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| **PBAS#:** | **National Office:** | **Programme site or ADP:** | **District/Region:** |
| **Name of Person Completing the Tool:** | **Title:** | **Type of Assessment:**  **Self-Assessment  Third Party  Mixed** | **Date of Assessment (mm/dd/yyyy):** |
| **Length of programme implementation:**  **< 6 months  6 - 12 months  > 12 - 24 months  > 24 months** | | **Level of Assessment (e.g. what level is this assessment being conducted):**  **Programme site  ADP  District/Regional  National** | |

Instructions on how to determine IQA score:

Beside each essential element, there is a checklist of critical components of the essential element. As you go through your assessment, check the boxes that apply to the programme. Use the CMAM IQA calculator for an automatic calculation of the IQA score. The overall IQA is the mean of individual IQA scores from all the essential elements. An overall IQA score of 1.5-2 indicates high fidelity; 1.0-1.4 indicates moderate fidelity; less than 1.0 indicates low fidelity.

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| **Essential Element** | **Check the box  for those that are present in the model.** | **IQA** |
| **1. National Level planning processes for CCM are undertaken prior to consideration of model implementation.** | Needs assessment and situation analysis for package of services conducted.  National policies and guidelines for CCM reviewed.  Mapping of CCM partners conducted. |  |
| **2. CCM strategies are developed through regular and transparent MoH and multi-stakeholder engagement.** | Key stakeholders implementing CCM are engaged regularly throughout national level planning processes, to define roles and discuss current policies held. Any existing NGO coordinating group where existent should be engaged in planning.  Participate in existing routine stakeholders meetings held to ensure coordination of CCM partners.  Establish written statement of protocol or working guideline between WV, stakeholders and MoH. |  |
| **3. Curriculum content should be IMCI-aligned and inclusive of essential components and skills.** | 80 per cent or more of the topics are covered within the curriculum review checklist (See Appendix I)  All curricula selected are agreed on by the MoH, WHO and UNICEF representatives in country for IMCI alignment. |  |
| **4. Package of materials is inclusive of training materials, treatment and care guidelines for CHWs as well as ethnographically accurate pictorial aids for family counselling.** | Facilitator’s manual available to enable the trainers to deliver training to CHWs.  Training package is appropriate for non-literate CHW and volunteers and all appropriate translations are provided.  CHW manuals or job aids including dosage and treatment protocols and care of the sick child are available for every CHW in a suitable format to accommodate their literacy level.  CHWs have pictorial job aids used for counselling families on care of the sick child. All materials to have undergone field testing in ethnographically equivalent communities prior to use. |  |
| **5. Long-term sustainable medical supply and restock strategies are established, and include quality, theft and stock out checking systems.** | Projects utilise and strengthen existing supply chains them rather than establish parallel mechanisms.  Stocks of medicines and supplies at all levels of the system monitored regularly (through routine information system and supervision), including medical stock quality controls at least twice per year.  A system for preventing misuse of medicines is in place with more than one person overseeing the medical stocks (e.g. a two-key box system). |  |
| **6. Training of CHW is done by qualified IMCI trainers, is a minimum of ten days for new recruits and includes two days of practical experience.** | Only qualified IMCI trainers are used to deliver training to facilitators.  Class size for the trainings of CHW will not be more than 30 CHW per trainer.  Minimum number of ten days is met for the face to face training of the CHWs, and will include a substantial proportion of field level practical exercises (at least 2 days of the 10).  CHWs are certified for iCCM protocols according to national standards. |  |
| **7. CHW allocation and household coverage is reasonable and not more than one CCM CHW per 100 households.** | One CCM competent CHW to serve no more than 100 households.  All communities further than 5 km from a functional health centre, and with more than 20 households should have at least one competent CCM CHW. |  |
| **8. Community health systems are strengthened and guided to support CCM activities (COMM engagement).** | All projects have a functional COMM or equivalent community based group who are actively overseeing CCM CHWs.  COMM receive an orientation training (developed in-country) within one to two months of start-up, which includes key programme aspects, key health messages, overview of data collection and reporting the CHW debriefing process and enables them to provide adequate oversight of CHWs work.  COMM participate in CCM CHW supervision debriefings at least once every six months.  CCM CHWs meet to integrate their activities with other community health actors once every six months.  A system to measure COMM involvement is in place. |  |
| **9. Community sensitisation activities involve key community stakeholders, include house-to-house approaches and are designed to target the most vulnerable and high risk households.** | Community sensitisation activities which promote CCM should take place at least once per year during the project.  CHWs conduct house to house sensitisation during roll out of CCM including households considered to be the most vulnerable. |  |
| **10. Health services assessment and health systems strengthening approaches are incorporated into project planning.** | A list of IMCI health facilities is in place.  Selected referral facilities should attain basic minimum standards according to child and maternal health services assessment (rapid or WHO assessment model). All selected referral facilities have:  IMCI-trained and competent staff  Overnight duty and inpatient care  Competence to treat severe and complicated malnutrition  Competence to treat severe pneumonia and malaria using IV and IM medicines  Neonatal (zero to four weeks) care facilities  Functional vaccine cold chain.    CCM monitoring systems should be aligned to HMIS and CHWs should report directly to health facilities as required.  Communicate with other NGOs working locally to ensure no duplication of Health Systems Strengthening (HSS) activities are occurring within the same facilities. |  |
| **11. Project staffing and training.** | One ADP manager and one health-dedicated development facilitator per ADP.  All programme management staff will have undergone an orientation on CCM methodology led by the MoH or public health unit staff overseeing CHWs.  Where public health unit staff unable to supervise regularly considers supervising technical aspects separately, and non-technical aspects using project staff. |  |
| **12. Service delivery methodology is developed with clear protocols and home based care follow up.** | National guidelines on care and treatment of the sick child in the community should include:  Plan for rational use of medicines and diagnostics (RDTs where appropriate) by CHWs and patients.  Guidelines for clinical assessment, diagnosis, management and referral by CHWs developed.  Home-based care follow-up visits for all illnesses are conducted at days two (24 hours post treatment), three, five and eight to ensure recovery. |  |
| **13. Management of diarrhoea in the home using low ORS and zinc, home care, hygiene and improved feeding.** | CHWs treat diarrhoea with:  Low osmolarity oral rehydration salts  Zinc.  Home based care inclusive of:  Mid-upper arm circumference (MUAC) screening for all children.  Detection of dehydration and dysentery.  WASH and hygiene guidance for family.  Improved breastfeeding and feeding during illness. |  |
| **14. Management of malaria using ACT-based treatment, RDTs where possible, detection and referral of anaemia, prevention of malaria and improved feeding.** | CHWs manage fever within 24 hours with:  ACT-based treatment for RDT positive cases.  Referral of malaria negative cases.  Home based care inclusive of:  24 and 48 hour home visits, with referral of cases with no improvement by day two.  Detection of anaemia and complicated malaria.  ACT adherence monitoring.  Care of the sick child and prevention of malaria.  Improved breastfeeding and feeding during illness.  Unused medicines are recollected by the CHW after treatment |  |
| **15. Management of ARI in the home for children aged 2 to 59 months using approved antibiotics.** | CCM CHWs are approved to treat pneumonia in the community following competency-based assessment:  Recognition of danger signs  Breath counting, looking for chest indrawing  Counselling on care of child with ARI  Antibiotic treatment per age group  Concurrent malaria treatment.    All children under 2 months of age must be referred to nearest functional health facility.  Home based care guidelines to include:  24 and 48 hour home visits, with referral of cases with no improvement by day two.  Medicine adherence monitoring.  Care of the sick child and prevention of pneumonia.  Improved breastfeeding and feeding during illness.  Unused medicines should be collected after treatment. |  |
| **16. Emergency referral and two-way communication is strengthened and include post-referral checks by CHWs.** | A system of written or facilitated referral is in place which is appropriate to CHW capacity or literacy.  All CHWs have developed a consistent and functional transportation plan for evacuation of severe cases (consider COMM role).  Systems for conducting and recording CHW visits following patient discharge from clinics is in place.  All CCM CHWs should have access to an emergency telephone through which they are able to contact facilities and or ambulance services if available. |  |
| **17. CCM activities are integrated with other existing child health treatment activities such as they exist in the project areas.** | *Integration (if applicable):*  If CMAM: iCCM should be fully integrated with CMAM programmes where concurrent initiatives exist.  If PMTCT and paediatric HIV treatment: iCCM should be fully integrated with these activities.  If paediatric DOTS and TB treatment: iCCM should be fully integrated. |  |
| **OVERALL IQA** | |  |

Instructions: Feel free to note any variances and the data source used in the IQA assessment of the essential elements. Document recommendations and next steps in the space below.

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| **EE** | **Notes** | **Data source** |
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| **Recommendations and next steps:** | | |

Appendix I: CCM CHW Curriculum Essentials

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| **CCM CHW curriculum essentials** | | **Covered** |
| **Child health** | Causes of child mortality |  |
| General danger signs of child illness and disease specific danger signs |  |
| Vaccine preventable diseases |  |
| Common childhood infections |  |
| Worms and parasite infections |  |
| Single disease management (CCM) |  |
| Integrated management of multiple symptoms (iCCM) |  |
| List of core competencies required for CCM and iCCM |  |
| Co-infection with HIV and TB and other high risk issues; malnutrition and orphans and vulnerable children (OVC) status |  |
| **Prevention** | Vitamin A |  |
| Deworming |  |
| Intermittent preventative treatment in pregnancy (IPTp) or intermittent  preventative treatment in infants (IPTi) |  |
| Vaccination schedules and child health cards |  |
| **Nutrition** | Exclusive breastfeeding |  |
| Complementary feeding |  |
| Growth monitoring and promotion |  |
| Mid-upper-arm circumference (MUAC) screening |  |
| Detection of malnutrition |  |
| Malnutrition danger signs |  |
| **Diarrhoea** | Causes and prevention |  |
| Safe drinking water |  |
| Hand washing |  |
| Cholera and dysentery |  |
| Classification of mild, moderate and severe dehydration |  |
| Danger signs (general and diarrhoea) |  |
| Making and giving ORS solution and zinc |  |
| Breastfeeding with diarrhoea |  |
| Home-based follow-up care |  |
| Feeding during diarrhoea |  |
| **Malaria** | Causes of malaria |  |
| Prevention (ITN, IPTp and IPTi) |  |
| Diagnostics and use of RDT |  |
| Danger signs and complications of fever |  |
| Artemisinin-based combination therapy (ACT) treatment regimens |  |
| Home-based care, counselling and follow up |  |
| Feeding during malaria |  |
| Other causes of fever, and danger signs |  |
| **Pneumonia** | Causes of pneumonia |  |
| Care of a sick child to prevent severe pneumonia or acute respiratory  infection |  |
| Danger signs of pneumonia |  |
| Breath counting technique with or without breath counter |  |
| Classification of mild, moderate and severe pneumonia |  |
| Diagnosis and referral |  |
| Treatment with antibiotics |  |
| Home-based care, counselling and follow up |  |
| **Other** | Record keeping and reporting including mobile apps |  |
| Safety with medicines and stock management |  |
| Effective communication and counselling skills |  |
| Counselling skills |  |