Tools to Introduce Community Case Management (CCM) of Serious Childhood Infection

Version: March 2011

Save the Children

INTRODUCTION

Integrated Community Case Management (iCCM) Four infectious diseases (pneumonia, diarrhea, neonatal sepsis, and malaria) account for nearly half (46%) of child death every year. Most of the nearly nine million children who die annually could be spared if we *just delivered the life-saving interventions that we already have* to families that need them most. These interventions include: antibiotics for pneumonia and newborn sepsis; antimalarials for malaria; and oral rehydration packets and zinc for diarrhea. Unfortunately the use of these interventions is low in most developing countries because services that deliver them are not accessible, not available, not of good quality, and/or not sought.

Preventive interventions can be electively scheduled. Curative interventions, on the other hand, must be continuously available (year-round, most of the day, every day,) because children acquire infections unpredictably and can rapidly deteriorate and die without treatment. Hundreds of millions of people in developing countries, especially those in rural areas, live beyond the reach of facilities. Indeed, facilities only treat a minority of most sick children in developing countries. Preventive interventions, of course, are essential, but an incomplete solution because use and efficacy will be incomplete. Curative services will remain a mainstay of disease control for the foreseeable future.

In response, Save the Children (SC) and many others, including governments and bilateral donors, have prioritized the "Integrated Community Case Management" (iCCM) strategy to deliver life-saving curative interventions for common serious childhood infections to remote communities. When non-governmental organizations (NGOs) are involved, they typically support Ministry of Health (MOH) partners to train community health workers (CHW) to assess, classify, treat, counsel, and refer children with signs of infection. NGOs also train them to support, supervise and supply the workers, and to train families to recognize and seek care prompt, appropriate care for illness signs.

Existing Tools and Gaps Numerous tools exist to support CCM, but no package completely addresses "integrated" CCM, which delivers treatments for more than one disease. The World Health Organization's (WHO) package, *Caring for the Sick Child in the Community*, is the gold standard training for integrated community case management. JSI developed a comprehensive package for semi-literate CHWs in Nepal to provide case management for pneumonia. The BASICS Project developed tools for integrated CCM in Francophone Africa. SC, IRC and other NGOs have developed tools as needed, often learning from one another. SC inspired *CCM Essentials – A Guide for Implementers* in 2005, and this multi-author, multi-institution document was finally published in 2010. Reviewers have found it promising, yet lacking some tools necessary to operationalize the strategy.

Despite extensive experience and some excellent tools, gaps include:

- Poor linkage between indicators and monitoring and evaluation tools.
- Existing tools address non-integrated (single disease) CCM.
- Training is not always competency-based.
- Training stresses assessment, classification and treatment more than counseling, recording, follow-up, home visits, and/or community engagement.
- Service quality is not routinely monitored.
- Supervision strategy is lacking in most program plans.
- Supervisors are commonly not trained in supervision.

- Supervisors are not supervised.
- Cost-recovery tools are uncommon.
- Planning tools are uncommon.
- Delivering treatments for newborn sepsis is lacking.
- Lack of consensus.

The Way Forward In light of: (1) the recognized need for community-based strategies like iCCM to achieve Millennium Development Goal 4; (2) concerted advocacy for iCCM by UNICEF, USAID, WHO, bilateral donors, and NGOs, among others; (3) increased donor support for iCCM; (4) iCCM policies, programs and plans gaining momentum; and (5) the lack of a complete set of iCCM implementation tools – SC offers this integrated tool-kit.

NOTE:

This set of CCM tools represents the work of many Save the Children staff and partners across the world. It is an evolving set of tools and therefore, your feedback and comments are always welcomed. Please direct any inquiries to: David Marsh, Tanya Guenther, Salim Sadruddin, Janani Vijayaraghavan or Jeanne Koepsell.
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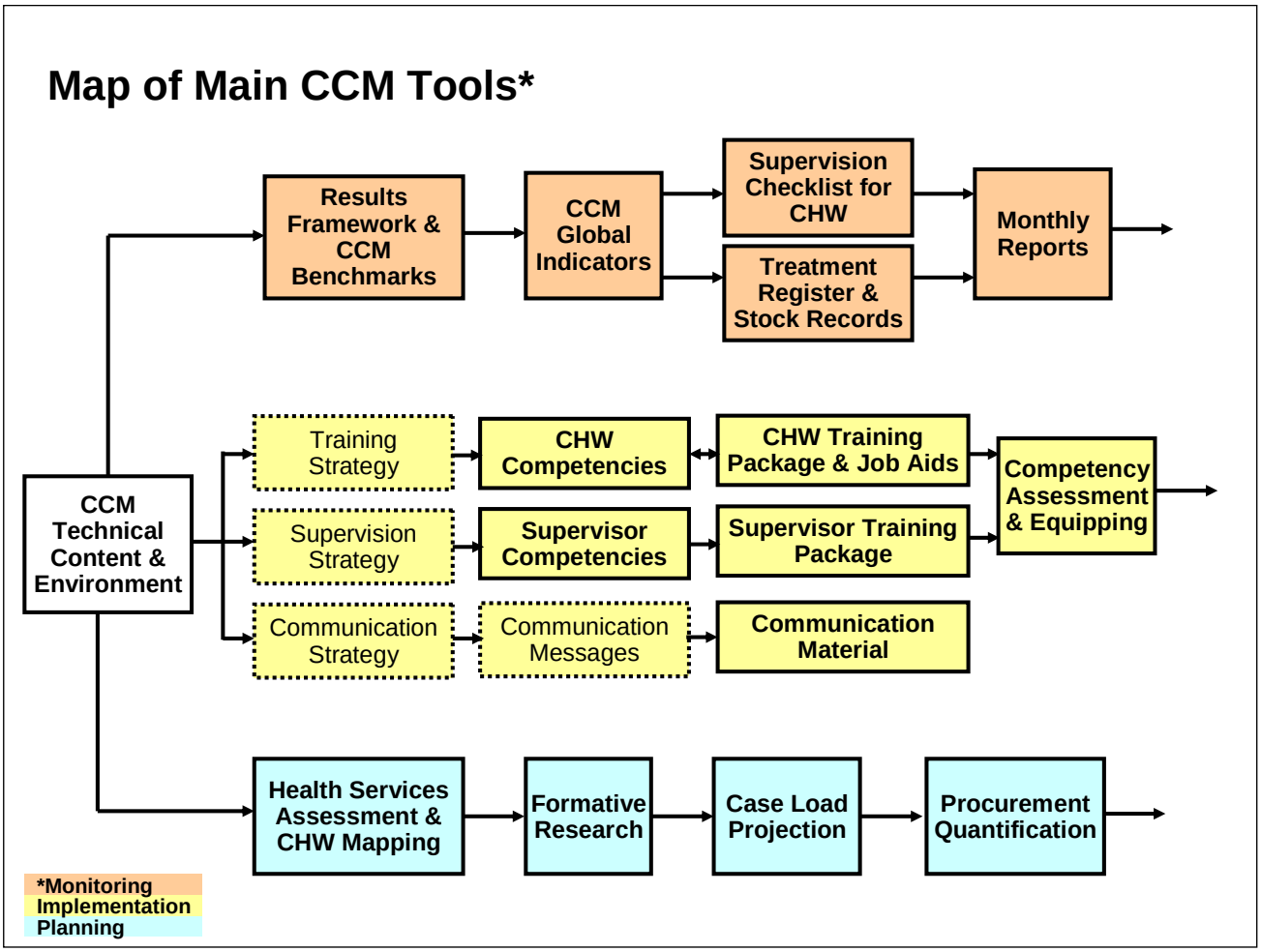
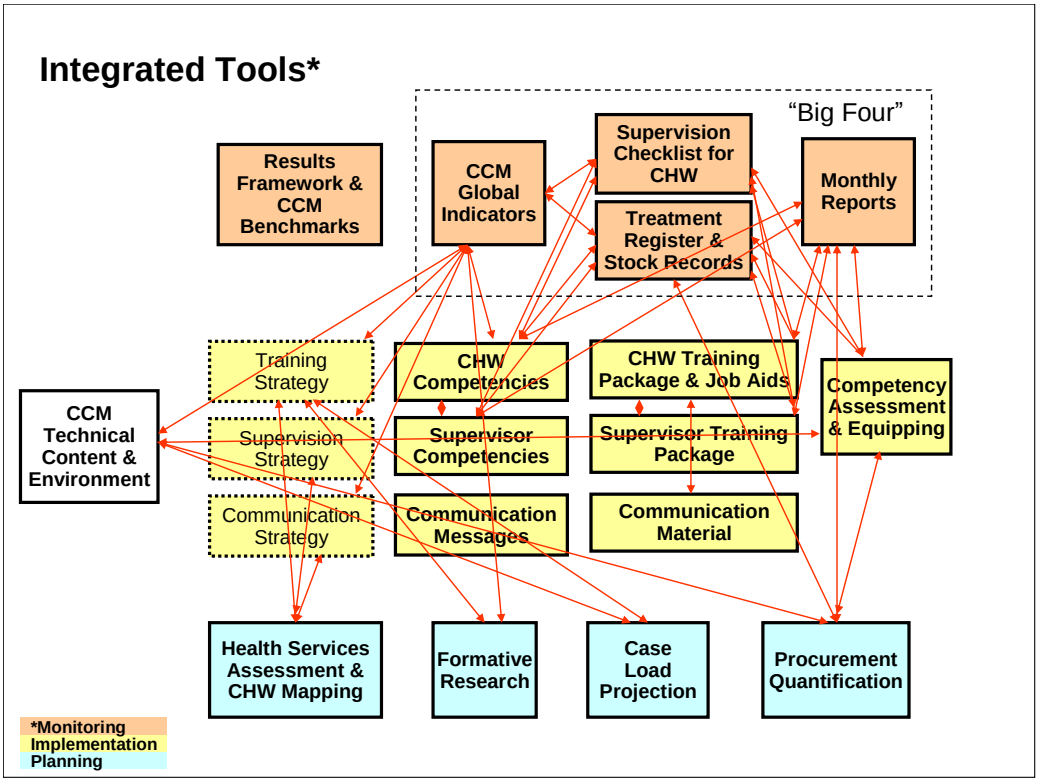
MAP OF TOOLS FOR CCM

Overview Programmers commonly request a "training package" when they decide to introduce a CCM strategy. A training package, while necessary, is incomplete for a successful program. The map specifies three families of 20 integrated tools (colored boxes with **bold** solid-line borders) which experience has shown to be indispensable.



The logic of the map flows from left to right. The starting point is the white box, **CCM Technical Content & Environment**, which refers to critical program and health systems characteristics that will influence the design of supporting tools. Examples include: beneficiary age-group, treatments to be delivered, CCM provider cadre(s), trainee literacy, community selection criteria, existing policies, health information systems, and cost-recovery, among others. Upon clarification, stakeholders can commence drafting three lines of tools: (1) monitoring (top row in pink), (2) implementation (middle row in yellow), and (3) planning (bottom row in blue), each briefly discussed below.

While the logic and the sequencing proceeds from left to right, the tools are uniquely integrated – an important contribution of this tool-kit. The figure illustrates some, but not all, of the important links and highlights the centrality of four tools which are connected to so many others.



Having established important parameters of the **CCM Technical Content & Environment**, stakeholders can then begin drafting monitoring tools (tan boxes), implementation tools (yellow boxes), and undertaking detailed planning (blue boxes).

Monitoring Years of experience with a six-box **Results Framework** has confirmed its usefulness in communicating among stakeholders, in focusing on results, and in selecting measures of success. Save the Children, as part of a multilateral effort led by USAID, contributed to the development of **CCM Benchmarks** that outline the systems and building blocks necessary to implement iCCM: (1) coordination and policy setting, (2) costing and financing, (3) human resources, (4) supply chain management, (5) service delivery and referral, (6) communication and social mobilization, (7) supervision and performance quality assurance, and (8) monitoring and evaluation and health information systems. The Results Framework and CCM Benchmarks inform the multilaterally developed **CCM Global Indicators**, which include 10 global and 42 country-level indicators to monitor and evaluate progress. Key documents that inform many of these monitoring indicators are the **Supervision Checklist for CHW** and the CHW's **Treatment Register** and **Stock Records** and the **Monthly Reports**. Not shown, but important, is a "report card" or "dashboard" to track higher level, generally qualitative indicators. The arrow pointing right from the right-most box (Monthly Reports) indicates the onward flow of information to the district and national health management information systems.

Implementation The **CCM Technical Content & Environment** directly informs implementation (yellow boxes), three streams of which we have prioritized: (1) CHW Training, (2) Supervision, and (3) Communication. The CCM Technical Content guides the development of a discreet list of **CHW Competencies**, i.e., the knowledge and skills for community case management. The competencies form the basis for the **CHW Training Package** for case management and allied activities. CHW training rests on the all-important case management **Job Aid**. Sometimes called the "Sick Child Recording

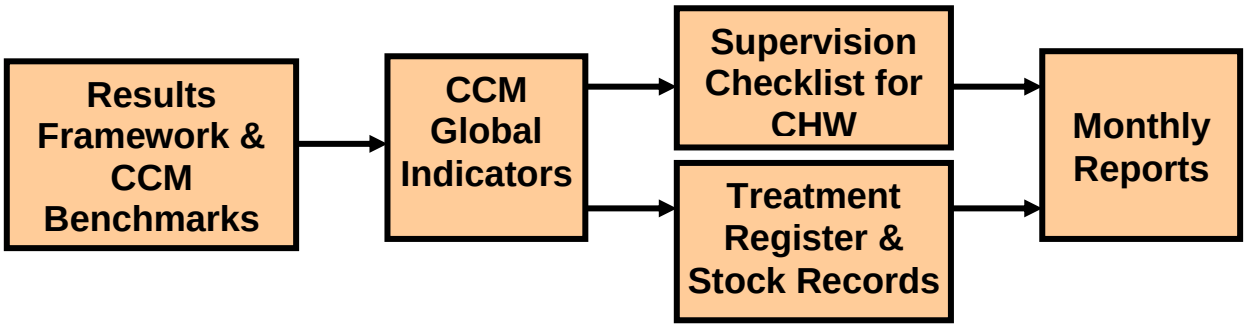
Form," this tool consists of one or more evidence-based flow-charts to guide the CCM worker through caring for sick children. Closely related is the CHW Kit (**Equipping**) containing all the medicines, equipment and supplies to perform case management. Other **Job Aids** include referral forms and evidence-based counseling cards and reminder cards for mothers. The training to impart these skills and follow-on supervision must include a **Competency Assessment** tool to identify which CHWs are capable and which will require additional support. The arrow pointing right from this, the right-most box, represents the deployment of competent workers who will need support, supply and supervision. The tools in the next yellow row support supervision. The CCM technical content and the CHW competencies plus specific competencies relating to the process of supervision all inform **Supervisor Competencies**, which in turn inform the **Supervisor Training Package** and **Competency Assessment** for supervisors. The bottom yellow row supports behavior change communication, specifically Communication Messages and **Communication Material**, typically group or inter-personal counseling for the recognition and labeling of signs of illness and prompt, appropriate care-seeking.

Planning The **CCM Technical Content & Environment** guides detailed planning, some of the tools for which are specified (blue boxes). The **Health Services Assessment** and **CHW Mapping** are two tools usually applied together at peripheral facilities. The former characterizes the readiness of the supporting facility to deliver case management – a prerequisite for CCM. The latter characterizes a facility's communities allowing stakeholders to identify those suitable for CCM, using public health criteria (geographic access, population, CHW presence, and the like). The **Formative Research** tools target groups of mothers (regarding illness recognition, home care, care-seeking, perceived quality of care, and referral for childhood illness) and individual CHWs (regarding roles, training, supervision and case management practice if relevant). The **Case Load Projection** tool applies expected disease-specific incidence rates to typical scenarios of community size and ratios of CHW to beneficiary to inform optimal CHW deployment density. The disease-specific incidence rates also inform **Procurement Quantification**, which informs **Stock Records**. The arrow pointing right from the right-most box (Procurement Quantification) indicates the procurement process, among other next steps.

Using the Tools Save the Children has additional unmapped tools (described in the following pages), and we are developing new ones. We have not developed tools for training, supervision or communication strategies since these are already appearing in countries' implementation guidelines. The electronic version of the toolkit has examples of implementation guidelines and supervision strategies for reference. Similarly, communication messages commonly already exist since iCCM basically extends the existing case management strategy. We have provided some examples of written communication materials and are actively collecting others to include in future versions of the toolkit.

We propose none of these tools as "final" or "non-negotiable." Rather they can guide planners to prioritize essential features, to knowledgeably review what exists, and to identify gaps to fill or profitable adaptations. These 20 tools and more are systematically detailed, each in a one-page format followed by one or more examples. Additional examples are available on the accompanying CD. An interested user can browse the CD (or flash-drive), accessing tools from the map by clicking on their boxes which are hyperlinked to the relevant sections in the document.

SECTION 1: MONITORING TOOLS



RESULTS FRAMEWORK

Developed by:	Save the Children	**Developed in:**	Headquarters
Adapted in:	Projects in: Nicaragua, Guatemala, Myanmar, Bangladesh, Nepal, Malawi, Mozambique National Programs in: Uganda, South Sudan		
Purpose:	To graphically depict a hierarchy of results that inform program design (strategies and activities); monitoring (indicators for each result); program learning (questions related to the best ways to achieve results); and communication (among partners and externally).		
Completed by:	Program designers and/or planners	**Frequency:**	Once (revise as needed)
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *CCM Global Indicators* Supported by: *Treatment Register*, *Supervision Checklist for CHW*, *CHW Monthly Report*, *Monthly Summary* and others		

Overview: A results framework is a tool that helps describe the logic of a program and how to achieve intended results. The framework serves two critical programmatic functions. By describing the steps towards a program's ultimate goal, it indicates the general programmatic direction to achieve that goal through stepwise results. Second, by outlining results at different hierarchical levels, it prompts managers to specify what indicators to track throughout the life of the project. The *Results Framework* informs the development of the *CCM Global Indicators*.

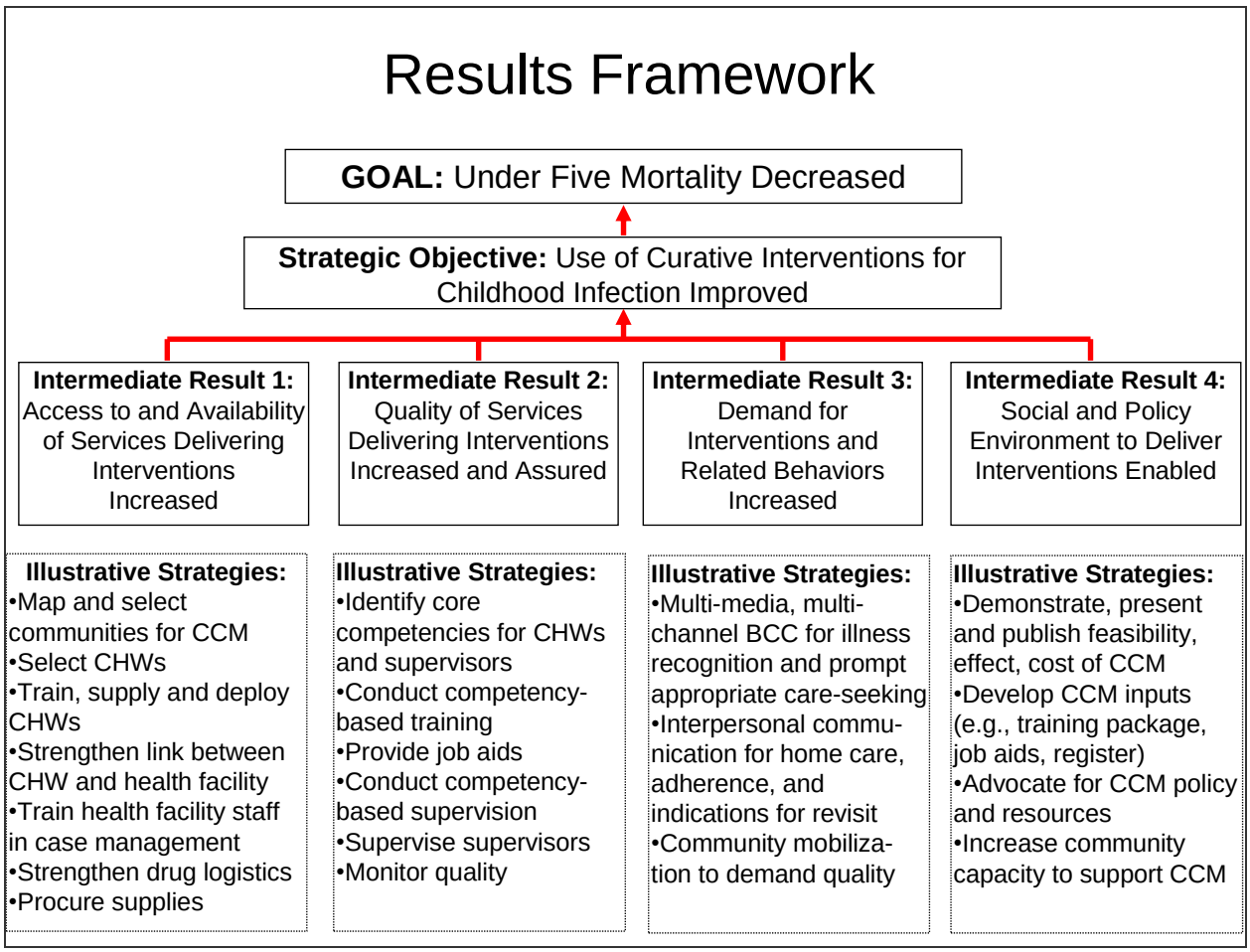
Experience has shown that the six results outlined in the framework (mortality decreased, use of curative interventions increased, access to and availability of services delivering interventions increased, quality of services increased and assured, demand for interventions and related behaviors increased, and social and policy environment to deliver interventions enabled) and their sequencing are universally relevant. Thus, results frameworks are commonly used to visually depict the relationship among these program results. The four groups of illustrative strategies, while generally relevant, need local adaptation and amplification. Of course, the actors and activities (and timing, frequency, duration, sequencing) to implement the chosen strategies are locally determined.

Use of data: The *Results Framework*, unlike tools that are used repeatedly throughout a program, does not produce a stream of data to "use." It is a planning tool which informs strategies, activities, monitoring, and communication.

Potential adaptations: Essential adaptations include: (1) specifying the technical CCM package (age-groups and interventions), (2) specifying the knowledge to inform the demand result, (3) characterizing the aspect(s) of the environment to enable, and (4) specifying the indicators and measurement methods, including specifying those for routine monitoring, for in-depth sentinel site monitoring, for evaluation, and possibly for operations research.

Other comments: CCM programmers are likely to come across several slightly different iterations of the CCM results framework. The generic *Results Framework* for CCM included in the CCM Essentials Guide includes the same results but in a different order. The consensus Stockholm Framework for Evaluating CCM also includes the same results but in addition specifies a "Health System Strengthened" result and indicates processes, unintended results and contextual factors.

RESULTS FRAMEWORK



CCM BENCHMARKS MATRIX

Developed by:	USAID; UNICEF and partners	**Developed in:**	N/A (Global product)
Adapted in:	N/A		
Purpose:	Outlines the essential components for CCM program planning and implementation across various levels (advocacy/planning; pilot and early implementation; and expansion/scale-up)		
Completed by:	Program designers and/or planners	**Frequency:**	N/A
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *CCM Global Indicators* Supported by: *Results Framework* and others		

Overview: The CCM Benchmarks Matrix outlines eight essential components for successful and sustainable CCM programs and provides a series of normative 'benchmarks' across three stages of program implementation (advocacy and planning; pilot and early implementation; and expansion/scale-up). The eight components of the CCM benchmark matrix are:

1) Coordination and Policy Setting
2) Costing and Financing
3) Human Resources
4) Supply chain management
5) Service delivery and referral
6) Communication and social mobilization
7) Supervision and Performance Quality Assurance
8) M&E and Health Information Systems.

The CCM benchmarks were initiated by USAID and UNICEF and refined in consultation with multiple stakeholders including WHO, MCHIP and Save the Children. Using the *CCM Benchmarks Matrix* and the *Results Framework* as a guide, an interagency working group developed a set of harmonized monitoring and evaluation indicators for CCM (see *CCM Global Indicators*) that correspond to each of the eight components of the benchmarks.

Use of data: The *CCM Benchmarks Matrix* does not generate data on its own but has been used as a framework for program evaluations in several countries (Senegal, DRC) and to organize the *CCM Global Indicators*. Like the *Results Framework*, it is a planning tool which informs strategies, activities, monitoring, evaluation and communication.

Potential adaptations: Could be made into a 'checklist' to help CCM programs take stock of where they are and how comprehensive their program is across the eight essential components.

CCM Benchmarks Matrix

Component	Advocacy and Planning	Pilot and Early Implementation	Expansion/Scale-up
Component One: Coordination and Policy Setting	Mapping of CCM partners conducted	MOH leadership to manage unified CCM established	MOH leadership institutionalized to ensure sustainability
	Technical advisory group (TAG) established including community leaders, CCM champion & CHW representation		
	Needs assessment and situation analysis for package of services conducted		
	Stakeholder meetings to define roles and discuss current policies held	Discussions regarding ongoing policy change (where necessary) completed	Routine stakeholders meetings held to ensure coordination of CCM partners
	National policies and guidelines reviewed		
Component Two: Costing and Financing	CCM costing estimates based on all service delivery requirements undertaken	Financing gap analysis completed	Long-term strategy for sustainability and financial viability developed
	Finances for CCM medicines, supplies, and all program costs secured	MOH funding in CCM program invested	MOH investment in CCM sustained
Component Three: Human Resources	Roles of CHWs, communities and referral service providers defined by communities and MoH	Role and expectations of CHW made clear to community and referral service providers	Process for update and discussion of role/expectations for CHW in place
	Criteria for CHW recruitment defined by communities and MOH	Training of CHWs with community and facility participation	Ongoing training provided to update CHW on new skills, reinforce initial training
	Training plan for comprehensive CHW training and refresher training developed (modules, training of trainers, monitoring and evaluation)		
	CHW retention strategies, incentive/motivation plan developed	CHW retention strategies, incentive/motivation plan implemented and made clear to CHW; community plays a role in providing rewards, MoH provides support	CHW retention strategies reviewed and revised as necessary.
			Advancement, promotion, retirement to CHWs who express desire offered

Component Four: Supply chain management	**Appropriate CCM medicines and supplies consistent with national policies (inclusion of RDTs where appropriate) and included in essential drug list**	**CCM medicines and supplies procured consistent with national policies and plan**	**Stocks of medicines and supplies at all levels of the system monitored (through routine information system and/or supervision)**
	Quantifications for CCM medicines and supplies completed		
	Procurement plan for medicines and supplies developed		
	Inventory control and resupply logistic system for CCM and standard operating procedures developed	**Logistics system to maintain quantity and quality of products for CCM implemented**	**Inventory control and resupply logistics system for CCM implemented and adapted based on results of pilot with no substantial stock-out periods**
Component Five: Service Delivery and Referral	**Plan for rational use of medicines (and RDTs where appropriate) by CHWs and patients developed**	**Assessment, diagnosis and treatment of sick children by CHWs with rational use of medicines and diagnostics**	**Timely receipt of appropriate diagnosis and treatment by CHWs made routine**
	Guidelines for clinical assessment, diagnosis, management and referral developed	**Review and modify guidelines based on pilot**	**Regular review of guidelines and modifications as needed**
	Referral and counter referral system developed	**Referral and counter referral system implemented: community information on where referral facility is made clear, health personnel also clear on their referral roles**	**CHWs routinely referring and counter referring with patient compliance, information flow from referral facility back to CHW with returned referral slips**
Component Six: Communication and Social Mobilization	**Communication strategies including prevention and management of community illness for policy makers, local leaders, health providers, CHWs, communities and other target groups developed**	**Communication and social mobilization plan implemented**	**Communication and social mobilization plan and implementation reviewed and refined based on monitoring and evaluation**
	Development of CSM content for CHWs on CCM and other messages (training materials, job aids etc)	**Materials and messages to aide CHWs**	
	Materials and messages for CCM defined, targeting the community & other groups	**CHWs dialogue with parents and community members about CCM and other messages**	

Component Seven: Supervision & Performance Quality Assurance	**Appropriate supervision checklists and other tools, including those for use of diagnostics developed**	**Supervision visit every 1-3 months, includes reviewing of reports, monitoring of data**	**CHWs routinely supervised for quality assurance and performance**
	Supervision plan, including number of visits, supportive supervision roles, self-supervision etc. established	**Supervisor visits community, makes home visits, provides skills coaching to CHWs**	**Data from reports and community feed-back used for problem solving and coaching**
	Supervisor trained in supervision and has access to appropriate supervision tools	**CCM supervision included as part of the CHW supervisor's performance review**	**Yearly evaluation that includes individual performance and evaluation of coverage or monitoring data**
Component Eight: M & E and Health Information Systems	**Monitoring framework for all components of CCM developed and sources of information identified**	**Monitoring framework tested & modified accordingly**	**Monitoring and evaluation through HMIS data performed to sustain program impact**
	Standardized registers and reporting documents developed	**Registers and reporting documents reviewed**	**OR and external evaluations of CCM performed as necessary to inform scale-up and sustainability**
	Indicators and standards for HMIS and CCM surveys defined		
	Research agenda for CCM documented and circulated	**CHWs, supervisors and M&E staff trained on the new framework, its components, and use of data**	

CCM GLOBAL INDICATORS

Developed by:		Interagency iCCM Task Force: (UNICEF/USAID/MCHIP/SC/Karolinska/ PSI/IRC/CDC/MSH/JHU etc)	**Developed in:**	N/A (Global product)
Adapted in:		Multiple programs		
Purpose:		Outlines indicators to monitor and evaluate CCM programs according to the *Results Framework* and the *CCM Benchmark Matrix*		
Completed by:		Program designers and/or planners	**Frequency:**	Once (revised as needed)
Submitted to:		N/A	**Frequency:**	N/A
Tool(s) linked to:		Directly: *Results Framework*, *CCM Benchmarks Matrix* Supported by: *Treatment Register*, *Supervision Checklist for CHW*, *CHW Monthly Report*, *Monthly Summary*, *Health Services Assessment and CHW mapping*, and others		
Indicators Served	**Use**	Treatment coverage, CCM treatment coverage by CHW, Treatment coverage by income quintile, Treatment rate, Treatment ratio, Successful referral		
	Access	CCM target areas defined, Targeted CHWs providing CCM, Annual CCM CHW retention, CCM CHW density, Target area coverage, Human resource strategy, Medicine and diagnostic registration, Medicine and diagnostic availability		
	Quality	Training strategy, Medicine and diagnostic adequate availability, Medicine and diagnostic storage, Medicine and diagnostic validity, Case load by site, Appropriate RDT use, Appropriate prescribing practice for positive RDTs, Appropriate prescribing practice for negative RDTs, Complete and consistent case registration, Follow up rate, Referral rate, Supervision strategy, Routine supervision coverage, Clinical supervision coverage, CCM supervisor training, CHW to supervisor ratio, Case management knowledge, Correct case management practice, Respiratory rate, First dose, Correct referral, Counselling quality, Classification consistency, District monitoring		
	Demand	First source of care, Communication strategy, Caregiver knowledge of community health worker, Caregiver knowledge of illness signs		
	Environment	CCM policy, CCM MOH focal point, CCM coordination, CCM partner map, Annual CCM costed plan, CCM national financial contribution, Expenditure (#1-3), CCM in HMIS		

Overview: The indicator table outlines the 52 global iCCM indicators according to the *CCM Benchmark Matrix*. The *CCM Global Indicators* were developed through an intense interagency effort to build consensus around a set of harmonized metrics to measure CCM implementation and results. Ten indicators are prioritized for cross-national comparisons purposes (these are highlighted in yellow) and the remaining 42 indicators are 'optional' depending on the country context. The indicator table shows indicator type (input, output, outcome), results framework level, indicator name and definition, data source and frequency for each indicator. The indicators can also be viewed according to the *Results Framework* hierarchy. The mid-level result, commonly called the **Strategic Objective**, represents the appropriate use or coverage of evidence-based interventions. The indicators listed at this level are best measured through household surveys, but can be monitored through service statistics as well. **Access** is measured through eight indicators captured through health services assessment, human resources documents and mapping tools. Access is heavily context-dependent and indicator definitions require local adaptation. **Quality** is a major result and 24 indicators are suggested. Many quality indicators can be measured through routine supervision, underscoring the need for strong supervision systems. **Demand** for CCM services has four indicators that focus on knowledge of signs of illness, sources of case management, and selection of CHWs as first source of treatment for CCM syndromes. These indicators are best measured through household survey; programs may explore monitoring approaches such as mini household surveys or spot checks during supervision to track during program implementation. The indicators for **Policy/Environment** are often context-specific and focus on tracking MOH financial and human resource contribution to programming and to policy and community support structures.

Use of data: Regular monitoring and periodic evaluation of CCM programs by program stakeholders.

Potential adaptations: As noted, indicators and associated data collection tools must be adapted to the country context.

CCM GLOBAL INDICATORS

Component	#	Indicator	Definition	Metric	Type	Frame-work level	Data source	Frequency
Component 1: Coordination and Policy Setting	1	CCM policy	CCM is incorporated into national MNCH policy/guideline(s) to allow CHWs to give: ●low osmolarity ORS and zinc supplements for diarrhea ● antibiotics for pneumonia ● ACTs (and RDTs, where appropriate) for fever/malaria in malaria-endemic countries	**Yes**: National policy guidelines adopted to allow CCM in line with WHO recommendations for all relevant conditions (diarrhea, pneumonia and malaria in countries with malaria) **Partial**: National policy guidelines adopted to allow CCM in line with WHO recommendations for at least one relevant condition **No**: No national policy guidelines that support CCM in line with WHO recommendations	Input	IR1- Policy	MOH policy, strategy or guideline document	Annual
Component 1: Coordination and Policy Setting	2	CCM MOH focal point	CCM focal point/unit within MOH in place	**Yes:** Focal point/unit for CCM established for all relevant conditions (diarrhea, pnuemonia and malaria in countries with malaria) **Partial:** Focal point/unit for CCM established for at least one relevant condition **No:** No CCM focal point/unit established for any relevant condition	Input	IR1- Policy	TORs / MOH administrative document	Annual
Component 1: Coordination and Policy Setting	3	CCM coordination	MOH-led CCM stakeholder group, working group or task force established and meeting regularly	**Yes:** MOH-led CCM stakeholder group established and meeting as outlined in terms of reference (or more frequently) or ad hoc (twice a year minimum) **Partial:** MOH-led CCM stakeholder group established but meets irregularly (less than terms of reference) or ad-hoc (less than twice per year, 0-1 meeting) **No:** MOH-led CCM statekholder group not established	Input	IR1- Policy	Established TOR and meeting minutes	Annual
Component 1: Coordination and Policy Setting	4	CCM partner map	List of CCM partners, activities and locations available and up to date	**Yes:** List/map of CCM partners, activities and locations available and updated within the last year **Partial:** List/map of CCM partners, activities and locations available but not updated within the last year **No:** List/map of CCM partners, activities and locations not available	Input	IR1- Policy	MOH Administrative document	Annual
Component 1: Coordination and Policy Setting	5	CCM target areas defined	Target areas for CCM defined based on country-specific criteria	**Yes:** Target areas for CCM defined based on country-specific criteria* **No:** Target areas for CCM not defined	Input	IR2-Access	MOH Administrative document	Annual

Component 2: Costing and Financing	6	Annual CCM costed plan	Costed plan for CCM exists and is updated annually	**Yes**: Costed plan for CCM for all relevant conditions (as specified by country policy or implementation status) exists and updated annually **Partial**: a) Updated costed plan exists for CCM including at least one relevant health condition OR b) Costed plan exists but not updated **No:** No costed plans for CCM available for any relevant health condition	Input	IR1- Policy	Administrative and budget documents	Annual
Component 2: Costing and Financing	7	CCM national financial contribution	Balance between national public sources and donor funding for CCM	Percentage of national public sources (MoH, provincial, municpal budgets) within the CCM total budget	Input	IR1- Policy	Administrative and budget documents	Annual
Component 2: Costing and Financing	8	Expenditure (1): CCM proportion of disease program	Average annual recurrent expenditure for CCM per child under five in target area by disease type as a percentage of total average expenditure per child under five by disease type	**Numerator:** Annual recurrent expenditure for CCM per child by disease type (Indicator **9**) **Denominator:** Total annual recurrent expenditure per child in target area by disease type	Output	IR1- Policy	Costing study	Episodic
Component 2: Costing and Financing	9	Expenditure (2): Average per child	Average annual recurrent expenditure per child under five in target area by disease type as per point of service	**Numerator:** Annual recurrent expenditure by disease type by point of service **Denominator:** population under five each year in target area	Output	IR1- Policy	Costing study	Episodic
Component 2: Costing and Financing	10	Expenditure (3): Average per contact	Average expenditure per contact by disease type as per point of service	**Numerator:** Annual expenditure by disease type by point of service **Denominator:** Number of contacts each year by disease type	Output	IR1- Policy	Costing study	Episodic
Component 3: Human Resources	11	Targeted CHWs providing CCM	Proportion of CHWs targeted for CCM who are trained and providing CCM according to the national policy	**Numerator:** # of CHWs targeted for CCM that are trained and that can provide evidence of providing CCM services in the last 3 months **Denominator:** # CHWs targeted for CCM	Output	IR2-Access	Administrative and budget documents/ Registers	Annual
Component 3: Human Resources	12	Annual CCM CHW retention	Proportion of CHWs trained in CCM who are providing CCM one year after initial training and deployment	**Numerator:** # of CHWs providing CCM services one year after initial CCM training and deployment (time frame can be modified) **Denominator:** # of CHWs trained and deployed to provide CCM services	Output	IR2-Access	MOH monitoring data and supervisor checklist	Annual
Component 3: Human Resources	13	CCM CHW density	Number of CHWs deployed for CCM per 1000 children under-five in target areas	**Numerator:** # of CHWs deployed in CCM **Denominator:** Total children under five per 1000 in target communities	Output	IR2-Access	MOH monitoring data	Annual
Component 3: Human Resources	14	Target area coverage	Proportion of targeted catchment areas for CCM who have a CHW trained and deployed in CCM	**Numerator:** # of targeted catchment areas with CHW trained and deployed for CCM as per country protocol **Denominator:** # of targeted catchment areas	Output	IR2-Access	MOH administrative data	Annual

Component 3: Human Resources	15	Training strategy	Comprehensive CCM training strategy that is competency based	**Yes:** strategy has all the critical components: ● A time frame that corresponds to/fits with the CCM implementation Strategy; ● Includes training of sufficient cadres (master trainers, supervisors, CHWs, others) at the different level of services (community, facility, district, regional, national); ● Includes X% of the training time devoted for actual clinical training including examining and treating actual cases (competency based); ● Includes refresher training to update/upgrade the skills of all the CCM cadres at the different levels; and ● Includes the development/adaptation of the up-to-date training and supervision modules, examination and treatment protocols and job aids. **Partial:** Strategy has some of the critical components **No:** Strategy has no critical components or there is no written training strategy	Input	IR3-Quality	Training strategy, implementation guideline	Annual
Component 3: Human Resources	16	Human resource strategy	CHWs are recognised within Human Resources for Health Development Plans and supported (with motivation, retention, rotation - where applicable - performance issues addressed)	**Yes:** Plan recognises CHWs and specifies performance elements to support their role (e.g. training strategies, supportive supervision structures in place, attention to motivation, provides a career path for the CCM cadres (where appropriate; e.g. offers future additional training for CWHs to promote them as Supervisors). **Partial:** Plan recognises CHWs but does not specify all performance elements to support them **No:** Plan does not recognise CHWs or there is no HRH plan	Input	IR2-Access	MOH documents	Annual
Component 4: Supply Chain Management	17	Medicine and diagnostic registration	CCM medicines and diagnostics are registered with National Regulatory Authority (NRA) ● ACTs and RDTs for malaria ● Zinc and low osmolarity ORS for diarrhea ● Antibiotics for pneumonia	**Yes:** CCM medicines and diagnostics appropriate for use with children for all relevant conditions registered with NRA **Partial:** CCM medicines and diagnostics for some CCM conditions registered with NRA **No:** CCM medicines and diagnostics not registered with NRA	Input	IR2-Access	Drug registration lists	Annual
Component 4: Supply Chain Management	18	Medicine and diagnostic availability	Percentage of CCM sites 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)	**Numerator:** # of CCM sites with all key CCM medicines or diagnostics in stock during the last visit OR last day of reporting period. (Key products defined by country policy or implementation status) **Denominator:** # of CCM sites	Output	IR2-Access	Supervision reports; direct observation: day of visit; surveys, routine reporting	Annual/ quarterly

Component 4: Supply Chain Management	19	Medicine and diagnostic adequate availability	Percentage of CCM sites with all key CCM medicines and diagnostics adequately stocked on the day of visit OR last day of reporting period whichever is most recent	**Numerator:** # of CCM sites with all key CCM medicines or diagnostics in adequate stocks, between a country defined maximum and minimum stock level, on the last visit OR last day of reporting period. **Denominator:** # of CCM sites	Output	IR3-Quality	Supervision reports, surveys, routine reporting	Annual/ quarterly
Component 4: Supply Chain Management	20	Medicine and diagnostic storage	Percentage of CCM sites with medicines and diagnostics stored appropriately	**Numerator:** # of CCM sites with medicines and diagnostics stored in an appropriate manner; appropriate to be locally defined, and may include: ● Storage area free of rodents or insects; ● Storage area secured with a lock and key, access limited; ● Medicines are protected from direct sunlight; ● Medicines are stored at appropriate temperature; ● Space is sufficient for the quantity of products that should be stored; and ● Space should be dry, free from flooding. **Denominator:** # of CCM sites	Output	IR3-Quality	Survey and/or supervisor checklist	Annual/ quarterly
Component 4: Supply Chain Management	21	Medicine and diagnostic validity	Percentage of CCM sites with no expired or damaged medicine or diagnostics on the day of observation	**Numerator:** # of CCM sites with no expired medicine, RDTs or non-functional timers/thermometers on the day of observation **Denominator:** # of CCM sites	Output	IR3-Quality	Survey and/or supervisor checklist	Annual/ quarterly
Component 5: Service Delivery and Referral	22	Treatment coverage	Percentage of sick children receiving appropriate treatment	**Numerator:** # of children under five with CCM condition receiving appropriate treatment **Denominator:** # of children under five with CCM condition (fever/malaria, diarrhea or suspected pneumonia)	Outcome	SO-Use	Survey	Episodic
Component 5: Service Delivery and Referral	23	CCM treatment coverage by CHW	Proportion of overall treatment coverage being provided by CCM by CHW	**Numerator:** # of children under five with CCM condition receiving appropriate treatment from CHW **Denominator:** # of children under five with CCM condition (fever/malaria, diarrhea or suspected pneumonia)	Outcome	SO-Use	Survey	Episodic
Component 5: Service Delivery and Referral	24	Treatment coverage by income quintile	Percentage of sick children receiving appropriate treatment by income quintile by point of service	**Numerator:** # of children under five with CCM condition receiving appropriate treatment by income quintile by point of service **Denominator:** # of children under five with any CCM condition (fever/malaria, diarrhea or suspected pneumonia) by point of service	Outcome	SO-Use	Survey	Episodic

Component 5: Service Delivery and Referral	25	Treatment rate	Number of CCM conditions treatments per 1000 children under five in target area in a given period by point of service and disease	**Numerator:** 1. # of treatments for children under five provided through CCM by disease in given time period in target area by point of service -- 2. # of treatments for children under five provided by health facility by CCM disease in a given time period in target area by point of service **Denominator:** # of children under five in target area by point of service at a given time divided by 1000	Outcome	SO-Use	CHW and HF treatment registers	Quarterly/ Annually
Component 5: Service Delivery and Referral	26	Treatment ratio	Ratio of treated cases to expected cases by CCM condition in a given catchment area stratified by point of service	**Numerator:** 1. # of treatments for children under five provided through CCM by disease in one year period in a given catchment area -- 2. # of treatments for children under five provided by health facility by disease in one year period in a given catchment area **Denominator:** # of illnesses expected in a given catchment area (by disease) in one year period	Outcome	SO-Use	CHW and HF treatment registers with denominator from CHERG model estimates	Annually
Component 5: Service Delivery and Referral	27	Case load by site	Proportion of CCM sites treating at least X cases per month (to be defined locally)	**Numerator:** # of CCM sites treating at least X cases per month **Denominator:** # of CCM sites	Output	IR3-Quality	CHW registers	Annual/ quarterly
Component 5: Service Delivery and Referral	28	Appropriate 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	Outcome	IR3-Quality	Record review, observation	Monitoring: Quarterly, Evaluation: 3 years
Component 5: Service Delivery and Referral	29	Appropriate prescribing practice for positive RDTs	Appropriate prescribing practices based on results of rapid diagnostic tests (where RDTs are part of the package)	**Numerator:** # of children that receive an ACT **Denominator:** # of children with a positive RDT RDT	Outcome	IR3-Quality	Record review, observation	Monitoring: Quarterly, Evaluation: 3 years
Component 5: Service Delivery and Referral	30	Appropriate prescribing practice for negative RDTs	Appropriate prescribing practices based on results of rapid diagnostic tests (where RDTs are part of the package)	**Numerator:** # of children with negative RDT who do not receive ACT **Denominator:** # of childrenwith a negative RDT	Outcome	IR3-Quality	Record review, observation	Monitoring: Quarterly, Evaluation: 3 years

Component 5: Service Delivery and Referral	31	First source of care	Proportion of caregivers of children under five in CCM target areas who sought CHWs as first source of care for the sick child	**Numerator:** # of sick children under five whose caregivers sought care from CHWs as first source of care for the child **Denominator:** # of sick children under five	Outcome	IR4-Demand	HH survey	Episodic
Component 5: Service Delivery and Referral	32	Complete and consistent case 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 4 of 5 cases reviewed for each condition **Denominator:** # of CHWs supervised	Output	IR3-Quality	CHW registers/ Supervision reports	Quarterly
Component 5: Service Delivery and Referral	33	Follow up rate	# and proportion of cases followed up after receiving treatment from CHW according to country protocol	**Numerator:** # of cases followed up after receiving treatment from CHW **Denominator:** total number of cases receiving treatment from CHW	Output	IR3-Quality	Monitoring: CHW registers Evaluation: HH survey	Monitoring: Quarterly, Evaluation: 3 years
Component 5: Service Delivery and Referral	34	Referral rate	Proportion of cases who are recommended for referral by the CHW	**Numerator:** # of cases seen by CHW who are recommended for referral **Denominator:** # of cases seen by CHW	Output	IR3-Quality	Monthly reports/ Registers	Annual/ quarterly
Component 5: Service Delivery and Referral	35	Successful referral	Proportion of children recommended for referral received at the referral facility	**Numerator:** # of children received at referral facility **Denominator:** Total # of children recommended for referral	Outcome	SO-Use	Special study/ survey/ CHW Registers and facility reports	Annual or less
Component 6: Communication and Social Mobilization	36	Communication strategy	Communication strategy for childhood ilness includes CCM	**Yes:** Childhood illness communication strategy includes CCM for all relevant conditions (pneumonia, malria, diarrhea) **Partial:** Communication strategy for childhood illness includes CCM for at least one relevant condition **No:** National childhood illness communication strategy does not exist OR does not mention CCM at all	Input	IR4-Demand	National strategy document; BCC materials, modules, job aids, and training curriculum	Annual
Component 6: Communication and Social Mobilization	37	Caregiver knowledge of community health worker	Proportion of care givers who know the presence and role of CHW	**Numerator:** # of caregivers of children under five interviewed from target communities who can name location and services provided by their CHW **Denominator**: total # of caregivers of children under five interviewed from target communities	Output	IR4-Demand	HH survey	Episodic

Component 6: Communication and Social Mobilization	38	Caregiver knowledge of illness signs	Proportion of care givers who know 2 or more signs of childhood illness that require immediate assessment	**Numerator:** # of caregivers of children under five interviewed who can correctly state 2 or more signs of childhood illness that require immediate assessment **Denominator:** # of caregivers of children under five interviewed	Outcome	IR4-Demand	HH survey	Episodic
Component 7: Supervision and Performance QA	39	Supervision strategy	Supervision strategy available and outlines designated cadres, job descriptions and standardardized supporting materials (i.e. checklists, training materials)	**Yes:** National supervision strategy for CCM available and includes designated cadres, job description and standardized supervision checklists, guidelines and training materials **Partial:** Supervision strategy for CCM available but does not include all required components and materials **No:** Supervision strategy and supporting materials for CCM are not available	Input	IR3-Quality	Supervisory tools and plans	Annual
Component 7: Supervision and Performance QA	40	Routine supervision coverage	Proportion of CHWs who received at least 1 supervisory contact in the prior 3 months during which registers and/or reports were reviewed	**Numerator:** # of CHWs who received at least 1 supervisory contact in the prior 3 months during which registers and/or reports were reviewed **Denominator:** # of CHWs trained in and deployed for CCM or # of CHWs interviewed	Output	IR3-Quality	Supervisory records	Quarterly
Component 7: Supervision and Performance QA	41	Clinical supervision coverage	Proportion of CHWs who received at least 1 supervisory contact during the prior 3 months where a sick child visit or scenario was assessed and coaching was provided	**Numerator:** # of CHWs receiving at least 1 supervisory contact in the prior 3 months where a sick child visit was observed or scenario was assessed and coaching provided **Denominator:** # of CHWs trained in and deployed for CCM or # of CHWs interviewed	Output	IR3-Quality	Supervisory records; survey and CHW interviews	Define Locally (during prior 3 month or as determined locally)
Component 7: Supervision and Performance QA	42	CCM supervisor training	Proportion of supervisors assigned to CCM (at all levels of 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)	Output	IR3-Quality	Administrative records	Annual
Component 7: Supervision and Performance QA	43	CHW to supervisor ratio	Ratio of CHWs deployed for CCM for each assigned CCM supervisor in the same target area	**Numerator:** # of CHWs trained in CCM **Denominator:** # of supervisors assigned to CCM supervision	Output	IR3-Quality	District reports; survey	Annual; episodic
Component 7: Supervision and Performance QA	44	Case management knowledge	Proportion CHWs (or proportion of cases) who correctly manage sick child case scenarios	**Numerator:** (a) # of CHWs who correctly manage case scenarios OR (b) # case scenarios correctly managed **Denominator:** (a) # of CHWs assessed OR (b) # case scenarios presented	Output	IR3-Quality	Supervision reports; direct observation	Quarterly for 1st year; episodic in subsequent years

Component 7: Supervision and Performance QA	45	Correct case management practice	Proportion of sick children who receive correct case management from a trained CHW	**Numerator:** # of sick children who were correctly treated/referred for all conditions **Denominator:** # of sick children assessed requiring treatment	Outcome	IR3-Quality	Direct observation	Episodic
Component 7: Supervision and Performance QA	46	Respiratory rate	Proportion of CHWs who correctly count respiratory rate	**Numerator:** # of CHWs who correctly count (+/- 2 breaths per minute) the respiratory rate of live case, supervisor, community infant, or video **Denominator:** # of CHWs assessed	Output	IR3-Quality	Direct Observation	Monitoring: Quarterly, Evaluation: episodic
Component 7: Supervision and Performance QA	47	First dose	First dose of treatment received in presence of CHW	**Numerator:** # of children given first dose of treatment in the presense of CHW **Denominator:** # of children treated by CHW	Evaluation: Outcome	IR3-Quality	Special study/ Direct observation	Annual; episodic
Component 7: Supervision and Performance QA	48	Correct referral	Proportion of cases with danger signs or severe disease recommended for referral	**Numerator:** # of cases with danger signs or severe disease recommended for referral according to protocol **Denominator:** # of cases with danger signs who should be referred according to protocol	Output	IR3-Quality	Special study/ surveys	Annual or less
Component 7: Supervision and Performance QA	49	Counselling quality	Proportion of CHWs who provide proper counselling during sick child visits	**Numerator**: # of CHWs who provide proper counselling to caretakers of sick children (dose, duration, frequency and follow-up) **Denominator:** # of CHWs assessed	Output	IR3-Quality	Direct observation	Episodic
Component 8: Monitoring & Evaluation and Health Information Systems	50	CCM in HMIS	One or more CCM indicators incorporated into HMIS	**Yes**: One or more CCM indicator collected and monitored through national HMIS **Partial:** One or more CCM indicator included in national HMIS **No**: No recommended CCM indicators included in national HMIS	Process	IR1- Policy	HMIS	Annual

Component 8: Monitoring & Evaluation and Health Information Systems	51	Classification consistency	Registers and reports for case management of children under five at facility and community levels align with standard WHO or national classifications	**Yes:** Registers and reports for case management of children under five at facility and community levels follow the same standard WHO or national classifications for malaria, pneumonia and diarrhea **Partial:** Registers and reports for case management of children under five at facility and community levels follow the same standard WHO or national classifications for only some conditions **No:** Registers and reports for case management of children under five at facility and community levels do not follow the same standard WHO or national classifications	Input	IR1- Policy	Registers and reporting documents	Episodic
Component 8: Monitoring & Evaluation and Health Information Systems	52	District monitoring	Proportion of implementing districts using monitoring data on case management at community and facility levels	**Numerator:** # of implementing districts using monitoring data for planning on case management at community and facility levels **Denominator:** # of districts implementing CCM	Process	IR3-Quality	HMIS records and reports (gold standard); other CCM reporting where relevant	Quarterly

SUPERVISION CHECKLIST FOR CHWs

Developed by:		Save the Children	**Developed in:**	Nicaragua
Adapted in:		Projects in: Guatemala, Myanmar, Bangladesh, Malawi; Mozambique National Programs in: Nicaragua, Zambia, South Sudan, Malawi		
Purpose:		To guide and document supportive supervision to the CHW and track availability of drugs and supplies, quality of care and community support.		
Completed by:		CHW Supervisor	**Frequency:**	Monthly/Quarterly
Submitted to:		Health Facility/District Office	**Frequency:**	Monthly/Quarterly
Tool(s) linked to:		Directly: *Monthly Summary*, *Treatment Register*, *CHW Competencies* Supported by: *Supervision Checklist Job Aid*, *Consistent Case Management Job Aid*, *Supervisor Competencies*, *Case Scenarios*		
Indicators served	**Use**	None		
	Access	Targeted CHWs providing CCM, Medicine and diagnostic availability		
	Quality	Medicine and diagnostic adequate availability, Medicine and diagnostic storage, Medicine and diagnostic validity, Complete and consistent case registration, Routine supervision coverage, Clinical supervision coverage, Case management knowledge, Respiratory rate		
	Demand	None		
	Environment	None		

Overview: This checklist is designed to assess the core competencies of the CHW and the CCM support system (e.g., drug and supply availability). It aids the supervisor to prioritize elements to monitor and reinforce. The checklist provides data that can be used at multiple levels for program monitoring and decision-making.

Within the tool, the column furthest to the left names the indicator, and the item column lists the indicator components. The next column, details the criteria for "passing" the indicator. The shaded rows at the bottom of each indicator section summarize each indicator's components according to locally developed decision rules and specify the overall indicator (pass or fail) for inclusion in the monthly report. This checklist must include criteria for scoring each component and for calculating overall indicators; indicator components and associated criteria should reflect the local setting. The supervision checklist should be included in the training of supervisors and ideally the CHWs, so both are aware of elements emphasized through supervision.

Most supervision tasks focus on assessing support systems (e.g., availability of drugs and supplies). Assessment of correct case management knowledge and respiratory rate tasks should ideally be performed by someone with a clinical background. Clinical assessments can use written or video case studies when actual cases are not available. Sample case studies have been developed (see *Case Scenarios*).

The CHW supervisor should summarize supervision results for each CHW on the *Monthly Summary* and submit a copy of the form to the next level. Two job aids have been developed to assist the CHW supervisor (*Supervision Checklist Job Aid* and *Consistent Case Management Job Aid*), and these should be adapted for each setting.

Use of data: To identify CHWs who require additional training and supervision; to track and respond to stock-outs of essential drugs and supplies.

Potential adaptations: The modular format of the checklist allows easy adding or removing of indicators according to program need. In Malawi, for example, CHWs are partially supervised by non-clinical personnel. Thus, the *Supervision Checklist for CHW* is separated into a clinical portion, which is completed by qualified staff at the health facility or the community, and a non-clinical portion, which is completed by non-technical staff during on-site supervision.

SUPERVISION CHECKLIST FOR CHW EXAMPLE

Supervision Checklist for CHW

Date: _____
Supervisor: _____
Facility: _____
Community: _____
CHW: _____
draft: March 2011

Indicator	#	Item	Check for each (tick if yes) A. Any available?	B. Adequate stocks?	C. No expired?	Comments	Not Part of Form: Data yields Indicator #
Medicine and diagnostic availability, adequacy and validity	1	ACT A (*Country Min-Max stock range: XX to XX*)					
	2	ACT B *(Country Min-Max stock range: XX to XX)*					
	3	Amoxicillin A *(Country Min-Max stock range: XX to XX)*					
	4	Amoxicillin B *(Country Min-Max stock range: XX to XX)*					
	5	Zinc A *(Country Min-Max stock range: XX to XX)*					
	6	Zinc B *(Country Min-Max stock range: XX to XX)*					
	7	Rectal artesunate A *(Country Min-Max stock range: XX to XX)*					
	8	Rectal artesunate B *(Country Min-Max stock range: XX to XX)*					
	9	ORS *(Country Min-Max stock range: XX to XX)*					
	10	RDT *(Country Min-Max stock range: XX to XX)*					
	11	Functional respiratory counter					
	12	Functional thermometer					
		MEDICINE AND DIAGNOSTICS AVAILABILITY INDICATOR SUMMARY	**YES**	**NO**	**COMMENTS**		
	A	**MEDICINE AND DIAGNOSTIC AVAILABILITY?** *(Criteria for yes: must have tick mark for Item1 through 12 under column A)*					**18**
	B	**MEDICINE AND DIAGNOSTIC <u>ADEQUATE</u> AVAILABILITY?** *(Criteria for yes: must have tick mark for Item1 through 10 under column B)*					**19**
	C	**MEDICINE AND DIAGNOSTIC <u>VALIDITY?</u>** *(Criteria for yes: must have tick mark for Item1 through 10 under column C)*					**21**
	#	**Item**	**YES**	**NO**	**COMMENTS**		
Medicine and diagnostic storage	13	Storage area free of rodents or insects					
	14	Storage area secured with lock and key					
	15	Medicines are protected from direct sunlight					
	16	Medicines stored at appropriate temperature					
	17	Space is sufficient for quantity of medicines to be stored					
	D	**MEDICINE AND DIAGNOSTIC STORAGE?** *(Criteria for yes: must have 'Yes' ticked for all mark for Items 13 to 17)*					**20**
Supply Availability	18	Diagnostic flowchart available					
	19	Counseling cards – complete and up-to-date					
	20	Child Treatment Register with blank pages					
	21	Monthly reporting forms available					
	22	Referral forms available					
	E	**SUPPLY AVAILABILITY?** *(Criteria for yes: must have 'Yes' ticked for all Items 18-22)*					

	#	Item	YES	NO	COMMENTS	
Complete and Consistent Case Registration	23	Case 1: complete and consistent for classification and treatment				
	24	Case 2: complete and consistent for classification and treatment				
	25	Case 3: complete and consistent for classification and treatment				
	26	Case 4: complete and consistent for classification and treatment				
	27	Case 5: complete and consistent for classification and treatment				
	F	**COMPLETE AND CONSISTENT CASE REGISTRATION** *(Criteria for yes: must have 'Yes' ticked for at least 4 of 5 cases)*				**32, 40**
	#	**Item**	**YES/NA**	**NO**	**COMMENTS**	
Case Management Knowledge (Case #:____)	28	Ask child's age?				
	29	Identify the problem or problems?				
	30	Ask or look for ALL danger signs?				
	31	Correct RR determined if cough?				
	32	Correct classification?				
	33	Correct decision to refer or treat in community?				
	34	Give correct first dose?				
	35	Correct counselling?				
	36	Facilitated referral if indicated?				
	37	Correctly complete register?				
	G	**CASE MANAGEMENT KNOWLEDGE?** *(Criteria for yes: must have #32 and #33 correct AND 6-8 of the remaining 8 questions correct)*				**44, 41**
RR	**H**	**CORRECT RESPIRATORY RATE?** *(Criteria for yes: must correctly count within +/- 2 breaths per minute of standard (supervisor, video, etc)*				**46**
SUMMARY THOUGHTS	38	I was able to restock all needed drugs.				
	39	I was able to restock all needed or outdated supplies.				
	40	I accompanied the CHW on a home visit.				
	41	I talked with community leadership about CCM progress.				
	42	CHW is meeting standards: Yes/No (circle one). If "No," write what you did and what else needs to be done.				
	43	Other observations:				

TREATMENT REGISTER

Developed by:		Save the Children	**Developed in:**	Nicaragua
Adapted in:		Projects in : Guatemala, Myanmar, Bangladesh, Zambia; National Programs in: Nicaragua, South Sudan, Uganda		
Purpose:		To record sick child encounters by age, sex, assessment, classification, treatment, referral, and follow up.		
Completed by:		CHW	**Frequency:**	Every encounter
Submitted to:		CHW supervisor	**Frequency:**	Monthly or quarterly
Tool(s) linked to:		Directly: *Stock Records*, *CHW Monthly Report*, *Monthly Summary*, *Supervision Checklist for CHW* Supported by: *Referral and Back Referral Form*, *Mother Reminder Cards*, *CHW Training Manuals*		
Indicators Served	**Use**	Treatment coverage, CCM treatment coverage by CHW, Treatment rate, Treatment ratio, Successful referral		
	Access	Targeted CHWs providing CCM		
	Quality	Case load by site, Appropriate RDT use, Appropriate prescribing practice for positive RDTs, Appropriate prescribing practice for negative RDTs, Complete and consistent case registration, Follow up rate, Referral rate, Classification consistency		
	Demand	None		
	Environment	CCM in HMIS		

Overview: The *Treatment Register* is a form that each CHW uses to record all sick child encounters. This register should be filled out every time a patient is seen, and should be organized by month (i.e., the CHW will have at least one *Treatment Register* page for each month).

When a new page is started each month: complete the identifying information at the top of the page. (Community, District, Reporting Month, CHW Name, CHW Cadre)

For each new sick child encounter: (1) Start a new row. (2) Write the encounter date and enough of the child's name to permit identification if reviewed later. (3) Tick the child's age group and sex. The upper number of any age group (for example, the "11" in "2-11") means "11.999" months or right up to, but not including 12 months. (4) Under the assessment column, write any relevant signs (respiratory rate = breaths per minute) and record use and results of an RDT where part of country policy. (6) Check all classifications that match the assessment. (7) Check all treatments given. Programs, especially those with pre-packaged treatments, can determine how to best identify the descriptions for each type of treatment (for example "amoxicillin young, amoxicillin old' or 'amoxicillin 2-11 months', 'amoxicillin 12-59 months'(8) Check whether child was referred or not. (9) Check the last three items during follow up visit (if the follow-up visit is made) or about 48 hours after the first encounter: whether the visit occurred, whether referral occurred – if recommended, and whether the treatment was administered according to plan. (10) Write observations as appropriate. (11) At the end of the interval (usually 1 month) or if the sheet is full before the interval is complete, tally the ticks in the bottom row, "Total"

Use of data: As "the heart of CCM," the register is a job aid, a record, and a source of data for supervision and program monitoring. Semi-literate CHWs can use it, especially if the rows and columns are big. Case management training should include recording. Testing is needed to see which aspects can be represented with pictures for semi-literate workers. A partially pictorial register from South Sudan is an example.

Potential adaptations: All programs will need to adapt the child treatment register to meet their country context and to accommodate existing tools. This register is meant as a guide to identify the type of information that should be included in a treatment register and to show how a potential format for how it can be recorded and tallied. Specifically, programs map opt to record age as # months or years (two columns) to better inform treatment and assess consistency between age and treatment; increase the assessment choices (danger signs, illness signs, MUAC reading); adapt the classifications and treatments to national policy; remove routine follow-up; and add outcome (recovered, died).

TREATMENT REGISTER: GENERIC EXAMPLE

Child Treatment Register

draft:March 2011

Community: ___________________________________

District: _____________________________________

Reporting Month: ___________________________

CHW Name: ________________________

CHWCadre: ________________________

Date	Patient Name	Age		Sex		Assessment					Classification							Treatment									Referral?		Scheduled Follow-Up Visit Made?		Referral Compl-iance on Day 1?		Treatment Complia-nce on Day 2?		Observations
									RDT Result																										
		2-11 months	12-59 months	Male	Female	Respiratory Rate	Fever?	RDT used?	RDT +	RDT -	Danger sign	Fast breathing (penumonia)	Cough/cold (no pneumonia)	Diarrhea <14 days	Fever, no malaria	Malaria	Other	Paracetamol (2-35 mos dose)	Paracetamol (36-59 mos dose)	ORS	Zinc (2-5 mos dose)	Zinc (6-59 mos dose)	ACT (5-35 mos dose)	ACT (36-59 mos dose)	Amoxicillin (2-11 mos dose)	Amoxicillin (12-59 mos dose)	Y	N	Y	N	Y	N	Y	N	
	TOTALS																																		
Not part of form: Boxes show which monitoring indicator is informed by		11, 27					28	28	29	30	25, 26												29,30				34		33		35				

Note: This register spreads across two pages in a "portrait" oriented book.

TREATMENT REGISTER: ZAMBIA EXAMPLE

CHW Treatment Register for Children Under Age Five Years (draft October 18, 2010)										
				Age		**Sex**			**Other Illnesses**	
Date	**Name**	**Less than age 2 months? (Tick)**	**Village**	Months	Years	Male	Female	**Under Five Card Number**	**Diagnosis**	**Treatment**
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**
Total										

CCM Illnesses																											Remarks
Assessment							Classification						Treatment									Referral			Follow Up		
		MUAC											Amoxycillin			ACT		Zinc		ORS							
Chest Indrawing	Breaths per Minute	Green	Yellow	Red	Swelling of both feet	RDT Test Done	Danger sign	RDT+ Malaria	Diarrhoea	Fast breathing	Malnutrition	Fever	Less than 2 months	2 Months-12 Months	12 Months-5 Years	2 Months-3 Years	3 Years-5 Years	2 Months-6 Months	6 Months-5 Years		Treated within 24 hours	Referral recommended	Referral Completed	Feedback from facility	Follow up made	Correct treatment on follow up	
12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	39	39

STOCK RECORDS

Developed by:	BASICS	**Developed in:**	N/A
Adapted in:	Zambia, South Sudan		
Purpose:	To track and manage essential CCM drugs and supplies		
Completed by:	CHW	**Frequency:**	Monthly
Submitted to:	Health Facility/District	**Frequency:**	Monthly
Tool(s) linked to:	Directly to: *CHW Monthly Report, CHW Kit*, *CHW Training Manuals*, *Mother Reminder Cards* Supported by: *Treatment Register, Supervision Checklist for CHW*		
Overview: Two tools inform stock management: ***CHW Drug Register*** and ***Requisition Form*.** These tools track the amount of drugs dispensed, the amount received, balance remaining, and stocks required. In some small CCM programs, in lieu of these forms, supervisors can be trained to inspect remaining drug supplies, record levels on the *Supervision Checklist for CHW*, reconcile the levels with treatments recorded in the *Treatment Register*, and re-supply – i.e., a "push" rather than a "pull" approach. In larger programs, more robust, combination push-pull systems will be required to ensure consistent supply of essential drugs and supplies.			
Use of data: To track levels of drugs and supplies, record stock-outs, investigate any drugs losses			
Potential adaptations: Tools should be adapted for each country context and integrate with existing stock management systems.			
Other comments: Substantial efforts are underway to strengthen CCM logistics systems and improved stock management tools are expected.			

CHW DRUG REGISTER EXAMPLES:

1. SOUTH SUDAN

Save the Children.

Save the Children in South Sudan
Community Case Management
Community Based Distributor Drug Register
To be completed by the Community Based Distributor Supervisor during each supervisory visit and the be submitted to Project Officer each month

Canadian Internat Development Age

Prepared by _____ Reporting Month _____ County _____ Village _____
CBD Name _____ Reporting Year _____ Payam _____
CBD ID Number _____ State _____ Boma _____

No	Child Name	Pneumonia Drawing here		Malaria		Diarrhea		CBD Supervisor Comments
		Pneumonia		Malaria		Diarrhea		
		Drawing of Amoxicillin		Drawing of ACT		Drawing of ORS	Drawing of Zinc	
		Amoxicillin		ACT		ORS	Zinc	
								
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
	TOTALS							

Drug Report	Amoxicillin	ACT	ORS	Zinc
Amount given at the beginning of the month				
Amount Added during the month				
Amount used during the month				
Balance at the end of the month				
Stockouts (0s)				

2. ZAMBIA

Daily Availability of Medicine and RDT Form (draft October 15, 2010)

District: _____ Month: _____ 20___

Facility: _____ Supervisor Name: _____

Community: _____ CHW Name: _____

No	Tracer item	Write a "0" for each day an item is out of stock; write "1" if item is available.																													Available ALL month? (Y/N)
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
1	Amoxicillin																																
2	RDT																																
3	ACT																																
4	Zinc																																
5	ORS																																
	Total number of items available ALL month																																

Explain reasons for any stockout

REQUISITION FORM EXAMPLE

Requisition/Issue Form

Requistion #: **Date:**
Health facility:
Name of health worker:
Name of Supervisor:

S. #	*Item Description*	*Unit of issue*	*Quantity*		*Unit Price*	*Total Price*	*Signature*	*Remarks*
			Ordered	*Delivered*				
1	Cotrimoxazole (single strength)	10 tablets						
2	Paracetamol 500 mg	10 tablets						
3	Zinc 10 mg	10 tablets						
4	Zinc 20 mg	10 tablets						
5	Iron folate	200						
6	Chloroquine 100 mg	1000 tablets						
7	ORS	50 sachets						
8								
9								
10								
11								
Grand Total								

To be completed in two copies

Total sum received (in words):_____
Date delivered: _____
Name and signature of store manager: _____
Name and signature of health worker: _____
Name and signature of Supervisor: _____

MONTHLY REPORTS: CHW MONTHLY REPORT

Developed by:		Save the Children	**Developed in:**	Zambia
Adapted in:		None		
Purpose:		To summarize information from a CHW's treatment register and stock records for reporting		
Completed by:		CHW	**Frequency:**	Monthly
Submitted to:		Health Facility/District	**Frequency:**	Monthly
Tool(s) linked to:		Directly: *Treatment Register*, *Stock Records (CHW Drug Register), Monthly Summary* Supported by: N/A		
Indicators Served	**Use**	Annual CCM retention, CCM treatment coverage by CHW, Treatment rate, Treatment ratio,		
	Access	Targeted CHWs providing CCM, CCM CHW density, Target area coverage, Medicine and diagnostic availability		
	Quality	Case load by site, Follow up rate, Referral rate		
	Demand	None		
	Environment	None		

Overview: The *CHW Monthly Report* summarizes the data collected through the *Treatment Register* and *Stock Records* (*CHW Drug Register*) and provides a summary across key indicators for each CHW. This summary tool can be used by literate CHWs to report on their monthly activities to their associated health facility and further summarized in the *Monthly Summary* (see next one-pager).

CHWs summarize their treatment activities in Part A, where there is a row for each classification and columns for age group (<2 months; 2-11 months; 12-59 months) followed by columns to summarize referrals and deaths. There is a row to record the total number of CCM cases and all cases (as some CHWs are trained to manage cases such as anemia, red eye, etc). Only totals are recorded for referrals and deaths. Part A also includes tables to summarize all new cases by sex and age, number of cases with danger signs, number cases treated within 24 hours and follow-up.

Part B summarizes information from the *CHW Drug Register* and records information on the total amount of each type of medicine available at the beginning of the month, the amount used during the month, any losses and the total balance remaining at the end of the month. There is also a column to record data on any quantities received. This information is used by the CHW and the CHW supervisor to manage supplies and avoid over and under-stocking.

Use of data: CHW supervisors: to review CHW activity levels against expected/desired levels; to track and respond to stock-outs of essential drugs and supplies.

Potential adaptations: Not all programs, especially those with illiterate CHWs, require CHWs to compile and submit monthly reports on their activities. Instead, the CHW supervisor may review each CHW's registers and summarize the information (see *Monthly Summary*). Some programs may have separate reports for treatment data and supply management.

CHW MONTHLY REPORT – ZAMBIA EXAMPLE

IMCI CCM MONTHLY REPORT FORM FOR UNDER FIVES (for CHWs) (draft October 18, 2010)

Primary Health Care Unit_____ **Month**_____
Neighbourhood Committee_____ **Year**_____
Name of Supervisor_____ **CHW Name**_____
Nearest Health Facility_____ **Date of Reporting**_____

PART A [Source of Data: CHW Register] Cases by Classification and Age Group

Classification	New cases				Referral Recommended				Deaths			
	<2 months	2 to 11 months	12 to 59 months	TOTAL	<2 months	2 to 11 months	12 to 59 months	TOTAL	<2 months	2 to 11 months	12 to 59 months	TOTAL
A	B	C	D	B+C+D	F	G	H	F+G+H	J	K	L	J+K+L
Malaria												
Fever												
Fast Breathing												
Diarrhoea												
Malnutrition												
Danger Signs												
Total CCM Cases												
Anemia/Pallor												
Red Eye												
Other conditions												
Total All Cases												

Sex and Age Group for All New Cases

Sex	<2 months	2 to 11 months	12 to 59 months	TOTAL
Male				
Female				
Total				

Danger Signs		Treated Within 24 Hours	Care on Follow Up	
Number of Children with danger signs			Follow Up Made	
			Correct Care on follow up	

PART B [Source of Data: CHW Stock Records] Supplies Management Table

		A	B	C	D	E	F	G	H	J	K	L
Name of Drug/ Supply	Unit of Issue	Opening balance	Qtantity Dis-pensed	A-B	Losses	C-D	Adjustment (+)	Adjustment (-)	E+F	Ending Balance (H-G)	Quantity Received	New Stock on Hand (J+K)
LA (Coartem) 6X1	Pack											
LA (Coartem) 6X2	Pack											
ORS	Sachet											
Amoxil 125 mg	Tablet											
Amoxil 250 mg	Tablet											
Susp. Amoxil	Bottle											
Zinc	Tablet											
Eye ointment	Tube											
GV Paint	Bottle											
Paracetamol	Tablet											
RDT Test Kit	Pack											

Name of Verifying officer_____ Signature_____

Name of Approving officer_____ Signature_____

MONTHLY REPORTS: MONTHLY SUMMARY

Developed by:		Save the Children	**Developed in:**	Nicaragua
Adapted in:		Projects in: Guatemala, Myanmar, Bangladesh, Malawi; Mozambique National Programs in: Nicaragua, South Sudan		
Purpose:		To summarize a health facility's CCM experience in terms of: each CHW's treatments, activity levels, supervision coverage and quality of care		
Completed by:		CHW Supervisor	**Frequency:**	Monthly/Quarterly
Submitted to:		Health Facility/District	**Frequency:**	Monthly/Quarterly
Tool(s) linked to:		Directly: *Treatment Register*, *Stock Records*, *Supervision Checklist for CHW* Supported by: *Mother Reminder Cards*, *Case Scenarios*		
Indicators Served	**Use**	Annual CCM retention, CCM treatment coverage by CHW, Treatment rate, Treatment ratio		
	Access	Targeted CHWs providing CCM, CCM CHW density, Target area coverage, Medicine and diagnostic availability		
	Quality	Medicine and diagnostic adequate availability, Medicine and diagnostic storage, Medicine and diagnostic validity, Case load by site, Complete and consistent case registration, Follow up rate, Referral rate, Routine supervision coverage, Clinical supervision coverage, CHW to supervisor ratio, Case management knowledge, Respiratory rate		
	Demand	None		
	Environment	CCM in HMIS		

Overview: This tool summarizes the data collected through the *Treatment Register* and the *Supervision Checklist for CHW* and provides a summary across key indicators for each CHW as well as an overall total for the health facility's CHW experience. This summary tool is the main vehicle for relaying critical service statistics and indicators onward for use by program managers.

There is a row for each CHW and columns to record summary data from the *Treatment Register* and *Supervision Checklist for CHW*. For the treatment data summary section, the columns link directly to columns in the *Treatment Register* that focus on classification, treatment and referral. The numbers in each column of the *Monthly Summary* should be totaled in the bottom row of the page to characterize the overall CHW CCM experience for the health facility. For the supervision data summary, the columns link directly to the indicators on the *Supervision Checklist for CHW* (denoted with shaded rows on the checklist) and should be filled with a 'Yes' or 'No' according to the supervision checklist results for each CHW supervised during the reporting period. The Total row at the bottom of the *Monthly Summary* should be completed by tallying all the 'Yes' scores in each column.

Use of data: CHW supervisors: to review CHW activity levels against expected/desired levels; to identify CHWs who require additional training and supervision; to track and respond to stock-outs of essential drugs and supplies.

Program managers/district officials: to identify health facilities that require additional support; to identify system-wide issues that affect many CHWs and could be addressed through refresher training or other means.

Potential adaptations: Detailed Information for individual CHWs is rarely required at higher levels, especially in programs operating at scale. To reduce the reporting burden, CHW supervisors can report the totals from the *Monthly Summary* with data required to calculate indicators (number of CHWs submitting reports, number of CHWs supervised, number CHWs treating at least X cases, etc). This can facilitate integrating CCM data into the existing HMIS in some countries.

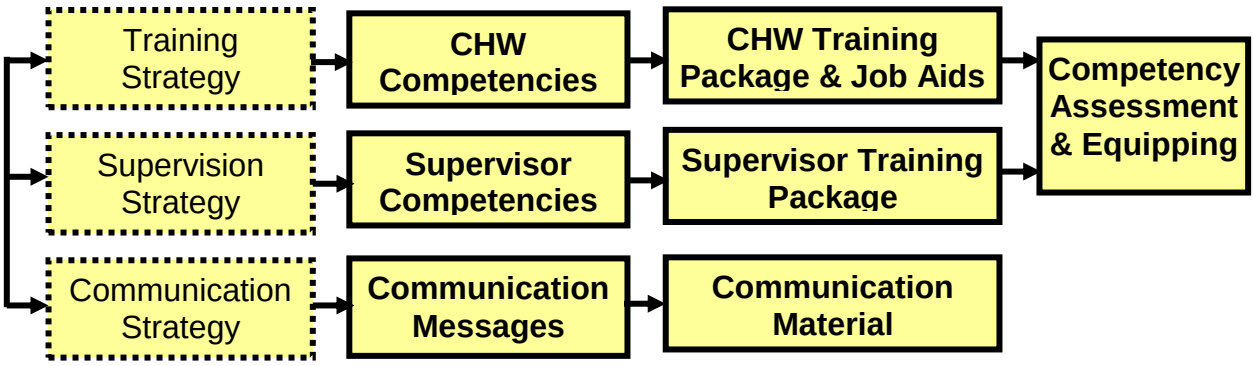
In many settings, CHWs are required to submit monthly reports that summarize the treatment and stock records, which the *Monthly Summary* can be designed to reflect, or these tallies can be extracted from other monthly reports (see Malawi and Zambia examples). The present *Monthly Summary* does not include summary data on drugs and supplies, but could be expanded to do so.

MONTHLY SUMMARY EXAMPLE

Monthly Summary
(draft March 2011)
CHW Supervisor Name: _____ **Reporting Month:** _____ **No. of CCM-trained CHWs in HF catchment area:** _____
Supporting Health Facility: _____ **District:** _____ **No. of CCM-trained CHWs reporting this month:** _____

CHW Name	Community	CHW reported this month?		Age Group (mos)		Sex		Classification							Referral?		Follow-Up Visit Made?		Referral Compliance on Day 1?		CHW Supervised this month? (Y/N)	Supervision Indicators								Observations
		Y	N	2-11	12-59	Male	Female	Danger sign	Fast breathing (penumonia)	Cough/cold (no pneumonia)	Diarrhea <14 days	Fever, no malaria	Malaria	Other	Y	N	Y	N	Y	N		Medicine and Diagnostic Availability	Medicine and Diagnostic Adequate Availability	Medicine and Diagnostic Validity	Medicine and Diagnostic Storage	Supply Availability	Complete and Consistent Case Registration	Case Management Knowledge	Respiratory Rate	
TOTAL																														
Percent of Group																														
Not part of form: Boxes show which monitoring indicator is informed by total columns.		**11, 12**		**11, 27**				**25, 26**							**34**		**33**		**35**		**40, 41**	**18**	**19**	**21**	**20**		**32, 40**	**44, 41**	**46**	

SECTION 2: IMPLEMENTATION TOOLS



CHW COMPETENCIES

Developed by:	Save the Children	**Developed in:**	Myanmar
Adapted in:	Projects in: Malawi, South Sudan, Mozambique, Bangladesh		
Purpose:	To define measurable essential competencies required for the management of diarrhea, pneumonia and malaria cases. These competencies ultimately determine program quality.		
Completed by:	N/A	**Frequency:**	N/A
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *Competency Assessment*, *Case Scenarios, Supervision Checklist for CHW*, *Supervisor Competencies*, *CHW Training Manuals*		

Overview: Before embarking on training and subsequent deployment of CHWs in the community, programs must identify the essential knowledge and skills that CHWs need to implement the program. This list of core competencies informs training, certification, supervision, and quality monitoring. The list informs *Competency Assessment* throughout training, including terminal assessments for certification, as well as post-deployment assessment (see *Supervision Checklist for CHW*). These proficiencies should be measurable and should focus on assessment, classification, treatment, counseling, referral, follow-up, and record keeping. Save the Children has identified 13 CHW core competencies for case management and follow-up (items 1-10 and 12) and for record keeping (items 11 and 13).

Use of data: N/A

Potential adaptations: For the Malawi program**,** Save the Children has modified the CHW competency list and added additional competencies and tasks, including: manage and maintain drug stocks; summarize treatment data, drug consumption and stock levels on a monthly basis; and submit completed summary forms to their supervisors (link). Programs should use the master *CHW Competencies* list as a guide and make changes according to program policies and strategies.

Other comments: The CCM strategy has skeptics who doubt that “para-professionals” can be trusted to deliver antibiotics and antimalarials according to protocol. They fear drug misuse and drug resistance. Competency-based training, certification, and assessment (and the results of achieved and sustained competencies) are approaches to reassure skeptics – not to mention communities and families!

LIST OF CHW COMPETENCIES

CHW Competencies	
1	Ask child identification (name AND age AND sex AND first vs. re-visit)
2	**Assess for general danger signs (all 4)**
3	**Ask and look completely (all problems, including additional information for "IF YES" questions)**
4	**Count respiratory rate within plus or minus 3 from standard**
5	**Classify child's illness correctly**
6	**Give correct treatment as per CCM manual (full course and observe child take 1st dose)**
7	**Counsel (correct messages, including correct drug AND dose AND duration and when to return for follow-up)**
8	Counsel (probe for questions AND request mother to repeat instructions)
9	**Make correct referral decision**
10	Referral Facilitated (give referral slip, first dose as appropriate)
11	Complete register (all relevant boxes in the row)
12	Make follow-up visit (can demonstrate content that would be included)
13	Finalize register after follow-up visit
**Competencies in bold (#2-6 and #9) are considered mandatory competencies*	

CHW TRAINING PACKAGE: CHW TRAINING MANUALS

Developed by:	Save the Children	**Developed in:**	Nicaragua
Adapted in:	Projects in: Myanmar		
Purpose:	(1) Manual for CHW: To guide CHWs how to treat common illnesses in the community, how to use job aids, and what to record. (2) Training Guide: To guide facilitators in charge of training CHWs on community case management as well as health personnel that will implement the CCM strategy.		
Completed by:	NA	**Frequency:**	NA
Submitted to:	NA	**Frequency:**	NA
Tool(s) linked to:	Directly: *WHO 'Caring for the Sick Child in the Community'*, *Case Management Job Aid*, *Treatment Register*, *CHW Kit*, *Counseling cards*, *Mother Reminder Cards*, *Referral and Back-Referral Form*, *Supervisor Training Manual*		

Overview: The technical content of the *WHO 'Caring for the Sick Child in the Community'* manual for Community Health Workers is the gold standard for the clinical training of CHWs on the assessment, classification and treatment of childhood illness in the community. However, non-clinical areas of the training require strengthening. Save the Children developed two manuals, one for the CHW and one as a guide for trainers, which provide context-specific guidance on how to integrate CCM activities into existing programs and outline procedures on conducting community meetings, reporting, counseling and referral.

Originally developed for Nicaragua, the Manual for CHW, in addition to the technical content: (1) explains what CCM is and the role and responsibilities of the CHW; (2) describes how to use *Counseling Cards and Mother Reminder Cards* to emphasize appropriate sick child care; (3) outlines how to record information on each episode in the Child Treatment Register; (4) explains how to prepare and conduct community meetings; (5) describes whom to refer and when, how to use the referral slips (*Referral and Back-Referral Form*), and what to do when families are unable to comply with referral; and (6) explains the purpose and content of home visits and advises on how to plan them.

The CHW Training Guide provides step-by-step guidance to facilitators and other health personnel on how to train and support CHWs to implement the content in the CHW Manual. The guide explains to facilitators how to prepare for the training and contains nine learning exercises and instructions on how to carry out these exercises to ensure that each of the learning objectives is met. These learning exercises apply adult education principles and seek to motivate CHW trainees to participate in the activities. Facilitators should be encouraged to review the training guide well in advance of the training so that they have mastered the content, learning exercises, and training approaches.

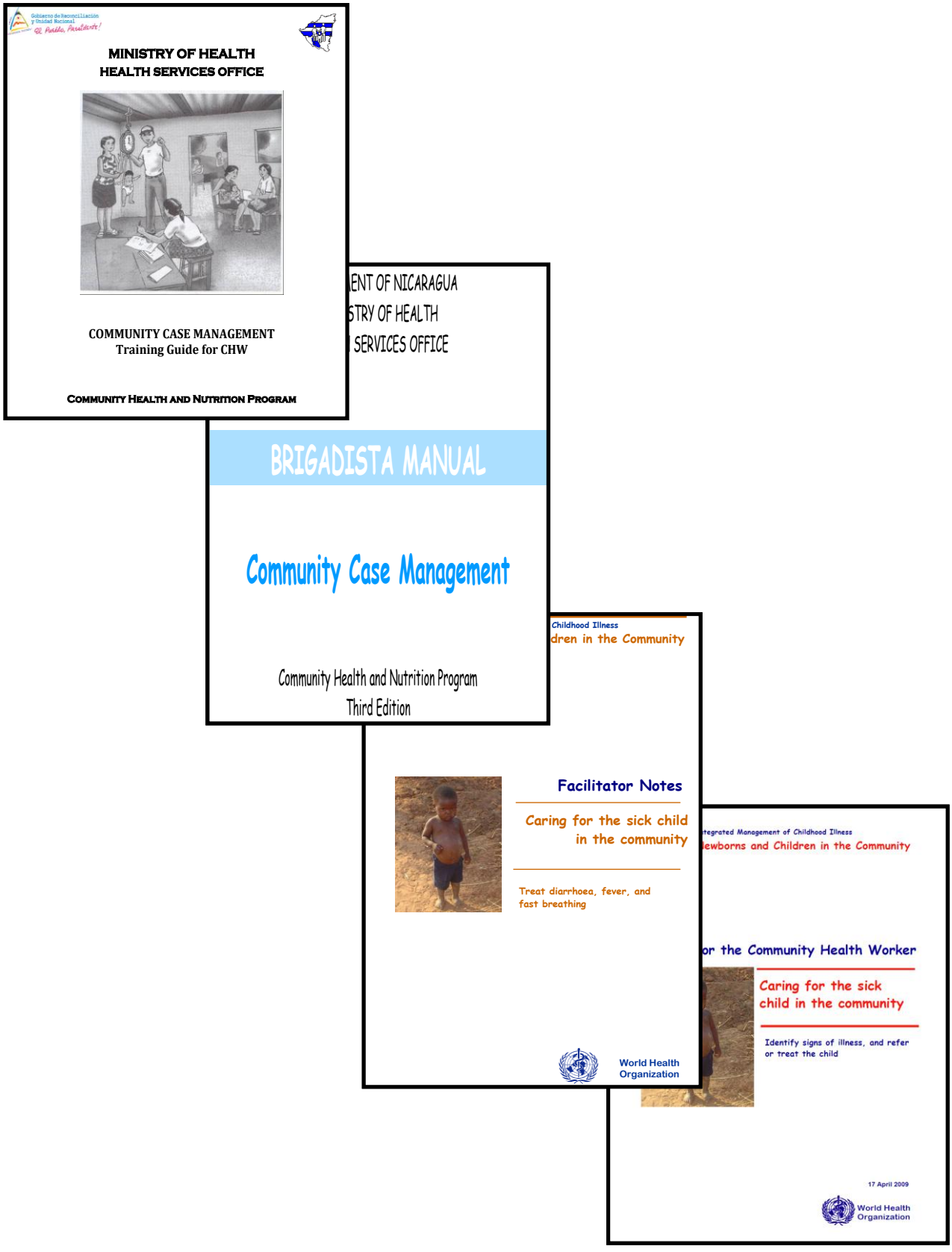
Use of data: NA

Potential adaptations: The CHW training manuals require substantial adaptation to reflect the working environment of the CHW, but these revisions can be accomplished relatively quickly. Adapting the additional areas of the Nicaragua handbook for use in Myanmar took approximately one week. Adaptation should be initiated once the CHW roles and responsibilities and supporting materials (treatment registers and job aids) are sufficiently developed. In Nicaragua, CHWs did not complete monthly reports as their supervisors extracted summary data from the registers. In situations where CHWs are required to submit monthly reports of their treatment and other activities, a section describing this should be added to the handbook. Note that Chapters 4, 6, 7, 8, 9 and 10 of the CHW materials could also be added to the *WHO 'Caring for the Sick Child in the Community'* and delivered to trainees as handouts during training. The present version of the CHW training guide does not include a section on competency assessment of the CHW, but it is recommended that such a section be added.

Other comments: The *CHW Training Manuals* content should be reviewed and updated on a regular basis so the materials stay relevant to CHWs.

CHW MANUAL EXAMPLES

Refer to full manuals provided as separate attachments



CHW TRAINING PACKAGE: TRAINING VIDEO

Developed by:	Save the Children	**Developed in:**	South Sudan
Adapted in:	None yet, but could be explored		
Purpose:	To guide CHWs on how to treat common illnesses in the community, in settings where access to real life cases of sick children is limited.		
Completed by:	N/A	**Frequency:**	N/A
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Supported by: *CHW Training Manual*, *Supervision Checklist for CHW*, *Competency assessment*		

Overview: This video is to be used in combination with the facilitator's guide to training. It was developed in South Sudan – a fragile state with various logistical challenges, where access to real life cases of sick children at hospitals during training is limited. The video is to be used over the course of the 6 day training and provides CHW s (called Community Based Distributors, or CBDs in South Sudan) with additional practice and video clips of sick children in the community. It is an additional tool to supplement regular training methods.

The technical content of the video is adapted from the WHO *'Caring for the Sick Child in the Community'* manual for CHWs and the video contains five chapters. The first chapter on how to identify danger signs is approximately 16 minutes. Clips of children exhibiting the various dangers signs, along with guided narration are shown in this section, and CHWs are encouraged to refer children presenting with such danger signs to the nearest health facility right away. The next three chapters are scripted role plays on how to carry out of a full assessment of a sick child in the community, with specific focus on diarrhoea, malaria and pneumonia. Each interaction contains approximately 9 minutes of video footage. These assessments outline the ideal steps to be taken from the moment a sick child is brought to the CHW. This includes greeting the caregiver, assessing and classifying the sick child, giving the first dose of treatment, counseling the caregiver on home care, and following up with the caregiver. The final chapter is approximately 11 minutes and is linked to the pneumonia assessment. It begins by explaining the cut offs for fast breathing and then shows how respiratory rates are counted by using video footage of a real child, as an example. This is followed by a few more examples and then interactive exercises to provide CHWs with an opportunity to practice their skills.

Guidance for the facilitators is provided in the training manual on when to play the video and when to pause for discussion. Facilitators should be encouraged to review the video well in advance of the training so that they have mastered the content and practice exercises.

Use of data: N/A

Potential adaptations: The scripted role plays can be adapted in all countries, even where access to hospital cases is feasible. It provides CHWs with an ideal model by which to carry out their assessments in a systematic manner. Video clips can be voiced over as needed. The examples of children with fast breathing and danger signs can be used during competency assessments and during supervision visits for additional practice and to reinforce concepts learned during training.

Other comments: While it important to review and edit the video to ensure it stays relevant, such modifications are costly as they may require re-filming some sections. This may only be feasible in certain contexts.

CHW TRAINING PACKAGE: TRAINING VIDEO (VIDEO SCRIPT FOR MALARIA CASE)

Video Script: How to properly manage Malaria in the Community

Authors: Janani Vijayaraghavan, Benjamin Atwine, Charles Ocan, David Marsh
Feb 6, 2010
Note: Items in red font are read by the narrator.

Act 1: CBD's house

Narrator: You will now see a video about a sick child called Ajok. Watch the CBD go through all the steps of how to correctly manage diseases in the community. These steps are: (1) Greeting the mother, (2) Gathering Basic Information, (3) Asking, (4) Looking, (5) Classifying, (6) Treating, (7) Counselling, and (8) Following up.

Ajok is from Korfluse and is 10 months old. Her mother brings her to the CBD because she is sick.

Mother: Good morning.

CBD: Good morning, how are you?

Mother: I am fine

CBD: Please sit (*shows her chair*)

CBD: Mrs. Deng, how is everything?

Mother: Uh, we are not ok. My child is sick.

CBD: I am very glad you brought Ajok here. I may need to ask you some few questions to know what is wrong with Ajok. Ok Mrs. Deng, what is Ajok's full name?

Mother: Her name is Ajok Grace

CBD: How old is Ajok?

Mother: She is 10 months old.

CHW: Ok Mrs. Deng, where do you live?

Mother: We live in Korfluse.

CHW: Ok, Korfluse. Thank you, Mrs. Deng. What is Ajok's problem?

Mother: She feels very hot and she is weak. She cry a lot.

CBD: How long has she had a fever?

Mother: For two days.

CBD: Has he had any convulsions?

Mother: No. She does not have any convulsions.

CBD: Does Ajok have any other problem?

Mother: She has been coughing.

CBD: For how many days?

Mother: Three days.

CBD: Does she have diarrhoea?

Mother: No. She does not have diarrhoea.

CBD: Does Ajok have any difficulty drinking or feeding?

Mother: She is not eating as much as usual and she is weak

CBD: Has she been vomiting?

Mother: No, she has not been vomiting

CHW: Does Ajok have any other problems that you may need to talk about today?

Mother: No. I am just worried about the fever.

CBD: Now I am now going to take a look at Ajok. I will need to look at her chest. Please help remove her dress.

Narrator: The CBD is looking at Ajok's chest to see if she has chest indrawing. He notices that when the child breathes in, the chest and stomach move out together. He decides that Ajok does not have chest indrawing.

CBD: I am going to count Ajok's breathing. Please can you keep her calm.

Narrator: The CBD now checks to see if Ajok has fast breathing. To count the breaths in one minute, the CBD uses the watch and puts it in a place where he sees the watch and the child's breathing. The CBD looks for the breathing movement anywhere on the child's chest or stomach. He prepares to start counting when the child is calm and counts the breaths for one full minute. The CBD counted 37 breaths per minute and decides that Ajok does not have fast breathing because the rate is below the cut-off of 50 or more breaths per minute for children 2-12 months of age.

CBD: I am now going to check for a fever. Can you please lift her dress (*Feel Ajok's abdomen using the back of the palm*). I can feel that Ajok has a fever now.

Narrator: The CBD sees that Akoj is not abnormally weak.

CBD: I am now going to check her nutritional status.

Narrator: The CBD will use the MUAC tape see if Ajok has severe malnutrition. He sees that the colour of the MUAC strap is green, so Ajok does not have severe malnutrition.

The CBD thinks about Ajok's problems again. Ajok has a fever for 2 days, cough for 3 days and no fast breathing. She does not have any danger signs. The CBD decides that Ajok has malaria.

How will the CBD treat Ajok's illness?

CBD: Ajok has malaria, Mrs. Deng. She needs antimalarial tablets. Ajok is 10 months old, she needs take ½ of this white tablet called Artesunate and ½ of this yellow tablet called Amodiaquine. (*Show tablet boxes*). I am going to give the first dose of the medicine now.

CBD: She needs to take this medicine once every day for three days. Just to make sure, can you repeat the instructions for giving medicine?

Mother: I will give her ½ of the white tablet and ½ of the yellow tablet tomorrow and the day after tomorrow.

CBD: I am now going to show you how to reduce her fever.

CBD: You should continue to breastfeed her often while she is sick. It will help her get strength.

Narrator: The CBD advises Mrs. Deng that she should come back right away if Ajok becomes more sick.

CBD: Do you have any treated mosquito net at home?

Mother: Yes I do.

CBD: Does Ajok sleep under the net?

Mother: Sometimes, not every night.

CBD: It is very important for Ajok and all the children to sleep under the treated mosquito net every night to prevent them from malaria.

Mother: Yes, I understand.

CBD: Now, I would like you to bring Ajok here after three days even if she is feeling better. I would know if she is ok.

Mother: Ok. Thank you very much for helping Ajok. I will bring her back after three days.

CBD: Thank Mrs. Deng. Take care. See you soon.

Mother: Thank you.

Act 2: Follow up visit

Narrator: After three days, Mrs. Deng brings Ajok back to the CBD for a follow up visit
Mother: Good afternoon.

CBD: Good afternoon Mrs. Deng, how are you? Please sit down.

Mother: I am fine.

CBD: Please sit down. How is Ajok feeling now?

Mother: She is feeling much better. I gave her the medicines just like said. She does not feel hot and she is stronger. She is even eating and drinking more.

CBD: That is very good news. I am glad that Ajok is feeling better and I'm glad that you bring her back here for a check up. Thank you Mrs. Deng.

Mother: Thank you for helping me.

CBD: You're welcome.

Narrator: If Ajok was not feeling better, the CBD should have urgently refer Ajok to the nearest health facility or hospital. Since Ajok is feeling better, the CBD thanks the mother for coming back for a follow up visit and for correctly giving her the medicines.

JOB AIDS: CASE MANAGEMENT JOB AID

Developed by:	World Health Organization	**Developed in:**	Geneva
Adapted in:	National programs: Malawi, Uganda, South Sudan		
Purpose:	A flowchart that guides the CHW through assessment, classification, treatment and referral for the management of sick children		
Completed by:	Used by CHW	**Frequency:**	Per episode
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *CHW Kit*, *CHW Training Manuals*, *Mother Reminder Cards*, *Counseling Cards*, *Referral and Back Referral Form*		

Overview: The *Case Management Job Aid* informs both training and practice. Flowcharts reflect local epidemiology and age-groups targeted (usually 2-59 months but can be adapted to include infants 0-2 months). Facility-based IMCI flow-charts usually inform CCM flowcharts. Most are color-coded to indicate severity and require basic literacy. Many, but not all, projects use the **WHO Sick Child Recording Forms**. The Sick Child Recording Form is an excellent training tool, and CHWs should be introduced to it during their CCM training. They should be encouraged to refer to the flowchart to guide the management of each sick child they encounter to ensure that they adhere to protocol. Likewise, when assessed for correct case management (through direct observation of an actual case or simulation) during supervision, CHWs should be permitted to refer to their *Case Management Job Aid*.

Use of data: N/A

Potential adaptations: For diseases, drugs, drug formulations, and culturally relevant and clear pictures. The flowchart can also be adapted for semi-literate or illiterate CHWs by adding pictures (see South Sudan and Uganda examples). Guidance for management of newborn illness can also be incorporated (also see Uganda example).

Other comments: Printing of cards at scale is costly. While ideally a form would be completed for each episode, CHWs can be provided with a laminated copy of the form and refer to it during each episode.

CASE MANAGEMENT JOB AID EXAMPLE: WHO SICK CHILD RECORDING FORM

Sick Child Recording Form

(for community-based treatment of child age 2 months up to 5 years)

Date:_____/_____/200____ (Day / Month / Year) **CHW:**_____

Child's name: First _____ Family _____ **Age:** __Years/__Months **Boy / Girl**

Caregiver's name: _____ **Relationship:** Mother / Father / Other: _____

Address, Community: _____

1. **Identify problems**

ASK and LOOK		Any DANGER SIGN or other problem to refer?	SICK but NO Danger Sign?
ASK: What are the child's problems? If not reported, then ask to be sure. YES, sign present → Tick ☑ NO sign → Circle ■			
☐	■ Cough? If yes, for how long? __ days	☐ Cough for 21 days or more	
☐	■ Diarrhoea (3 or more loose stools in 24 hrs)? IF YES, for how long? _____days.	☐ Diarrhoea for 14 days or more	☐ Diarrhoea (less than 14 days AND no blood in stool)
☐	■ IF DIARRHOEA, blood in stool?	☐ Blood in stool	
☐	■ Fever (reported or now)? If yes, started _____ days ago.	☐ Fever for last 7 days or more	☐ Fever (less than 7 days) in a malaria area
☐	■ Convulsions?	☐ Convulsions	
☐	■ Difficulty drinking or feeding? IF YES, ☐ not able to drink or feed anything?	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, ☐ vomits everything?	☐ Vomits everything	
☐	■ Any other problem I cannot treat (for example, problem breast feeding, injury, burn)? See 5 If any OTHER PROBLEMS, refer.	☐ Other problem to refer:	
LOOK:			
☐	■ Chest indrawing? (FOR ALL CHILDREN)	☐ Chest indrawing	
☐	**IF COUGH, count breaths in 1 minute:** _____breaths per minute (bpm) ■ Fast breathing: Age 2 months up to 12 months: 50 bpm or more Age 12 months up to 5 years: 40 bpm or more		☐ Fast breathing
☐	■ Unusually sleepy or unconscious?	☐ Unusually sleepy or unconscious	
	For child 6 months up to 5 years, MUAC strap colour: _____	☐ Red on MUAC strap	
☐	■ Swelling of both feet?	☐ Swelling of both feet	

2. **Decide: Refer or treat child** (tick decision)

☐ **If ANY Danger Sign or other problem, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

GO TO PAGE 2 →

Child's name: _____ **Age:**_____

3. Refer or treat child (tick treatments given and other actions)

☐ **If ANY Danger Sign or other problem, refer to health facility**

☐ **If NO Danger Sign, treat at home and advise caregiver**

If any danger sign, **REFER URGENTLY to health facility:**	
ASSIST REFERRAL to health facility: ☐**Explain why child needs to go to health facility.** ☐**FOR SICK CHILD WHO CAN DRINK, BEGIN TREATMENT:**	
☐ If **Diarrhoea**	☐**Begin giving ORS solution** right away.
☐ If **Chest indrawing**, or ☐ **Fast breathing and danger sign**	☐**Give first dose of oral antibiotic** (amoxycillin tablet—250 mg) ☐Age 2 months up to 12 months—3/4 tablet ☐Age 12 months up to 5 years—1 1/2 tablets
☐**For any sick child who can drink, advise to give fluids and continue feeding.** ☐**Advise to keep child warm, if child is NOT hot with fever.** ☐**Write a referral note.** ☐**Arrange transportation, and help solve other difficulties in referral.** →**FOLLOW UP child on return at least once a week until child is well.**	

If no danger sign, **TREAT at home and ADVISE on home care:**	
☐ If **Diarrhoea** (less than 14 days AND no blood in stool)	☐**Give ORS.** Help caregiver give child ORS solution in front of you until child is no longer thirsty. ☐**Give caregiver 2 ORS packets to take home.** Advise to give as much as child wants, but **at least** 1/2 cup ORS solution after each loose stool. ☐**Give zinc supplement.** Give 1 dose daily for 10 days: ☐Age 2 months up to 6 months—1/2 tablet (total 5 tabs) ☐Age 6 months up to 5 years—1 tablet (total 10 tabs) Help caregiver to give first dose now.
☐ If **Fever** (less than 7 days) in a malaria area	☐**Do a rapid diagnostic test (RDT).** __Positive __Negative ☐**If RDT is positive, give oral antimalarial ACT.** ☐Age 2 months up to 3 years—1 tablet (total 6 tabs) ☐Age 3 years up to 5 years—2 tablets (total 12 tabs) Help caregiver give first dose now, and 2nd dose after 8 hours. Then give dose twice daily for 2 more days. ☐**Advise caregiver on use of a bednet (ITN).**
☐ If **Fast breathing**	☐**Give oral antibiotic** (amoxycillin tablet—250 mg). Give twice daily for 5 days: ☐Age 2 months up to 12 months—3/4 tablet (total 7 1/2 tabs) ☐Age 12 months up to 5 years—1 1/2 tablets (total 15 tabs) Help caregiver give first dose now.
☐ For **ALL children treated at home, advise on home care**	☐**Advise caregiver to give more fluids and continue feeding.** ☐**Advise on when to return.** Go to nearest health facility or, if not possible, return immediately if child ☐Cannot drink or feed ☐Becomes sicker ☐Has blood in the stool ☐**Follow up child in 3 days** (schedule appointment in item 6 below).

4. CHECK VACCINES RECEIVED (tick ☐ vaccines completed, circle ■ vaccines missed)

Age	Vaccine		→ **Advise caregiver, if needed: WHEN is the next vaccine to be given?** **WHERE?**
Birth	☐ ■ BCG	☐ ■ OPV-0	
6 weeks*	☐ ■ DPT—Hib + HepB 1	☐ ■ OPV-1	
10 weeks*	☐ ■ DPT—Hib + HepB 2	☐ ■ OPV-2	
14 weeks*	☐ ■ DPT—Hib + HepB 3	☐ ■ OPV-3	
9 months	☐ ■ Measles	[Give OPV-4, if OPV-0 not given at birth]	

5. If any OTHER PROBLEM or condition I cannot treat, refer child to health facility, write referral note. **(If diarrhoea, give ORS. Do not give antibiotic or antimalarial.)**

Describe problem: _____

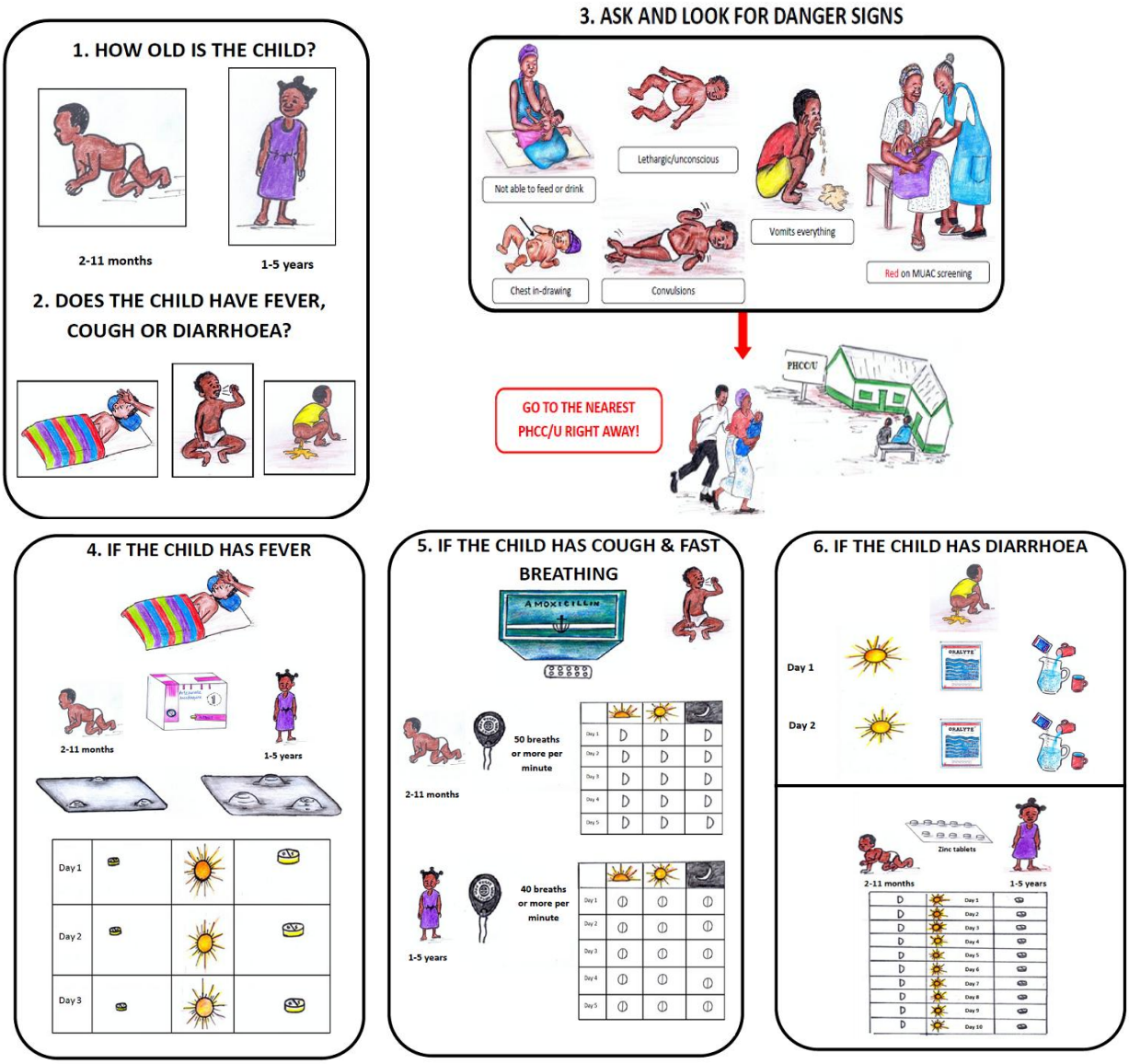
6. When to return for FOLLOW UP (circle): Monday Tuesday Wednesday Thursday Friday Weekend

7. Note on follow up:

☐ Child better—continue to treat at home. Day of next follow up:_____.
☐ Child is not better—refer URGENTLY to health facility.
☐ Child has danger sign—refer URGENTLY to health facility.

CASE MANAGEMENT JOB AID EXAMPLE: PICTORIAL EXAMPLE FROM SOUTH SUDAN

NOTE: EACH OF THESE PANELS ARE ON A SINGLE PAGE BUT HAVE BEEN CONDENSED TO FIT THIS PAGE



JOB AIDS: COUNSELING CARDS

Developed by:	Save the Children	**Developed in:**	Nicaragua
Adapted in:	Myanmar		
Purpose:	To facilitate interpersonal communication between CHW and caregiver for treating the child.		
Completed by:	Used by CHW	**Frequency:**	Per episode
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly to: *CHW Kit*, *CHW Training Manuals*, *Mother Reminder Cards*		

Overview: Many countries have standard pictorial tools to support behavior change communication (BCC) and/or interpersonal communication (IPC). The cards are often spirally bound (i.e., fixed) or linked with a circular key-ring (i.e., adaptable). They commonly have messages on the back, typically promoting the use of preventive interventions (i.e., exclusive breastfeeding, complementary feeding). The CCM strategy requires BCC messages supporting curative care.

The 15 *Counseling Cards* from Nicaragua illustrate a range of topics. The first six (violet border), part of the pre-CCM preventive community-based program, also support CCM: (1) Caring for the Child with Cough and Cold, (2) Prevention of Diarrhea, (3) How to Give ORS, (4) Caring for the Child with Fever (no malaria in this setting), (5) Feeding the Sick Child, and (6) Feeding the Disinterested Child. The remaining nine (yellow border) were added to support CCM: (7) Caring for a Child with Pneumonia at Home, (8) Caring for a Child at Home with Diarrhea, (9) How to Give Amoxicillin for Severe Pneumonia (first dose only), (10) How to Give Amoxicillin for Pneumonia, (11) How to give Cotrimoxazole for Dysentery, (12) How to Give Furazolidine for Dysentery to Children Less than Two Years of Age, (13) How to Give Furazolidine for Dysentery to Children Aged Two to Four Years, (14) How to Give Zinc for Diarrhea, and (15 How to give Acetaminophen for Fever.

These cards are not distributed to the caregivers (*Mother Reminder Cards* are, instead); rather these are tools to help the CHW explain treatment and home care to the caregiver during the sick child visit.

Use of data: N/A

Potential adaptations: For diseases, drugs, drug formulations, and culturally relevant and clear pictures.

Other comments: Cards at scale are costly. Pictures should be pre-tested. Cards must be changed to accommodate new drugs (i.e., when furazolidine replaced cotrimoxazole for dysentery in Nicaragua) or drug formulations. For this reason, cards should be dated to facilitate identifying those that need to be replaced. Programs using *Mother Reminder Cards* should employ the same graphics on both the *Counseling Cards* and *Mother Reminder Cards* to reinforce communication.

¿Cómo le va a dar el Acetaminofén al niño con fiebre?

EDAD	CUATRO VECES AL DIA POR TRES DIAS	
	Gotero 100 mg/cc	Tabletas 500 mg
2 a 5 meses	 15 gotas	–
6 meses a 2 años	–	
3 a 4 años	–	

JOB AIDS: MOTHER REMINDER CARDS

Developed by:	Save the Children	**Developed in:**	Nicaragua
Adapted in:	Myanmar		
Purpose:	To increase compliance with home drug treatment of CCM syndromes.		
Completed by:	Caregiver	**Frequency:**	Each syndrome
Submitted to:	CHW for review	**Frequency:**	Follow-up visit
Tool(s) linked to:	Directly to: *CHW Kit*, *CHW Training Manuals*, *Counseling Cards*, *Treatment Register*, *CHW Monthly Report, Monthly Summary*		

Overview: These cards pictorially specify each dose of each treatment that the CHW can dispense, that are given to the child's caregiver. The title shows the drug formulation, the syndrome and drug name. Columns represent day (sun) or night (moon). Rows specify days. The caregiver marks each dose given (with an "x" written with a writing implement or charcoal or with a hole punched through it). The CHW inspects the card to assess compliance during follow up and records in the *Treatment Register*.

Nicaragua has 18 different *Mother Reminder Cards* because of multiple formulations of two drugs (acetaminophen and cotrimoxazole) and because the drug policy for treating dysentery changed from cotrimoxazole to furazolidine. Thus the cards are: (1) amoxicillin syrup (2-11 months), (2) amoxicillin syrup (1-4 years), (3) zinc tablets (2-6 months), (4) zinc tablets (6 months-5 years), (5) acetaminophen drops and syrup (2-5 months), (6) acetaminophen drops and syrup (6 months-2 years), (7) acetaminophen drops and syrup (3-4 years), (8) acetaminophen tablets (6 months -2 years), (9) acetaminophen tablets (3-4 years), (10) cotrimoxazole syrup (2-11 months), (11) cotrimoxazole syrup (1-4 years), (12) cotrimoxazole tablet (2-11 months), (13) cotrimoxazole tablet (1-4 years), (14) furazolidine syrup (2-5 months), (15) furazolidine syrup (6-11 months), (16) furazolidine syrup (12-23 months), (17) furazolidine syrup (2 years), and (18) furazolidine syrup (3-4 years). Many programs do not treat dysentery or treat fever with acetaminophen, so the number of card will be much less.

Nicaragua's *Mother Reminder Cards* do more than recall the details of a prescription – they also remind the mother of a "contract" she has signed (or on which she has made her mark) on the top statement, "I _____ promise to give my child _____ this medicine." Thus, there can be both factual and "commitment" elements to assuring compliance.

Use of data: The cards can produce proxy information to measure compliance up to the time of the follow-up, which may be before treatment will have been completed. Information on treatment compliance can be recorded on the *Treatment Register* and summarized in the *CHW Monthly Report* and *Monthly Summary* for program monitoring.

Potential adaptations: For diseases, drugs, and drug formulations.

Other comments: Cards at scale are extremely costly (one card per drug!). Pre-packaged, color-coded drugs may assure compliance just as well. Cards must be changed to accommodate new drugs (i.e., when furazolidine replaced cotrimoxazole for dysentery in Nicaragua) or drug formulations. For this reason, cards should be dated to facilitate identifying those that need to be replaced. Programs using *Counseling Cards* should employ the same graphics on both the *Counseling Cards* and *Mother Reminder Cards* to reinforce communication.

Recordatorio de Compromisos Manejo de Casos Comunitarios 2 a 11 meses

Yo_____ Me Comprometo a darle

Medicamento a mi hijo: _____

Neumonía 	**Amoxicilina**
Días 	
Día 1 	
Día 2 	
Día 3 	
Día 4 	
Día 5 	

Recordatorio de Compromisos Manejo de Casos Comunitarios 1 a 4 años

Yo_____ Me Comprometo a darle

Medicamento a mi hijo: _____

Neumonía 	**Amoxicilina**
Días 	
Día 1 	
Día 2 	
Día 3 	
Día 4 	
Día 5 	

JOB AIDS: REFERRAL AND BACK-REFERRAL FORM

Developed by:	Save the Children	**Developed in:**	Nicaragua
Adapted in:	Projects in: Myanmar		
Purpose:	To facilitate early and appropriate treatment of patients referred to the health facility		
Completed by:	CHW	**Frequency:**	For each referral
Submitted to:	Health Facility	**Frequency:**	For each referral
Tool(s) linked to:	Directly to: *Treatment Register, CHW Monthly Report*		

Overview: A quality CCM program includes treatment at community level and referral of some cases to the appropriate health facility for management, specifically children with danger signs (severe disease) and those who are not improving. Many programs overlook this component and concentrate on the community treatment part alone. Along with the CHWs trained in CCM, the referral facility needs to be equipped and its staff trained to manage patients referred from the community. A linkage between the two should be established from the very beginning of program implementation. This includes development of a *Referral and Back-Referral Form* that serves the need of the patient and the program, i.e., facilitated timely referral, treatment at the facility and follow-up by the CHW. The referral mechanism commonly includes an identifier (colored bandana or badge) to ensure priority treatment at the facility and to build community confidence in the CCM program.

The *Referral and Back-Referral Form* developed in Nicaragua is in the form of a receipt book and has three parts; receipt; referral; and back-referral. The identification and community management information in all three parts is completed by the CHW. The receipt is retained in the book and the referral and back referral are given to the caregiver. The ***receipt*** has space for identifying information, the reasons for referral, whether a referral identifier was given. In the Nicaragua program a red scarf loosely tied around the neck of the child ensures priority care at the health facility. Besides identifying information, the ***referral*** form has a list of referral conditions plus a space for additional observations or reasons for referral. The referral is retained at the health facility for future reference and follow-up. The ***back-referral*** completed by the health facility staff has space for brief description of the treatment and instructions for home care. The caregiver gives the back-referral to the CHW for appropriate follow-up and ensuring compliance.

Use of data: The main use of the referral forms is patient care. The referral portion of the form provides information to assist case management at the receiving facility. The back-referral portion informs follow up at home AND should provide feedback to the referring CHW regarding her case management – the validity of her assessment and the course of the patient. Using the forms to assess referral compliance is risky because the absence of a back-referral does not mean that the referral did not happen. The absence could stimulate problem-solving (Did the family go? Did they leave against advice? Why? Did they receive a back-referral? And so on.)

Potential adaptations: Many CHWs encounter a host of conditions and age-groups for referral (maternal danger signs, chronic diseases, injuries, etc.), so CCM is likely to piggy-back onto an existing multi-purpose form.

Other comments: Programs with semi-literate or illiterate CHWs will need pictorial forms to facilitate referral. The Nepal MOH pneumonia CCM program referral form (link) is an excellent example.

Referral and Back-Referral Form

CHW to complete all shaded sections.

1. ***CHW Referral Form*** (retained by CHW)

Name of Patient: _____ _____Age: _____Male/Female
Caregiver's name & relationship: _____
Village/sub village: _____ Date of Referral: _____ Time: _____
Referred to facility (name): _____
Major complaints: _____
Classification (if CCM patient): _____
Treatment given: _____
_____
Emergency scarf given: yes/no

****

2. ***CHW Referral Form*** (retained at the facility)

Name of referring CHW: _____
Name of Patient: _____ _____Age: _____Male/Female
Caregiver's name & relationship_____
Village/sub village: _____ Date of Referral: _____Time: _____
Referred to health facility (name):_____
Classification (if CCM patient): _____
Treatment given: _____
_____

****

3. ***CHW Back-Referral Form*** (returned to CHW by family)

Name of Patient: _____ _____Age: _____Male/Female
Caregiver's name & relationship: _____
Village/sub village: _____ Name of referring CHW: _____
Health facility (name):_____
Referred on (date): _____ Arrived on: Date _____Time _____
Patient condition on arrival: _____
_____
Diagnosis or Classification (if CCM patient): _____
Treatment given: _____
_____
Instructions for referring CHW: _____
_____
Follow-up date: _____ Feedback by (name & designation):_____

REFERRAL AND BACK REFERRAL EXAMPLE 2: MALAWI

Referral note from Health Surveillance Assistant: Sick Child

Child's First Name: _____ **Surname** _____ **Age:** __Years/__Months **Boy / G**

Caregiver's name: _____ **Relationship:** Mother / Father / Other: _____

Physical Address: _____**Village / TA**_____

	The child has (tick ☐ sign, circle ■ no sign):	**Reason for referral:**	**Treatment given:**
☐	■ Cough? If yes, for how long? __ days	☐ Cough for 21 days or more	
☐	■ Diarrhoea (loose stools)? _____days.	☐ Diarrhoea for 14 days or more	☐ Oral Rehydration Salts (ORS) solution for diarrhoea
☐	■ If diarrhoea, blood in stool?	☐ Blood in stool	
☐	■ Fever (reported or now)? _____ days.	☐ Fever for last 7 days	
☐	■ Convulsions?	☐ Convulsions	☐ LA for fever
☐	■ Difficulty drinking or feeding? If yes, ☐ not able to drink or feed anything?	☐ Not able to drink or feed anything	
☐	■ Vomiting? If yes, ☐ vomits everything?	☐ Vomits everything	
☐	■ Red eyes? If yes, for how long _____days. ☐ ■Difficulty in seeing? If Yes for how long __days	☐ Red eye for 4 days or more ☐ Red eye with visual problem	☐ Antibiotic eye ointment
☐	■ Chest indrawing?	☐ Chest Indrawing	☐ Oral antibiotic cotrimoxazole for chest indrawing or fast breathing
☐	**IF COUGH, breaths in 1 minute:** _____ ■ Fast breathing: ☐ Age 2 months up to 12 months: 50 bpm or more ☐ Age 12 months up to 5 years: 40 bpm or more		
☐	■ Very sleepy or unconscious?	☐ Very sleepy or unconscious	
☐	■ Palmar pallor	☐ Palmar pallor	
	For child 6 months up to 5 years, MUAC Tape colour: _____	☐ Red on MUAC Tape	
☐	■ Swelling of both feet?	☐ Swelling of both feet	

Any OTHER PROBLEM or reason referred: _____

Referred to (name of health facility): _____

Referred by (name of HSA):_____ Date: _____ Time: _____

✂ ----------**Cut Here**----------

FEEDBACK FROM HEALTH FACILITY (Please give feedback)

Date : ……

Child's identified problem(s) : ……

…….. ……

Treatments given and actions taken : ……

. ……

Advice given and to be followed : ……

…….. ……

…….. ……

Name of attending clinician : ……

Signature : ……

Name of Health Facility :……..

COMPETENCY ASSESSMENT: COMPETENCY ASSESSMENT TOOL

Developed by:	Save the Children	**Developed in:**	Myanmar
Adapted in:	Projects in: Malawi, South Sudan, Mozambique, Bangladesh		
Purpose:	To assess the core competencies of the CHW, post training. Trainees who do not meet 8 – 10 of the core competencies assessed in this tool should receive additional training prior to deployment.		
Completed by:	Trainer; Supervisor	**Frequency:**	Post training; quarterly/bi-annually after deployment
Submitted to:	District Manager	**Frequency:**	Quarterly/bi-annually
Tool(s) linked to:	Directly: *CHW Competencies*, *Supervision Checklist for CHWs* Supported by: *Case Scenarios*, *Case Management Job Aid*		

Overview: Based on the *CHW Competencies* list, the *Competency Assessment* Tool (CAT) is the backbone of competency-based training. The CAT must be completed post-training for each trainee to assess these core competencies before they can be deployed to the field. In addition, programs may administer the CAT periodically, e.g. during refresher trainings. CHWs who cannot reliably demonstrate core competencies should not be deployed in the field, and programs should plan additional coaching and/or extra support for these trainees.

The CAT has three sections. The first section entitled "Part. 1 General Case Management Assessment" is for competencies required to correctly classify conditions routinely encountered by the CHW. This section of the assessment can be done by observing clinical cases or by administering case scenarios either verbally (link) or by playing video cases. The table in Part 1 provides space for trainers to assess at least five cases managed by the CHW. Trainers should ensure that a CHW is assessed on at least one case of severe disease and one case of pneumonia. For each case there are 11 competencies. The trainers mark Y, N or N/A for each competency. Based on the number of correct items per case (7 essential items for correct case management) the trainer scores the case (item C) as either correctly or incorrectly managed. At the end of the row, a total score for all of the cases assessed as (out of 5) correctly managed is entered.

Part 2. Respiratory Rate Assessment is for assessing CHW skill in counting respiratory rate and in correctly classifying the child according to age. The table provides space for assessing five cases. If the CHW gets both items correct (respiratory rate count and classification by age), the trainer scores Yes for RR assessment (item D). At the end of row, a total score for all of the cases (out of 5) correctly assessed is entered.

Part 3. "Overall Summary of Assessment and Recommendations" is for overall competency scoring and perhaps certification (if countries so choose – strongly recommended). The numbers in row C of Part 1 and the numbers in row D of Part II are totaled and entered in the box. We recommend the following decisions, but programs must develop local criteria: a score of 8-10 (of 10) is considered proficient to deploy; a score of 6-7 requires additional follow-up post-deployment; a score is 0-5 requires additional training prior to deployment and probably extensive follow-up and supervision, depending on re-assessment after further training.

Use of data: Determines which CHWs are certified, which require additional training, supervision, and follow-up.

Potential adaptations: (1) Based on the WHO sick child recording form (see *Case Management Job Aid*), Malawi's program adopted this tool for monthly mentoring sessions at the health facilities (link to mentoring checklist). Instead of disease condition, the assessment is done for an individual child. During monthly continuing education sessions the mentor administers this checklist while observing HSA case management. (2) Based on program strengths, weaknesses and CHW background, individual programs can revisit the scoring, certification and accordingly plan deployment strategies. (3) A CCM project in Guatemala postponed certification till several rounds of post-deployment supervision with systematic competency assessment.

COMPETENCY ASSESSMENT EXAMPLE

Competency Assessment

Trainee Name and ID#: _____ Training start date:_____ Training end date:_____

Trainee level (circle one): CHW CHW Supervisor Other_____ Assessor(s):_____

PART 1. GENERAL CASE MANAGEMENT ASSESSMENT

INSTRUCTIONS: Enter Yes, No or N/A (Not applicable) for each of the competencies for each of the cases managed by the CCM trainee; If possible, try to ensure that each trainee is assessed on a clinical case for Severe Disease and Pneumonia Cases		**Illness Classification Type**					**TOTAL CORRECT**	**COMMENTS/ OBSERVATIONS**
		#1	**#2**	**#3**	**#4**	**#5**		
		Severe Disease	***Pneumonia***	***Malaria***	***Diarrhea***			
	Circle type of assessment conducted for each case:	i. Clinical obs ii. Case scenario iii. Video case	i. Clinical obs ii. Case scenario iii. Video case	i. Clinical obs ii. Case scenario iii. Video case	i. Clinical obs ii. Case scenario iii. Video case	i. Clinical obs ii. Case scenario iii. Video case		
#	**COMPETENCIES**							
1	Ask child identification (name AND age AND sex AND first vs. re-visit)							
2	**Assess for general danger signs (all 4)**							
3	**Ask and look completely (all problems, including additional information for "IF YES" questions)**							
4	**Count respiratory rate within plus or minus 3 from standard**							
5	**Classify child's illness correctly**							
6	**Make correct referral decision**							
7a	**Give correct treatment as per CCM manual (full course and observe child take 1st dose)**							
7b	**Referral Facilitated (give referral slip, first dose as appropriate)**							
8	**Counsel (correct messages, including correct drug AND dose AND duration and when to return for follow-up)**							
9	Counsel (probe for questions AND request mother to repeat instructions)							
10	Complete register (all relevant boxes in the row)							
11	Make follow-up visit (can demonstrate content that would be included)							
A	**Total number of relevant items assessed (Count all Yes and No and exclude any NA)**							
B	**Total correct items**							
C	**Correct case management (at least items 2,3,4,5,6, 7 and 8 correct)**						**_____/ 5**	

PART 2. RESPIRATORY RATE ASSESSMENT

INSTRUCTIONS: Assess each trainee with 5 cases (actual or video) and write Yes or No for each case on items 1 and 2 below		**#1**	**#2**	**#3**	**#4**	**#5**	**TOTAL CORRECT**	**COMMENTS/ OBSERVATIONS**
1	Count respiratory rate within plus or minus 3 from standard							
2	Classification of RR is correct for child's age group							
D	**Correct RR assessment (both 1 and 2 must be correct)**						**_____/ 5**	

PART 3. OVERALL SUMMARY OF ASSESSMENT AND RECOMMENDATIONS

1 **Overall Competency Score (**add numbers in Total Correct column for rows C and D to obtain score out of 10**)** **_____/10**

2 **CCM Competency Score Classification (Circle one):**

8-10: Competency Met
6-7: Requires some additional follow-up
0-5: Requires extensive follow-up and supervision

COMPETENCY ASSESSMENT: CASE SCENARIOS

Developed by:	Save the Children	**Developed in:**	Nicaragua, Uganda
Adapted in:	Myanmar		
Purpose:	To introduce case management skills during training, to reinforce them during supervision; to measure them during monitoring		
Completed by:	Trainer or supervisor	**Frequency:**	As needed
Submitted to:	Depending on use, results submitted to certifier (if used for certification during training) or to supervisor's supervisor (if used for monitoring)	**Frequency:**	Once (for certification); on-going (for monitoring)
Tool(s) linked to:	Directly to: *CHW Competencies*, *Supervision Checklist for CHW*, *Competency Assessment* Supported by: *Case Management Job Aid*		

Overview: Central to the success of a CCM strategy (both for saving lives and for advocacy to skeptics) is showing that cases are managed according to protocol. Direct observation followed by clinical verification, the "gold standard," is costly and impractical in community settings where sick children, especially those severely ill, are rarely present. *Case scenarios* offer a feasible alternative. A library of scenarios of various ages and syndromes can be cycled to anticipate seasonal disease trends. Scenarios have different formats, but the steps will measure and reinforce core competencies (assessing, classifying, treating, etc.).

The Nicaraguan library of seven scenarios, mimics real encounters step-by-step. For example, "Pneumonia and Fever in a 6-Month Old in a Non-malaria Area" has 19 steps, starting with "Maria's mother brings her to see you for a cough. *What do you do?"* The assessor marks pass/fail on the scenario for each step. If the answer is incorrect, the assessor says, *"Very good. And suppose…"*, supplying the correct information and moving to the next step. Assessors request the CHW to act as if she is caring for a real child in her community. The CHW is free to use (or not use if that is their habit) their job aids (i.e. *Case Management Job Aid*) during the scenario. Non-use of a job aid, even if the case is managed correctly, should be discouraged when providing feedback afterwards.

The Ugandan library of eight scenarios is a leaner approach. Each scenario consists of 7-10 bullets that specify the correct result for the common case management steps: identifying information, asking, looking, classifying, treating, giving first dose now, counseling, referring – if indicated, and recording.

Correct implementation of any case scenario requires training, of course, especially to allow flexibility when steps are undertaken slightly out of order (which is acceptable). Assessors must be experts in case management.

Programs will have to adapt the scenarios (syndromes, treatments) to their epidemiology, targeted classifications, treatments and age-groups. The Ugandan library is easier to adapt than the Nicaraguan because the latter is keyed to the specific steps of its *Case Management Job Aid*. The former is more generic. Programs will also have to specify criteria for a "pass" for each step and overall (refer to *Competency Assessment* for scoring suggestions).

Use of data: The results immediately inform on-the-spot coaching and/or encouraging. The overall score (pass/fail) yields the indicator, Correct Case Management Knowledge. The aggregate of this indicator for all CHWs in a catchment area or program is an excellent summary measure of the quality of case management. A common target is 80% (of CHWs demonstrate case management according to protocol, defined as 90% or X/Y steps correctly performed during direct observation or administered scenario). Low scores for aggregated step-specific data (e.g., recording) or disease-specific data (e.g., rarely seen conditions) can inform refresher training.

Potential adaptations: Linking scenarios to video-taped cases could enhance interest and realism.

Other comments: Perhaps "peer-experts" could use scenarios to strengthen less skillful peer's case management.

CASE SCENARIO EXAMPLES

Refer to set of case scenarios provided as separate attachments

Pneumonia and Fever in a 6 Month Old in a Non-Malaria Area (draft February 2009)					
Say: "Hello. Our CCM Program wants to help you achieve and maintain your skills. One way to do that is to discuss cases that you might see. Can we do that? What I will do is to describe a child, giving you information step-by-step. Let's try." **Instructions:** Read the steps, scoring each one Pass or Fail. If the worker gives the correct response, say **"Very good,"** and proceed. If the worker did not give the correct response, say, **Very good. And suppose…"** and proceed to the next step. Note that the worker may not always follow the exact order of the responses. If so, score opposite the row that matches the response.				***Not part of the questionnaire; Show which CHW competency they link to***	
#	**Step**	**Essential Correct Answer**	**Score**	**Skill**	**#**
1	Maria's mother brings her to see you for a cough. **What do you do?**	Ask Maria's age, full name, and whether this is her first visit or a revisit.		Identification	1
2	You learn that Maria Gomez is 6 months old and that this is her second visit for this illness episode **What would you do now?**	Check for all four general danger signs: (1) Vomits everything, (2) Lethargic, (3) Convulsions, (4) Won't feed.		Assess general danger signs (all)	2
3	You checked for general danger signs, and there were none. **What would you do now?**	Ask if the child has cough or difficulty breathing.		Assess consecutively, completely	3
4	You asked about cough or difficult breathing, and the mother said, "Yes." **What would you do now?**	(1) Ask the mother to raise the shirt to look for chest in-drawing and (2) Listen for stridor		Assess consecutively, completely	3
5	You observed for chest in-drawing and stridor, and there were none. **What would you do now?**	Count the respirations.		Count RR	4
6	You counted the respirations and found the rate to be 56. **What would you do now?**	Recount the respirations.		Count RR	4
7	You counted the respirations again and found the rate to be 58. **What would you do now?**	Classify the illness as pneumonia		Classify	5
8	You classified the illness as pneumonia. **What would you do now?**	Ask the mother if the child has diarrhea.		Assess consecutively, completely	3
9	You asked if the child has diarrhea, and she did not. **What would you do now?**	Ask the mother if the child has fever.		Assess consecutively, completely	3
10	You asked if the child has fever, and the mother thought so, but did not know. **What would you do now?**	Measure the temperature with a thermometer.		Assess consecutively, completely	3
11	You measured the temperature with a thermometer, and found it to be 39 degrees. **What would you do now?**	Classify the illness as pneumonia AND fever.		Classify	5
12	You classified the illness as pneumonia AND fever. **What would you do now?**	Explain the treatment using the appropriate counseling cards.		Counsel (card, messages, drug, dose, duration)	8
13	You counsel the mother. **What would you do now?**	Give the first dose of Amoxicillin now (shows correct dose for age)		Treat (give first dose)	6
14	You give the first dose of Amoxicillin. **What would you do now?**	Give the mother the medicines and the mother reminder cards and explain the treatment using the reminder cards.		Counsel (reminder card)	7
15	You give the mother the reminder cards and explain them. **What would you do now?**	(1) Ask her if she has questions; (2) Ask her to repeat the instructions.		Counsel (question, repeat, follow-up)	8
16	She has no questions and understands the instructions. **Now what would you do?**	Arrange for a follow-up visit in two days.		Counsel (follow-up)	8
17	You arranged for a follow-up visit in two days. **Can you now show me how you would complete the Patient Register for Maria?**	All relevant boxes completed.		Register	11
18	Next day you make a home visit. **What would you do?**	(1) See if the child is better, the same, or worse. (2) Check for compliance with recommendations.		Home Visit	12
19	The child is better. The family is giving the medicine correctly. **Can you now show me how you would complete the Patient Register for Sarah?**	All relevant boxes completed.		Register	13

EQUIPPING: CHW KIT

Developed by:	Save the Children	**Developed in:**	Headquarters
Adapted in:	Many programs and projects have informed this list.		
Purpose:	The CCM technical content (diseases treated, drugs required, literacy level, budget envelope) directly informs the CHW Kit. The Kit directly informs required competencies and procurement.		
Completed by:	Planners	**Frequency:**	Once (revise as needed)
Submitted to:	Procurement, Curriculum Designer	**Frequency:**	At program start
Tool(s) linked to:	Directly: *CHW Competencies*, *Case Management Job Aid*, *CHW Training Manuals*		

Overview: Kits for CHWs implementing CCM vary widely in size and cost, directly according to budget and indirectly according to CHW salary and literacy status. The menu is divided into sections for (1) Identification, (2) Mobility, (3) Case Management, (4) Documentation, and (5) Newborn. Identification options range from name tag to sign. Mobility options range from torch to bicycle. Because many sick infants present in the evening due to diurnal fever and caregiver availability patterns, a torch – perhaps wind-up – is advisable. Likewise are protection against rain and a bag to carry essential items on home visit. Bicycles are highly motivating but are costly to purchase and maintain. Case management sections are: assessment and classification, treatment, counseling, and referral. Some well financed programs with well schooled CHWs may opt for a handbook for CHWs (see *CHW Training Manuals*), but all CHWs need a Treatment Guideline or *Case Management Job Aid* (e.g. WHO Sick Child Recording Form) – the central job aid which underpins training, competencies, and quality assurance. CCM programs treating pneumonia need a timepiece to count respiratory rate. Hand-washing with soap before assessing a child models good behavior and is an incentive, but is costly at scale. All programs need a drug box and drugs. The box should be ventilated, securable from children and animals, and not made of metal – which can become overheated in the tropics. Communities can contribute materials and labor, making the box according to a standard template. Experience shows that CHWs who can provide simple wound care have added credibility. Referrals with an accompanying identifier that permits "jumping the queue" may be more successful. Documentation includes the forms and writing tools. Programs requiring caregiver "signature" sometimes use an ink pad for thumb print. Some very busy cadres request calculators, but we know no program which supplies these. CHWs often provide some newborn care, including recognizing, initiating treatment, referring, and sometimes completing treatment for possible severe bacterial infection. The items in *CHW Kit* list will change with experience.

Use of data: The availability of some of these essential items (especially life-saving drugs and assessment tools) is regularly measured on supervision.

Potential adaptations: Discussed in the overview.

Other comments: Kits are costly. Programs should supply essential case management tools, including recording. Others (torch, more elaborate identification items, and bicycle) could be awarded for sustained, good quality service, ideally on a transparent schedule.

CHW KIT EXAMPLE

- Identification
  - Name tag/ID card
  - Sign at residence
  - T-shirt, shawl, coat – according to culture and environment
  - Cap
- Mobility
  - Torch
  - Hat or plastic head-cover
  - Raincoat
  - Umbrella
  - Gum boots
  - Shoulder bag or backpack with small drug box
  - Bicycle
- Assessment and Classification
  - CCM Handbook
  - Treatment guideline or flowchart
  - Watch, clock, or ARI timer
  - Soap
  - Thermometer
  - Rapid diagnostic tests
  - Mid-upper arm circumference (MUAC) strips
- Treatment
  - Drug box or cabinet suitable for drug storage (well cross-ventilated, preferably non-metal)
  - Drugs (vary in type, formulation and amount by country)
  - Envelopes for drugs
  - Mixing container (1 liter)
  - Spoons to stir ORS and crush tablets
  - Materials for wound care (scissors, forceps, gauze, cotton)
- Counseling
  - Counseling cards (flip, or looped set)
  - Mother reminder materials
- Referring
  - Referral forms
  - Identifying tool (scarf, badge) facilitating urgent care
- Documenting
  - Register with register forms
  - Encounter forms (check-lists to assess, classify, treat, counsel)
  - Drug control forms (inventory, requisition)
  - Accordion file to organize forms
  - Pen, pencil, eraser
  - Ink pad
  - Stapler
  - Calculator
- Newborn
  - Newborn weighing device or “foot size” approximation tool
  - Newborn hats
  - Syringe, needle, spirit, etc. if treating newborn sepsis with injectable antibiotic
  - Drugs for sepsis, conjunctivitis, pustulosis

SUPERVISOR COMPETENCIES

Developed by:	Save the Children	**Developed in:**	Myanmar
Adapted in:	Projects in: Malawi, South Sudan, Mozambique, Bangladesh National Programs in: Uganda		
Purpose:	To define measurable essential proficiencies required for CHW supervisors.		
Completed by:	N/A	**Frequency:**	N/A
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *CHW Competencies*, *Supervision Checklist for CHW*, *Supervision Checklist for Supervisors*		
Overview: Supervision is essential for program support and maintaining service quality. However, in most CCM programs, supervisors receive minimal training in supervisory functions, and they themselves are rarely supervised. At the planning stage, all programs should identify the skills required to support and supervise the CHWs, develop appropriate training materials, and identify the cadre most appropriate for this assignment. The Save the Children *Supervisor Competencies* list includes all *CHW competencies* and additional competencies focused on supervision. The list is categorized into (1) planning supervision; (2) conducting on-site supervision; (3) establishing monthly health facility meetings; and (4) completing and submitting monthly reports. The assessment of CHW case management skills can be done during the on-site supervision or during monthly health facility meetings.			
Use of data: N/A			
Potential adaptations: The HSA supervisors in Malawi are senior HSAs whose case management skills are not superior to those of their colleagues. Therefore, the *Supervisor Competencies* list has been redefined, and related tasks have been assigned to two cadres – HSA supervisor and HSA mentor (link for Malawi core competencies list). The case management assessment competency has been delegated to the HSA mentor, who has a clinical background. Uganda's competencies for supervisors include non-technical ("be on time") and attitudinal ("point out errors in a friendly way") aspects.			
Other comments:			

LIST OF SUPERVISOR COMPETENCIES

Supervisor Competencies	
1	Plan monthly supervision schedule that reaches each CHW at least once per month for on-site supervision
2	Be able to conduct monthly on-site support supervision (supervisory skills)
3	Encourage CHW to identify any problems and frustrations and share any updates
4	Problem solve, together with CHWs, if appropriate
5	Observe case management as possible to identify strengths and weaknesses, provide feedback
6	Administer one or more case scenarios in proper sequence (compared to last visit)
7	Provide performance feedback in a constructive way (identify/promote strengths, weaknesses, etc)
8	Provide onsite refresher training as appropriate to address any problems
9	Provide or plan for support to strengthen any identified weaknesses
10	Complete CHW supervisory check-list
11	Establish a monthly meeting at the health facility for all CHWs to attend each month
12	Review register and extract key summary data and record on monthly summary sheet
13	Forecast and supply drugs and supplies for CHWs in his/her catchment according to need/consumption
14	Assess case management skills every second month according to MOH guidance
15	Aggregate CHWs' activities and supervisory visits on the relevant monthly summary form
16	All CHW core competencies

SUPERVISOR TRAINING PACKAGE: SUPERVISOR TRAINING MANUAL

Developed by:	Save the Children	**Developed in:**	Uganda
Adapted in:	None to date		
Purpose:	This guide supports the competency-based training of the supervisors of CHWs.		
Completed by:	N/A	**Frequency:**	
Submitted to:	N/A	**Frequency:**	
Tool(s) linked to:	Directly: *Supervisor Competencies*, *CHW Competencies*, *Treatment Register*, *Stock Records, CHW Monthly Report, Monthly Summary*, *Supervision Checklist for CHW* Supported by: *Case Scenarios*, *Supervision Checklist for Supervisor*		

Overview: This 80+ page guide aims to teach the following supervisory skills: (1) review CHW *Treatment Registers* for completeness and accuracy; (2) acknowledge what was done well; (3) replenish medicine and stocks; (4) complete *Supervision Checklist for CHW*; (4) observe CHW operating environment, especially medicine storage; (5) observe the CHW providing CCM or use a *Case Scenario*; (6) give direct verbal feedback to the CHW; (7) in a friendly way, point out errors and agree on areas for improvement; (8) complete the supervisor's summary form (can be part of *Monthly Summary*); (9) liaise with the caregivers and local leaders; (10) report on progress by individual CHWs; (11) identify constraints, challenges and solutions; (12) conduct group meetings introducing new information, ascertaining knowledge gaps and refreshing one or two competencies, and agreeing on action points for follow up.

This 3-day training has four main parts: introduction (1-3), community-based supervision (4-19), group meetings (20-21), and test and wrap-up (22-23). The course devotes far more time to community-based supervision than group meetings because there are many more steps, many of which are applicable to group meetings.

The format for each module includes: objectives, time, method, preparation, and steps with a "remember" box of main points at the end. Adult learning methods are used throughout, including: brain-storming, short exercises, demonstrations, role-plays, discussions, and practice. The guide occasionally refers to video-segments. The accompanying video-script can serve as the basis for a role-play or, in time, can be developed into a training video – according to resources and interest.

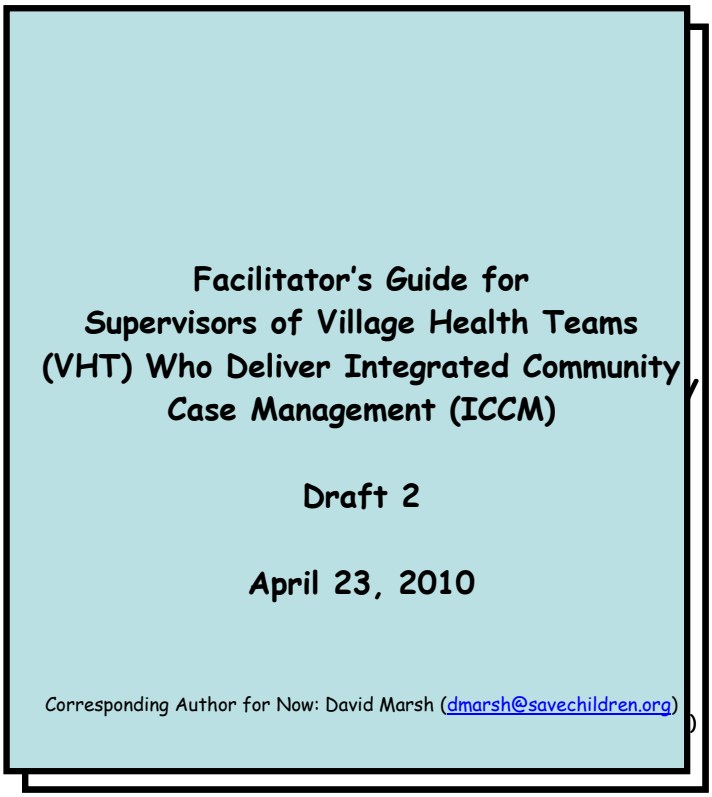
Use of data: The *Supervisor Training Manual* is not structured to produce data. However, course evaluations, competency-based trainee evaluations, and input from facilitators and trainees will incrementally strengthen the guide.

Potential adaptations: This must be adapted to local protocols, especially local supervision checklists and summary forms. It is likely that the more common supervision strategies will be the occasional one-on-one community-based visit and group facility-based meetings.

Other comments:

SUPERVISOR TRAINING MANUAL EXAMPLE

Refer to full manual provided as a separate attachment



SUPERVISOR TRAINING PACKAGE: SUPERVISION CHECKLIST FOR SUPERVISOR

Developed by:		Save the Children	**Developed in:**	Nicaragua
Adapted in:		Projects in: Malawi, Mozambique		
Purpose:		To introduce supervision skills during the training of supervisors for CHWs, to reinforce skills during supervision of the supervisors		
Completed by:		Trainer or supervisor of supervisors	**Frequency:**	As needed
Submitted to:		Depending on use, results submitted to certifier (if used for certification during training) or local program manager (if used for monitoring)	**Frequency:**	Once (for certification); annually (for monitoring)
Tool(s) linked to:		Directly to: *Supervisor Competencies*, *Supervisor Training Manual* Supported by: *Supervisor Checklist Job Aid*, *Consistent Case Management Job Aid*, *Case Scenarios*		
Indicators Served	**Mortality**	None		
	Use	None		
	Access	Human resource strategy		
	Quality	Supervision strategy, Routine supervision coverage, Clinical supervision coverage, CCM supervisor training, CHW to supervisor ratio		
	Demand	None		
	Environment	None		

Overview: The *Supervision Checklist for Supervisor* is designed to assess the core competencies of the supervisor both during training and after deployment – both through direct observation. Most programs lack strong supervision, and supervising the supervisors is not even considered. Periodic, systematic "checking the checkers" (as infrequently as perhaps once a year, unannounced) might result in stronger supervision of CHWs delivering CCM and thus a stronger program.

Within the tool, the column furthest to the left names topics, and the adjacent rows list the topics' components, each linked to specified *Supervisor Competencies*. For each component the supervisor of the supervisor marks Yes, No or Not Applicable (NA) and may record comments. Programs must specify competencies and criteria for "pass." These latter criteria should be included on the checklist. The *Supervisor Training Manual* introduces the checklist during supervisor training. Trainees use it to "score" one another, and assessors use it to inform certification of supervisors demonstrating core competencies.

Use of data: Trainers (and supervisors of supervisors) use the data to provide direct feedback to trainees (and deployed supervisors). The current indicator list does not include an indicator to track the quality of supervision because it is so rarely measured. Nonetheless, programs that employ the *Supervision Checklist for Supervisor* should definitely aggregate, analyze, interpret and respond to the experience. The first three questions of this checklist can inform Supervision Coverage and Report Completion, but these are probably better measured through simpler means, such as a catchment area's line-listing of CHWs, specifying months (or quarters) of planned and actual supervision. This could be posted on the manager's wall and continually updated after every supervision visit.

Potential adaptations: Programs must first specify *Supervisor Competencies*. These will then inform the adaptation of the *Supervisor Training Manual*. The training will then inform the adaptation of the *Supervision Checklist for Supervisors*, essential for competency-based training and certification of supervisors.

Other comments: Supervisors require some job aids; several have been drafted (*Supervisor Checklist Job Aid* and *Consistent Case Management Job Aid*), but these have not yet been applied and further work in this area is encouraged.

SUPERVISION CHECKLIST FOR SUPERVISOR EXAMPLE

Supervision Checklist for Supervisor

draft (October 2008)

Supervisor: _____ Date: _____

Supervisee: _____

Supervisee's Facility: _____

Community: _____

CHW: _____

Topic	#	Item	Number			Comment	Not part of form. They indicate which competency (see tab) is measured by which question.
Planning	1	How many CHWs do you supervise?					2
	2	Last month, how many CHWs did you supervise?					
			Yes	No	N/A	Comment	
	3	This month do you have a plan to supervise each CHW? May I see it?					1
		Did the supervisor...					
Supportive Supervision	4	Encourage CHW to identify any problems and frustrations?					3
	5	If applicable, problem solve with CHW?					4
	6	Review register?					12
	7	If applicable, swap registers (i.e.,. If using a double-register system)?					
	8	Cross-check drug inventory to register?					12
	9	If applicable, re-supply with drugs?					13
	10	If applicable, re-supply with supplies (forms, reminder cards, etc.)?					13
	11	If applicable, observe case management?					5
	12	If applicable, administer one or more case scenarios in proper sequence (compared to last visit)?					6
	13	If applicable (and feasible), observe home visit?					
	14	Liaise with community leadership?					
	15	Confirm that counseling cards and reminder cards were current?					
	16	Provide performance feedback in a constructive way?					7
	17	If applicable, provide or plan for support to strengthen any identified weaknesses?					8, 9
	18	Plan for next supervision visit?					2
Record Keeping	19	Complete supervisory check-list?					10
	20	Aggregate CHWs' activities on the relevant form last month?					15
Summary	21	Is Supervisor meeting standards?					
	22	If "No," write what you did and what else needs to be done.					
	23	Other observations:					

COMMUNICATION MATERIAL: FLIPCHART

Developed by:	Save the Children	**Developed in:**	South Sudan
Adapted in:	None		
Purpose:	1) To facilitate interpersonal communication between health facility staff and caregivers for treating the child 2) To provide caregivers with additional information on practicing healthy behaviors, recognizing danger signs and prompt care seeking		
Completed by:	Used by health facility staff	**Frequency:**	Ongoing
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly: *CHW Kit*, *CHW Training Manuals, Mother Reminder Cards* Supported by: *Formative Research*		

Overview: Effective CCM implementation requires communication materials to help deliver messages to caregivers about what signs of illness are, where to seek care, and when. This flipchart was designed to be used by health facility staff or health educators during group or individual health education sessions to support behavior change communication (BCC) and/or interpersonal communication (IPC). Each card is printed in color, laminated and often spirally bound or linked with a circular key-ring. Each card has messages on the back for the health worker and corresponding pictorial representations that the caregiver can see while the health worker is carrying out the health session.

The content and messages of the flipchart are illustrated by 11 corresponding pictorials on a range of topics including: (1) Immunizations (2) Vitamin A supplementation (3) General danger signs (4) Caring for the child with malaria combined with prevention and treatment (5) Caring for a child with pneumonia combined with treatment (6) Caring for a child with diarrhoea combined prevention and treatment (7) Hygiene promotion (8) Exclusive breastfeeding. These cards are tools to help health staff explain treatment and home care to the caregiver at the health facility. They also remind caregivers that when their child is sick, they can go the nearest CHW for care closer to the home.

Use of data: N/A

Potential adaptations: For diseases, drugs, drug formulations, and culturally relevant and clear pictures.

Other comments: This tool is still under draft and review. A number of the individual graphics can be adapted to other tools for posters or *Mother Reminder Cards*.

COMMUNICATION MATERIALS: FLIP CHART EXAMPLE FROM SOUTH SUDAN

Standardized Messages

PNEUMONIA

. Sometimes, children with a cough have fast and difficulty breathing and can get very sick.

. If your child has a cough and fast or difficult breathing, take him/her to the nearest CBD or CHW in your community right away.

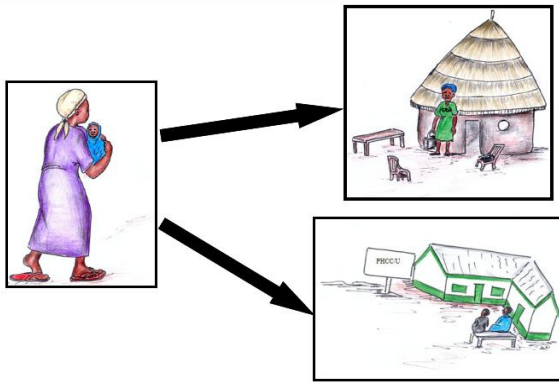
17

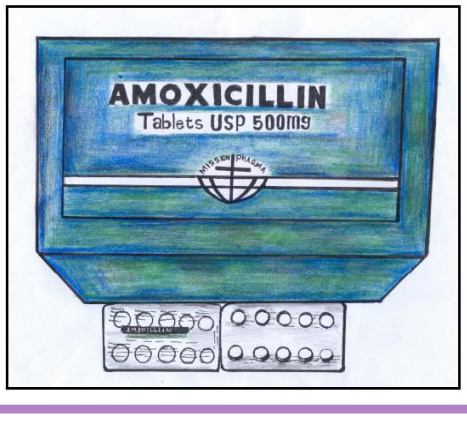
. Make sure your child takes ALL of the medicine on time, as instructed by the health provider.

. Continue to breastfeed your child and give extra fluids during the sickness to give your child strength.

. Return to the health provider if your child is not getting better.

Accompanying Images





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ROUTINE INTERNAL PROCESS EVALUATION (RIPE)

Developed by:	Save the Children	**Developed in:**	Headquarters
Tested in:	Projects in: Mozambique		
Purpose:	To guide implementation of CCM projects or programs.		
Completed by:	Typically internal or external providers of technical assistance, with key informants for programs and policy (Ministry of Health, WHO, UNICEF)	**Frequency:**	Every one to two years
Submitted to:	Stakeholders	**Frequency:**	Every one to two years
Tool(s) linked to:	Directly: *CCM Global Indicators*, *CCM Benchmarks Matrix* Supported by: *CHW Competencies*, *CHW Competency Assessment*, *CHW Kit*, *Treatment Register*, *Job Aids*, *Supervision Checklist for CHW*, *Communication Material*		

Overview: The Routine Internal Process Evaluation (RIPE) has two questionnaires for a systematic largely qualitative program review. Form A is organized into nine domains: a general description of the CCM program, plus each of the eight CCM Benchmark components: policy and planning, costing and financing, human resources, supply chain management, communication and social mobilization, supervision and quality assurance, and monitoring and evaluation and health information systems. The 20-page landscape spreadsheet has 145 questions that inform all CCM global indicators (so indicated within the questionnaire) and much more. Many questions arose from Save the Children's "CCM Best Practices" working paper of accumulated experience. Each question has space for the answer, an assessment, and a response – if any mid-course program correction seems advisable. Experience has shown that the interviews and the suggested review of 18 documents and a photograph requires about 10-12 hours over two to three days. Preparatory work is required to obtain the documents and the photograph of the CCM worker's medicines and supplies.

A complementary tool (Form B) is an adaptation of the "Intervention Assessment" table from University Research Corporation[*] that characterizes if and how a given CHW cadre delivers a host of interventions (counsel, provide, refer, not done, not applicable). We have found that this is an efficient way to summarize much programmatic complexity. It is important to remember the other responsibilities of CHWs who are designated to deliver CCM.

Use of data: The interviewing process is capacity building for programmers. The findings are of immediate use to program implementers. More experience is needed, but the most profitable use may be in a work-shop setting where stakeholders review, prioritize, and respond to the main findings.

Potential adaptations: Clearly, the user need not ask every question. On the other hand, even 145 questions is not the universe of potentially useful lines of inquiry.

Other comments: The questions for the qualitative global indicators may be the first attempt to systematically gather them. This is the newest tool in the toolkit. It needs testing and refinement. Feedback is welcome.

[*] University Research Co. and USAID. ***Assessing and Improving Programs Extending Health Services to Communities: The Community Health Worker Program Assessment and Improvement Matrix (CHW AIM), DRAFT FOR BETA TESTING.*** April 2010.

ROUTINE IMPLEMENTATION PROCESS EVALUATION: EXCERPT OF FORM A AND FORM B

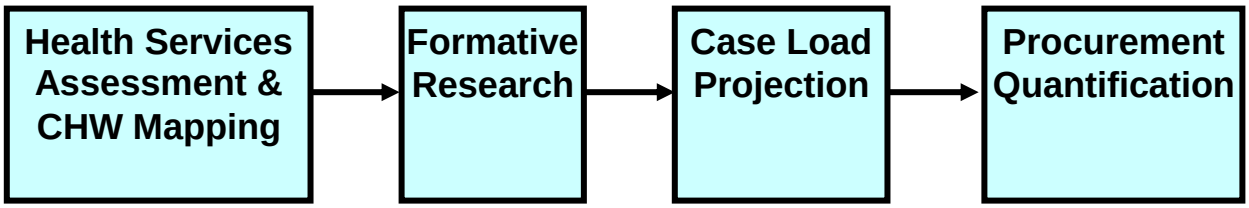
Form A: Data Collection Form for a Systematic Routine Implementation Process Evaluation

Topic	#	Question	Indicator	Answer	Assessment	Response
CCM Program Descrip-tion	1	What age group does the CCM strategy target?				
	2	What syndromes are classified in the CCM strategy? Specify age group for each syndrome.				
	3	Specify any syndromes that are classified and referred, but NOT treated, excluding severe disease and danger sign?				
	4	What treatments are given for each syndrome that is treated?				
	5	Which worker(s) actually perform(s) case management in the community?				
	6	What other interventions does this cadre deliver? Please complete an "Intervention by Activity Matrix" (Form B)				
	7	When (year) and where was the current CCM strategy first implemented in your country?				
	8	At what scale was the CCM strategy first implemented in your country? Specify total population targeted.				
	9	At what scale is the CCM strategy now implemented in your country? Specify total population targeted.				
	10	Which term best describes the current phase of the CCM strategy (testing, introduction, early replication, scale up, etc.)?				
	11	Has the strategy changed since first implemented in terms of syndromes classified or age groups targeted? If yes, specify.				

Form B: Intervention x Activity Matrix for Community Health Workers (after URC's CHW AIM, 2010)

Interventions	Cadre #1					Cadre #2					Comment
	Counsel	Provide	Refer	NA	Not Done	Counsel	Provide	Refer	NA	Not Done	
Maternal and Newborn Care: Antenatal Care											
Birth preparedness; ENC											
Maternal nutrition											
TT											
De-worming											
Malaria: ITN											
Malaria: IPTp											
Maternal and Newborn Care: Delivery											
Clean delivery											
AMTSL											
ENC											
DS											
NBR											
Abx for NB Sepsis											
LBW care											
Abx for Maternal Sepsis											
Refer for pre-eclampsia											
Stabilize/refer hemorrhage											

SECTION 3: PLANNING TOOLS



HEALTH SERVICES ASSESSMENT AND CHW MAPPING

Developed by:		Save the Children	**Developed in:**	Myanmar
Adapted in:		Projects in: Malawi, Mozambique, South Sudan		
Purpose:		To assess the availability, accessibility and quality of case management at facility level and plan for community service delivery		
Completed by:		CCM Program Staff	**Frequency:**	Baseline and End line
Submitted to:		District Manager	**Frequency:**	Baseline and End line
Tool(s) linked to:		Directly: *Case Load Projection*, Supported by: *Donut Map (Myanmar example)*		
Indicators Served	**Use**	None		
	Access	CCM target areas defined, CCM CHW density, Target area coverage		
	Quality	CHW to supervisor ratio, Case management knowledge, Classification consistency, District monitoring		
	Demand	None		
	Environment	CCM in HMIS		

Overview: This is a planning tool to provide information to program managers and health facility staff – specifically information on availability, accessibility and quality of case management to the catchment area population; health facility capacity to support community-based services; and human resource requirements for providing CCM. The tool has two sections (Form 1 and 2). Form 1 assesses the availability of staff, services and supplies at health facility; catchment area population; existing coverage by CHWs, if any; supervision structure and frequency; case load; quality of services; and data maintained at the facility. Form 2 identifies and characterizes villages in the catchment area needing CCM and facilitates better planning for support and supervision. This form can be used by programs at different stages of development. In a new program, it can help define culturally and logistically feasible criteria for access to case management. In a country like Malawi, where CHWs already exist and a distance of 8 km or greater from the health facility defines the need for CCM, Form 2 can identify physical, seasonal, cultural and security barriers to case management.

Instructions: Form 1 is self-explanatory. In a new program where CHWs have not been recruited, skip sections D (CHW coverage) and E (Supervision). Section F (Q 29-33) inquires about health facility staff trained in IMCI and availability of case management during different times of the day on weekdays, weekends and holidays. Even if the staff is not trained in IMCI, question 30 should be answered. Section J assesses the staff capacity to apply standard case management for pneumonia. Inquiring directly about patient care can be sensitive and should be undertaken in a supportive, friendly way. Explain to the staff member that the assessment is for capacity development needs and will not reflect negatively on their performance. The Form 2 presented here has been adapted for Malawi, which already had CHWs deployed. Questions 1-6 are self explanatory. Q 7 (sub-sections a-e) asks for detailed information about villages located within 8 km of health facility to assess whether there are non-distance barriers which restrict the population's access to care. Section (a) concerns physical barriers (e.g., mountains, ravines, rivers/lakes) which require people to walk for more than 1 hour to reach the facility; (b) concerns seasonal barriers like flooding or snow and the annual duration in months; (c) concerns security barriers ; and (d) concerns cultural barriers (e.g., language, religion, ethnicity, caste).

Use of data: To identify facility staff who require additional training and supervision in case management; to develop or revise supervision strategy; to develop catchment area map (see *Donut Map (Myanmar example)*); to select villages for CCM; to demarcate and assign villages to CHWs.

Potential adaptations: Form 1 is not required for a new program, but could be adapted to assess if staff have the necessary skills to supervise. Also, for new programs, Q7 of Form 2 can be completed for all villages, irrespective of their distance from the facility. Using traveling time to a health facility could refine criteria to select CCM communities, assign CHWs, and revise supervision strategy.

HEALTH SERVICES ASSESSMENT TOOL EXAMPLE

Effective Access to Case Management for Sick Children in Lufwanyama District, Zambia
(draft May 17, 2010)

Date:	
Health Facility:	
Respondent(s):	
Interviewer:	

1. Does this facility have health staff trained in standard case management of fever, pneumonia & diarrhea in children under 5 years of age (MOH approved curriculum)? **Yes / No**

2. How many staff at this facility are trained to treat these conditions in children under 5 years? _____

3. Now I am going to ask you about the availability of case management services for children under 5 at this facility last week. Please tell me about the availability of these staff (or this person) trained to treat sick children during these times each day? **Enter the number of hours available for each 4 hour period.**

	8 AM – 12 noon	12 noon – 4 PM	4 PM – 8 PM	8 PM – 12 midnight
Monday				
Tuesday				
Wednesday				
Thursday				
Friday				
Saturday				
Sunday				

Now I'd like to ask you about your health facility's catchment area. This will take a bit of time. You might want to refer to a map or record.

a. First we will list all the communities.
b. Then we need estimates their total population (or number of households).
c. Then we need to know if a CHW is in that community.
d. Then we need to know if a TBA is in that community.
e. Then we need to know the distance (in kilometers) from each community to the health facility
f. Then, for communities 5 km or less from the facility we want to know if there were any permanent or temporary barriers during any of the last year that would have made the walk more than 1 hour, specifically
    i. Permanent physical barriers, like rivers
    ii. Temporary physical barriers, like flooding
    iii. Security barriers, like violence
    iv. Cultural barriers, like language

#	Community Name	What is the esti-mated Total Population or number of House-holds? (specify "HH" as needed)	Is there a trained CHW? (Y/N)	Is there a trained TBA? (Y/N)	How far is the com-unity from the health facility?	If the community is 5 km or LESS from the HF			
						Are there any permanent physical barriers (like mountains or rivers) to make it >1 hr to walk to the HF? (Y/N)	In the past year, were there any physical barriers (like flooding) that made the walk >1 hour to this HF for part of the year? If Yes, give # months. Otherwise "N"	In the past year, were there any security barriers (like gangs or sectarian strife) that discouraged care-seeking at this HF? If Yes, give # months. Otherwise "N"	In the past year, were there any cultural barriers (like language, religion, and ethnicity) that discouraged care-seeking at this HF? If Yes, give # months. Otherwise "N"
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

DONUT MAP EXAMPLE - MYANMAR

FORMATIVE RESEARCH

Developed by:	Save the Children	**Developed in:**	Myanmar
Adapted in:	Projects in: China		
Purpose:	To provide information to inform strategies for CC plan for community service delivery		
Completed by:	CCM Program Staff	**Frequency:**	Baseline and End line
Submitted to:	District Manager	**Frequency:**	Baseline and End line
Tool(s) linked to:	Directly: *Health Services Assessment with Community Mapping*, *Case Load Projection* Supported by: *Donut Map (Myanmar example)*		

Overview: This is set of two planning tools to provide information to program managers. The first tool is a Focus Group Discussion Guide that guides a small group interview to generate information on caregivers' knowledge of illness signs, perceptions of quality of care, and referral practices. It is meant to be administered to a small group of 6-12 mothers of children under five. The tool includes 68 questions that capture information on signs of illness and home care practices, knowledge of danger signs and care-seeking practices, satisfaction with existing health care services and referral. This information can help program planners to support community-based services; and human resource requirements for providing CCM. This form can be used by programs at different stages of development. In a new program, it can help define culturally and logistically feasible criteria for access to case management.

The second tool is an in-depth interview guide for CHWs. The tool assesses CHW demographic background, catchment area population, range of community-based services, training, supervision, record keeping and supply availability. There are also questions on case management knowledge. The tool can be applied to establish a baseline and repeated for monitoring.

Use of data: To understand community beliefs and practices; to inform development of CCM communication materials; to inform training materials for CHWs

Potential adaptations: Each form should be adapted for the particular context and stage of CCM programming

FORMATIVE RESEARCH TOOL: (1) FOCUS GROUP DISCUSSION GUIDE FOR MOTHERS

Focus Group Discussion Guide: 6-12 mothers of children <5 (draft Sep 21, 2008) **Formative Research: Community Case Management**			
Interviewer Name:			**Village:**
Date:			**Township:**
Time (start):			**Participants and Number:**
Time (end):			**Closest Health Facility:**
Thank you for sharing some of your valuable time to talk to us today. We are interested in learning about caring for children from your village who get sick. Is that OK? We would like to hear from everyone, so don't be "shy." Do you mind if we take notes? We are not writing down names, so your thoughts will be confidential.			
Theme	**#**	**Questions & Probes**	**Responses**
Identification	1	**Village name**	
	2	**Total population**	
	3	Total households	
	4	<5s	
	5	**Distance (time) from nearest health facility**	
	6	Frequency of outreach clinic	
	7	Content	
	8	**MOH health workers in the village?**	
	9	Who?	
	10	Responsibilities	
	11	Other sources of care: quacks	
	12	Other sources of care: drug shops	
Illness and Home Care	13	**What are the most common <5 illnesses in your village?**	
	14	What do you mean by "diarrhea"?	
	15	What do you mean by "pneumonia"?	
	16	What do you mean by "malaria"?	
	17	**What do you do at home for diarrhea?**	
	18	For fever?	
Danger Signs and Care-seeking	19	**How do you decide if a baby needs care outside the home?**	
	20	Any other signs?	
	21	Who decides?	
	22	What if husband is away in the field?	
	23	What if there is cash expenditure?	
	24	Where do you go?	
	25	How do you get there?	
	26	How do you know someone will be there?	
	27	What do you do if no one is there?	
	28	Do you expect to pay for care at government facilities? How much?	
Quality of Care	29	**What makes you happy or satisfied with outside care?**	
	30	Anything else?	
	31	If not already, mentioned, ask the following: Don't have to wait?	
	32	Effective?	
	33	Clean?	
	34	Private?	
	35	Free?	
	36	Other?	

Quality of Care (con'td)	37	What is the SINGLE most important factor of all these?	
	38	**Are the instructions received there easy to understand?**	
	39	Why or why not?	
	40	Did you ever leave that place a bit confused?	
	41	Can someone tell us an example of some instructions?	
	42	Were you able to follow the instructions?	
	43	Why or why not?	
	44	What makes it easier to follow instructions?	
Referral	45	**Sometimes health workers recommend referral to larger facilities. Did this ever happen?**	
	46	What was the reason?	
	47	Did the referring worker help with the referral? How?	
	48	Did the worker offer to accompany you and your child?	
	49	Did you accept the referral?	
	50	Why or why not?	
	51	What happened at the referral site?	
	52	How long did you wait before treatment was started?	
	53	What happened at discharge?	
	54	What instructions did you receive?	
	55	Were you able to follow the instructions?	
	56	Why or why not?	
	57	What makes it easier to follow instructions?	
ONE Case	58	**This can be to talk about, but did any children die in your village last year? What happened?**	
	59	How long was the baby sick?	
	60	When was care outside the home first sought?	
	61	Could anything be done differently next time?	
CCM	62	**We are considering training community health workers to treat sick children in villages that are more than an hour's paddle from a health center. What do you think of this idea?**	
	63	Who would be good health workers?	
	64	What advice do you have for us?	
	65	Would volunteers be willing to do this?	
	66	Would you be willing to pay for treatment?	
	67	Is there anyone would might NOT like this plan?	
Anything else?	68	**Is there anything else that you would like to tell us? About anything at all?**	
Thank you very much for sharing your experience. I think we have learned a lot!			

FORMATIVE RESEARCH TOOL: (2) IN-DEPTH INTERVIEW GUIDE FOR CHWS

Community Health Worker Assessment

Formative Research for Community Case Management

Thank you for sharing some of your valuable time to talk to us today. We are interested in learning about caring for sick children in your community. Is that OK? Do you mind if we take notes?

Theme	#	Question	Response
Identifying Information	1	District/Ward	
	2	Village	
	3	Interviewer	
	4	Date	
	5	Name of CHW/Community Worker	
	6	Age of the CHW	
	7	Educational level (please circle response)	1. illiterate 2. literate (no schooling) 3. Completed grade (write) _____
	8	When did you start working as a CHW (month & year)?	
	9	Are you attached to a specific health facility? (name)	
	10	Are you paid any monthly salary/stipend by the program?	
	11	Do you receive any fee/remuneration in cash or kind from the community?	
Catchment Area & Target Population	12	How many households are there in your village/community?	
	13	Are you responsible for a certain number of households?	
	14	What is the total population of these households?	
	15	How many U5 children are there in these families?	
	16	How many women 15-45 years of age are there in these families?	
	17	How much time does it take you to reach the farthest household in your service population?	
	18	Is any other CHW working in your community?	
	19	If yes, how do you divide your work? (please circle response)	1. Households 2. Working hours 3. Services
Service Provision	20	What are your main functions as a Community Health Worker? (please circle response)	a) Register households b) Conduct group health education sessions c) Assess, classify and refer cases of pneumonia d) Assess, classify and treat cases of pneumonia with antibiotics e) Identify and treat cases of uncomplicated malaria f) Follow- up patients on treatment to ensure compliance g) Refer sick children to the health facility h) Assess, classify and treat cases of diarrhea i) Weigh children j) Manage stock of essential drugs k) Organise, with the community, a transfer system for patients referred l) Maintain daily activity register m) Draft a report at the end of each month
	21	Is there a separate designated room/area in your residence for patient consultation?	
	22	Do you have a drug box?	
	23	How many days a week do you perform your duties as a CHW?	
	24	What are your daily working hours?	
	25	Do you see patients after ----- pm daily and on weekends?	
	26	Do you conduct regular home visits as part of your job?	
	27	Do you charge a fee for drugs provided to the patients?	
Training	28	Did you attend a training before starting work as a CHW? (month and year)	
	29	Where did the training take place? (please circle response)	1. District Health facility 2. Basic Health Facility 3. Community
	30	How many days did the training last?	
	31	How many CHWs participated in the training?	
	32	Was a test conducted before and after the training?	
	33	Did the training include practical sessions (interaction with patients)?	
	34	Do you have a guide/handbook to help you carry out your work?	
	35	Have you attended refresher trainings in the last 12 months?	Topics Number of Days

Supervision	36	Who is your supervisor?	1.Health facility staff (specify) _____ 2. Special project staff (specify) _____ 3. Any other (specify) _____
	37	When was his/her last visit?	
	38	What did he/she do during her last visit? (please circle response)	a) Checked your registers b) Discussed cases treated/referred by you c) Checked drug stocks d) Reviewed training materials with you e) Visited house of a sick/recovered child
	39	Did she/he use a checklist?	
	40	Is there a monthly meeting of CHWs at the health facility?	
	41	What happens in these meetings? (please circle response)	a) Review of CHW registers b) Review of cases treated/referred by CHWs c) Drug resupply d) Continued education sessions e) Submission of monthly reports
	42	Do you visit the health facility on regular basis for reasons related to your work?	
Register Review	43	Which of the following data are recorded in the activity register? (circle all)	1. name 2. age 3. first vs. re-visit 4. village 5. diagnosis 6. treatment
	44	How many sick children < 5 were seen?	last month _____ Last 12 month _____
	45	How many sick children < 5 had pneumonia?	last month _____ Last 12 month _____
	46	How many sick children < 5 had malaria?	last month _____ Last 12 month _____
	47	How many sick children < 5 had diarrhea?	last month _____ Last 12 month _____
	48	Pneumonia treatment ratio (observed/expected)	
	49	Sick child treatment rate, annualized	
Inventory	50	Which drug do you use for treating pneumonia?	
	51	Was there any stock-out of pneumonia drug last month?	
	52	Which drug do you use for treating childhood malaria?	
	53	Was there any stock-out of the childhood malaria drug last month?	
	54	Was there any stock-out of ORS last month?	
	55	What do you do if you have a stock-out?	
	56	Do you have patient management protocol?	
	57	Do you have a thermometer?	
	58	Do you have a container to mix ORS?	
	59	Do you have a weighing machine/MUAC strip?	
	60	Do you have a timer?	
	61	Do you have health education materials?	Please list:
Case Management:	**Say, "Now I'd like to ask you about caring for a sick baby. Suppose a 6-month old infant comes with cough and difficult breathing. What would you do?...Anything else?...Anything else?" (Tick each of the 3 that is mentioned. Do NOT prompt.)**		
	62	Unprompted: Check for danger signs?	
	63	Unprompted: Check for fast breathing?	
	64	Unprompted: Check for chest in-drawing?	
	65	**Say, "When you check the breathing rate, do you use a timer with a second hand? Can you show me?"**	
	66	**Say, "This sick baby actually had a respiratory rate of 55, but had NO chest in-drawing. How would you classify this case?**	
	67	**Say, "The baby, in fact, had pneumonia. How would you treat this case?**	
Other	68	Thank you so much! Is there anything else you would like to tell us? Do you have any questions?	
Thank you very much for sharing your experience. I think we have learned a lot!			

CASE LOAD PROJECTION

Developed by:		Save the Children	**Developed in:**	Uganda
Adapted in:				
Purpose:		To use official or modeled disease incidence to estimate coverage through service statistics (treatment ratios) and for planning CHW deployment.		
Completed by:		Program designers and planners	**Frequency:**	During design or planning
Submitted to:		Donor or planning team	**Frequency:**	Once
Tool(s) linked to:		Directly: *Procurement Quantification*, *Stock Records*, *Health Services Assessment and CHW Mapping*		
Indicators Served	**Use**	Treatment Ratio		
	Access	None		
	Quality	Case Load by site		
	Demand	None		
	Environment	None		

Overview: Treatment ratios use service statistics to estimate use (or coverage) of treatment by comparing actual treatments given to the projected incidence of disease. Ministries of Health use incidence estimates, based on historical and/or global experience, to inform planning. For example, in Uganda the predicted incidence of diarrhea and fever/malaria is 3 and 4 episodes/child/year (e/c/y), respectively. Recently, Rudan et al. (*Bull WHO*, May 2008) modeled the incidence of childhood pneumonia based on the prevalence of countries' risk factors. The incidences range from 0.2-0.5 e/c/y in high mortality countries. Government health information systems usually track treatments for common childhood diseases dispensed at their facilities. In settings (say, a district) where reporting is good and where the private sector is not robust, one can aggregate a year's treatment experience (substituting for missing data by averaging the existing or straddling data) and divide it by the projected level for the estimated number of children to derive disease-specific treatment ratio. To calculate treatment ratios, enter the <5 population and the expected incidences (yellow boxes), plus a year of data – to avoid error due to seasonal fluctuation in disease incidence. The example uses data from Uganda's Moroto District.

Planners can use e/c/y data to project average case loads for CHWs (thereby assessing if deployment patterns are reasonable) and to quantify need for drugs and related supplies. The *Case Load Projection* tool requires the user to enter: the number of children per CHW, the number of children in the CCM program, disease-specific incidence estimates, and estimated use of CCM services per disease (yellow boxes). Reasonable incidence estimates include those from projections (high), current use[†] (low), and a third – perhaps realistically in-between. Care-seeking for diarrhea should be lower than for fever/malaria or pneumonia since much can be treated at home. The table is repeated allowing the comparison of different ratios of children per CHW and care-seeking assumptions. The example provided continues using data from Uganda.

Use of data: Use pre-program treatment ratios to advocate for the CCM strategy, if necessary and/or to help prioritize districts for CCM. Use treatment ratios during the program to track changes in use. Use activity levels to inform the density of CHW deployment in a given context. Case loads, especially of non-salaried CHWs, should neither be so low as to risk skill loss, nor so high as to risk demotivation. A case load of five to 15 cases per month seems appropriate for many non-salaried CHWs. The ideal range is unknown and an area for study.

Potential adaptations: Adding other diseases (i.e., newborn sepsis, acute malnutrition)

Other comments: Remember that the ratio of children per CHW is an average. CHWs will be deployed at the community level where the variation in population means that the CHW activity levels may vary widely. For example, despite a target of 1000 total population (~200 children) per CHW, communities of 700 and 1400 will likely each have a single CHW, one with twice the activity level of the other. Also remember that the denominator represents children from CCM communities only – i.e., not necessarily from a whole district.

[†] Because this is the product of incidence x care-seeking, it only estimates incidence if care-seeking is 100%. It is a reasonable lower limit, however.

CASE LOAD PROJECTION EXAMPLE - UGANDA

Activity Levels

# children per CHW	200
# children in CCM program	33000

Predicted Activity Levels at Provider and Program Levels @ Different Usage Rates*

Scenario	Disease	Episodes/ child/ year	CCM Care-seeking (%)	Cases per Year		Cases per Month	
				Per CCM Worker	Per Program	Per CCM Worker	Per Program
MOH and literature projections	Diarrhea	3	0.4	240	39600	20	3300
	Malaria	4	0.5	400	66000	33	5500
	Pneumonia	0.3	0.5	30	4950	3	413
	Total	7.3		670	110550	56	9213
Current MOH OPD use (Moroto)	Diarrhea	0.11	0.4	9	1452	1	121
	Malaria	0.86	0.5	86	14190	7	1183
	Pneumonia	0.07	0.5	7	1155	1	96
	Total	1.04		102	16797	8	1400
Realistic	Diarrhea	0.3	0.4	24	3960	2	330
	Malaria	2	0.5	200	33000	17	2750
	Pneumonia	0.2	0.5	20	3300	2	275
	Total	2.5		244	40260	20	3355

# children per CHW	100
# children in CCM program	33000

Predicted Activity Levels at Provider and Program Levels @ Different Usage Rates*

Scenario	Disease	Episodes/ child/ year	CCM Care-seeking (%)	Cases per Year		Cases per Month	
				Per CCM Worker	Per Program	Per CCM Worker	Per Program
MOH and literature projections	Diarrhea	3	0.6	360	59400	30	4950
	Malaria	4	0.7	560	92400	47	7700
	Pneumonia	0.3	0.7	42	6930	4	578
	Total	7.3		962	158730	80	13228
Current MOH OPD use (Moroto)	Diarrhea	0.11	0.6	13	2178	1	182
	Malaria	0.86	0.7	120	19866	10	1656
	Pneumonia	0.07	0.7	10	1617	1	135
	Total	1.04		143	23661	12	1972
Realistic	Diarrhea	0.3	0.6	36	5940	3	495
	Malaria	2	0.7	280	46200	23	3850
	Pneumonia	0.2	0.7	28	4620	2	385
	Total	2.5		344	56760	29	4730

*These data are for Moroto District, Uganda. The first two scenarios use the data in "Rx Ratio" tab.

TREATMENT RATIOS EXAMPLE - UGANDA

Outpatient Childhood Diagnoses at MOH Facilities in Moroto District, Karamoja, Uganda (2007)

Month	Acute Diarrhea			Dysentery			Malaria			Pneumonia		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Jan	220	237	457	52	52	104	1621	1767	3388	114	163	277
Feb	218	255	473	84	48	132	1210	1227	2437	86	95	181
Mar	170	195	365	72	81	153	1369	1361	2730	164	88	252
Apr	195	139	334	63	59	122	1099	1130	2229	54	57	111
May	231	222	453	96	103	199	1429	1463	2892	217	173	390
Jun	255	301	556	111	98	209	1667	1685	3352	132	146	278
Jul	259	277	536	91	108	199	2281	2127	4408	111	153	264
Aug	275	296	571	90	95	185	3399	3706	7105	262	254	516
Sep	276	272	548	71	61	132	2757	2709	5466	288	337	625
Oct	269	261	530	63	63	126	2714	2609	5323	251	210	461
Nov	211	204	415	49	63	112	2031	1873	3904	123	102	225
Dec	180	182	362	35	52	87	1215	1193	2408	74	133	207
Total	2759	2841	5600	877	883	1760	22792	22850	45642	1876	1911	3787
Actual E/C/Y*			0.11			0.03			0.86			0.07
Expected E/C/Y**			3						4			0.3
Treatment Ratio (Actual/Expected)			4%						22%			24%

<5 population	53060

*Episodes per child per year based on 53,060 children under five in Moroto District (total population: 265,300).
**Based on MOH estimates (diarrhea, malaria) and upper end or Rudan projection (pneumonia).

Comment: Low levels of treatment exist for all three diseases for which we have forecasts. The low treatment ratios may be worst-case-scenarios because non-MOH statistics are not included, and MOH statistics are probably not complete. Curiously, the ratios for pneumonia and malaria are nearly identical - about one in four cases, which suggests a common cause, such as low access. In fact, these ratios are nearly identical to the experience to date for 2008. These treatment ratios are not consistent with the relatively reassuring reported care-seeking in Karamoja for fever (66%) or ARI needing assessment (79%) in the 2006 DHS. Lower care-seeking for diarrhea is not surprising since many cases should be treated at home. Dysentery is common, almost one third (31% [1760/5600]) the level of acute diarrhea. There was no evidence of sex preference in care-seeking at MOH facilities.

	Acute Diarrhe	Dysentery	Malaria	Pneumonia	Total
Male	2759	877	22792	1876	28304
Female	2841	883	22850	1911	28485

/000

	Acute Diarrhe	Dysentery	Malaria	Pneumonia	Total
Male	2.759	0.877	22.792	1.876	28.304
Female	2.841	0.883	22.85	1.911	28.485

PROCUREMENT QUANTIFICATION

Developed by:	JSI for Save the Children	**Developed in:**	Malawi
Adapted in:	Projects in: Mozambique; South Sudan		
Purpose:	To estimate the amount of CCM drugs required by program area		
Completed by:	CCM Planners	**Frequency:**	Once (and updated as needed)
Submitted to:	N/A	**Frequency:**	N/A
Tool(s) linked to:	Directly to: *Case Load Projection*, *Stock Records*, *CHW Kit*, *Health Services Assessment and CHW Mapping*		
Overview: This tool estimates the drug requirements for CCM programs. The tool includes a set of Excel spreadsheets in which the user specifies information on the size of the target population, the illness to be covered, the products used to treat the illnesses, and the estimated number of episodes of illness expected each year of the program. Based on these parameters, the tool calculates the estimated number required per year with the buffer stock that should be maintained, and outlines a rough procurement plan.			
Use of data: To inform drug orders for CCM programs; to estimate costs of CCM; to plan for stock management and drug storage.			
Potential adaptations: The illnesses, products, and dosing schedules and associated assumptions regarding the expected number of episodes of each illness in the program areas must be locally defined. Information from the *Case Load Projection*, *Health Services Assessment and CHW Mapping*, and other sources (such as national household surveys; HMIS, etc) should be used to used to inform the parameters used in the model.			
Other comments:			

PROCUREMENT QUANTIFICATION EXAMPLE – MALAWI

Refer to accompanying excel files for full details.

DOSING SCHEDULE FOR ACTs and ANTIBIOTICS
Source: Standard Treatment Guidelines

Country	*Illness*	*Age Group*	*Product*	Treatment Course	*Units per treatment course*
Malawi	Malaria	6 months - 3 years	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	1 6x1 packet (1 tablet 2x per day for 3 days)	1
	Malaria	3 - 5 years	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	1 6x2 packet (2 tablets 2x per day for 3 days)	1
	Pneumonia	2 months to 12 months	Cotrimoxazole (400/80mg) scored tablets	1/2 tablet 2x per day for 5 days	5
	Pneumonia	12 months to 5 years	Cotrimoxazole (400/80mg) scored tablets	1 tablet 2x per day for 5 days	10
	Diarrhea	2 months to 5 years	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	10-20 ml/kg/hour until hydration normal	2
	Diarrhea	2 months to 5 years	Zinc Sulphate 20mg tablets, dispersible	1 tablet 1x per day for 10 days	10

Assumptions:

- 648 HSAs will be trained as part of SC's CCM program; 300 will be trained and be provided services in the first year
- An average of 80 children under age five will be seen per month per APE throughout the course of SC's CCM program
- 50% of children brought to APEs will show signs of fever and will be treated for malaria
  - Of these 50%, the distribution between the two age groups will be:
    6 months - 3 years = 55% (30 months/54 months)
    3 years – 5 years = 45% (24 months/54 months)
- 30% of children under 5 brought to APEs have rapid breathing and will receive antibiotics for pneumonia
  - Of these 30%, the distribution between the two age groups will be:
    2 months - 12 months = 18% (10 months/58 months)
    1 year – 5 years = 82% (48 months/58 months)
- 50% of children under 5 brought to APEs will have diarrhea and will be treated with 2 ORS sachets and 10 Zinc Sulphate 20mg, dispersible tablets
- Forecasts includ 25% buffer stock the first year and 15% the second year, as forecasting data improves and the CCM pipeline is filled

PROCUREMENT PLAN

Planned Shipment Arrival Date	Product	# of packets or bottles
December 31, 2009	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	64,650
	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	51,750
	Cotrimoxazole (400/80mg) scored tablets	500
	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	
	Zinc Sulphate 20mg, dispersible tablets	
March 31, 2010	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	64,650
	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	51,750
	Cotrimoxazole (400/80mg) scored tablets	430
	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	
	Zinc Sulphate 20mg, dispersible tablets	
October 31, 2010	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	104,250
	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	83,400
	Cotrimoxazole (400/80mg) scored tablets	780
	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	
	Zinc Sulphate 20mg, dispersible tablets	
March 30, 2011	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	104,250
	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	83,400
	Cotrimoxazole (400/80mg) scored tablets	750
	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	
	Zinc Sulphate 20mg, dispersible tablets	

- Assumes product lead time of 10-16 weeks, if this is significantly different based on procurement mechanism, these dates will have to shift; also may shift due to consumption rate of changes in usage trends

Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	1 packet = 1 treatment, 30 packets = 1 carton
Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	1 packet = 1 treatment, 30 packets = 1 carton
Cotrimoxazole (400/80mg) scored tablets	1 bottle = 1,000 tablets

PROCUREMENT QUANTITIES

Dosing Schedule by Illness and Age Group					YEAR ONE					YEAR TWO				
Illness	Age Group	Product	Treatment Course	Units per treatment course	Units required for Year One (12 months)	Buffer Year 1 (25%) units	# of units/ carton	Units to Order - Year One	Cartons/ Bottles To Order - Year One	Units required for Year Two (12 months)	Buffer Year 2 (15%) units	# of units/ carton	Units to Order - Year Two	Cartons To Order - Year Two
Malaria	6 months - 3 years	Artemether/ Lumefantrine (LA 20/120mg 6x1 blister pack)	1 6x1 packet (1 tablet 2x per day for 3 days)	1	103,257	25,814	30	129,071	4,310	181,286	27,193	30	208,478	6,950
Malaria	3 - 5 years	Artemether/ Lumefantrine (LA 20/120mg 6x2 blister pack)	1 6x2 packet (2 tablets 2x per day for 3 days)	1	82,606	20,651	30	103,257	3,450	145,029	21,754	30	166,783	5,560
Pneumonia	2 months to 12 months	Cotrimoxazole (400/80mg) scored tablets	1/2 tablet 2x per day for 5 days	5	69,961	17,490	1,000	926,977	930	129,520	19,428	1,000	1,578,851	1,580
Pneumonia	12 months to 5 years	Cotrimoxazole (400/80mg) scored tablets	1 tablet 2x per day for 5 days	10	671,621	167,905	1,000			1,243,393	186,509	1,000		
Diarrhea	2 months to 5 years	Oral Rehydration Salts (ORS), low osmolarity, 1L sachet	10-20 ml/kg/hour until hydration normal	2	371,726	92,931	100	464,657	4,650	652,628	97,894	100	750,522	7,510
Diarrhea	2 months to 5 years	Zinc Sulphate 20mg, dispersible tablets	1 tablet 1x per day for 10 days	10	1,858,628	464,657	100	2,323,284	23,240	3,263,141	489,471	100	3,752,612	37,530

*** If # of units per carton differs, the quantities needed to order will change. Base orders on units, if carton or bottle size is different**