

Summative evaluation of the WHO Rapid Access Expansion (RAcE) Initiative

Evaluation brief - 2018

Objectives and scope of the evaluation

The RAcE Initiative was funded by the Government of Canada in 2012 with a grant of 75 million Canadian dollars over six years to the WHO Global Malaria Programme to support expanding and consolidating services for integrated community case management of diarrhoea, malaria and pneumonia (iCCM) to reduce child mortality in the Democratic Republic of the Congo, Malawi, Mozambique, Niger and Nigeria (2 programmes). The evaluation assessed the relevance, effectiveness, sustainability and impact of the RAcE contribution to institutionalising iCCM in the health systems of partner countries and informing the global dialogue on iCCM.

Key findings and conclusions

Question 1: Did RAcE respond to the needs of the main stakeholders in national health systems and was it in line with national health strategies?

RAcE was well aligned with national health policies and strategies. It complemented national efforts to achieve universal health coverage by reaching a large number of children who had no access to health facilities. iCCM, however, has limitations in reaching children in very remote and thinly populated regions. In some programme areas, the barriers to access to health care were related to cost and quality rather than to distance. Many caregivers changed their pattern of care-seeking towards consulting Community Health Workers (CHWs) supported by RAcE. The quality of care improved, but other options to reduce user charges and increase quality of care could be explored.

Question 2: Did RAcE contribute to enhancing the utilisation of iCCM services?

RAcE contributed to the development or revision of national iCCM strategies, guidelines and tools. CHW reporting systems were established and the flow of data from the community to the health district level improved. Integration of community health data in national health information systems was, however, only achieved in one country and partially in a second.

Major stock-outs of medicines at community level were experienced in only two programmes. Only one programme established a parallel procurement and supply management system, while the others supported national systems to varying degrees. The

uninterrupted supply of commodities to the community level is critical for successful iCCM programming and continues to be an issue of concern.

Caregivers of children expressed a high level of satisfaction with the services provided by CHWs. Issues of quality and availability of services in the health centres serving as first-level referral facilities for iCCM were a commonly observed constraint to quality of care.

About 8 900 CHWs were trained, of whom about 7 400 were active at the time of programme closure. CHWs were supervised by trained facility-based health staff. CHWs were volunteers, except in one country where they were salaried employees. Approaches to maintain their motivation and retention were in line with national policies. CHWs in all programmes affirmed that training opportunities, the uninterrupted supply of commodities and the recognition and status in the community were their main motivating factors. Financial incentives were, however, also considered important. Engaging communities in supporting CHWs had mixed results.

Question 3: Did RAcE contribute to a supportive policy and regulatory environment for iCCM?

Combining WHO support to central governments in the development or revision of iCCM policies and tools with operational support to decentralised levels of government by sub-contracted non-State actors contributed to the effectiveness of RAcE.

RAcE contributed to the sustainability of iCCM in the five programme countries by strengthening the policy and regulatory environments. iCCM services in these countries, however, continue to be predominately funded by international development partners. Financing gaps are a major threat to sustainability. The end of the RAcE Initiative created critical situations of medicine stock-outs and reductions of CHW supervision.

Question 4: Can the modelled impact of RAcE on child mortality be independently corroborated?

The evaluation generated qualitative evidence that the RAcE Initiative contributed to a reduction in child mortality. However the extent of mortality reduction estimated with the aid of the Lives Saved Tool model could not be corroborated. Reliable input data of baseline mortality and of specific treatment coverage

were not available to generate credible model outputs.

Question 5: Did RAcE contribute to achievements of gender equality results?

The RAcE Initiative did not live up to its commitments on gender mainstreaming. The evaluation found no evidence that a gender analysis was done, nor that gender mainstreaming was actively pursued.

Lessons learned

iCCM can fill important gaps in national strategies for universal health coverage by creating access to essential health services for children who need timely treatment for malaria, diarrhoea and pneumonia but who do not have easy access to primary health care facilities. iCCM is an effective contribution to child survival when it is applied to overcome geographic barriers in access to care. The key to effective iCCM is its link to health systems building blocks, particularly:

- an uninterrupted supply of quality medicines;
- a human resources for health framework that includes CHWs;
- a health management information system that captures community-level data;
- a national health financing framework that integrates iCCM;
- the implementation of effective community engagement and demand generation activities.

Recommendations

Recommendation 1: WHO should take immediate action to assure that the achievements of the RAcE Initiative are not lost, by working with partner governments in assessing potential funding gaps for iCCM in RAcE programme areas and assisting ministries of health in resource mobilisation to assure that the services established in these areas continue without interruption.

Recommendation 2: WHO should include programme implementation through non-State actors as a possible alternate option to the established approach of direct implementation through governments, based on a contextual analysis and a capacity assessment of potential government and non-State actor programme partners.

Recommendation 3: WHO should consolidate and disseminate the lessons learned by RAcE, apply them in consultation with technical partners to update the guidelines for 'Caring for the Sick Child in the Community' and initiate actions to close persistent knowledge gaps by:

- Supporting research to better understand the role and the effectiveness of community engagement

strategies for iCCM, including an assessment of the community role in contributing to CHW motivation and retention.

- Conducting, in collaboration with interested partners, a systematic review of gender equality issues in the supply and demand of iCCM in different social and cultural contexts.

Recommendation 4: WHO should focus its technical and programme support on iCCM to ministries of health and development partners at country level on:

- Targeting iCCM services at remote rural communities living distant from health facilities, while in each case examining all possible options to assure that children have timely access to quality health care, including alternate options to iCCM if these exist.
- Embedding programme support to iCCM firmly in a system of a continuum of care by assuring that first-level referral facilities for CHWs have the capacity to provide accessible and affordable quality services to referred children.
- Assuring that national systems are in place to manage the provision of an uninterrupted supply of iCCM commodities to the community level, or that support to iCCM programming is paralleled by support to the development of such national systems.
- Advocating for the inclusion of CHWs in the national human resources for health framework as a salaried workforce or, where this is not accepted by governments, as a volunteer cadre with a fixed minimal level of stipends and incentives that is commensurate to the scope of expected services.
- Supporting the development and implementation of quality civil registration and vital statistics systems, as well as the integration of reliable community health data in national health management information systems in order to generate valid information about the impact of iCCM on the reduction of child mortality.
- Assuring that financing of iCCM services (from domestic or international sources) is firmly embedded in the national health financing framework, keeping in mind that iCCM services easily break down when there are financing gaps interrupting supervision and the flow of commodities.

Contacts

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The evaluation report is available here: www.who.int/about/evaluation/race_eval_synthesisr_eport_v1.pdf