A THEMATIC EVALUATION OF
Integrated Community Case Management Activities in MSF OCB settings

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STOCKHOLM EVALUATION UNIT

BACKGROUND

Integrated Community Case Management (iCCM) is a community-based strategy that enables trained community health workers (CHWs) to diagnose and treat the leading causes of under-five mortality and morbidity particularly in underserved and hard-to-reach populations. These include uncomplicated cases of malaria, diarrhea, and pneumonia, and referral for severe cases. In many MSF contexts, CHWs also screen for malnutrition and necessary vaccines.

This thematic evaluation explores the implementation, performance, and strategic recommendations for scalability and sustainability of iCCM activities in the MSF-OCB portfolio as per end of 2024. To do so, it explores programmatic areas against the eight WHO/UNICEF benchmarks for iCCM. The evaluation was conducted using information and data gathered from eight MSF-OCB projects with iCCM activities: Masisi (DRC), Niono and Tombouctou (Mali), Cibitoke (Burundi), Kenema (Sierra Leone), Yei and EGPAA (South Sudan), and Kebbi (Nigeria).

METHODOLOGY

- Mixed Methods Approach
- Desk review of 2,700 documents
- Analysis of routinely collected medical data
- 115 Key Informant Interviews
- 3 case studies and 2 in-person visits (Mali and South Sudan)

RECOMMENDATIONS

1. **Determine the level of prioritization which MSF-OCB places on iCCM activities within the continuum of care provided by project teams.** As iCCM is determined to be a priority approach, MSF-OCB can build on its current updates to its Medical Strategy to incorporate clear objectives for iCCM's role within the strategy.
2. **Identify resources needed and if resources (budget, dedicated staff time) are available, and proceed with developing a formal MSF-OCB iCCM strategic framework and Toolkit** with user-friendly adaptable operational and technical tools to support harmonized scale up of iCCM activities in each site. A dedicated iCCM technical resource person would be needed. Toolkit development could be prioritised by benchmark and/or health interventions and produced in phases, according to the available budget and resources.
3. **Pilot and Scale Adaptable Tools and Innovations** across the eight benchmarks.
4. **Continue Government Engagement and Transition Planning:** Continue to reinforce MOH involvement in new iCCM sites, with shared supervision, training, and commodity planning from day one.
5. **Improve Data Feedback and Community Ownership**: Roll out user-friendly data tools and participatory planning forums that empower CHWs and communities to drive service improvement.

CONCLUSION

While the iCCM intervention package is broadly consistent — providing case management of malaria, diarrhoea, and (in some contexts) pneumonia as well as malnutrition screening and referral — **the delivery strategies and operational models vary considerably.** These differences reflect MSF's responsiveness to geographic, security, and infrastructural challenges, and population need. But they also underscore the absence of a strategy guiding a common understanding of the design and implementation of iCCM activities across the continuum of care, and a lack of MSF-OCB specific operational norms and quality standards.

CHW selection, training, and supervision varied across project sites. While some sites implemented MOH-aligned criteria and co-developed selection processes with communities, others relied on more informal models, leading to inequitable CHW coverage. Similarly, differences in training duration, refresher schedules, and access to literacy-adapted tools impacted the quality and confidence of service delivery. Planning and budgeting processes also varied.

Overall, interventions have expanded access to care, and community trust in CHWs is consistently high, due to their proximity, cultural competence, and ability to provide first-line care. **But challenges remain.** Referral systems face persistent barriers with long distances, insecurity, stigma, and financial constraints undermining continuity of care. Supply chain reliability and storage of medications also varied. In most sites, CHWs transported and stored medications in backpacks or plastic bags, with some using community-owned storage.

Supervision was another area of uneven implementation, leading to missed opportunities for skills reinforcement and data quality monitoring. Yet, MSF and MOH staff, community leaders, and CHWs demonstrated remarkable dedication.

Finally, **sites that engaged MOH counterparts from the outset demonstrated stronger prospects for long-term continuity**. Joint supervision, shared tools, and integration into health information systems helped ensure government ownership and transition readiness.