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COMMUNITY CASE MANAGEMENT ESSENTIALS GUIDE

¹ *Immunization essentials: a practical field guide*. Washington, DC, Office of Health, Infectious Diseases, and Nutrition, Bureau for Global Health, U.S. Agency for International Development, 2003.

This guide offers basic immunization methodologies, organizational ideas for application, and explanations for why certain approaches may render themselves ineffective. Produced by the United States Agency for International Development, this guide is divided into twelve (12) all-encompassing chapters. *Immunization Essentials* provides information regarding everything from program management and evaluation tools to proper vaccine handling advice, anticipated costs, and thorough descriptions of prominent diseases for which vaccines are available. This document is a vital publically available resource for those working with health in development.

² Winch P et al. *Reaching communities for child health and nutrition: a framework for household and community IMCI* [Report of Workshop Reaching Communities for Child Health: Advancing PVO/NGO Technical Capacity and Leadership for Household and Community Integrated Management of Childhood Illness (HH/C IMCI). Baltimore, MD, 17–19 January 2001]. Washington, DC, CORE Group, Inc., April 2001.

A compilation of information from a conference on “advancing PVO/NGO technical capacity and leadership for household and community integrated management of childhood illness (HH/C IMCI)”, this report approaches childhood illness and leadership issues through a diverse, experienced academic lens. The four primary topics included in the report are: partnerships between health facilities and communities, appropriate and accessible care provision, integrated promotion of key family practices, and the role of Private Voluntary Organizations (PVOs) in leadership. Included are summaries of the conference along with the presentation papers from all three days of lecture and discussion. This report is from the perspectives of over a dozen experienced practitioners from diverse fields of child health in development.

³ *Caring for the sick child in the community*. Draft. Geneva, WHO and UNICEF, 2009.
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⁴ *Global burden of disease 2004*. Geneva, WHO, 2008.

This report, generated by the World Health Organization to reflect the 2004 global health situation, summarizes the severity of various diseases, including cancer. Of special interest to the WHO in this report is the concept of a disability-adjusted life year (DALY) and how diseases reduce the number of healthy years of life that a given person may experience. All statistics for the “burden of disease” are broken down by region, sex, income level, and age. This document is especially useful for obtaining precise facts and figures concerning the global health situation.

⁵ Black R et al. Maternal and child undernutrition: global and regional exposures and health consequences. *Lancet*, 2008, 371(9068):243-26.
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⁶ Morris SS et al. How Many Child Deaths Can We Prevent? New Estimates for 2003. Poster presented at Countdown to 2015 Conference, London, 13–14 December, 2005 (<http://cs.server2.textor.com/view-posters.html>).
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⁷ Jones G et al. *How many child deaths can we prevent this year?* *Lancet*, 2003, 362:65–67
The scope of the implications of this document is radical for health practitioners. Having categorized intervention methods according to evidence of effectiveness, Jones and his colleagues found higher level interventions to not be universally available. Because these interventions are not accessible for children and mothers who most need them, about two-thirds of childhood deaths which could be prevented are not being prevented. Furthermore, it is concluded that these interventions are feasible, but simply are not being implemented. This document functions as a challenge to health practitioners to focus on key interventions in striving for the maternal and childhood health benchmarks of the Millennium Development Goals (MDGs).

⁸ *Community-based management of severe acute malnutrition: a joint statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund.* WHO/World Food Programme/United Nations System Standing Committee on Nutrition/UNICEF, 2007.

The World Health Organization here offers tangible evidence of how a community-based approach in conjunction with a facility-based approach can prevent thousands of child deaths. This information, directed both at health worker and countries themselves, addresses the advantages of early detection of severe acute malnutrition and also the advantages of community-based care for uncomplicated forms thereof. Moreover, challenges that could result from high HIV prevalence are discussed and the role of global partners such as the WHO is addressed. The document concludes with a thorough explanation of ready-to-use therapeutic foods (RUTFs) and how to judge the relative effectiveness of particular food compositions. This document, though brief, offers helpful information for community-based approaches to severe acute malnutrition, particularly in the area of RUTFs.

⁹ *Progress for children: a world fit for children.* Statistical review number 6. New York, UNICEF, December 2007.

This UNICEF document is packed full of valuable statistics regarding the global situation of women and children, particularly in developing countries. Compiled primarily of data assessments in graph, chart, and table forms, the statistical evidence is on the whole very encouraging, as the general situation of these groups appears to be steadily improving in much of the world. UNICEF used the Millennium Development Goals (MDGs) as tools of evaluating the progress being made and has projected whether various countries are on track to meet each goal. Students, educators, researchers, development practitioners,

politicians, public officials, and those in countless other sectors will find the information in this document simple to decipher and utilize.

¹⁰ Victora CG et al. Co-coverage of preventive interventions and implications for child-survival strategies: evidence from national surveys. *Lancet*, 2005, 366(9495):1460–1466.

Compiled by four university professors, this short article provides information regarding child health interventions in nine states: Bangladesh, Benin, Brazil, Cambodia, Eritrea, Haiti, Malawi, Nepal and Nicaragua. Although the data compared in this document are all from another source, the Demographic and Health Surveys datasets (primarily from a research and evaluation company called Macro International), this peer-reviewed article appears to be highly reliable. The intended audience is somewhat ambiguous and the selection set fairly narrow, but the analyses offered are of high quality. The interventions of interest to the authors are those directed toward children (primarily vaccinations), those directed toward mothers (focused on nutrients and vaccines), and those directed toward households (namely, sanitation resources). The article's intent is to compare percentages of those receiving 0-7 of the specified interventions and how those percentages also vary across income brackets.

¹¹ Gilroy KE, Winch PJ. *Management of sick children by community health workers: intervention models and programme examples*. New York and Geneva, UNICEF/WHO, March 2006, p. 12, 23.

The product of collaboration between UNICEF and WHO, this article provides seven different intervention models for community health workers, designed principally for the management of pneumonia and malaria. The document also takes into account managerial practices for effectively utilizing community health workers. One of the key contributions of this article to those working in community-based health initiatives is that of theorizing the role of community health workers in a number of situations and how to integrate various programs and practices pertaining to pneumonia, malaria, and diarrhea within the community.

¹² *Implementing the new recommendations on the clinical management of diarrhoea: guidelines for policy makers and programme managers*. Washington, DC, WHO, UNICEF, Johns Hopkins University Bloomberg School of Public Health, and USAID, 2006.

Produced by the World Health Organization, this document focuses on how health practitioners may further decrease the prevalence of acute diarrhea in accordance with more recent findings. The traditional oral rehydration salts (ORS) used to prevent dehydration have been reformulated with lower concentrations of glucose and salt and zinc supplements are now recommended to be used in conjunction with them for 10-14 days. These changes, in order to be effective, must be disseminated throughout communities to help mothers in particular manage diarrhea in their children. These recommendations also must be understood at the policy level, according to the document, and it is the responsibility of health practitioners to encourage dialogue among stakeholders.

¹³ *Roll Back Malaria Partnership consensus statement: assuring access to effective malaria case management.* Geneva, Roll Back Malaria Partnership, March 2004.

The consensus statement produced by the Roll Back Malaria Partnership in 2004 serves the sole purpose of outlining the intentions of the partnership and the tenants to which the members adhere. The RBM Partnership is comprised of countries and institutions, with the largest percentage belonging to malaria endemic countries. Therefore, certain portions of the consensus statement which are directed toward countries to help them choose antimalarial drugs, develop policies and implement methodologies are designed for RBM's own members. RBM operates in accordance with WHO antimalarial drug recommendations and strives to "address both short-term and long-term barriers to meeting the demand for efficacious malaria treatment."

¹⁴ *WHO/UNICEF joint statement: Management of pneumonia in community settings.* New York and Geneva, UNICEF/WHO, 2004.

UNICEF and WHO have concluded that pneumonia, the leading killer of children under age five, can be effectively treated within the community. This statement presents the idea that of the major strategies for reducing pneumonia mortality, treatment in the community may very well be one of the best options. Assuming this conclusion to be accepted, the statement continues with suggestions regarding the integration of antibiotics into community treatment and how to scale up projects sustainably, even as far as the national level. Finally, the statement addresses countries directly, offering concrete responsibilities of countries if they intend to reap the results of effective community-based pneumonia treatment programs.

¹⁵ *WHO/UNICEF joint statement: Home visits for the newborn child: a strategy to improve survival.* Geneva, WHO, 2009 (WHO/FCH/CAH/09.02).

According to this statement, nearly "40% of all under-five child deaths occur in the first 28 days of life (the neonatal or newborn period)." This period is thus especially crucial for health practitioners. WHO and UNICEF specify in this document that skilled practitioners are recommended for neonatal home visits and that more severe conditions should be referred to facilities rather than treated at home. This document provides not only compelling evidence of why newborns need external attention in the first days and weeks of life, but also why and how maternal health should be addressed. This resource offers questions that skilled practitioners should pose to mothers of newborns in order to assess their health, as well as how home visits should be made and by whom. Furthermore, as is typical with such statements, recommendations are offered for countries. Overall, the document gives very thorough, reliable information about the significance of home visits in preventing newborn mortality.

¹⁶ *State of the world's children 2008: child survival.* New York, UNICEF, 2007.

The amount of information in this lengthy UNICEF document is staggering. It addresses everything from current facts and figure regarding child survival rates to lessons learned throughout decades of healthcare shifts. Specific case studies are included in order to demonstrate more fully how to incorporate community-based interventions into healthcare norms in developing countries, particularly addressing child and maternal

health. One of the main objectives of the document is to discuss how to scale up programs to reduce child mortality on a larger scale.

¹⁷ World Development Indicators Database [online database]. Washington, DC, World Bank Group, 2008.

Generated by the World Bank and dozens of its partner, the World Development Indicators Database assesses development indicators as could perhaps be expected: in economic and MDG terms. Bursting with a vast array of text figures, graphs and tables, the 2008 WDI publication answers any question the reader may have regarding the standard of living of individuals within a given country. The document is broken down into six (6) sections to make the information more manageable: World View, People, Environment, Economy, States and Markets, and Global Links. It is perhaps helpful in the case of such a large document to have an intended section in mind before beginning to peruse the pages.

¹⁸ *Tracking progress in maternal, newborn and child survival: the 2008 report*. New York, UNICEF, 2008.

In an attempt to track countries' progress leading up to 2015, marking the "end" of the Millennium Development Goals initiative, "Countdown to 2015" was created. This particular document regarding Countdown to 2015 is a product of UNICEF and assesses the progress made at the country level within sixty-eight (68) priority countries. The data in this particular report was compiled in 2008 regarding maternal, newborn and child mortality rates due to various causes. This document serves as an important tool, providing concrete information regarding individual countries' progress and thus offering a "call to action" specific to certain countries that aggregate data would not be able to offer.

¹⁹ Bryce J et al. Countdown to 2015: tracking intervention coverage for child survival. *Lancet*, 2006, 368:1067–1076.

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²⁰ *Case management of acute respiratory infections in children: intervention studies*. Geneva, WHO, 1988 (WHO/ARI/88.2).

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²¹ *Technical basis for the WHO recommendations on the management of pneumonia in children at first-level health facilities*. Geneva, WHO, 1991 (WHO/ARI/91.20).

As the name would imply, this report is filled with the technical bases for philosophies related to the control of pneumonia. One of the most crucial concepts is that bacterial pneumonia requires little or no laboratory equipment to diagnose and is more prevalent in developing countries than developed countries. Therefore, in developing countries the advantages to empirical observation may be stronger. Among the technical information provided in the document is the classification of acute respiratory infections (including pneumonia) and the steps that should be taken with the different classifications with children of different age groups. These hands-on, explicit explanations and

recommendations are excellent take-away information for whoever should read the document.

²² Arifeen SE et al. Effect of the Integrated Management of Childhood Illness strategy on childhood mortality and nutrition in a rural area in Bangladesh: a cluster randomised trial. *Lancet*, 2009, 374(9687):393–403.

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²³ Degefie T et al. Community case management improves use of treatment for childhood diarrhea, malaria and pneumonia in a remote district in Ethiopia's Oromiya region. *Ethiopian Journal of Health Development*, October 2009 [in press].

This case study was compiled by leaders within the non-governmental organization *Save the Children*. It takes into consideration a case study for improving community case management within a rural area of Ethiopia. The report, although confined to the limited region in which the case study took place, offers a valuable example of how community case management availability may be improved. For instance, although the Ethiopian government was already working to provide more health extension workers (HEW), there was often a gap in the treatment of pneumonia with the workers not adequately equipped to respond, but only to refer the sick to facilities. Training provided by *Save the Children* served to provide community health workers (CHW) with essential knowledge about treatment of primary health concerns for children, including pneumonia. This document outlines how the process of training was carried out, what barriers existed (e.g. illiteracy of CHW), and what the analysis of the case workers' registers demonstrated about their use of the training. This document would be very useful for those looking to improve community case management practices, particularly NGOs.

²⁴ Simoes EAF et al. Acute respiratory infections in children, chap. 25, p. 490. In: Jamison DT et al., eds. *Disease control priorities in developing countries*, 2nd ed. New York, Oxford University Press, 2006.

This, the twenty-fifth (25th) chapter in *Disease Control Priorities in Developing Countries* confronts acute respiratory infections (ARI) as one of the leading causes of illness and mortality in non-neonatal children under five. The primary subcategories of ARIs are discussed, along with the interventions available to prevent and treat them. Also discussed are recommended courses of action for treating various levels of pneumonia and the cost in disability-adjusted life years (DALY). The document concludes with discussion of vaccination intervention strategies and case management strategies which would be especially helpful for health practitioners and those involved in program implementing and training in developing countries.

²⁵ Rosales A. Christian Children's Fund. Personal communication, 2007.

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²⁶ Bryce J et al. [On behalf of the MCE-IMCI Technical Advisors]. Programmatic pathways to child survival: results of a multi-country evaluation of integrated management of childhood illness. *Health Policy and Planning* 2005, 20-S1:i5–i17.

This evaluation contributes useful information regarding the Integrated Management of Childhood Illness. Because the project deals with the progress being made in five separate countries (an in-depth subset of a larger assessment of twelve countries), it is called a Multi-Country Evaluation (MCE-IMCI). The evaluation focuses on the three major components of the IMCI model: improvement of health worker skills, improvement of health systems, and improvement of family and community practices. During the course of the evaluation, the scholars leading the project made several noteworthy observations, contributing to their ultimate conclusions. They found that in many cases, governmental issues (such as extensive centralization) were hindering the expansion of health systems. These findings support the idea that the generic three-part model could be applied to all developing countries, with modifications and adaptations being made to meet the needs and assets of specific countries. Directed at policy makers, researchers, and public health professionals, this document provides additional support and specific implementation techniques that could be used to improve health worldwide.

²⁷ *Tracking progress in child survival: the 2005 report*. New York, UNICEF, 2005.

According to this UNICEF document (part of the Countdown to 2015), a chief focus in working toward newborn and child survival should be on intervention coverage, as intervention coverage relates very strongly and directly to newborn and child survival rates. While Countdown to 2015 is interested in aggregate global progress, this report clearly states that individual country profiles for the sixty-eight (68) priority countries are also crucial. Individual countries progress must be taken into account in conjunction with global progress. This document also outlines for the reader how the priority countries were selected and which indicators will be used to measure change within them over the next several years.

²⁸ Marsh DR et al. Community case management of pneumonia: at a tipping point? *Bulletin of the World Health Organization*, 2008, 86(5):381–389.

As its name would imply, this bulletin (published by the WHO) confronts the issue of pneumonia-related fatalities in children from the vantage point of community case management. Countries with high child mortality rates were of the utmost concern in this bulletin, as the discussion revolves around increasing quality implementation of pneumonia prevention and treatment techniques in an effort to close the “pneumonia gap” and reduce the pneumonia burden. One of the major obstacles to this effort to improve and implement community case management of pneumonia is how to effectively scale up plans that have been successful. Thus, specific attention to individual countries is necessary in order to monitor their progress and take them from their current level of implementation (even if it be nil) to the next level.

²⁹ West A. Community case management: mapping CORE members’ CCM programs. Presentation at Save the Children Health and Nutrition PLG, Easton, MD, 20 May 2008.

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³⁰ Ashwell HE, Freeman P. The clinical competency of community health workers in the Eastern Highlands province of Papua New Guinea. *Papua New Guinea Medical Journal*, 1995, 38(3):198–207.

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³¹ Kelly JM et al. Community health worker performance in the management of multiple childhood illnesses: Siaya district, Kenya, 1997–2001. *American Journal of Public Health*, 2001, 91(10):1617–1624.

Selecting hundreds of community health workers for comparison with expert clinicians who used the same algorithm(s) for sick children, this research team evaluated CHW work in Siaya District, Kenya. The team attempted to account for deficiencies in the care provided by CHWs as part of the report. The researchers found it disconcerting to find that CHWs often improperly assessed cases and in cases which were properly assessed, the CHWs often chose improper treatment. These findings are very useful, calling to attention the need for quality community care in addition to quantity. The team concludes in this report ideas for remedying the deficiencies, including increased supervision, more straightforward guidelines, and more practice hours prior to receiving certification.

³² Zeitz PS et al. Community health worker competency in managing acute respiratory infections of childhood in Bolivia. *Bulletin of the Pan American Health Organization*, 1993, 27(2):109–119.

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³³ Mullany LC et al. Development of clinical sign based algorithms for community based assessment of omphalitis. *Archives of Disease in Childhood: Fetal and Neonatal Edition*, 2006, 91(2):F99–104.

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