STOCKHOLM EVALUATION UNIT

MÉDECINS SANS FRONTIÈRES LÄKARE UTAN GRÄNSER

A THEMATIC EVALUATION OF

INTEGRATED COMMUNITY CASE MANAGEMENT ACTIVITIES

IN MÉDECINS SANS FRONTIÈRES (MSF) - OPERATIONAL CENTRE BRUSSELS (OCB) SETTINGS

SUMMARY REPORT

November 2025

This publication was produced at the request of Médecins Sans Frontières (MSF) – Operational Centre Brussels (OCB) under the management of the Stockholm Evaluation Unit (SEU).

It presents a summary based on the full evaluation report. We invite readers to refer to this report for more details as well as nuances and formulations from the evaluation team.

All evaluators contracted by the SEU must adhere to the SEU Ethical Guidelines for Evaluations.

The evaluation was conducted independently by Eau Claire Consulting - Mary Kante, Malia Skjefte, and Laure Moukam.

INTRODUCTION

This thematic evaluation, conducted by Eau Claire Consulting, explores the implementation, performance, and strategic recommendations for scalability and sustainability of **integrated Community Case Management (iCCM) activities** in the Médecins Sans Frontières-Operational Centre Brussels (MSF-OCB) portfolio as per end of 2024. In line with the Terms of Reference, this evaluation is intended for use by MSF teams in OCB for accountability, continuous improvements and organisational learning. Likewise, results of the evaluation can inform better understanding of operational realities of MSF and Ministry of Health (MOH) staff, community health workers (CHWs), and other partners to inform current and future planning for and implementation of iCCM activities.

iCCM is an evidence-based community-based health strategy that enables trained CHWs to diagnose and treat the leading causes of under-five mortality and morbidity particularly in underserved and hard-to-reach populations, especially in remote or other settings where access to facility-based services is limited. These include uncomplicated cases of **malaria, diarrhoea, and pneumonia**, and referral for severe cases. In many contexts where MSF operates, CHWs also screen for malnutrition and necessary vaccines.

METHODOLOGY

The evaluation team gathered in-depth information across three data streams (document review, qualitative and quantitative) for **eight MSF-OCB projects** where iCCM activities were implemented in 2024[1] and which include between 2 to 115 iCCM activity sites per project,: Masisi (Democratic Republic of the Congo), Niono and Tombouctou (Mali), Cibitoke (Burundi), Kenema (Sierra Leone), Yei and EGPAA - East Greater Pibor Administrative Area - (South Sudan), and Kebbi (Nigeria). These sites represent diverse geographic, political, and epidemiological contexts, ranging from conflict zones to remote pastoralist communities.

The evaluation followed a **mixed-method design**, including a comprehensive document review of more than 2,700 documents, analysis of routinely collected medical data (RCMD), and over 100 in-depth stakeholder interviews across all project sites, including in-person visits to iCCM activities in Niono, Mali, and EGPAA, South Sudan. Key informants included CHWs, caregivers, community leaders, MSF staff, MOH representatives, and global health actors. Ethical considerations included written and verbal sharing of detailed informed consent for voluntary and confidential participation in key informant interviews (KIIs) or small focus group discussions (FGDs) for participants above 18 years of age for this study intended for MSF's internal use. Translation was provided as needed for non-French or -English speaking participants.

[1] It came to the knowledge of the SEU, during the course of the evaluation that Bangassou project, CAR, was apparently implementing iCCM activities. As not included from start of the evaluation process, it remained out of scope.

EVALUATION QUESTIONS AND MAIN FINDINGS

The evaluation examined five core evaluation questions based on the original Terms of Reference. These questions were refined and updated during the Inception Phase. To organize the analysis, the evaluation used the **RE-AIM Framework** (Reach, Effectiveness, Adoption, Implementation, and Maintenance) and aligned with the **eight iCCM benchmarks (programmatic areas) identified in the WHO and United Nations Children's Fund (UNICEF) Joint Statement for iCCM.**[2] These programmatic areas include coordination and policy making, costing and financing, human resources, supply chain management, service delivery and referral, communication and social mobilization, supervision and performance quality improvement, and monitoring and evaluation (M&E) and health information systems (HIS).

Limitations of the evaluation include a lack of clear guidelines for MSF-OCB project teams and resultant gaps in knowledge management as well as collection, analysis, presentation, quality and use of RCMD for iCCM activities within MSF-OCB; logistical constraints for the on-site interviews; and staff turnover which in some cases limited institutional awareness of iCCM activities.

The five evaluation questions are listed below, with summary findings from the report.

EQ1: What are the components of each iCCM intervention within the MSF-OCB portfolio, how is iCCM operationalized within MSF-OCB projects, and how are key decisions made?

Across the MSF-OCB portfolio, the **core iCCM package** is consistently focused on the management of **malaria and diarrhoea in children under five**. Case management of acute respiratory infections (ARI) is not implemented as part of iCCM activities in two MSF-OCB projects due to concerns expressed by MSF staff and the MOH regarding CHW capabilities and administration of antibiotics at the community level. Operationalization varies significantly across sites based on contextual needs, population movement, security challenges, and national health system structures. For example, some sites (e.g., Kenema and Masisi) integrate maternal and newborn health services, while others (e.g., EGPAA) use mobile models to reach nomadic populations. Key decisions around CHW management, supervision modalities, and referral systems are shaped by logistical constraints, security, and availability of human and financial resources. The absence of standardized implementation guidance across projects leads to wide variation in how iCCM is delivered, monitored, and evaluated.

EQ2: What is the rationale for site selection, design of the iCCM package in response to contextual factors, budget and planning approaches used, as well as differentiated project design for iCCM interventions across MSF-OCB projects?

Selection of iCCM sites typically relies on a combination of disease burden, remoteness, access barriers, and population vulnerability. Project teams use data from disease surveillance systems, population movement tracking, and reported project specific health assessments to guide decisions.

[2] WHO/UNICEF (2012). Joint Statement for iCCM: An equity-focused strategy to improve access to essential treatment services for children. who.int/publications/m/item/an-equity-focused-strategy-to-improve-access-to-essential-treatment-services-for-children. Note: The iCCM Programmatic Benchmarks are further described later in the report.

Community participation in planning is common, with CHWs often selected by local leaders and populations. However, formal engagement with MOH in early design phases is inconsistent across sites.

MSF's projects reflect the priorities of MSF's humanitarian mandate to serve vulnerable populations in complex operating environments with limited access to care. Projects are often initiated in response to conflict, displacement, or the collapse of local health systems. The design of iCCM packages for children under five reflects these priorities and context and likewise aligns with and supports national and sub-national primary health systems taking into consideration specific geographical, security, health, and other contextual factors. For example, in Niono, Masisi, and Tombouctou, iCCM fills critical service gaps in conflict-affected areas. In EGPAA, iCCM is delivered through mobile services to pastoralist communities when water availability requires them to move away from fixed primary health units (PHUs). Related services to reach remote populations over five years are also incorporated alongside iCCM in these project settings. In Tombouctou and Masisi, for example, MSF teams also incorporate additional services at community level, such as mental health, nutrition, and gender-based violence screening and referral.

Budgeting and planning approaches are often reactive, driven by operational feasibility, resource availability constraints, and evolving security and logistical considerations. While iCCM activities may be planned and resourced through the Annual Review of Operations (ARO) process of MSF-OCB, the evaluation noted varying criteria used to make the decisions and ad hoc approaches to documenting decisions to fund, scale, sustain, expand, or cancel iCCM projects. Combined with the nature of MSF support, which in some cases is time-limited to address arising emergency situations, this significantly reduces options for long-term planning including financial one. Furthermore, guidelines and tools for managing continuity of care after MSF support ends, were not available. Interviews in one project site noted frustration from MOH and community members following the announcement of the termination of MSF iCCM activities. Feedback provided was that the decision was made in a unilateral fashion and without solutions for community health care seeking options. Guidelines and tools could include, for example, a checklist, case study, and/or best practice brief to reinforce MOH leadership of iCCM activities, ensure alignment with national policies, and support planning for domestic resource mobilization after MSF funding ends. The lack of consistent funding for CHW incentives, supervision, and supply chain support threatens scalability of iCCM activities.

Alongside these challenges, the **adaptability of iCCM interventions in MSF settings is a strength**. MSF teams demonstrate creativity in tailoring services to shifting needs, using real-time data and local insights to navigate dynamic contexts. However, a lack of an MSF-OCB-specific iCCM strategic plan, documented MSF expectations for operationalizing technical quality norms, as well as operational standards of practice (SOPs) across iCCM benchmarks limits opportunities to scale up iCCM activities and extend a harmonized set of additional services critical to community health in the contexts in which MSF operates. Operational SOPs could be developed, for example, in the form of a step-by-step guide or toolkit for standard design and implementation considerations for each programmatic benchmark.

EQ3: What are the successes, challenges, and lessons learned for iCCM interventions in the MSF-OCB portfolio for improving access to prompt, quality, person-centred care delivered closer to patients?

Through iCCM, MSF has strengthened **delivery of care to populations** otherwise excluded from the health system. In Masisi and Niono, for instance, CHWs are often the only accessible source of healthcare. Community ownership and involvement have increased trust and use, particularly where CHWs are locally selected and trained.

Integration with other services—such as nutrition, vaccination, and maternal care—has improved quality and expanded the package of services available and reach of iCCM. Investments in training, supervision, and community engagement have bolstered service quality.

Challenges persist in ensuring consistent commodity supply, supervision coverage, and CHW motivation. Geographic and security barriers were also noted by stakeholders as limitations to referrals and in-person supervision. Additionally, CHW incentives are often insufficient or irregular, undermining retention. Community behaviour, such as reliance on traditional medicine and referral refusal, further complicates access and continuity of care.

Key lessons include the **value of flexibility in service delivery**, the critical role of non-financial CHW incentives (training, recognition), and the importance of community participation in promoting trust and uptake. Mobile models and peer-to-peer supervision were also identified as effective strategies in insecure or remote settings.

EQ4: What are the strategic recommendations for iCCM interventions in the MSF-OCB portfolio for enhancing their effectiveness and reach?

Les priorités stratégiques visant à améliorer l'efficacité et la portée de l'iCCM sont présentées dans la dernière section « Prochaines étapes et recommandations », basée sur l'analyse des résultats des trois flux de données.

Strategic priorities for enhancing iCCM effectiveness and reach are presented in the last section “Next steps and recommendations”, based on the analysis of results from the three datastreams.

EQ5: How should iCCM interventions across MSF-OCB projects in the portfolio align with national health strategies and opportunities to inform the future extension and scale-up of iCCM interventions and reinforce their sustainability?

The **scalability and sustainability** of iCCM interventions - focused on ensuring efficient implementation at scale as well as the long-term viability of iCCM service delivery, even after MSF resources are no longer available - depends on deeper alignment with national health strategies, improved government buy-in, and co-financing. While some projects (e.g., Yei) have successfully integrated with MOH structures and aligned with national frameworks like the Boma Health Initiative (BHI), others operate in parallel to national systems.

Formal recognition of CHWs by MOH remains limited in many contexts. Policy advocacy is needed to support the inclusion of CHWs in health workforce planning and budgeting. Overall, MSF can play a catalytic role in piloting innovative approaches, demonstrating impact, and facilitating handover to local actors.

Recommendations include:

- Engaging MOH early in project design and planning.
- Harmonizing tools and indicators with national systems (e.g., DHIS2 integration).
- Supporting MOH-led supervision and training models.
- Documenting and disseminating lessons learned to inform scale-up.

NEXT STEPS AND RECOMMENDATIONS

The evaluation team recommends that MSF-OCB undertake a light-touch strategic planning process and develop a draft MSF-OCB Strategy which identifies standard iCCM care packages, additional elements which may be considered (or not), and links to a standard iCCM Toolkit. Strategy development can build on this iCCM Thematic Evaluation which provides an up-to-date landscape of challenges, opportunities, and recommendations which can directly inform development of the MSF-OCB strategy. The evaluation team also recommends MSF-OCB to:

- **Determine the level of prioritization it 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 updates to its Medical Strategy to incorporate clear objectives for iCCM's role within the strategy.

- **Assess the level of resources required (budget, staff), and as they become available, develop a formal MSF-OCB iCCM strategic framework** outlining standardized care packages, technical quality norms, and operational standards. **Accompany this strategic framework with a toolkit** with user-friendly, adaptable operational and technical tools to support harmonized scale up of iCCM activities on the foundation of the eight benchmarks. The evaluation team estimates that 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. Standard implementation guidance would help reduce variation in how iCCM is delivered, monitored, and evaluated across projects.
    - **Strengthen and formalize the needs assessment process** used to plan iCCM activities. This includes developing a standard assessment tool or questionnaire that outlines essential data points and guidance for participatory consultation.
    - **Review the MSF-OCBA Decentralized Models of Care (DMC) strategic plan** and its 14 community-adapted care packages and use this as a foundation to develop step-by-step standardized iCCM design, technical and operational guidance, and tools—consolidated into an online iCCM technical platform or toolkit, modelled after the OCBA DMC online toolkit.
    - Establish an **internal iCCM strategy and knowledge management platform** to support

learning, scalability, and sustainability across the portfolio.

- **Pilot, document and scale tools and innovations across the eight benchmarks**. Learn from and build on the experiences and expertise of MSF-OCB teams implementing iCCM activities. For example:
  - In Niono, a planned community management board was developed to reinforce community ownership and accountability for service delivery.
  - In Yei and Kenema, the use of structured supervision plans combined bi-monthly individual visits with monthly group sessions for reinforcing clinical skills and improving the quality of data collection.
  - In EGPAA, the transition to the BHI model disrupted existing M&E routines, requiring the adaptation of registers and indicators mid-implementation.

- **Aim for a greater implication of the MoH and better transition planning:** continue to reinforce the participation of MoH in current and future iCCM sites, with joint planning, training and supervision, from day one.
- **Strengthen partnerships with national and global stakeholders** as this will be critical to leveraging learning and identifying optimal approaches for scaling and sustaining MSF's contribution to community health delivery in fragile settings.
- **Improve feedback loops on data and community ownership**; Strengthen community participation strategies to build trust and increase service uptake; Develop user-friendly data tools and participatory planning allowing for CHW and communities to improve services Support feedback loops to share health data with CHWs and communities that are accessible or actionable for frontline workers or the public.
- **Identify additional non-financial incentives for CHWs** such as training and recognition
- **Support a standard yet adaptable approach to training** that can scale while maintaining quality:
  - Develop a harmonized yet flexible iCCM training manual and tools, adapted to conflict-affected and/or low-literacy contexts and which can be used across project sites and iCCM activities; include participatory learning exercises.
  - Incorporate mobile models and peer-to-peer supervision, identified as effective strategies in insecure or remote settings.
  - Develop CHW self-assessment tools and simplified supervision grids to reinforce accountability in low-access zones, building community-based supervision, CHW capacity building and stronger collaboration with local health structures into iCCM activity designs.
  - Strengthen supervisor capacity through targeted training and reduced caseloads to enable more effective clinical mentoring and qualitative feedback, beyond activity volume monitoring.

- **Reinforce clearer pharmaceutical and supply planning and shared accountability between MSF, MOH actors and health facility personnel:**
  - Develop reliable transport and clearly defined contingency protocols
  - Pre-position commodities, engage local transportation networks, and ensure buffer stocks for CHWs operating in remote zones.
  - Support supervisors to conduct monthly drug and patient register reconciliations.
  - Develop plans for maintaining iCCM supplies after MSF support has ended. This may include drafting a supply transition roadmap during initial planning stages, detailing how procurement, storage, and reporting will be handed over to MOH or other actors over time.