

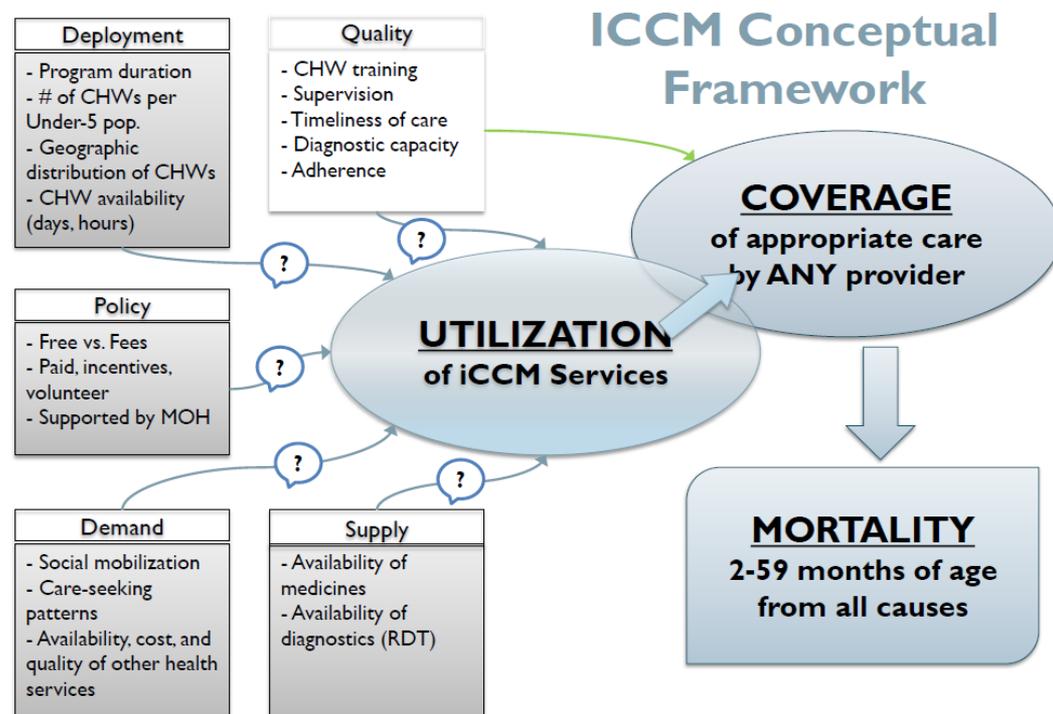


**Nutrition as part of ICCM:
Evidence, Challenges and
Future Directions of
Research
& Practice**

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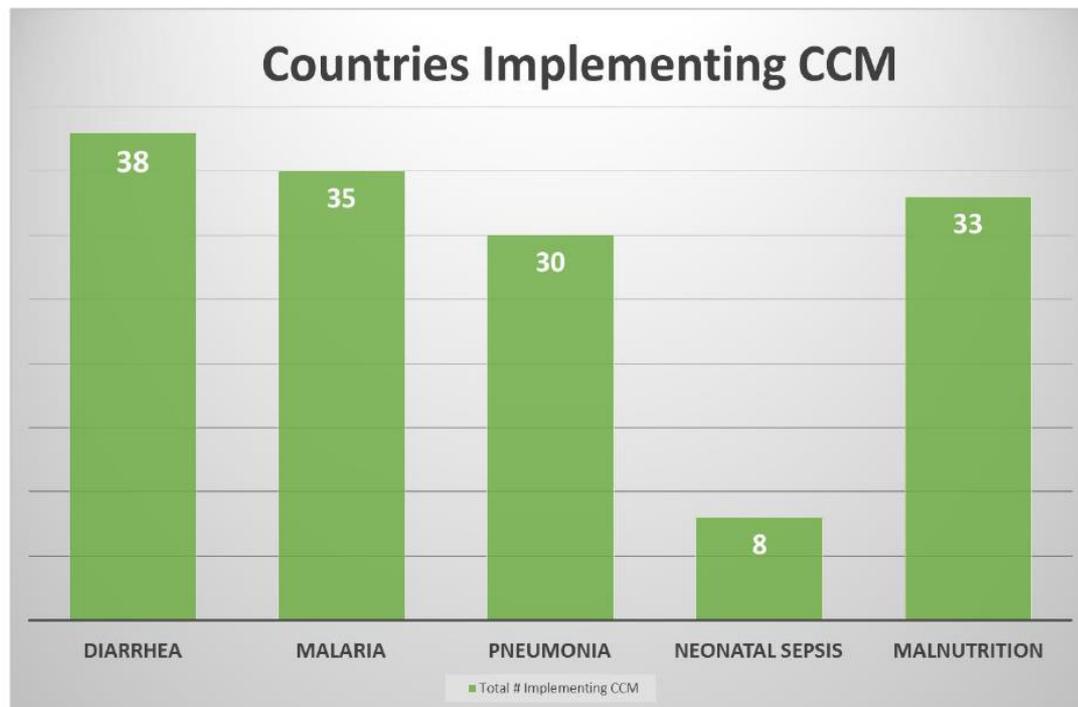
ICCM Background

- Integrated Community Case Management (ICCM) strategy **uses simplified IMCI protocols to treat common childhood illnesses in communities** where the distances between them and the nearest health facility are so great that the treatment services are inaccessible
- **Community Health Workers (CHWs) are trained, equipped and supervised to deliver treatment for diarrhoea, malaria and pneumonia;** and in some contexts, treatment for dysentery, newborn sepsis and acute malnutrition



ICCM Background

- ICCM as an approach is being scaled up globally
- ICCM symposium, UNICEF presented the state of implementation of CCM programmes that **33 countries reporting to be implementing CCM of malnutrition.**
- But to what extent are these 33 programmes actually implementing nutrition through CHWs?



iCCM 2014

**Integrated Community Case Management (iCCM):
Evidence Review Symposium**
3-5 March 2014, Accra, Ghana

Existing evidence

- In May 2014, a group of organisations came together to review past/present experiences integrating nutrition and ICCM
- The group reviewed programmes from a range of contexts including Bangladesh, South Sudan and Angola
- In doing so, they reached a number of preliminary conclusions



Preliminary Conclusions

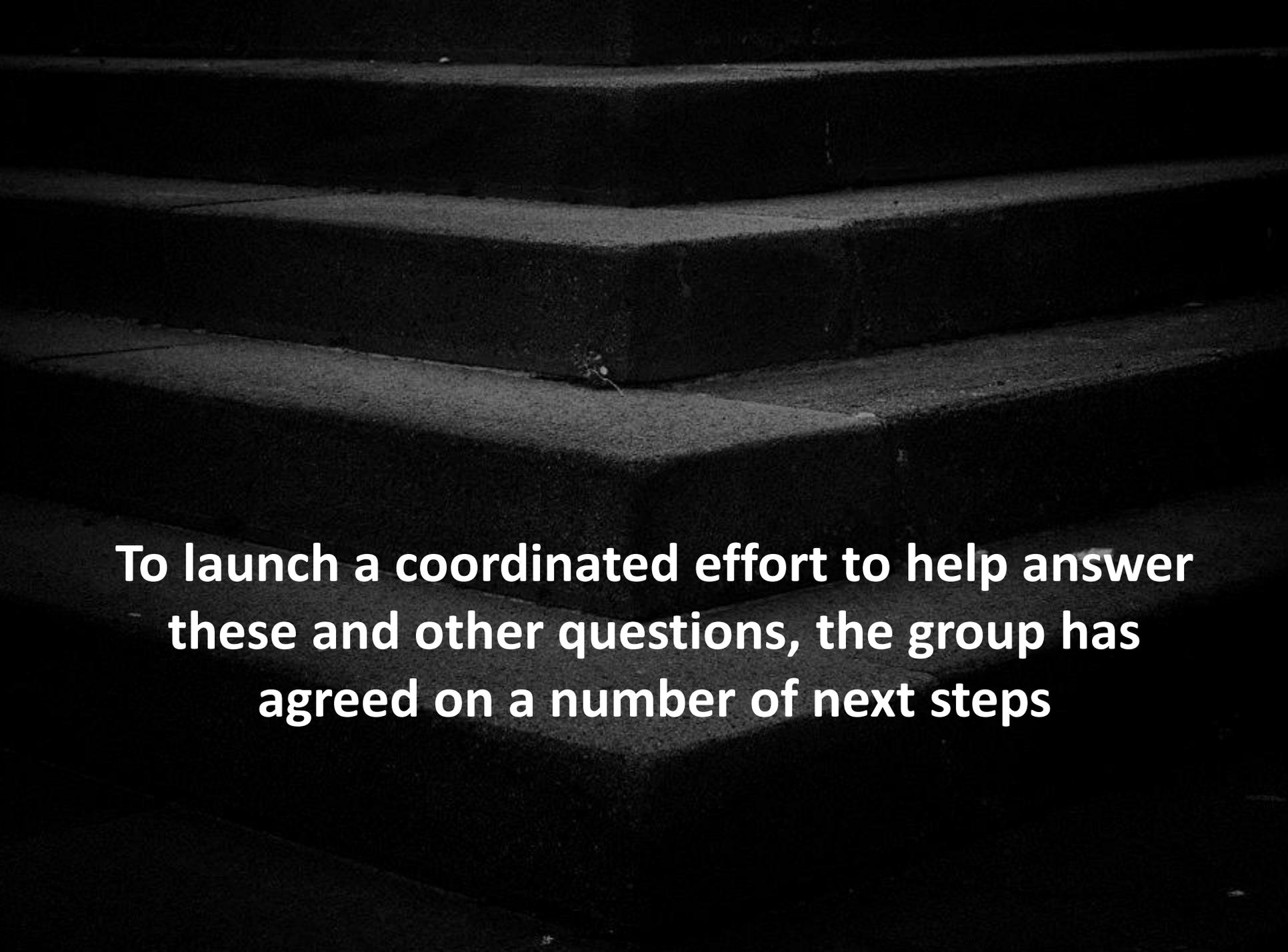
1. **Coverage of services:** ICCM of SAM can achieve extremely high coverage rates
2. **Quality of Care:** CHWs can deliver a high quality of care for SAM
3. **Cost effectiveness:** CCM and SAM can be cost-effective, in the
4. **Supervision:** CHW supervision is essential
5. **Protocols:** CMAM protocols/tools can be simplified in line with simplifications made to IMCI protocols for ICCM
6. **Supply chain:** Supply chain is a fundamental aspect of present and future implementation
7. **Demand and community participation:** Community satisfaction and participation were due to: CHWs were a familiar, trusted source of information and treatment
8. **CHW workload:** CHWs reinforced program awareness, access, compliance
9. **Types of interventions:** Different nutrition interventions will be appropriate in different contexts
10. **Integration into the health system:** CHWs need to be supported and integrated into the health system at all levels for successful service delivery
11. **Incentives:** Appropriate incentives for CHWs should be considered for this additional workload
12. **IYCF and feeding of the sick child:** while proper identification and treatment of sick children is increased through ICCM, nutritional counselling, especially optimal feeding during illness and recovery is not adequately emphasized during treatment and follow-up.



But a number of fundamental questions remain...

Remaining Questions

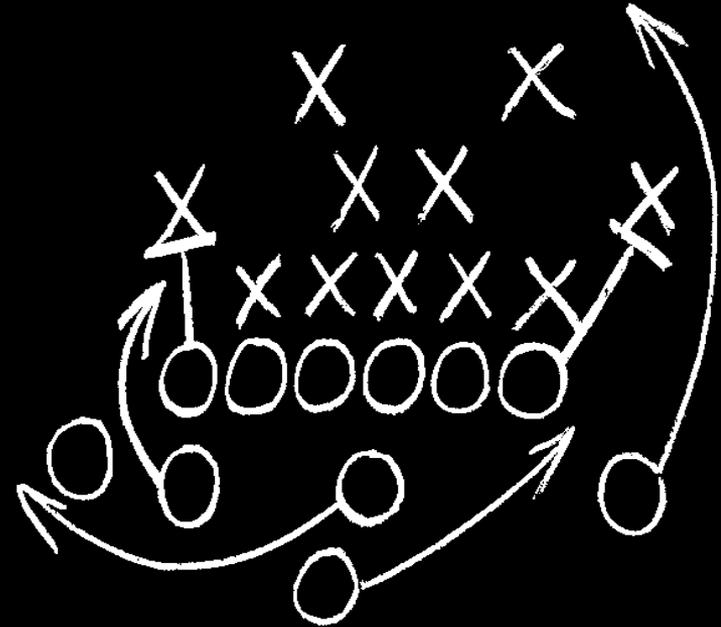
1. **Motivation:** How long can we sustain motivation of CHWs? What are the factors that affect CHW motivation particularly when providing additional services?
2. **Policy Environment:** What is the minimum in terms of policy involvement (or environment?)
3. **Protocols:** Do CMAM protocols need to be simplified/ aligned with ICCM? What would it look like?
4. **Nutrition Packages:** What bundles of interventions should be delivered and in what order? Which aspects of nutrition (e.g. IYCF, MAM, SAM, micronutrients) are appropriate in each context? How can we promote continuity of care?
5. **Health Systems:** What are the lessons about Health System Strengthening that we can take into ICCM and nutrition?



To launch a coordinated effort to help answer these and other questions, the group has agreed on a number of next steps

Game Plan

- **October 2014:** Launch of an external desk review to consolidate available evidence, lessons learned and knowledge gaps
- **December 12th/13th 2014:** Follow-up Meeting (NY) Presentation of main review findings and prioritisation of research questions
- **January 2015:** preparation of operational research plans/projects to address knowledge gaps



How should we work effectively as ICCM and nutrition communities to generate this kind of evidence?

How should we work as ICCM and nutrition communities to influence and advocate for work in this area?

