

Summative evaluation of the WHO Rapid Access Expansion Initiative Executive Summary

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EXECUTIVE SUMMARY

BACKGROUND OF THE RAcE INITIATIVE

1. Integrated community case management (iCCM) refers to health care provided by community health workers (CHWs) to children with limited access to health facilities. It generally comprises the diagnosis and treatment of diarrhoea, malaria and respiratory infections among children aged from 2-59 months but may also include the diagnosis and treatment of acute malnutrition, neonatal care and interventions for health promotion and disease prevention.
2. The Rapid Access Expansion (RAcE) Initiative was funded by the Government of Canada in 2012 with a grant of C\$ 75 million over six years to the WHO Global Malaria Programme (GMP) to increase the coverage of iCCM services for the achievement of the health-related Millennium Development Goals and to generate evidence to inform WHO policy recommendations and guidance on iCCM.
3. Under the Initiative, WHO provided renewable sub-grants to five non-state actors (NSAs) to implement six iCCM programmes in five countries in cooperation with national and sub-national authorities. Two of these countries, Malawi and Mozambique, had established iCCM services that the RAcE programmes intended to strengthen. In the other three countries, the Democratic Republic of Congo (DRC), Niger and Nigeria, RAcE introduced iCCM services in regions where they did not yet exist. The RAcE initiative distinguished itself from other internationally funded iCCM programmes by aiming to achieve universal health coverage (UHC) for all children in hard-to-reach areas within selected geographic boundaries. The number of children covered was estimated at 1.9 million.

EVALUATION PURPOSE, OBJECTIVES, SCOPE AND METHODOLOGY

4. The evaluation of the RAcE Initiative was implemented by **hera**, a consulting company based in Belgium, under contract to the WHO Evaluation Office. Data were collected between November 1st 2017 and February 28th 2018. The scope of the evaluation was defined by five indicative areas of investigation:
 - 1) The extent to which the original design of the RAcE Initiative responded to the needs and priorities of the main stakeholders in national health systems and was in line with national health strategies.
 - 2) The extent to which the RAcE Initiative, through country level activities in combination with implementation research activities, was able to contribute to enhancing the utilisation of essential health commodities and supplies needed to diagnose and treat the main causes of death among children under five in programme countries.
 - 3) The extent to which the RAcE Initiative contributed to a supportive policy and regulatory environment in support of iCCM as a key component of health care service delivery.
 - 4) The extent to which the assessed changes in iCCM treatment coverage and the changes in child mortality in RAcE programme areas identified in the evaluations conducted by ICF, as well as the plausible contributions of RAcE to any changes, can be independently corroborated.
 - 5) The extent to which the RAcE Initiative contributed to the achievements of gender equality results.

5. The evaluation covered all six programmes funded under the RAcE Initiative with field visits and the preparation of country briefs for each of the five programme countries. In preparation of the country missions, the evaluation team conducted a literature review of recent studies and reports about iCCM in the five programme countries.

6. The evaluation employed a qualitative methodological approach, using a combination of Contribution Analysis (CA) and Process Tracing (PT) by assigning a prior probability that an impact has occurred and testing it to determine a posterior probability in the light of new evidence. The evaluation design included the post-hoc development of a Theory of Change (TOC) framework and the preparation of an evaluation matrix including evaluation questions, assumptions, indicators, data sources and data collection methods and a chain of reasoning linking the evaluation question to the TOC. Data were collected in document reviews, key informant interviews (KIIs) and focus group discussions (FGDs). The data collection tools were pretested during an inception mission to Niger State, Nigeria. The data of baseline and end-line household surveys conducted by the implementing partners were used throughout the evaluation as evidence of programme results, triangulated with data from KIIs, FGDs and the review of documents and databases.

FINDINGS AND CONCLUSIONS

KEY FINDINGS AND CONCLUSIONS

7. The RAcE Initiative showed that iCCM can fill important gaps in national strategies for universal health coverage (UHC) by creating access to essential health services to children who need timely treatment for malaria, diarrhoea and acute respiratory infections but who do not have easy access to primary health care facilities. iCCM is an effective contribution to child survival when it is applied to overcome geographic barriers in access to care. The services are highly appreciated by caregivers of children. The key to effective iCCM is its link to health systems building blocks, particularly:

- the uninterrupted supply of quality medicines
- a human resources for health framework that includes CHWs
- a health management information system (HMIS) that includes community-level data
- the integration of iCCM in the national health financing framework
- effective community engagement and demand generation

8. iCCM services, as they were delivered under the RAcE Initiative, are highly dependent on international funding which is their greatest threat to sustainability. In contrast to facility-based services that can mitigate periods of medicine stock-outs or financing bottlenecks, iCCM services are vulnerable to interruptions in medicine supplies and supervision as there are no alternatives for mitigation.

9. Despite many years of experience in the implementation of iCCM, important knowledge gaps persist, particularly in the African context. More studies about the modalities and the effectiveness of iCCM have been conducted in Asia, and there is a persistent need for validation of this evidence in Africa. Additional knowledge needs to be generated on:

- The status, the incentives and the motivation of CHWs
- Effective approaches to community engagement in support of iCCM
- Gender equality in the supply and demand for community health services

10. While the RAcE Initiative has generated qualitative evidence that iCCM has an impact on reducing child mortality, the evaluation found that this impact could not be estimated by the application of epidemiological models because input data for reliable modelling were not available. These will only become available when there are significant improvements in national civil registration and vital statistics systems and in community health information systems.

DID THE RAcE INITIATIVE RESPOND TO THE NEEDS AND PRIORITIES OF THE MAIN STAKEHOLDERS IN NATIONAL HEALTH SYSTEMS AND WAS IT IN LINE WITH NATIONAL HEALTH STRATEGIES?

11. The RAcE Initiative was well aligned with national health policies and strategies in all five programme countries. Ministries of health were closely involved in designing and planning the RAcE programmes, including in the selection of regions and communities to receive services. Supported by the WHO Country Offices (WCOs), the ministries of health led the coordination fora and technical working groups on iCCM in all countries and had primary responsibility for assuring the complementarity and coordination of internationally-supported iCCM programmes.

12. The RAcE Initiative demonstrated that iCCM complements national efforts to achieve UHC by reaching a large number of children who have no access to health facilities. The limitations are in thinly populated regions where some communities are so remote that they even cannot be reached with iCCM services. In all five programme countries, a significant proportion of caregivers changed their pattern of care-seeking towards consulting CHWs. In some programme areas, however, private and public service providers already provided a relatively high level of access to care, although of uncertain quality. In these cases, overall access to care did not increase or only increased marginally. The limitations to access in these programme areas were not primarily due to geographic distance, but rather to cost and perceived quality. In such contexts, iCCM may not be the only solution to increasing access. Other options to reduce point of service user charges and increase quality of care exist.

DID THE RAcE INITIATIVE CONTRIBUTE TO ENHANCING THE UTILISATION OF ESSENTIAL HEALTH COMMODITIES TO DIAGNOSE AND TREAT CHILDREN IN PROGRAMME COUNTRIES?

13. The national capacity to implement iCCM was strengthened in all programmes by the collaboration of the WCOs with ministries of health at the national level and the operational support to the ministries by contracted NSAs at the decentralised level. RAcE contributed to the development or revision of strategies, guidelines and tools in all countries. CHW reporting systems and tools were established or improved, and the programmes supported the flow of data from the community sites via supervisors to the health district level. Repeated data quality audits confirmed an increasing quality of transmitted information. Community health data were already integrated in the national HMIS in Malawi and partially in Mozambique. In the other programmes this was not achieved although some progress was observed.

14. National systems for procurement and supply-chain management (PSM) of iCCM commodities were used fully or partially in all countries except Malawi where a parallel system was maintained throughout the programme. In Mozambique, national PSM systems were used from the start, in the other programmes there was a gradual transfer of responsibility to national PSM, combined with some capacity strengthening of national institutions. All programmes experienced some stock-outs of medicines. Major stock-outs over long periods were only

reported in Mozambique and the DRC but stock-outs were also reported by the other programmes towards the end of the RAcE implementation period.

15. Programmes under the RAcE Initiative reached more than twice the targeted number of 750,000 children per year with nearly eight million consultations performed by RAcE-supported CHWs over the programme period. Quality of care assessments that were available from four programmes indicated that between 48 to 55 percent of children were assessed and treated for all conditions according to the standards of an observing clinician. In community FGDs, caregivers universally expressed a high level of satisfaction with the services provided by CHWs.

16. iCCM is an element of the health system service delivery building block. Effective service delivery requires the provision of a continuum of care, and effective iCCM requires a reliable first level referral service for children who cannot be treated by CHWs. Several NSA programme proposals included plans to strengthen the capacity of primary health care facilities, but they were not fully implemented. District supervisors in several programmes noted that CHWs often perform better in adhering to diagnostic and treatment algorithms than staff in primary health care facilities. Shortage of medicines in facilities was a common complaint heard in community FGDs. In three programme reviews, respondents mentioned that sick children were referred by health facility staff to CHWs because medicines were not available at the health facility.

17. The RAcE Initiative achieved the target of 7,500 CHWs trained and supported. Indeed, about 8,900 CHWs were trained of whom about 7,400 were active at the time of programme closure or the time of the evaluation mission. Attrition rates were highest in the DRC which was to a large extent explained by the insecurity in the programme region and related displacements of communities. Training and re-training was conducted according to national curricula or curricula based on the UNICEF/WHO curriculum 'Caring for the sick child in the community' that was adapted to local needs and contexts. CHWs were supervised by trained facility-based health staff. All programmes except in Malawi provided financial incentives, and in some cases bicycles, motorcycles or canoes to supervisors. Systems for the supervision of supervisors by district health authorities, and joint supervisions of CHWs and supervisors were implemented in all programmes.

18. CHWs are volunteers, except in Malawi, where they are salaried employees of the Ministry of Health. Different approaches to maintain their motivation and retention were used by RAcE programmes in line with national policies. They ranged from strictly material support (e.g. provision of a bicycle) to the payment of a fixed allowance contingent on the submission of monthly reports. Interviewed CHWs in all programmes affirmed that training opportunities, the uninterrupted supply of commodities and the recognition and status in the community were their main motivating factors. Stipends and financial incentives were considered important and emphasised more by male than by female CHWs, but they were also considered insufficient by all interviewed CHWs. A common complaint was that they were not adjusted to inflation nor to expansion of the scope of assigned tasks. Material or financial support from the community (construction of houses, bicycles, stipends, etc.) were promoted and monitored by several programmes and highlighted in annual programme reports. A number of interviewed CHWs acknowledged receiving some support, but none considered it a substantive contribution to their own motivation.

19. The RAcE programmes used multiple approaches for demand creation for iCCM services that were largely effective. This is documented in the surveys and FGDs which confirmed that the

great majority of community members considered CHWs as trusted health care providers and would choose them as their first source of care for a sick child. Community engagement strategies to promote the support of CHWs by their communities, however, had mixed results. Some highly successful examples were cited in programme reports, but the KIIs and FGDs conducted by the evaluation team indicated that these were exceptional and anecdotal. Several community discussions revealed a disconnect between the offer of iCCM as a service to the community, and the expectation that communities provide support to maintain this service.

DID THE RAcE INITIATIVE CONTRIBUTE TO A SUPPORTIVE POLICY AND REGULATORY ENVIRONMENT FOR ICCM AS A KEY COMPONENT OF HEALTH CARE SERVICE DELIVERY?

20. The RAcE Initiative was implemented by WHO through sub-contracts to national or international NSAs that were selected through competitive bidding. The results of this modality of programme delivery were positive and widely appreciated. The WCOs, with support of the Regional Office (RO) and the GMP, provided normative support for the development or revision of iCCM policies, strategies and tools to central governments. This resulted in all countries in progress towards a more supportive policy and regulatory environment for iCCM. The contracted NSAs, on the other hand, provided operational support to decentralised levels of government. There was an effective flow of information between the decentralised implementation and the central policy level, assuring that the experience of RAcE fed into national policies and strategies and into the partner coordination dialogue.

21. Some key informants at national and global level, however, cautioned that the sub-granting approach should not be viewed as a universal best practice, but rather as a transitional approach to be applied on the basis of an assessment of systems and capacities of governments and potential NSA implementing partners.

22. The NSA implementing partners, in collaboration with ministries of health, conducted ten operational research projects on issues such as supervision systems for CHWs, appropriate training and data collection tools, or the use of mHealth for improving quality of care and data collection. Some of these research projects were completed at the time of data collection for the evaluation and had already resulted in programme improvements. The final results of most, however, had not yet been disseminated or discussed. Other research results and lessons drawn at the level of the RAcE Initiative were also still being prepared for documentation. Data collected by the end of February 2018 did not yet allow a full assessment of the contribution of the RAcE Initiative to new knowledge about iCCM at global, regional and national levels. Work in this area by the GMP is on-going and is expected to generate results that will likely contribute to more and better guidance for national policy and regulatory frameworks on iCCM.

23. The national policy and regulatory environment for iCCM is a major determinant of the sustainability of services. The RAcE programmes contributed extensively to this dimension, for instance by supporting the inclusion of iCCM in national health strategies. While much was achieved in this area, including the creation of iCCM budget lines in national or sub-national health budgets, iCCM services in the five programme countries continue to be predominately funded by international development partners. Appropriation of funds for iCCM budgets from national resources was at best partial and in most countries contingent on on-going international grant negotiations. This created critical situations of medicine stock-outs and reductions of CHW supervision as the RAcE programmes were nearing their end. To avoid iCCM service gaps in RAcE

programme areas, a process of sustainability planning was initiated in 2016. It was still on-going in some countries at the time of the evaluation. While the structured process was highly appreciated by all key informants at country level, most were of the opinion that starting it in the last programme year was too late, and that financing gaps could have been avoided if a sustainability roadmap would have been developed and implemented from the start of the programme.

DID THE EVALUATION CORROBORATE THE ESTIMATED CHANGES IN ICCM TREATMENT COVERAGE AND CHILD MORTALITY MODELLED BY ICF?

24. Data collected by the evaluation provide evidence that the RAcE Initiative contributed to a reduction in child mortality. This evidence is based on qualitative data collected in focus groups and interviews. Reliable health facility data that documented a reduction of admissions of children with severe life-threatening conditions were only partially available in one programme. Population surveys conducted after the evaluation may provide further evidence of reduced child mortality in RAcE programme areas. The mortality reduction estimated with the aid of the Lives Saved Tool (LiST) model could, however, not be corroborated. Reliable input data of baseline mortality and of specific treatment coverage were not available to generate credible model outputs. This is the same finding as in a previous multi-country iCCM evaluation in 2014.

DID THE RAcE INITIATIVE CONTRIBUTE TO ACHIEVEMENTS OF GENDER EQUALITY RESULTS?

25. The RAcE Initiative did not live up to its commitments on gender mainstreaming. The evaluation found no evidence that a gender analysis was done in any of the programmes nor that gender mainstreaming was pursued actively. The indicators in the quarterly performance reports asking for sex-disaggregated data in all programmes except the DRC were consistently ignored. Differences in access to treatment observed in baseline and end-line surveys were not analysed for causes. Low literacy rates of women in rural areas were uniformly cited as the only reason for difficulties in recruiting female CHWs. In interviews, however, many other reasons related to gender relations in communities were mentioned. No analysis or approaches to address these issues were explored beyond encouragements for communities to nominate female CHW candidates. The findings of the overall lack of gender awareness of the RAcE Initiative mirrors the findings of the literature review which found practically no discussion of gender issues.

RECOMMENDATIONS

26. The evaluation of the RAcE Initiative generated four key recommendations to WHO

Recommendation 1. Considering that iCCM services established under the RAcE Initiative are threatened by financing gaps, WHO should take immediate action to assure that the achievements of the RAcE Initiative are not lost by:

- Working with partner governments in assessing potential funding gaps for iCCM in RAcE programme areas and assisting ministries of health in resource mobilisation to assure that the services established in these areas continue without interruption.

Recommendation 2. Considering the effectiveness of implementing the RAcE Initiative through sub-grantee contracts with non-state actors, WHO should:

- Include programme implementation through NSAs as a possible alternate option to the established approach of direct implementation through governments, based on a contextual analysis and a capacity assessment of potential government and NSA programme partners.

Recommendation 3. Considering that the RAcE Initiative generated new evidence on implementing iCCM as a health systems intervention for the achievement of universal health coverage which is, however, not yet fully documented and disseminated, WHO should:

- Consolidate and disseminate the lessons learned by RAcE and apply them in consultation with technical partners to updating the guidelines for ‘Caring for the Sick Child in the Community’ that are currently integrated in the multi-agency planning handbook ‘Caring for Newborns and Children in the Community’
- Initiate actions to close persistent knowledge gaps, by:
 - Supporting research to better understand the role and the effectiveness of community engagement strategies for iCCM, including an assessment of the community role in contributing to CHW motivation and retention.
 - Conducting, in collaboration with interested partners, a systematic review of gender equality issues in the supply and demand of iCCM in different social and cultural contexts.

Recommendation 4. Considering that the RAcE Initiative underlined the role of iCCM services in national health systems development for the achievement of universal health coverage, WHO should focus its technical and programme support on iCCM to ministries of health and development partners at country level on:

- Targeting iCCM services at remote rural communities living distant from health facilities, while in each case examining all possible options to assure that children have timely access to quality health care, including alternate options to iCCM if these exist.
- Embedding programme support to iCCM firmly in a system of a continuum of care by assuring that first level referral facilities for CHWs have the capacity to provide accessible and affordable quality services to referred children.
- Assuring that national systems are in place to manage the provision of an uninterrupted supply of iCCM commodities to the community level, or that support to iCCM programming is paralleled by support to the development of such national systems.
- Advocating for the inclusion of CHWs in the national human resources for health framework as a salaried workforce or, where this is not accepted by governments, as a volunteer cadre with a fixed minimal level of stipends and incentives that is commensurate to the scope of expected services.
- Supporting the development and implementation of quality civil registration and vital statistics systems, as well as the integration of reliable community health data in national health management information systems in order to generate valid information about the impact of iCCM on the reduction of child mortality.
- Assuring that financing of iCCM services (from domestic or international sources) is firmly embedded in the national health financing framework, keeping in mind that iCCM services easily break down when there are financing gaps interrupting supervision and the flow of commodities.

KEY LESSONS FOR GOVERNMENT PARTNERS IN THE RAcE INITIATIVE

27. The evaluation was based on data collected at programme level, but it was not an evaluation of each country programme. While the recommendations of the evaluation are directed to WHO, there are a number of lessons that can be drawn by partner governments in

the RAcE Initiative. The Initiative demonstrated that iCCM is a mature component of a UHC strategy in countries with populations that live beyond easy reach of primary health care facilities. As such, iCCM has to be treated as an integral part of the national health system which requires that governments:

- 1) Assess the feasibility, efficiency and effectiveness of all options to increase health service coverage and access, including through iCCM, keeping in mind that timeliness of access is critical for child survival. iCCM services should be targeted at communities where constraints of providing services through health care facilities cannot be overcome with available means and resources.
- 2) Assure that the uninterrupted supply of quality commodities for the community level are an integral part of national procurement and supply planning and management systems. iCCM services can only function when there is an uninterrupted supply of commodities at community care site.
- 3) Acknowledge that CHWs are part of the national health workforce. The option of salaried CHWs may not be feasible or acceptable in all countries. Volunteer workers, however, also require financial support that is commensurate to their scope of services and the associated effort. A situation where incentives and stipends are negotiated separately for each international health project is not conducive to maintaining a stable cadre of volunteers providing iCCM. Supervision of CHWs also has to be included in national human resource planning.
- 4) Assure that there are functional systems and mechanisms to feed iCCM data into the national health management information system. iCCM services are part of national health service delivery, and they can only be planned and resourced when there are reliable monitoring data on the same level and platform and in the same format as other health service monitoring data.
- 5) Integrate the cost of providing iCCM in the national health financing framework and budget estimates and assure that iCCM receives equal attention in budgeting and financing from national and international sources as other priority health services.
- 6) Analyse, on the basis of services to be provided and on the basis of social context, whether iCCM services are best provided by male or female CHWs, or if they require paired CHWs of both sexes. Analyse any gender-related constraints in recruiting CHWs such as differential education levels or systemic gender discrimination and develop strategies to overcome them.