned. Include more supervision in year one. **Ratio:** An appropriate supervision ratio of CHWs: supervisor is established, e.g. 30 CHW per supervisor. Supervision data are available to community members and community health structures.	• Supervisors have completed basic competence training on the programme model and are selected as those with a background in the technical area of implementation. • At least four face-to-face contacts with supervisor per year.

Essential elements and recommended practices	Minimum standards for implementation
8. Supervision activities are designed and implemented to identify and resolve individual performance quality.	
Recommended practices: Supervision, typical one of the weakest areas of programming, is essential for the learning progress of CHWs. Individual mentoring may have more impact on skills and quality than classroom training alone. Clinical models such as CCM and community-prevention of mother-to-child transmission of HIV (PMTCT) do require adequately trained clinical mentors. *Highly recommended:* • Qualitative data review: use of CHW diaries to review information on barriers to service access. • Trouble shooting (technical advice) is offered during supervision. • Problem solving (non-technical) is offered during supervision. • Refresher training: knowledge checking, revision exercises or additional training using the CHW manuals during supervision as required by CHW.	• *Case assessment:* Home visit and assessment of at least three recorded cases to ensure service quality, focussing on adverse events, referrals and follow up for quality monitoring four times per year. Especially important in CCM and treatment programmes. • *Observation of service delivery:* home visits done with CHW, providing skills coaching through observation. At least twice, as soon as possible following training as part of practical CHW training. • *Record review, data collection and reporting:* Data gathered is used for problem solving and coaching, conduct at every supervision (four times per year).
9. Individual performance evaluation occurs at least annually and is designed to fairly assess work and improve quality.	
Recommended practices: Individual performance is evaluated using time-series data and supervision is in place and is widely known by supervisors, PHC staff and CHWs, incorporates community involvement including beneficiary feedback, and is linked to rewards (financial or other).	• At least once per year, a minimum of four goal indicators of programme coverage are tracked through time-series at the individual CHW level. • Community inputs are incorporated and performance is rewarded and recognised.

Essential elements and recommended practices	Minimum standards for implementation
10. Incentives: Standards and methods for performance-based incentives are ethical, non-competitive, sustainable, and under a unified country policy. (See 'Box 1: CHW principles of practice' for more information.)	
Recommended practices: • One country one policy: Where a national policy is not in existence, investigate the incentives paid by MoH and NGOs in the surrounding areas, and convene meetings to achieve an agreement in which incentives will not vary widely or be competitive at district or regional if not national levels. MoH should sign off on the agreed rates. • Community participation and accountability: Community involvement, transparency and accountability are very important in the determination of the incentives. To avoid conflict the incentives schemes need to be explained, agreed and documented in a transparent manner. • Non-payment of services: CHWs should not receive financial incentives from families via sale of services which may result in service inequality to the poorest households. • Sustainability: Financial incentives paid for activities including both short term and long term projects, an agreed stipend should be applied to all circumstances which can be recreated in an ADP budget or similar. • Reasonable compensation: Incentives provided in line with expectations placed on CHW, based on the estimated number of work hours applied. *Suggested practices:* • Performance-based application: Linked to successful supervision or performance evaluation, subject to provision of expected services. Not given for non-activity and reported misconduct. • Non-financial incentives and advancement, e.g. training, certification, advancement opportunities, uniforms, medicines, bicycles etc., are awarded in accordance with project needs with agreement with MoH and communities.	• Incentives are developed in collaboration with MoH and partners in line with local or national policies and practices. • Community is involved in incentives and provides feedback on performance which is taken into consideration. • No payment for services is applied. • Incentive scheme is comparable and sustainable across all project types in the area. • Incentives are in line with expectations placed on CHW in time and opportunity cost. • Incentives given are linked to performance-based assessment and not given in cases where CHW is not active. • Job tools (e.g. phones, bicycles) are for exclusive use of CHW and are documented and transparent. They should not be given by beneficiaries as payment.

Essential elements and recommended practices	Minimum standards for implementation
11. Communities are continuously engaged in the support of CHW's work at all levels, and kept informed.	
Recommended practices: The community, including the beneficiaries, should be involved in the project planning, feedback, review and incentives to the CHW. Community leaders or existing health committees have ongoing dialogue with CHW regarding health issues in village using data gathered. Community provide feedback during supervision visits to resolve issues.	• Community-wide meetings to discuss and sensitise on CHW initiatives should take place at least once per year. • COMMS or community health committees (CHCs) should be involved in feedback review of CHW supervision at least twice per year (CHW debriefing sessions).
12. Referral system for emergency evacuations of cases is in place and referrals documented.	
Recommended practices: CHW has a logistic plan for referral and current knowledge of emergency transport and funds if available. CHW records all emergency referrals recommended and then follows up in the home at least once to ensure referral compliance and care. CHWs should report and record the result of the referral and experience of client (client discharge guidance). Counter referral is encouraged to enable increased communication on specific cases to the CHW and to improve case management.	• A facilitated referral system is in place and referrals and evacuations are recorded. • Post-referral follow up visits by CHWs are conducted for all emergency evacuations. • Counter referral system is available to the health centre for severe or chronic cases.
13. Opportunity for advancement, growth, promotion and retirement for CHWs is considered.	
Recommended practices: Advancement (promotion) offered to CHWs who perform well and express interest in advancement if opportunity exists (formal accrediting or role change). Advancement rewards good performance or achievement, based on fair evaluation.	• A minimum CHW AIM score of two or above.
14. Documentation and information management is in place which is consistent, transparent and used for service improvements.	
Recommended practices: CHWs document activities consistently using appropriate job aids. Supervisors monitor quality of documents and provide help when needed. CHWs work with supervisor or facility to use data in problem-solving at the community. Health staff are involved in reviewing data, and systems are aligned to WV's health management information system (HMIS).	• A minimum CHW AIM score of three. • Data submitted to health facility or authority on a quarterly basis. • Data is made available to COMM twice per year.

Essential elements and recommended practices	Minimum standards for implementation
15. Linkage to the greater health system.	
Recommended practices: CHWs are formally recognised by the health authority in a direct relationship and not solely to the project. Links between the community health structures managing CHWs and the district health authorities are built through regular communication, contact, meetings and training events. Two-way reporting and sharing or information and data are supported throughout the project cycle. Each CHW is assigned to a PHC technical staff member with a personal mentoring relationship and direct contact.	• A minimum CHW AIM score of two or above. • CHW has a direct reporting relationship to the local health facility or authorities. • CHW community management structures and district health teams should interact at least twice yearly.
16. Programme performance evaluation.	
Recommended practices: • There is a general programme evaluation of performance against targets, overall programme objectives, and indicators that is carried out on a regular basis. • There is a yearly evaluation conducted of CHW activities, assessing achievements in relation to programme outcomes and targets. Includes evaluation of the quality and coverage of service delivery and community feedback. Health staff also provide feedback based on data received from CHW. Feedback given to CHWs on programme indicators and targets and against standards.	• Programme evaluation should be scheduled to occur after 12 months in the first instance, and every 18 months thereafter. • Includes CHW functionality assessment and time-series programmatic data. • Report findings summary shared at local, regional and national levels with partners.
17. Country ownership: National level MoH partners have direct involvement, oversight and decision-making powers over programme methodology and implementation and review processes.	
Recommended practices: Ideally work should be done through partners as much as possible, ensuring that all trainings and skills that WV supports are building the capacity of these state actors to continue the project in WV's absence. A national-level committee coordinates CHW programming involving key stakeholders, MoH and partners. WV activities promote legitimisation of CHWs and task shifting within the national health service and are in alignment with existing MoH strategies. MoH partners are involved in training at national and regional levels and retain rights to review methods. MoH involved in all stages of including piloting, curricula choice and adaptation, incentives, data systems and evaluation. Adequate accompanying activities contributing to health systems strengthening are applied.	• A minimum CHW AIM score of two or above.

Quality standards for community case management

Additional considerations for CHW programming standards and CCM

For CCM projects to function effectively they must first ensure functionality of the CHW programming structure, a prerequisite for introducing CCM. This has been described in the previous section on minimum standards for each CHW programming element. Projects should work to meet the minimum standards, whilst for CCM, it is important to pay attention to the details required for specific elements. Table 3 describes what programmes ought to pay attention to. This framework is particularly important for the technical staff who review project documents. These elements should be used as a checklist for critical activities that should not be left out.

CHW recruitment process

Where national CCM programmes are endorsed there are clear guidelines for which categories of CHWs ought to be targeted for CCM. Follow the country guidelines as this contributes to the health systems strengthening. Ascertain that the CHWs targeted for CCM underwent the basic training. If they did not, budget for and work with the MoH to provide this training.

CHW role

CCM tends to provide a superior image for CHWs. Ensure that the role of the CCM CHWs does not overshadow the basic CHW roles. Clearly involve community structures and community leaders to explain the additional role that CCM CHWs have, and the importance that all CHWs in the catchment area play in health promotion activities.

Ongoing training

CCM will provide CHWs with additional training to do their job. This falls under the category of ongoing training as described in the functionality assessment. Use the established MoH or WHO standardised curriculum, and ensure that MoH staff provide this training. Given that CCM is a competence-based package, budget for refresher trainings as well. These should focus on elements of quality of care, ensuring that challenges identified during the course of supportive supervision and monitoring activities are addressed in these subsequent trainings.

Equipment and supplies

It is important that all projects utilise existing supply chains where feasible and establish sustainable long-term plans for medicines management. See the iCCM standards for the use of gift-in-kind (GIK) supplies.

CHW supervision

CCM supervisors for technical support should be qualified integrated management of childhood illness (IMCI) trainers, preferably health technicians. Feasibility of division of labour in terms of technical and non-technical support supervision amongst MoH and programme staff might be considered. If the readiness assessment indicates the absence of IMCI-trained health personnel, budget for this training.

Case assessment and case management observations as well as medical stock quality checks can only be conducted by trained staff. It is crucial that plans include activities that will be supportive of technical supervision. Data records and non-technical elements could be supervised separately and this latter aspect can be done through creative means like peer supervision.

Community involvement

Ensure that plans clearly include community engagement activities that will explain the role of CCM CHWs. Alongside this, emphasise the role of all CHWs in health promotion. This will help avoid the appearance that some CHWs are more special than others.

Referral and linkage to health system

Place additional emphasis on CHW post-referral follow-up in the community after facility-based treatments. This is particularly essential in CCM programmes. All CCM CHWs should have a direct reporting relationship with the local health facilities and authorities rather than to project staff.

Country and ADP readiness assessment

Besides conducting the functionality assessment, when planning for CCM, it is also crucial for a country and ADP readiness assessment to be done. A rapid assessment of all the health facilities in the target CCM area should be done in the ADP and in the referral units beyond the ADP catchment area.

CCM minimum standards

Good programming starts with a good assessment. This will lead to a good design that addresses the critical gaps identified during the assessment and that will ensure quality CCM programming. It is important, therefore, that the NO and ADP pay attention to the details of the process because it will reflect in the outcomes of the intervention. The following tables outline this three-part process:

5.1. Project design phase standards
5.2. Programmatic implementation standards
5.3. Technical implementation standards.

Table 5. CCM programming standards

Table 5.1. Project design phase standards

Essential element and recommended practices	Minimum standards
1. National Level planning processes for CCM are undertaken prior to consideration of model implementation.	
Recommended practices: Prior to proceeding with CCM for the local or regional levels within a country, complete the national level planning steps need in collaboration, with the MoH representatives where possible. Initial steps should include a needs analysis for integrated CCM (iCCM) and which services within the package can and should be provided, conduct a review of existing policies and guidelines which support or hinder CCM or CHW functionality, as well as mapping CCM efforts of other agencies within the country.	• Needs assessment and situation analysis for package of services conducted. • National policies and guidelines for CCM reviewed. • Mapping of CCM partners conducted.
2. CCM strategies are developed through regular and transparent MoH and multi-stakeholder engagement.	
Recommended practices: In countries where more advanced CCM policies are present, there may be a unified strategy or policy in place. If not, multi-stakeholder engagement may be a necessary part of national level planning. Ideally the country would have established working groups for national collaboration (e.g. CHW working groups and consortia), in which World Vision may participate. Project planners should develop work plans together with the MoH and other important stakeholders and draft protocol for project process.	• Key stakeholders implementing CCM are engaged regularly throughout national level planning processes, to define roles and discuss current policies held. Any existing NGO coordinating group where existent should be engaged in planning. • Participate in existing routine stakeholders meetings held to ensure coordination of CCM partners. • Establish written statement of protocol or working guideline between WV, stakeholders and MoH.
3. Curriculum content should be IMCI-aligned and inclusive of essential components and skills.	
Recommended practices: Where a MoH approved CCM curriculum exists it should be used and compared to the curriculum checklist to identify any weaknesses and explore options for improvements to the existing materials. All materials must be IMCI-compliant and approved within country.	• 80 per cent or more of the topics are covered within the curriculum review checklist (Table 8). • All curricula selected are agreed on by the MoH, WHO and UNICEF representatives in country for IMCI alignment.
4. Package of materials is inclusive of training materials, treatment and care guidelines for CHWs as well as ethnographically accurate pictorial aids for family counselling.	
Recommended practices: Ensure training methods and tools are consistent across programmes according to a high standard and are inclusive of diverse training methodologies. CHW materials ought to be provided at appropriate literacy level, which they can use for revision and field level trainings. Facilitator's manuals should be provided to guide trainers through the correct steps and apply multi-method training techniques. Ideally supervisor's manuals should be provided which can support the process of revision and support supervision in the field. Household and CHW job aids are provided for all CHWs to support the process of	• Facilitator's manual available to enable the trainers to deliver training to CHWs. • Training package is appropriate for non-literate CHW and volunteers and all appropriate translations are provided. • CHW manuals or job aids including dosage and treatment protocols and care of the sick child are available for every CHW in a suitable format to accommodate their literacy level. • CHWs have pictorial job aids used for counselling families on care of the

Essential element and recommended practices	Minimum standards
household counselling, giving and keeping medicines safely, and care of the sick child. Job aids must be appropriate for illiterate users, and field tested in ethnographically equivalent communities.	sick child. All materials to have undergone field testing in ethnographically equivalent communities prior to use.
5. Long-term sustainable medical supply and restock strategies are established, and include quality, theft and stock out checking systems.	
Recommended practices: At project outset, WV may be required to provide buffer stocks. Long term plans should be developed from the outset to ensure the renewability of the stock supply and quality and consistency of existing supply chain mechanisms. Ensure a resupply logistic system for CCM and standard operating procedures developed, by which CHWs can report stock outs and procure quickly between supervisions. Inventory control must include appropriate checks and balances against misuse and quality control which is evaluated during supervisions. Buffer stock quantities should be appropriately estimated by usage rates to avoid distribution of stock quantities which may expire or spoil in field conditions prior to use.	• Projects utilise and strengthen existing supply chains them rather than establish parallel mechanisms. • Stocks of medicines and supplies at all levels of the system monitored regularly (through routine information system and supervision), including medical stock quality controls at least twice per year. • A system for preventing misuse of medicines is in place with more than one person overseeing the medical stocks (e.g. a two-key box system).
6. Training of CHW is done by qualified IMCI trainers, is a minimum of ten days for new recruits and includes two days of practical experience.	
Recommended practices: Only qualified trainers can be used, preferably local health authority staff. CHWs need more time than facilitators to learn the materials, and may need greater practical support. Ratios of classroom sizes should be kept low, ideally 15 per facilitator, not more than 30. Ensure time is sufficient to cover all materials, possibly applied in a modular approach so that individual trainings do not overwhelm participants. CHWs should undergo a form of competency-based practical assessment before they are formally approved to provide treatments and supplied medical stocks. If CHW have received no training within the last two years, consider a five day refresher training including practical experience and assessment.	• Only qualified IMCI trainers are used to deliver training to facilitators. • Class size for the trainings of CHW will not be more than 30 CHW per trainer. • Minimum number of ten days is met for the face to face training of the CHWs, and will include a substantial proportion of field level practical exercises (at least 2 days of the 10). • CHWs are certified for iCCM protocols according to national standards.

Table 5.2. Programmatic implementation standards

Essential element and recommended practices	Minimum standards
7. CHW allocation and household coverage is reasonable and not more than one CCM CHW per 100 households.	
Recommended practices: It is generally recommended that CCM CHWs are not allocated to communities within 5 km of a health facility, as CCM is an alternative to professional medical services. Depending on the country policy this strategy should be observed, however where WV implements CCM, all communities greater than 5 km from a health centre and with more than 20 households should have at least one competent CCM CHW. Due to the high workload with CCM, a recommended ratio would be 50 households per CHW, but no more than 100 households in any context. In many areas the CHWs will already have been identified and have undergone prior training. During project designs, it is useful to provide mapping of the areas where they are covering, particularly where there are multiple CHWs working in individual communities. Regional health authorities should undersign any agreement on CHW allocation and supervisor distributions and new recruits.	• One CCM competent CHW to serve no more than 100 households. • All communities further than 5 km from a functional health centre, and with more than 20 households should have at least one competent CCM CHW.
8. Community health systems are strengthened and guided to support CCM activities (COMM engagement).	
Recommended practices: Community health committees (COMMs) should be identified programming in all proposed CCM project areas. COMMs will need to receive adequate orientation training in order to: • provide support, oversight and promotion of CCM CHWs, and participate in the supervisions and manage any grievances that emerge. • At least one member of COMM should have oversight of medical supplies. • A meeting every one to six months should be encouraged, not necessarily facilitated by WV which actively seeks to integrate other community based health activities with CCM, amongst existing community health actors.	• All projects have a functional COMM or equivalent community based group who are actively overseeing CCM CHWs. • COMM receive an orientation training (developed in-country) within one to two months of start-up, which includes key programme aspects, key health messages, overview of data collection and reporting the CHW debriefing process and enables them to provide adequate oversight of CHWs work. • COMM participate in CCM CHW supervision debriefings at least once every six months. • CCM CHWs meet to integrate their activities with other community health actors once every six months. • A system to measure COMM involvement is in place.

Essential element and recommended practices	Minimum standards
9. Community sensitisation activities involve key community stakeholders, include house-to-house approaches and are designed to target the most vulnerable and high risk households.	
Recommended practices: Cultural religious and community leaders in communities ought to be engaged in CCM and the promotion of service uptake and demand. Strategies should be developed for communicating CCM with local leaders, health providers, CHWs, communities and other target groups. Community sensitisation during start-up should be delivered in a house-to-house way, especially reaching households that are most vulnerable or at risk of child mortality, such as: rural and isolated households, single or adolescent mothers, families affected by HIV and AIDs or TB, large families or those living in conditions of extreme poverty, and families in which there have been recent cases of child death or child malnutrition. Care-seeking behaviour varies widely within communities and not all households are likely to actively seek CCM in the event of child illness, efforts to engage those at most risk of child deaths are part of a successful CCM strategy.	• Community sensitisation activities which promote CCM should take place at least once per year during the project. • CHWs conduct house to house sensitisation during roll out of CCM including households considered to be the most vulnerable.
10. Health services assessment and health systems strengthening approaches are incorporated into project planning.	
Recommended practices: During project set up, a health facility functionality assessment can be used during planning to ensure that services at referral centres are fully functional and able to manage severe cases Specifically, they should be able to provide inpatient care, management of severe pneumonia and neonatal sepsis. Typically CHWs may make referrals to the nearest basic health facility which may be unable to provide this high level care, so a preferred strategy would be to refer directly from the community to secondary level care facilities. Visit all primary health facilities in the ADP where work is planned, assess service available and readiness to treat second line IMCI care. Links between facilities and CHW activities are strengthened through referral and counter referral, as well as improving communication access where possible. • HMIS training should be considered to ensure adequate management of the project data at the health centre with data aggregations and summaries at least twice per year. • Health facilities should be directly involved in the trainings, supervision and reporting line for the CCM CHWs. • As per needs assessment, undertake activities to strengthen delivery of maternal, newborn and child health (MNCH) services: o IMCI refresher training and facility based supervision o Neonatal care training and support o Mobile clinics for IDS o CHW supervision systems and data support o Advocacy and Citizen Voice and Action (CVA).	• A list of IMCI health facilities is in place. • Selected referral facilities should attain basic minimum standards according to child and maternal health services assessment (rapid or WHO assessment model). All selected referral facilities have: o IMCI-trained and competent staff o Overnight duty and inpatient care o Competence to treat severe and complicated malnutrition o Competence to treat severe pneumonia and malaria using IV and IM medicines o Neonatal (zero to four weeks) care facilities o Functional vaccine cold chain. • CCM monitoring systems should be aligned to HMIS and CHWs should report directly to health facilities as required. • Communicate with other NGOs working locally to ensure no duplication of Health Systems Strengthening (HSS) activities are occurring within the same facilities.

Essential element and recommended practices	Minimum standards
11. Project staffing and training.	
Recommended practices: For each ADP implementing CCM, it is recommended to have at least on ADP manager and one health dedicated development facilitator staffing per ADP. In addition to this, at a regional or district level, or where multiple ADPs are covered under the programme, one public health qualified technical resource person is advisable. • If MoH is to conduct supervision, work with regional and national MoH staff to consider human resources capacity for training and supervising CCM. They should be able to provide commitments over number and frequency of supervision events. Supervisor ratios may vary between contexts, and if availability of IMCI qualified supervisors is low consider separation of technical and non-technical supervision elements. • If WV is to conduct supervision, WV staff who are IMCI qualified can supervise technical components under permission from MoH if needed to provide supervision coverage.	• One ADP manager and one health-dedicated development facilitator per ADP. • All programme management staff will have undergone an orientation on CCM methodology led by the MoH or public health unit staff overseeing CHWs. • Where public health unit staff unable to supervise regularly considers supervising technical aspects separately, and non-technical aspects using project staff.

Table 5.3. Technical implementation standards

Essential elements and recommended practices	Minimum standards
12. Service delivery methodology is developed with clear protocols and home based care follow up.	
Recommended practices: National guidelines and protocols are to be applied in all conditions, unless for the purposes of piloting and research, under which conditions MoH approvals are sought at highest level. Where possible, aim to include in the service delivery model high recommended practices: • Home based care protocols for the sick child. • Referral of all cases if child does not recover after 24 hours. • Post-referral follow up visits: assessment of recovery and re-referral deadline (48 hours if child does not recover).	• National guidelines on care and treatment of the sick child in the community should include: o Plan for rational use of medicines and diagnostics (RDTs where appropriate) by CHWs and patients. o Guidelines for clinical assessment, diagnosis, management and referral by CHWs developed. • Home-based care follow-up visits for all illnesses are conducted at days two (24 hours post treatment), three, five and eight to ensure recovery.
13. Management of diarrhoea in the home using low ORS and zinc, home care, hygiene and improved feeding.	
Recommended practices: CHWs under World Vision CCM projects to provide only oral rehydration salts (ORS) solution with zinc and not sugar salt solution alternatives. Home based care guidelines and counselling should be inclusive of effective home management, nutrition and hygiene, as well as future prevention of diarrhoeal disease.	• CHWs treat diarrhoea with: o Low osmolarity oral rehydration salts o Zinc. • Home based care inclusive of: o Mid-upper arm circumference (MUAC) screening for all children. o Detection of dehydration and dysentery. o WASH and hygiene guidance for family. o Improved breastfeeding and feeding during illness.

Essential element and recommended practices	Minimum standards
14. Management of malaria using ACT-based treatment, RDTs where possible, detection and referral of anaemia, prevention of malaria and improved feeding.	
Recommended practices: CHWs under World Vision CCM projects to provide only Artemisinin-based combination therapy (ACT) treatment, not chloroquine or other less effective treatments unless supported by current MoH policies. Rapid diagnostic tests (RDTs) to be used in all locations where this is current policy, as an alternative to presumptive treatment of fever. Home based care guidelines and counselling should be inclusive of effective home management, nutrition and hygiene, as well as future prevention of malaria.	• CHWs manage fever within 24 hours with: o ACT-based treatment for RDT positive cases. o Referral of malaria negative cases. • Home based care inclusive of: o 24 and 48 hour home visits, with referral of cases with no improvement by day two. o Detection of anaemia and complicated malaria. o ACT adherence monitoring. o Care of the sick child and prevention of malaria. o Improved breastfeeding and feeding during illness. • Unused medicines are recollected by the CHW after treatment.
15. Management of ARI in the home for children aged 2 to 59 months using approved antibiotics.	
Recommended practices: Current approved protocols include co-trimoxazole (CTX) or amoxicillin (AMX), not inclusive of chloramphenicol, and to provide only for those children with fast breathing (no home based treatment of severe cases and for children under 2 months of age). Home based care guidelines and counselling should be inclusive of effective home management, nutrition and hygiene, as well as future prevention of pneumonia.	• CCM CHWs are approved to treat pneumonia in the community following competency-based assessment: o Recognition of danger signs o Breath counting, looking for chest indrawing o Counselling on care of child with ARI o Antibiotic treatment per age group o Concurrent malaria treatment. • All children under 2 months of age must be referred to nearest functional health facility. • Home based care guidelines to include: o 24 and 48 hour home visits, with referral of cases with no improvement by day two. o Medicine adherence monitoring. o Care of the sick child and prevention of pneumonia. o Improved breastfeeding and feeding during illness. • Unused medicines should be collected after treatment.

Essential element and recommended practices	Minimum standards
16. Emergency referral and two-way communication is strengthened and include post-referral checks by CHWs.	
Recommended practices: Written referral and counter referral systems are preferable. During trainings CHWs should be supported to identify strategies for emergency communication systems, evacuation plans and transport methods as well as cost recovery systems for emergency transport and ambulances are considered in project design or via COMM. In many places child deaths may occur after a child is discharged from a health facility which can occur due to treatment non-compliance, underlying health conditions, inadequate treatment or access correct treatment. Post-referral follow up after patient discharge is done by CHW, which support the family to complete treatment, care and ensure they return to the facility if needed.	• A system of written or facilitated referral is in place which is appropriate to CHW capacity or literacy. • All CHWs have developed a consistent and functional transportation plan for evacuation of severe cases (consider COMM role). • Systems for conducting and recording CHW visits following patient discharge from clinics is in place. • All CCM CHWs should have access to an emergency telephone through which they are able to contact facilities and or ambulance services if available.
17. CCM activities are integrated with other existing child health treatment activities such as they exist in the project areas.	
Recommended practices: Where possible integrate CCM activities with existing treatment-based services for children, especially including CMAM, paediatric HIV and TB treatment services by CHW. Ideally such service would be delivered by the same providers due to overlapping needs of the patient. If this is not possible, iCCM CHWs should be made aware of any child currently under treatment for HIV TB or malnutrition where these programmes are running.	*Integration:* • If CMAM: iCCM should be fully integrated with CMAM programmes where concurrent initiatives exist. • If PMTCT and paediatric HIV treatment: iCCM should be fully integrated with these activities. • If paediatric DOTS and TB treatment: iCCM should be fully integrated.

Learning needs and resources self-assessment

The following assessment is to be completed by national offices (NOs) currently planning to support or integrate CCM activities within the 7-11 health strategy.

1. Under the existing MoH policies in the country, what diseases are currently supported for treatment by CHWs through CCM? (Please circle all that apply.)
   a. Diarrhoea
   b. Malaria
   c. Pneumonia
   d. Other _____

2. What capacity currently exists within the NO to lead on CCM introduction?
   a. IMCI-trained staff
   b. CCM-trained staff
   c. Other (explain) _____

3. What CHW training curricula are currently being used or adapted in the country? List the guidelines, manuals, handbooks and tools available from each source.
   a. Government or MoH
   b. UNICEF
   c. Other _____

   If curriculum currently exists, please complete the curriculum checklist below according to what topics are covered in the existing curriculum.

4. What training materials and job aids are currently available and what elements are included?
   a. Low literacy versions of dosage and child assessment and triage guidance
   b. Pictorial counselling cards
   c. Pictorial reminder or reference cards for danger signs and management
   d. Low literacy version of record and reporting
   e. Low literacy care guidance
   f. Written guidance
   g. None
   h. Other _____
   i. Are these provided for every CHW?

5. What data collection tools and forms are currently available for use by the CHW? (Indicate all available and from which source this is provided.)

Tools and forms for use by the CHW

Resource type	MoH version available	Other (indicate source)	Not available Required / not required?
a. Stock control			
b. Case record or treatment form			
c. Referral form (pictorial or written)			
d. Active case finding form (a form in which high risk children are regularly assessed)			
e. Training record for each CHW			

6. What data collection tools and forms are available for the use by the CHW supervisor?

Tools and forms for use by the CHW supervisor

Resource type	MoH version available	Other (indicate source)	Not available Required / not required?
a. Stock control			
b. Treatment or case statistics			
c. Real-time observation skills assessment (used when a supervisor observes sick child assessment and classification, and determines the adherence and accuracy of the CHW's method)			
d. Case evaluation tool (used when a supervisor randomly selects previously treated cases and conducts a retrospective case assessment)			
e. Health knowledge assessment or revision tool			
f. Performance- or competency-based assessment tool			
g. Health centre or hospital discharge form (counter referral form)			
h. Database or spreadsheet to manage statistics (which?)			
i. CHW registration database			

7. What current challenges exist for World Vision to implement iCCM in the country? What else is needed for this process to happen?
   a. Policies
   b. Partnering with other NGOs and agencies or government
   c. Implementation within ADPs
   d. Capacity and skills of World Vision staff
   e. Capacity and skills of existing health workers and facilities
   f. Resources and tools for implementation
   g. Designing for quality CCM
   h. Community support and involvement in CCM
   i. Health facility with functional IMCI services offered by IMCI trained health staff
   j. Single standardised monitoring and reporting system for national, district, health facility and private sectors

CCM curriculum checklist

A CCM curriculum is important since it provides the basis for quality CCM roll out. It is important, therefore, for the WV team to crosscheck their country curriculum to ascertain that all the critical components, listed in Table 6, are covered.

Table 6. CCM CHW curriculum essentials

CCM CHW curriculum essentials		Covered
Child health	Causes of child mortality	
	General danger signs of child illness and disease specific danger signs	
	Vaccine preventable diseases	
	Common childhood infections	
	Worms and parasite infections	
	Single disease management (CCM)	
	Integrated management of multiple symptoms (iCCM)	
	List of core competencies required for CCM and iCCM	
	Co-infection with HIV and TB and other high risk issues; malnutrition and orphans and vulnerable children (OVC) status	
Prevention	Vitamin A	
	Deworming	
	Intermittent preventative treatment in pregnancy (IPTp) or intermittent preventative treatment in infants (IPTi)	
	Vaccination schedules and child health cards	
Nutrition	Exclusive breastfeeding	
	Complementary feeding	
	Growth monitoring and promotion	
	Mid-upper-arm circumference (MUAC) screening	
	Detection of malnutrition	
	Malnutrition danger signs	
Diarrhoea	Causes and prevention	
	Safe drinking water	
	Hand washing	
	Cholera and dysentery	
	Classification of mild, moderate and severe dehydration	
	Danger signs (general and diarrhoea)	
	Making and giving ORS solution and zinc	
	Breastfeeding with diarrhoea	
	Home-based follow-up care	
	Feeding during diarrhoea	
Malaria	Causes of malaria	
	Prevention (ITN, IPTp and IPTi)	
	Diagnostics and use of RDT	
	Danger signs and complications of fever	
	Artemisinin-based combination therapy (ACT) treatment regimens	
	Home-based care, counselling and follow up	
	Feeding during malaria	
	Other causes of fever, and danger signs	

Pneumonia	Causes of pneumonia	
	Care of a sick child to prevent severe pneumonia or acute respiratory infection	
	Danger signs of pneumonia	
	Breath counting technique with or without breath counter	
	Classification of mild, moderate and severe pneumonia	
	Diagnosis and referral	
	Treatment with antibiotics	
	Home-based care, counselling and follow up	
Other	Record keeping and reporting including mobile apps	
	Safety with medicines and stock management	
	Effective communication and counselling skills	
	Counselling skills	

CCM country readiness steps and planning tools

The following table describes a list of processes that will be undertaken at the NO level when planning to undertake CCM activities, including key decisions to be taken in partnership with the MoH and other stakeholders. See the wvcentral.org CCM Toolkit page for accompanying Excel tools for planning and calendars.[8]

In the fourth column, the status of each step may be ranked as follows:

0: Not started
1: Just started
2: Some progress
3: Significant progress
4: Ready for next stage

Table 7. Country readiness steps

No.	Item	Description	Status
National level preparation			
1	High level MoH dialogue	Shared CCM ideas with MoH and partners, held discussion.	
		Understand and explored alignment to other MNCH efforts, existing CCM strategies.	
		Agreed priorities (regions, illnesses) and CCM model selection.	
		Developed work plan together with the MoH and other important stakeholders.	
		Have established (or belong to) working groups for national collaboration (e.g. CHW working groups or consortia).	
		Have attained a written statement of protocol or MoU or working guidelines between WV, stakeholders and MoH.	
2	CHW functionality Assessment	Have used the CHW AIM tool to coordinate an assessment of current functioning of existing CHW programmes for 15 programme components at the NO and ADP level.	
		Have evaluated the mechanisms of reporting between CHWs and PHC or district health management team.	
		Have reported field assessments to MoH or regional health authorities and identify gaps in current functioning.	

[8] www.wvcentral.org/community/health/HNH%20Wiki/Community%20Case%20Management%20Toolkit.aspx

3	CHW functionality, CHW policy comparison	Results of field assessment of CHW functionality have been compared to existing policies and guidelines.	
		Gaps in policies and guidelines have been identified and focal areas for strengthening implementation of programmes.	
4	Decision-making on CHW policy and programme review and MoH and stakeholder engagement	Shared information from the CHW functionality and policy analysis.	
		Agreed on a road map to strengthening CCM CHW guidelines, policies, and implementation.	
		Discussed best practice experience and evidence based findings of CCM CHW programmes.	
		Key decisions taken on training materials, incentives, allocation, data, supervision and management.	
5	Curriculum and job aids and tools review	Training materials reviewed: Aligned to new or existing CHW policy, MNCH and community health strategy and ttC and CVA (where applicable).	
		Review job aids to ensure they cover all aspects of the 15 programmatic components of CHW AIM.	
		To what extent has WV contributed to the development and design of materials and job aids?	
6	Modification or adaptation of job aids and tools (if applicable)	Training materials and job aids have been piloted and are deemed ethnographically accurate and suitable for purpose in the area of interest.	
		Supervision and monitoring and reporting forms have been piloted and are suitable for the purpose.	
Regional preparation steps			
7	Review ADP budgets and planning	Identified possible ADPs for CCM on the basis of location, population sizes, MNCH priorities, capacity and existing budget and plans (has funding been allocated for CCM).	
8	ADAPT process	Preparation and needs assessment.	
		Identification of gaps and priorities for ADP.	
		Prepare a proposal for the ADP redesign.	
9	WV staffing decisions	Unmet staffing and training requirements and capacity building needs have been identified.	
		Recruitment and redeployment of staff.	
10	PHC health services assessment	Visit all primary health facilities in the ADP where work is planned, assess service available and readiness to treat second line IMCI care.	
11	CHW allocation, training and supervision plan development	Project area or health authority area has been mapped, and geographic allocation of CCM completed.	
		Community assessments: household numbering, existing CHW identification.	
		Regional health authorities agreement on CHW allocation and supervisor distribution.	
Implementation 1: ToT and ToCHWs			
12	Mobilise finance	Following country readiness steps; programme is ready to launch, relevant funding is mobilised to begin plan implementation.	
13	Scheduling of activities	Identified trainers, facilitators, supervisors mobilised and available to attend trainings; venues and dates secured.	
14	Procurement	Local procurement of supplies and medicines as required.	

	and printing of materials	Local or regional printing of training materials and forms.	
15	Training of trainers (ToT)	Held at national or regional level as appropriate.	
16	COMM readiness	Community groups (COMMs) have been identified for linkage with CCM programming in all proposed CCM project areas.	
		COMMs have received the orientation training to prepare for their participation in CCM.	
		COMMs are participating as per guidance provided in the CHW programming functionality assessment.	
17	Community election of CHWs	Communities are sensitised with respect to CCM, CHW selection and voting or nomination methods.	
		Elections held in communities and written agreements with CHWs signed.	
18	CHW training, practice and approval process	CHW training events conducted as required (choose modular, gradual progressive training methods).	
		Community-based practical trainings and supervision conducted for CHWs (one-on-one).	
		Technical approval and COMM feedback process (reselection if required).	
Next steps			
19	Support and supervision process	MoH or PHC conduct supportive supervision in the communities.	
		Supervision frequency and quality – engaging WV and COMMs.	
20	External process	Monitoring survey of care seeking behaviour and knowledge.	
		Referral effectiveness review.	
21	Evaluation surveys and community evaluations	Conduct multi-indicator cluster-style survey on health knowledge and health seeking behaviour to evaluate the effect of CCM for children under 5.	
		Repeat CHW functionality assessment to determine how CCM is being implemented by the PHCs.	
		WV to work together with COMMS and CVA to address the implementation challenges and also barriers to health education that CHWs encounter in the field.	
22	Programme review MoH and stakeholder engagement	Present evaluation findings to MoH and stakeholders.	

Childhood health services assessment

This basic assessment is meant to provide general trends for childhood illness management and should be based on desk review of secondary data and information. The purpose is to indicate the need to establish a CCM programme. Importantly, the results for this should be considered when determining an appropriate location to refer severe cases to. If severe case management protocols cannot be carried out at lower-level rural health facilities, CHWs would refer directly to the nearest location that has the required capacity. Detailed assessments will be done through Health Assessment, Design and Planning Tools (ADAPT) and Learning through Evaluation with Accountability and Planning (LEAP) processes.[9]

Strategic objectives of CCM

- Does the national health strategy or CHW policy include standardised approaches and protocols for managing infectious diseases in children at all levels in the country?
- Has national policy been adapted to authorise CCM with antibiotics, antimalarials and zinc?
- Is data on pneumonia, diarrhoea and malaria morbidity among children under 5 years old collected and available?
- For areas with high HIV-prevalence, are services for HIV-positive children available at the health facility level?
- Is the use of health facilities low or moderate? Add general trends.
- What are the major barriers that cause low health facility usage? List barriers if available.
- What is the immunisation rate (in percentages) in the area for DPT 3 and for measles?
- Are new vaccines approved and available for PCV, HiB and rotavirus vaccine?
- Are there existing CHWs or equivalent health workers?
- Are there other NGOs involved in addressing pneumonia, diarrhoea and malaria in children under age 5?
- What is the level of community participation in health? Add general trends.

WV ADP features

• WV national health strategy	Yes	No
• ADP design document includes a health project	Yes	No
• ADP budget includes a health budget	Yes	No
• Childhood infectious disease problem identified	Yes	No
• ADP manager	Yes	No
• Technical health staff at ADP level	Yes	No
• Community-based networks established	Yes	No
• Partnership for health programmes with district health and at the provincial level	Yes	No

[9] World Vision's LEAP tools may be found at http://www.wvi.org/guidancefordevelopmentprogrammes, for more information on the ADAPT process contact health@wvi.org

District health services: desirable features

- Under-5 mortality rate: overall _____ cause-specific _____
- Infant mortality rate: overall _____ cause-specific _____
- Proportion of death occurring at home or in the community % _____
- Recording and reporting forms or registers available Yes No
- CHW training programme offered Yes No
- General lab functional at health facility level Yes No
- Rapid diagnostic test kits for malaria available Yes No
- Treatment guidelines and protocols available Yes No
- Consistent supply of antibiotics, ACTs, ORS and other medicines Yes No
- Health personnel:
  - Pulmonologist or medical officer Yes No
  - District nurse Yes No
  - Primary care physician Yes No
  - Community health nurse Yes No
  - Lab technician Yes No

Current health services

Table 8. Current health services

Health facility feature	Strengths	Weaknesses/gaps
General characteristics • Priority is given to early diagnosis and early treatment of pneumonia and malaria. • IMCI standards are introduced; staff are fully trained and are implementing services. • National policy on incentives exists. • Cost recovery system exists. • Health centre is equipped to provide secondary care, including intramuscular or intravenous treatments.		
Supervision • Supervision of CHWs conducted by MoH, central or provincial health unit. • Health worker supervision by nurse.		
Prevention education at health facility • Counselling sessions, information, education and communication (IEC) or mother care groups are provided. • Facility-based CMAM competence exists and is implemented at the health facility.		

Health facility evaluation

The Health facility evaluation helps to assess the readiness of the health facilities in the ADP catchment area to provide Integrated Management of Childhood Illnesses (IMCI) services. These services are important given that all children that CHWs are unable to manage will be referred to these facilities.

Find the manager or most senior health worker responsible for patient services who is present at the facility. Read the following greeting:

> Hello. My name is _____. We are here on behalf of World Vision to learn more about health services provided in the community.
>
> We will be asking you questions about various health services and will ask to see patient registers. No patient names from the registers will be reviewed, recorded or shared. The information about your facility may be used by World Vision and other organisations supporting services in your facility to plan service improvement or for further studies of health services.
>
> We are asking for your help to ensure that the information we collect is accurate. If there are questions for which someone else is the most appropriate person to provide the information, we would appreciate you introducing us to that person.
>
> You may refuse to answer any question or choose to stop the interview at any time. Do you have any questions about the survey? Do I have your agreement to proceed?
> Signature: _____ Job title: _____ Date: _____ _____

Table 9. Health facility evaluation

Table 9.1. Facility identification FI			
CFI01. Date of survey: _____/_____/_____ *(MM/DD/YYYY)*	CFI02. Name of the surveyor:	CFI03. Cluster #:	
CFI04. Region:	CFI05. District:	CFI06. Village or ADP:	CFI07. Facility name:
CFI08. Paper survey = 1. Electronic or mobile device = 2			

Table 9.2. Facility type FT		
CFT01.	Type of health facility: 1 = Hospital 2 = Health centre 3 = Health clinic 4 = Health post 5 = Other (specify) _____	

CFT02.	Managing authority: 1 = Government 2 = Private 3 = NGO, mission, faith-based 4 = Other (specify)_____		
CFT03.	**Optional question** What services are provided at this health facility? How many days a week is each service offered? Are the services provided free of charge? If the service is not offered, write 0 days per week.	Days per week	Free? Yes =1 No = 0
	a. Routine child immunisation		
	b. CMAM, severe acute malnutrition (SAM)		
	c. Growth monitoring		
	d. Vitamin A capsule (VAC)		
	e. Iron folate (IFA)		
	f. Anthelmintics (used to treat parasite infestations)		
	g. CCM for sick children		
	h. Antibiotics and antimalarials available through CHW		
	i. Antibiotics for pneumonia		
	j. Artemisinin-based combination therapy (ACTs) for malaria		
	k. Management of severe pneumonia and malaria		
	l. Behaviour change communication (BCC)		
	m. Family planning services including contraceptives		
	n. ORS sachets with zinc for management of diarrhoea		
	o. Antenatal care		
	p. Labour and delivery		
	q. Basic emergency obstetric and newborn care, including resuscitation		
	r. Communication with referral		
	s. PMTCT promoters		
	t. PMTCT services		
	u. TB services, DOTS		
	v. Sexually transmitted infections (STI) screening and treatment		
	w. HIV counselling and testing		
	x. HIV and AIDS care and support services		
	y. HIV and AIDS antiretroviral prescription		
	z. HIV and AIDS case management		

Table 9.3. Demographic profile DP		
The following questions refer to the demographic characteristics of the health facility catchment area.		
CDP01.	What is the population size of the catchment area that this facility serves? That is, the target or total population living in the area served by this facility. Provide an estimate if an exact number is not known.	
CDP02.	How many women of childbearing age are in the catchment area?	
CDP03.	How many children under 1 year (0 to 11 months) are in the catchment area?	
CPD04.	How many children under 5 years (0 to 59 months) are in the catchment area?	

Table 9.4. Health providers HP

CHP01. **Optional question**

Now I have some questions about staffing for this facility. Please tell me how many staff with this qualification are currently assigned to this facility and whether they are male or female staff. Then please tell me how many of these staff are part time. We want to know the highest technical qualification that any staff may hold (such as a nurse or doctor) regardless of the person's actual assignment or specialist studies. If the sex of the staff is not known, write the total number in the part time or full time column.

Qualification	# Males	# Females	# Part time	# Full time	# Total
a. Doctor					
b. Nurse					
c. Midwife					
d. CHW					
e. Trained birth attendant (TBA)					
f. Skilled birth attendant (SBA)					
g. Other					

Table 9.5. HIV counselling and testing CT		
This section refers to HIV counselling and testing not for PMTCT.		
CCT01.	When a provider wants a client to receive an HIV test, what is the procedure that is followed? 1 = Testing by rapid test in this facility 2 = Testing by blood drawn and lab testing inside facility 3 = Blood drawn and sent to outside facility 4 = Client is sent to another facility	
CCT02.	Do providers in this clinic provide any individual pre- or post-test counselling for HIV tests? 1 = Yes, provide HIV counselling 2 = Only provide general advice for testing and prevention 0 = No	
CCT03.	Do you provide individual HIV counselling for children aged 5 to 14 years with a staff member who has had specific training? (Note, age for paediatric testing may vary by country.) 1 = Yes, child alone 2 = Yes, with parental consent 0 = No	

CCT04.	Does this clinic provide individual HIV testing for children aged 5 to 14 years? 1 = Yes, child alone 2 = Yes, with parental consent 0 = No	
CCT05.	Do you provide individual HIV counselling for youth and adolescents between ages 15 and 19 years with a staff member who has had specific training? 1 = Yes, adolescent alone 2 = Yes, with parental consent 0 = No	
CCT06.	Does this clinic provide HIV testing for youth and adolescents aged 15 to 19 years? 1 = Yes, adolescent alone 2 = Yes, with parental consent 0 = No	
CCT07.	Is there a written policy on confidentiality provided to the client that specifies that no one will be told the HIV test result without the permission of the client? If yes, may I see it? 1 = Yes, observed 2 = Yes, not observed 0 = No	
CCT08.	If no, is there any other confidentiality policy reaffirming that no one will be told the results without the specific permission of the client? 1 = Yes 0 = No	
CCT09.	Ask to observe the setting where client counselling related to HIV and AIDS is provided. Please choose relevant description. 1 = Private room with visual and auditory privacy 2 = Other room with visual and auditory privacy 3 = Visual privacy only 0 = No privacy	
CCT10.	**Optional question** Ask to see the HIV counselling and testing registers. Record the following data from the previous 12 months.	

	# Male	# Female	# Positive	# Negative	# Total
pre-, post-test counselling					
received result					
5 to 11 years received result					
12 to 18 years received result					
>18 years received result					

Table 9.6. PMTCT services PM

This section refers to all PMTCT services provided in the clinic. Record data from clinic registers from all departments that provide PMTCT services.

CPM01.	**Optional question** Does this clinic provide any services related to preventing transmission of HIV between the mother and the child (PMTCT)? Are they provided for free to the clients?	1 = Yes 0 = No Offered?	Free?
	a. Clinic PMTCT Policy		
	b. Copy of the WHO 2010 PMTCT Guidelines		
	c. HIV counselling to pregnant women		

	d. HIV testing to pregnant women		
	e. Couple counselling when mother is HIV-positive		
	f. Counselling on infant feeding to HIV-positive women		
	g. Counselling on maternal nutrition to HIV-positive women		
	h. Counselling on family planning services for HIV-positive women		
	i. Counselling on condom use for dual protection		
	j. Distribute condoms to PMTCT clients		
	k. CD4 count for HIV-positive women		
	l. Antiretroviral (ARV) prophylaxis for pregnant women		
	m. Lifelong ART available for all pregnant women with advanced clinical disease		
	n. ARV prophylaxis for newborn		
	o. ARV prophylaxis for mother during breastfeeding		
	p. HIV virological test: DNA polymerase chain reaction (PCR), dried blood spot (DBS) testing for early infant diagnosis of newborns aged 6 weeks to children aged 18 months		
	q. HIV testing at delivery		
	r. PMTCT services with delivery		
	s. ARVs for PMTCT during delivery		
	t. HIV counselling to women at delivery		
	u. PMTCT promoters and community services (specify):_____		

CPM02. Ask to review the antenatal clinic register and data from **all** PMTCT services. These services may be provided in multiple departments so ask to review all the registers. (e.g., labour and delivery, PMTCT, ART etc.) Look for all new entries in the last 12 months and fill in the following table.

Clients	Total #	HIV counselling	HIV test	Received HIV test results	HIV-positive	HIV-negative	Enrolled in ART for prophylaxis / PMTCT	Enrolled in ART for own health
Antenatal care								
Labour and delivery								

CPM03. Ask to review the register where data on infants born to HIV-positive women is recorded. This should include data at delivery and subsequent follow-up visits. Look for all new entries in the last 12 months and fill in the table. The table refers only to infants born to HIV-positive women (exposed infants). An infant is aged less than 12 months. 'Early diagnosis' is defined as an infant born to an HIV-positive woman who received an HIV virological test by 4 to 6 weeks of age.

Infant category	Total #	ARV Prophylaxis until 4 to 6 weeks old	Received HIV test results	HIV-positive	HIV-negative	Initiated ART
All HIV exposed						
Early diagnosis						
Late diagnosis						

CCM programme outline for ADPs

CCM and the development programme approach (DPA)

At the ADP level, health programming takes place within the context of overall ADP programming. For certain ADPs health programming will be implemented within the context of the Development Programme Approach (DPA).

It is important for ADP staff to understand how this all fits together. The DPA begins with an assessment which will trigger the need for health programming. ADP staff, together with community members, will then follow the steps of the critical path to determine the specifics of the programming. In the assessment process and engaging with communities, remember to use secondary data to engage. Typically health issues may not be prioritised given that they don't seem to be felt needs. Information therefore becomes the critical tool to help community members engage in meaningful discourse. In order for CCM to be adopted within the context of a single ADP or grant-based project, it is typically prerequisite that CCM will have been selected at a national level as part of the NO's health sector strategy or technical programming approach, and infectious disease should have been identified as a focal problem that calls for attention within the ADP programme design documents.

Typically ADPs have development facilitators that lead all development activities, and in many cases these people do not have any public health background. This is also true of DME specialists. Given the need to have detailed analysis of the health issues in ADPs and narrow down on the critical pieces the ADP might want to focus on, it is important that the ADP and the DME people work with and seek input from technical health specialists at the national level. Where the NO has a critical mass of health specialists, work with them.

This toolkit includes a CCM generic framework and a monitoring and evaluation framework (Annex 1). These tools will only be useful if a thorough analysis of the problem has been done, critical thought has been given to the problem and interventions, and elements of the results framework have been picked that will best enhance programming.

In planning interventions, a key challenge that WV has is the limited coverage area compared to the health districts. Also, in many countries the MoH wants partners who undertake CCM to cover the health administrative district. Engage in discussions with the NO and local health offices to figure out what activities can be supported beyond the ADP coverage area. Given that CCM works in a health systems strengthening approach, some CHW aspects like training, equipping of CHWs, and supportive supervision activities can go beyond the ADP. Where WV is covering CCM commodities, negotiate with the MoH and partners like UNICEF to provide commodities to widen coverage, and focus on software that enhances quality of care for the communities.

CCM within a technical programming approach

The technical programming approach for WVI Global Health, developed in response to concerns over gaps between strategy and programming, is a process by which a set of technical approaches

are clearly defined by the NO for its ministry priorities within a multi-year strategy implementation plan, then applied flexibly during programme design and redesign. A technical approach (TA) will include selection of one or more project models that define how the WV operations in that country will achieve the objective. In addition to identifying the project models for each of the strategic objectives, a TA will also outline other operational elements such as national level partnerships, advocacy and learning networks at the national level, and the role of NO-level technical staff support required. Health technical programming requires appropriate technical management at multiple levels, and the TA process can identify these staffing requirements with greater precision. The approach is better able to ensure implementation standards embedded in project models and monitoring and evaluation indicators that can be aggregated for management purposes at national level, providing a bench mark against which all projects can be compared.

As CCM is increasingly an MoH-led activity, deployed through approved NGOs and agencies and in coalitions or multiple stakeholder approaches, the TA is particularly conducive to improved programming. It enables local-level activities to support CCM to be determined in alignment with national health plans and with partners through harmonised approaches.

NO quality assurance leads should ensure the TA is disseminated to all DME staff and ADPs, since the guidance can easily be followed. Where ADPs are undertaking a review of their project design documents and log frames, the TA enables them to refine these documents in a consistent manner.

The technical approach is further guided by the DADDs for the CCM conditions. These can be found on pages 40 to 42.

Table 10. TA advantages and risks

Advantages of the TA for CCM	Risk mitigation of the TA for CCM
• Improve scale and consistency and therefore quality of CCM programming through the application of implementation standards. • Pooling the technical expertise efficiently, and less reliance on external expertise brought in on a project by project basis. • Time, cost and effort-saving at the ADP level in the adaptation of materials, training events, development and start-up costs. • Time and cost saving for NO-level and SO-level in the review of programme and project designs. • Unified monitoring and evaluation systems across diverse project sites. • Ensuring all CCM project designs have partnership agreements with relevant national government bodies and other key stakeholders. • Ensuring that ADPs within a single health authority catchment area are aligned. • Coming into alignment with WV's CHW POP.	• Ensure that the assessment done for contextualisation of the CCM curriculum enables response to local epidemiology or cultural contexts, and is sufficiently flexible to permit the development of innovative methods. • If the development of CCM is low quality at the NO level and taken to scale, this undermines the impact across all programmes.

CCM strategic framework

As stated earlier, under CCM and the DPA, a generic CCM results framework and monitoring and evaluation plan (Annex 1) were developed to provide guidance around CCM programme planning. These documents were developed through a consultative process that involved representation from East, Southern and West Africa regional, national and ADP staff. The monitoring and evaluation plan was also developed based on globally identified indicators. Indicators in the WV CCM monitoring and evaluation plan apply to the elements agreed on in the CCM results framework.

For those ADPs that have decided to include CCM in their project design documents, the CCM strategic framework is a reference point to identify outcomes, outputs, and indicators relevant to the analysed focal problem. This strategic framework can be used to adapt national-level project plans, or to guide ADP level design processes.

Goal

The goal of CCM interventions within WV health programmes is to reduce mortality among children under 5 years of age from common childhood illnesses by increasing the use of curative and preventive interventions.

Expected outcomes and results

1. Increased access to and availability of services for childhood illnesses in a prompt and timely manner.
2. Improved quality of services at community and facility levels.
3. Increased demand for essential health services by caregivers.
4. Enabled environment to facilitate, sustain and scale-up CCM.

Key outputs and activities

Overall, the idea behind the framework is guidance in terms of what the ADP is likely to contribute to. At this stage in the design process, it is important to fall back to the quality of standards document and map activities aligned to the findings. At any one moment, the intervention will fit in any of the four outcomes stipulated. However, some key activities to include may be:

1. Increased access to and availability of services for childhood illnesses.
    a. Training of CHWs for ttC; reinforce prevention.
    b. Train selected CHWs to recognise pneumonia, diarrhoeal dehydration, malaria and fever and administer antibiotics, ORS and antimalarials according to national policy.
    c. Training or refreshing IMCI staff at health facilities.
    d. Buffer stocks for ACTs, antibiotics for pneumonia (according to national policy).
    e. Establishing referral system with IMCI for severe and complicated cases.
    f. Develop, replenish and provide job aids: registers, ttC module, reporting forms etc.
2. Improved quality of services at community and facility level.
    a. Improving CHW knowledge and skills through ongoing competency-based training on treatment of pneumonia, diarrheal dehydration and malaria.
    b. Developing and institutionalising supervision of CHW to ensure technical quality of services.

   c. Strengthening logistics, management information system and supply chain of commodities.
3. Increased demand for services.
   a. Developing and adapting BCC materials for timely care-seeking from an appropriate health provider or CHWs for sick children.
   b. Health education and ttC at community level through CHWs and community structures like COMMs.
   c. Mobilising communities and COMMs at the ADP level to support CHWs.
4. Enabled environment to facilitate, sustain and scale-up CCM.
   a. Building capacity of MoH staff for IMCI at health centre level.
   b. Improving community groups (COMMs, care groups etc.) to support management of CCM programme.
   c. Programme learning and operational research to create evidence for scale-up (national-level decision).
   d. Improving monitoring, reporting and linkage with WV's health management information system (HMIS).

Further reading

Please refer to the following documents for health programme planning:

- 2011 Health and WASH Cluster Programme Design Guidance (internal use only: https://www.wvcentral.org/community/health/Documents/Forms/AllItems.aspx)
- 7-11 Start-up Field Guide (http://www.wvi.org/health/publication/7-11-start-field-guide)
- Partnership Child Well-Being Targets (http://www.wvi.org/topics/child-well-being-targets)
- Partnership Compendium of Outcome Indicators (http://www.wvi.org/publication/compendium-english)

Core focus for malaria CCM programmes

Table 11. Malaria DADDs

<table>
<tr><th>DO (Core focus)</th><th>ASSURE/PARTNER</th></tr>
<tr><td>Expand malaria prevention
Universal coverage of insecticide treated nets (ITN) or long-lasting insecticide treated nets (LLINs): distribution and hanging (context specific)
Information, education and communication (IEC), behaviour change communication and advocacy for malaria prevention (e.g. ttC or similar)
Materials, campaigns, lobbying
Facilitate access to CCM for malaria
Malaria competence, community systems strengthening and CHW training and follow-up for CCM
Facilitate access for intermittent preventative treatment in pregnancy (IPTp) and in children (IPTc) according to national policy
Demand creation, monitoring, and promotion of access to antenatal clinics.</td><td>IEC materials and job aids for indoor residual spraying (IRS) and other vector control interventions
Diagnostic for malaria testing according to national policy
Functional supply chains exist for the provision of ACTs at community level</td></tr>
<tr><td colspan="2">Key partners for malaria</td></tr>
<tr><td colspan="2">Local churches and faith-based institutions, schools, government and ministries responsible for mothers and children, national malaria programmes, local grassroots and community-based organisations, and businesses
WHO; President’s Malaria Initiative (PMI); Global Fund for AIDS, TB and Malaria; UNICEF; Roll Back Malaria; international NGOs</td></tr>
<tr><td colspan="2">ADDITIONS
Additions are generally undertaken with partners, since these would not be WV core technical competencies.
Additions to consider are:
gifts-in-kind (GIK) for commodities and medicines
other malaria interventions which may be complementary to ‘DO’ areas of work, contextual to each country.</td></tr>
<tr><td>EXCEPTION ONLY</td><td>Criteria for exception</td></tr>
<tr><td>Long-term purchasing of commodities e.g. ACTs, sulfadoxine-pyrimethamine (SP) for IPTp
Provision of LLINs</td><td>In emergencies and very weak health infrastructures
Where national policies require us to provide commodities
In special circumstances in interventions with key populations at high risk
Purchase and distribution to local health facilities as buffer stocks</td></tr>
<tr><td colspan="2">DON’T DO</td></tr>
<tr><td colspan="2">Purchasing or providing testing equipment
Purchasing or providing or spraying of insecticide for IRS
Building major health care infrastructure</td></tr>
</table>

Core focus for diarrhoea programmes

Table 12. Diarrhoea DADDs

<table>
<tr><th>DO (Core focus)</th><th>ASSURE/PARTNER</th></tr>
<tr><td>

Enhance diarrhoea prevention
- Exclusive breastfeeding
- Regular hand washing
- Improved hygiene practices
- Complete immunisation according to national protocol

IEC, behaviour change communication and advocacy for diarrhoea prevention (ttC or similar)
- Prompt initiation of oral rehydration therapy and ORS preparation

Facilitate access to CCM for diarrhoea management
- Recognition of dehydration, seeking care for complications and CHW training and follow-up

Facilitate access to new ORS formula and zinc
- Demand creation
- Monitoring

</td><td>

- Lobbying for the International Code of Marketing of Breast-milk Substitutes
- Access to improved water and sanitation through WASH
- Lobby for rotavirus vaccine
- Lobby for CCM
- Lobby for national policy for new ORS formula and zinc

</td></tr>
<tr><td colspan="2">Key partners for diarrhoea</td></tr>
<tr><td colspan="2">

- Local churches and faith-based institutions, schools, government and ministries responsible for mothers and children, local grassroots and community-based organisations, and businesses
- WHO; UNICEF; WASH sector partners; international NGOs

</td></tr>
<tr><td colspan="2">

ADDITIONS

Additions are generally undertaken with partners, since these would not be WV core technical competencies.

Additions to consider are:
- gifts-in-kind (GIK) for ORS and medicines
- other diarrhoea interventions which may be complementary to ‘ DO’ areas of work, contextual to each country.

</td></tr>
<tr><td>EXCEPTION ONLY</td><td>Criteria for exception</td></tr>
<tr><td>

- Provision of ORS packets

</td><td>

- In emergencies and very weak health infrastructures
- Where national policies require us to provide commodities
- In special circumstances in interventions with key populations at high risk
- Purchase and distribution to local health facilities as buffer stocks

</td></tr>
<tr><td colspan="2">DON’T DO</td></tr>
<tr><td colspan="2">

- Long-term provision of commodities without a sustainability plan in place
- Building major health-care infrastructure

</td></tr>
</table>

Core focus for pneumonia programmes

Table 13. Pneumonia DADDs

<table>
<tr><th>DO (Core focus)</th><th>ASSURE/PARTNER</th></tr>
<tr><td>

Enhance pneumonia prevention

Exclusive breastfeeding
Complete immunisation according to national protocol
Vitamin A supplementation
Regular hand washing
Reduce indoor smoke (reduce biomass fuel use)

IEC, BCC and advocacy for CCM for pneumonia (ttC or similar)

Materials, campaigns, lobbying

Facilitate access to CCM

Recognise pneumonia danger signs and seek care for danger signs
CHW training and follow-up to provide treatment

Facilitate access to appropriate health care at health facilities

Demand creation
Monitoring
Promotion of access
Availability of continual care

</td><td>

Lobbying for International Code of Marketing of Breast-milk Substitutes
Lobby for HiB and PCV vaccines
Access to improved water through WASH
Lobby for policy change for community treatment of pneumonia with antibiotics
Provision of antibiotics at community level
Breath counters for mothers and CHWs (contextual)
Assure IMCI at health facility level

</td></tr>
<tr><td colspan="2">Key partners for pneumonia</td></tr>
<tr><td colspan="2">

Local churches and faith-based institutions, schools, government and ministries responsible for mothers and children, local grassroots and community-based organisations and businesses
WHO; UNICEF and IMCI; international NGOs

</td></tr>
<tr><td colspan="2">

ADDITIONS

Additions are generally undertaken with partners, since these would not be WV core technical competencies.

Additions to consider are:

gifts-in-kind (GIK) for commodities and medicines
other pneumonia interventions which may be complementary to ‘ DO’ areas of work.

</td></tr>
<tr><td>EXCEPTION ONLY</td><td>Criteria for exception</td></tr>
<tr><td>

Provision of antibiotics
Mass immunisation against measles campaigns

</td><td>

In emergencies and very weak health infrastructures
Purchase and distribution to local health facilities as buffer stocks

</td></tr>
<tr><td colspan="2">DON’T DO</td></tr>
<tr><td colspan="2">

Purchasing or providing testing equipment without a sustainability plan in place
Building major health-care infrastructure

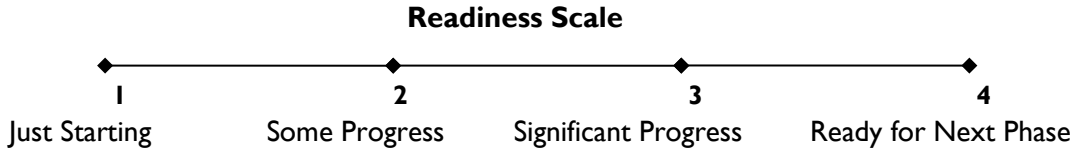
</td></tr>
</table>

Mobile health applications for iCCM

Mobile phone technology is increasingly being applied for health projects around the world and mobile health (mHealth) offers many opportunities to improve iCCM programming. World Vision has a global specification for an iCCM mHealth application using the CommCare platform, which includes improved diagnostics using the WHO protocols and reporting of data from the community. Additional modules for stock tracking (CommTrack) and supervision of CHWs are under development. For more information on this and other mobile applications, contact World Vision's ICT4D department. The mHealth country readiness self-assessment is used as a preliminary assessment to determine if an mHealth approach is suitable for a particular context. An additional resource for developing mHealth is the white paper *Scaling Up Mobile Health: Elements Necessary for the Successful Scale Up of mHealth in Developing Countries.*[10]

mHealth country readiness self-assessment: Typical activities by project phase

This tool is a review checklist of the 'readiness', i.e. how well prepared a country are to consider the integration of a mobile component for iCCM programming. The tool comprises a list of typical activities implemented during the preparation, assessment, design and build and implementation phases of mHealth. During assessment of readiness, you can use the tool to rate each activity by assigning a score of 1 (just starting activity) to 4 (completed activity and ready for next phase). The activities list can also be used amongst the diverse stakeholders as a project planning guidance for the key steps in the process.



Prepare

- ❒ Communicate about mobile solutions options with potential users in communities.
- ❒ Undertake informal scoping to determine where interest and demand for mobile health already exist and where it makes sense to target.
- ❒ Cultivate interest and political will from WV leadership, government, communities and local healthcare structures as soon as possible.
- ❒ Understand high-level needs of community and end users, as well as processes and data which will be automated, while also considering how best to empower the most vulnerable.
- ❒ Ensure alignment of proposed solution with programming models.
- ❒ Identify and confirm a project business sponsor.
- ❒ Initiate collaboration with national Ministry of Health (MoH) and participation on existing MoH or government-led electronic health (eHealth) or mHealth working groups.
- ❒ Scope existing similar initiatives and stakeholders to avoid duplication of efforts.

[10] Lemaire, J. *Scaling Up Mobile Health: Elements Necessary for the Successful Scale Up of mHealth in Developing Countries.* Advanced Development For Africa, December 2011. <https://www.k4health.org/sites/default/files/ADA_mHealth%20White%20Paper.pdf> accessed 26 June 2014.

- ❒ Budget for adequate funding to cover initial prototyping or pilot, with a sustainability plan for continuity of funding and income.
- ❒ Intentionally consider scale up and sustainability, if viable and desirable in the relevant context.
- ❒ Collaborate with the Global ICT Enterprise Architecture group to review compatibility of solution with WV system architecture and standards.

Assess

- ❒ Allocate initial human resources to undertake assessment.
- ❒ Formally assess and document priority needs and motivational factors of target end users, using a rapid baseline assessment or other methodology.
- ❒ Formally map the local landscape of existing stakeholders and solutions, policies, local settings and practices, literacy levels, facility with mobile devices, cellular network coverage, etc. in the geographical area of implementation.
- ❒ Continue to collaborate with other organisations for broader scale and sustainability and deeper impact.
- ❒ Plan and budget for strong project management as well as health and IT technical staff to be recruited and work together and in the field before the project starts.
- ❒ Plan and budget for external solution provider and developer to be contracted to build or customise an appropriate solution.[11] Consult IT and ICT4D staff for advice on contractor options as appropriate.
- ❒ Draft and refine a monitoring and evaluation plan, through which the effectiveness of the mobile solution can be measured.
- ❒ Formally evaluate solution against needs of community and caregivers, as well as processes and data that will be automated, before selecting a solution provider.
- ❒ Specify clear selection criteria and choose mobile health solution(s) and provider based on a competitive approach.
- ❒ Initiate or continue discussion, collaboration and negotiation around partnering opportunities, data package bundles and options for handling interactive voice response (IVR) with mobile network operators with dominant market share at the national and project level.
- ❒ Identify potential SMS aggregators that can provide bundled SMS rates across some or all mobile network operators.

Design and build

- ❒ Apply assessment results related to end users' motivational factors, local conditions, environment, stakeholders and adoption barriers to the design.
- ❒ Allocate time for iterative, collaborative and evolutionary community and staff engagement and feedback in the design and build of the solution.
- ❒ Continue stakeholder collaboration to foster alignment and complementarity of solution with national health priorities as well as the national ecosystem of mHealth initiatives (MoH, bi-laterals, multi-laterals, community based organizations, NGOs, INGOs, etc.) as appropriate.

[11] World Vision Global ICT and NO IT departments are not adequately resourced to design, develop, test, deploy and train users on mobile health systems. Therefore it is typically necessary to partner with and manage external solution providers.

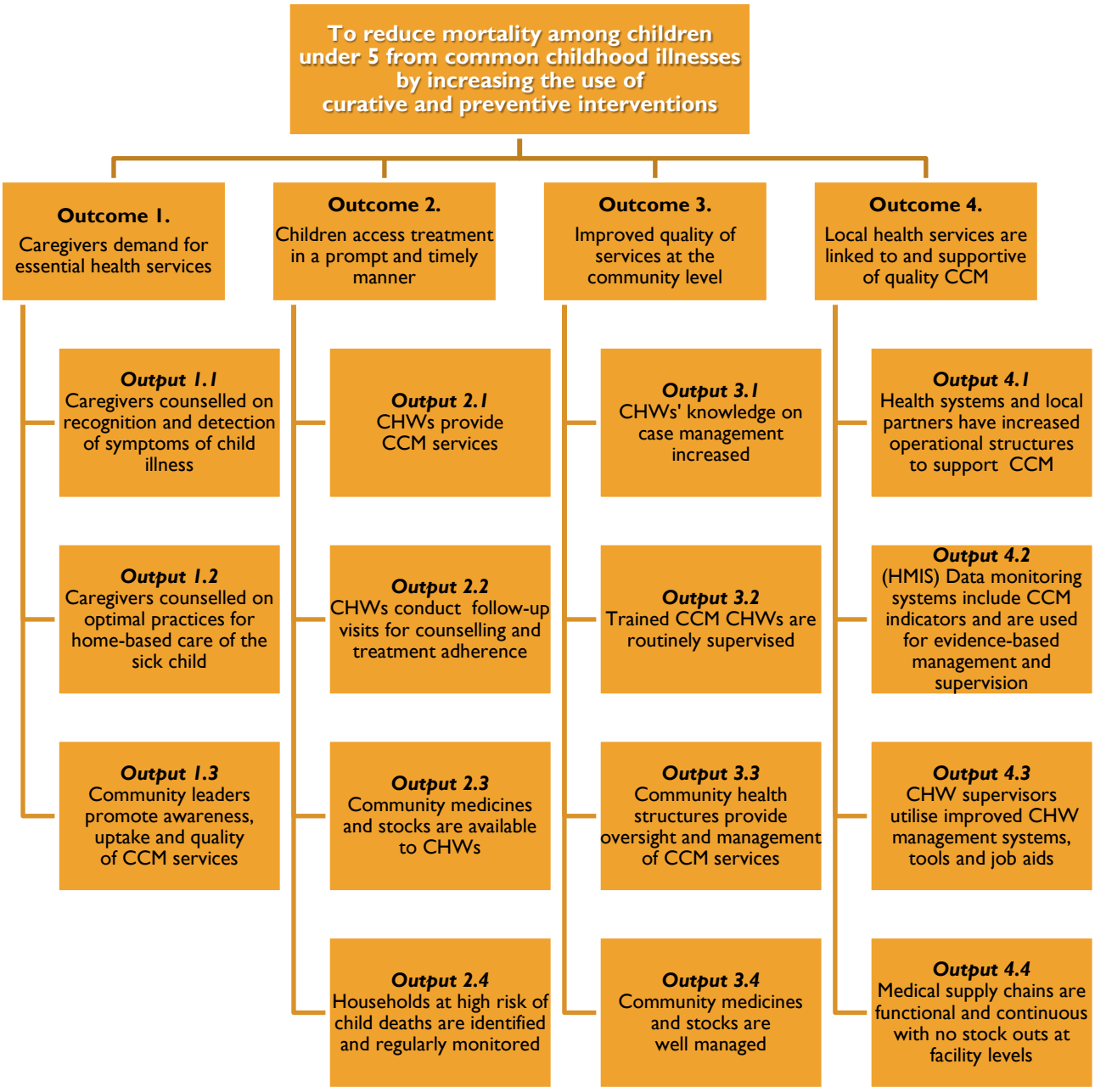
- ❒ Continue participation on existing MoH or stakeholder-led mHealth working groups.
- ❒ Expand strategic partnerships to support scale up of the project with entities such as mobile network operators, regulatory and policy bodies (Groupe Speciale Mobile Association, International Telecommunication Union, WHO, etc.).
- ❒ Consult WV's Global ICT Enterprise Architecture group to reconfirm compatibility of solution with WV system architecture and standards.
- ❒ Explore opportunities for technical integration with MoH, mobile network operators and other existing IT systems to mitigate future risk to scale-up.
- ❒ Update health project logframe to reflect mobile solution metrics considering quantitative and qualitative approaches. Undertake or include in existing baseline that incorporates mobile solution metrics.
- ❒ Identify opportunities to build local capacity to minimise costs and support local ownership of the project.
- ❒ Create viable and sustainable cost recovery models which incorporate entrepreneurial opportunities for income generation.
- ❒ Seek potential cross-sectoral uses of mobile solution across various sectors (health, education, communications, advocacy, etc.).
- ❒ Anticipate the users' learning curve and identify potential incentives to promote the consistent and effective use of the mHealth tool.
- ❒ Undertake formal user acceptance testing of the solution, in collaboration with technical partner and representative solution users.
- ❒ Design train-the-trainers or direct user training on mobile solution capabilities.

Implement

- ❒ Implement train-the-trainers or direct user training, in phases if appropriate.
- ❒ Maintain flexibility in mobile solution project implementation to adapt to changing needs and priorities of beneficiary populations and to minimise risk of failure.
- ❒ Consider a phased approach to rolling out the solution, taking into consideration absorption capacity of solution users and their pace of adoption.
- ❒ Work with public-private partnership colleagues to negotiate agreements with private sector partners following initial prototyping or piloting.
- ❒ Design and negotiate collaboration agreements with key stakeholders.
- ❒ Use potential incentives to prepare and perform social marketing to facilitate uptake by local communities.
- ❒ Implement or acquire appropriate customer support and system maintenance services for problem resolution.
- ❒ Perform monitoring, evaluation and assessments of programme effectiveness using meaningful and measureable metrics.
- ❒ If an area of the project is failing, regroup and redesign quickly based on thorough user feedback and adjust the programme accordingly.

Annex 1. Design, monitoring and evaluation tools

CCM results framework



CCM results framework indicator matrix

This matrix provides a complete list of monitoring indicators for CCM for WV programmes.

	Summary of objective	**Indicator**	**Indicator definition**	**Means of verification**	**Frequency of data collection**	**Person responsible**	Alignment to Standard Monitoring Indicators for Health & WASH
Outcome 1	**Caregivers demand for essential health services**	Caregiver knowledge of danger signs	% of caregivers knowing two or more illness signs (as locally defined); danger signs include: laboured, fast breathing, lower chest indrawing and nasal flare **Numerator:** # of caregivers of children under 5 interviewed who can correctly state two or more signs of childhood illness that require immediate assessment. **Denominator:** # of caregivers of children under 5 interviewed	HH survey, baseline report, ending report	Determined by by ADP processes	ADP manager	
		First source of care	Proportion of caregivers of children under 5 in CCM targeted areas who sought CCM-trained CHWs as first source of care for the sick child. **Numerator**: # of children under 5 whose caregivers sought care from CHWs as first source of care for the child **Denominator**: # of sick children under 5	HH survey, baseline report, ending report	Determined by ADP processes	ADP manager	
Output 1.1	Caregivers counselled on recognition and detection of symptoms of child illness	Caregivers counselled on child illness	Number (and %) of caregivers counselled on recognition and symptoms of child illness	CHW reports	Biannually	CCM CHW supervisor, ADP staff	Standard Monitoring Indicator – **# 3**

	Summary of objective	Indicator	Indicator definition	Means of verification	Frequency of data collection	Person responsible	Alignment to Standard Monitoring Indicators for Health & WASH
Output 1.2	Caregivers counselled on optimal practices for home based care of the sick child	Caregivers counselled on optimal practices for home-based care of the sick child	Number (and %) of caregivers counselled on optimal practices for home based care of the sick child including drug adherence (medicine completion) and improved feeding during illness	CHW reports	Biannually	CCM CHW supervisor, ADP staff	Standard Monitoring Indicator – **# 3**
Output 1.3	Community leaders promote awareness, uptake and quality of CCM services.	Increased awareness of the CCM services including the role of CHWs	Number of meetings at which community leaders promoted uptake of CCM services.	Activity reports	Biannually	ADP staff	
Outcome 2	**Children access effective treatment in a prompt and timely manner**	Children received timely and appropriate treatment for CCM condition	Percentage of sick children who received timely and appropriate treatment for CCM condition **Numerator:** # of children under 5 with a CCM condition (diarrhoea, suspected pneumonia, or malaria in malaria-endemic areas) that received timely and appropriate treatment during the last two weeks **Denominator:** # of children under 5 with a CCM condition in the last two weeks	HH survey, baseline report, ending report	Annually	ADP manager	
		CCM treatment coverage by CHWs increased	Proportion of overall treatment coverage being provided through CCM by CHWs	HH survey, baseline report, ending report	TBD by ADP processes		
		Treatment adherence ratio	% of caregivers completing treatment as instructed by the CHW; and, number of treatments by the CHW, expressed as a % by worker, by supervision unit, or by programme	HH survey, baseline report, ending report	TBD by ADP processes	ADP manager	

	Summary of objective	**Indicator**	**Indicator definition**	**Means of verification**	**Frequency of data collection**	**Person responsible**	Alignment to Standard Monitoring Indicators for Health & WASH
		Referral compliance	Number or % of referred children who were treated at a health facility	HH survey, baseline report, ending report	TBD by ADP processes	ADP manager	
Output 2.1	CHWs provide CCM services	Targeted CHWs for CCM completed competency based training	Proportion of CHWs targeted for CCM who have completed training using a standard CCM curriculum in the past six months disaggregated by gender **Numerator**: Number of CHWs targeted for CCM that have completed competence-based training **Denominator**: Number of CHWs targeted for CCM	Training reports	Biannually	ADP staff	Standard Monitoring Indicator – **# 1**
		Functional CHWs for CCM	Proportion of CCM trained CHWs who are providing CCM services according to national protocol in the last six months **Numerator**: Number of CCM CHWs that are trained and can provide evidence of providing CCM services in the last six months. **Denominator**: Total number of CHWs targeted for CHW	CHW registers, supervision reports	Biannually	CHW supervisors	Standard Monitoring Indicator – **# 2**
Output 2.2	CHWs conduct follow up visits for counselling and treatment adherence	Follow-up rate	Number and proportion of cases followed up after receiving treatment from CHW according to country protocol; follow-up visits could be counted as the CHW visiting the child's home, or the mother bring the child to the CHW for a follow-up visit **Numerator**: # of cases followed up after receiving treatment from a CHW. **Denominator**: Total # of cases receiving treatment from a CHW	CCM CHW reports, CHW register	Quarterly	CHW supervisor, ADP staff	

	Summary of objective	Indicator	Indicator definition	Means of verification	Frequency of data collection	Person responsible	Alignment to Standard Monitoring Indicators for Health & WASH
Output 2.3	Community medicines and stocks are available to the CHWs	Availability of CCM medicines with CHW	% of CHWs with each antibiotic, antimalarial, ORS (and other treatments) on day of supervision	Supervisor report	Quarterly	CHW supervisor	
Output 2.4	Households at high risk of child deaths are identified and regularly monitored	High risk households monitored by CHWs regularly	% of high risk households that received a monitoring visit by a CHW **Numerator**: Number of high risk households that received a monitoring visit in the last three months. **Denominator**: Total Number of high risk households	CHW reports	Quarterly	CHW supervisor	
Outcome 3	**Improved quality of services at the community level**	Caregiver satisfaction with CHW services	% of caregivers with children under 5 rating CHW as good or excellent	HH survey, baseline report, ending report	TBD by ADP processes	ADP manager	
		Increased RDT use	Use of rapid diagnostic tests (for child presenting with fever where RDTs are part of the package) **Numerator**: # of children tested with an RDT **Denominator**: # of children presenting with fever	Record review, observation	TBD by ADP processes	ADP manager	
		Appropriate prescribing practice for positive RDTs	Appropriate prescribing based on RDT results **Numerator**: # of children that receive an ACT **Denominator:** # of children with a positive RDT	Record review, observation	TBD by ADP processes	ADP manager	
		Appropriate prescribing practice for negative RDTs	Appropriate prescribing based on RDT results **Numerator**: # of children with negative RDT who do not receive an ACT **Denominator**: # of children with a negative	Record review, observation	TBD by ADP processes	ADP manager	

	Summary of objective	**Indicator**	**Indicator definition**	**Means of verification**	**Frequency of data collection**	**Person responsible**	Alignment to Standard Monitoring Indicators for Health & WASH
			RDT				
		CHWs accomplishing core competencies for case management practice	Proportion of sick children who receive correct case management from a trained CHW **Numerator**: # of sick children who were correctly treated or referred for all conditions **Denominator**: # of sick children assessed requiring treatment	Direct observation	TBD by ADP processes, supervisor's checklist	ADP manager	
Output 3.1	CHWs knowledge on case management increased	Complete and consistent registration	Proportion of CHWs whose registers show completeness and consistency between classification and treatment **Numerator:** # of CHWs whose registers show completeness and consistency between classification and treatment for at least four or five cases received for each condition **Denominator**: # of CHWs supervised	CHW registers, supervision reports	Quarterly	CHW supervisor, ADP staff	
		Referral rates	# (%) children referred and total # of children seen by a CHW in a given period	CHW records, CCM register	Quarterly	CHW supervisor and ADP staff	
Output 3.2	Trained CCM CHWs are routinely supervised	Routine supervision coverage	Proportion of CHWs who received at least one supervisory contact in the prior three months during which registers or reports were reviewed **Numerator**: # of CHWs who received at least one supervisory contact in the prior three months during which registers or reports were reviewed **Denominator**: # of CHWs trained in and	Supervisor report	Quarterly	CHW supervisor, ADP staff	

	Summary of objective	Indicator	Indicator definition	Means of verification	Frequency of data collection	Person responsible	Alignment to Standard Monitoring Indicators for Health & WASH
			deployed for CCM or # of CHWs interviewed				
		CCM supervisor training	Proportion of supervisors assigned to CCM (at all levels of the health system) that have been trained in CCM **Numerator**: # of supervisors assigned to CCM (at all levels of the health system) that have been trained in CCM **Denominator**: # of supervisors assigned to CCM (at all levels of the health system)	Training reports	Biannually	ADP staff	Standard Monitoring Indicator – **# 1**
Output 3.3	Community health structures provide oversight and management of CCM services	COMM and CHC review meetings	Number of COMM and CHC meetings with CCM CHWs where the purpose of the meeting or part of the agenda item is to review CCM activities	Minutes, attendance lists	Biannually	ADP staff	
Output 3.4	Community medicines and stocks are well managed	Medicines and stocks properly stored	Percentage of CHWs with medicines and diagnostics stored appropriately; the following six criteria are commonly used to define appropriate storage: 1. storage area free of rodents or insects 2. storage area secured with a lock and key, access limited 3. medicines are protected from direct sunlight 4. medicines are stored at appropriate temperature	Supervisor report	Biannually	CHW Supervisor ADP staff	

	Summary of objective	**Indicator**	**Indicator definition**	**Means of verification**	**Frequency of data collection**	**Person responsible**	Alignment to Standard Monitoring Indicators for Health & WASH
			5. space is sufficient for the quantity of products that should be stored 6. space should be dry, free from flooding				
Outcome 4	**Local health services are linked to and supportive of quality CCM**		% of those who had a CCM condition who were referred % of those who were referred that received appropriate treatment at the health facilities	Evaluation reports	Annually	ADP staff	
Output 4.1	Health systems and local partners have increased operational structures to support CCM	Increased operational structures to support CCM	# and % of functional COMMs actively supporting CCM CHWs (have participated in a CHW debriefing activity) within the last six months	Activity reports	Biannually	ADP staff	
Output 4.2	(HMIS) Data monitoring systems include CCM indicators	CCM utilisation indicators included in HMIS	One or more CCM indicators incorporated into HMIS **Yes**: One or more CCM indicators collected and monitored through national HMIS **Partial**: One or more CCM indicators included in national HMIS **No**: No recommended CCM indicators included in national HMIS	HMIS	Annually	National Health contact person	
Output 4.3	CHW supervisors	CHW supervisors	# of CHW Supervisors that have uninterrupted	Supervisor	Biannually	CHW	

	Summary of objective	**Indicator**	**Indicator definition**	**Means of verification**	**Frequency of data collection**	**Person responsible**	Alignment to Standard Monitoring Indicators for Health & WASH
	utilise improved CHW management systems, tools and job aids	are equipped for their work	access to user friendly appropriate jobs aids	report		supervisor	
			# of PHUs or CHWs reporting improved CHW management systems		Quarterly		
Output 4.4	Medical supply chains are functional and continuous with no stock outs at facility level	Availability of CCM medicines at supply point	Percentage of supply points with all key CCM medicines or diagnostics in stock during the last visit or last day of reporting period, whichever is most recent (key products defined by country policy**)**	Supervisor report, ADP report	Biannually	CHW supervisor	
			Number of facilities reporting no significant stock outs of essential second line treatments and products in the last six months	Supervisor report, ADP report	Biannually	CHW supervisor	Standard Monitoring Indicator – **# 19**

External tools for planning and design

Community Health Worker Assessment and Improvement Matrix: A Toolkit for Improving CHW Programs and Services. USAID (2011). http://www.urc-chs.com/resource?ResourceID=444

- This is a qualitative tool for assessing existing programmes.

Community Case Management Essentials: Treating Common Childhood Illnesses in the Community; A Guide for Program Managers. CORE Group (2010). http://www.coregroup.org/storage/documents/CCM/CCMbook-internet2.pdf

- This is a guide for programme managers who are implementing CCM. It covers all key areas of design, supervision and implementing CCM.

Tools to Introduce Community Case Management (CCM) of Serious Childhood Infection. Save the Children (2011). http://www.coregroup.org/storage/documents/Community_Case_Management_of_Children/CCM_toolbox_V2_March_2011.pdf

- This is a useful toolbox created and used by Save the Children.

Annex 2. Additional operational tools

Operational tools may be found at:
https://www.wvcentral.org/community/health/HNH%20Wiki/Community%20Case%20Management%20Toolkit.aspx

Tool	Description
Additional tools for CCM	Excel files containing: • CCM stock control card • Referral and counter-referral tool • High risk household targeting
Case load and procurement planning tool	A tool to calculate estimated case load for CHWs and buffer stock procurement calculations for essential medicines for CCM. This tool helps to calculate the expected number of children to be seen by a CHW, how much medicine is needed for buffer stocks and costs per unit and a six month supply. Population numbers will come from district statistics, MoH and HMIS. The tool also helps in monitoring of stock and managing stock-outs. The aim is to negotiate medicine use by health facilities and CHWs in WV ADPs.
Supervision tool	A modular based supervision model which includes the following elements: • Stock quality check and control • Data collection • Randomised case evaluation • Observation case assessment for IMCI • Health knowledge and revision needs assessment • Qualitative performance assessment

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