Toolkit for Community Case Management of Childhood Illnesses:

ARI / Pneumonia and Diarrhea

Implementation Guide
(Myanmar)
The present document is one of the seven elements in the MOH/UNICEF Community Case Management of Childhood Illnesses Toolkit. The Toolkit includes:

Manuals and Guides

I. Implementation Guide
II. Trainer’s Guide
III. CCM Volunteers’ Guide
IV. CCM Volunteers’ Handbill
V. Photo Album
VI. Video
VII. Technical Supplements
   1. Patient register book
   2. Patient treatment record form
   3. Medicine stock record book
   4. Monthly reports forms
   5. Information, Education and Communication (IEC) materials
   6. Training of Trainers (TOT) Schedule
   7. Supervisors’ Training Schedule
   8. CCM Volunteers’ Training Schedule
   9. Assessment Questionnaires
   10. Supervision Checklist

Adaptation of the toolkit for use in Myanmar was completed in close collaboration between the Ministry of Health and UNICEF in consultation with Technical Working Group.
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Most of the deaths among under-five children investigated by verbal autopsy (85.5%) occurred at home. This serious situation is due to difficult access to quality health care and medicines, ignorance of danger signs and low involvement of the community. Malnutrition was considered to be a direct cause of death only in 1.0% of all deaths investigated but it was a contributing factor in vast majority of deaths. Given the magnitude of this problem, the Ministry of Health has adopted Community Case Management through health volunteers (CCM) as medium term strategy to reduce child mortality.

The development of this implementation guide for CCM is part of the implementation of community case management through health volunteers in Myanmar. This is an important tool that outlines the essential elements to the attention of all partners at various levels for the implementation of CCM in Myanmar.

The goal is to provide implementing partners with a sufficient understanding on the implementation process of CCM of pneumonia and diarrhea among under-five through health volunteers. More specifically, this planning document serves as a reference document for implementing partners at different stages of implementation of field activities and will enable them to familiarize with the tools used in CCM. We therefore urge all those responsible for health care at all levels to meet the instructions in this document in order to standardize the process of implementation of CCM in Myanmar. We strongly believe that through the implementation of CCM we may significantly contribute to the achievement of the Millennium Development Goal with equity approach regarding child survival and the reduction of disparity in accessing health care services.

Dr. Min Than Nyunt
Director General
Department of Health
Ministry of Health
# Abbreviation

<table>
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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<td>AMW</td>
<td>Auxiliary Midwife</td>
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<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<td>BHS</td>
<td>Basic Health Staff</td>
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<td>C4D</td>
<td>Communication for Development</td>
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<td>CCM</td>
<td>Community Case Management</td>
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<td>CHW</td>
<td>Community Health Worker</td>
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<td>CSO</td>
<td>Central Statistical Organization</td>
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<td>DHP</td>
<td>Department of Health Planning</td>
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<td>HMIS</td>
<td>Health Management Information System</td>
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<td>IEC</td>
<td>Information, Education and Communication</td>
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<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
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<td>MCH</td>
<td>Maternal and Child Health</td>
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<td>MICS</td>
<td>Multiple Indicator Cluster Survey</td>
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<tr>
<td>MO</td>
<td>Medical Officer</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>ORS</td>
<td>Oral Rehydration Salts</td>
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<td>RHC</td>
<td>Rural Health Centre</td>
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<td>THA</td>
<td>Township Health Assistant</td>
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<td>THN</td>
<td>Township Health Nurse</td>
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<td>TMO</td>
<td>Township Medical Officer</td>
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<td>TOT</td>
<td>Training of Trainers</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund Women and Child Health Development</td>
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GLOSSARY (defined as they are used in this guide)

**Auxiliary Midwife (AMW):** Voluntary health workers who received six months training on maternal health following standard curriculum to provide health services at the village level. They particularly assist midwife with maternal health care service delivery.

**Basic Health Staff (BHS):** Health Assistant, Lady Health Visitor, Midwife and Public Health Supervisor Grade I & II are categorized as BHS. They are paid government staff. The BHS down to the grass root level are providing promotive, preventive, curative and rehabilitative services through Primary Health Care approach. Infrastructure for service delivery is based upon sub-rural health centre and rural health centre where Public Health Supervisors, Midwives, Lady Health Visitor Health Assistant and Public Health Supervisor II are assigned to provide primary health care to the rural community.

**Communication for Development (C4D):** It is defined as a systematic, planned and evidence-based strategic process to promote positive and measurable individual behaviour and social change that is an integral part of development programs, policy advocacy and humanitarian work.

**Community Health Worker (CHW):** Voluntary health workers who received one-month training on standard curriculum for providing Primary Health Care especially for preventive and promotive services to the community in outreach villages.

**Health Assistant (HA):** Earlier to be certified as health assistant, 27-month course had to be completed in Health Assistant training school. The Health Assistant training school became the university in 1995 and began offering a four-year bachelor’s degree program. The graduates are allowed to practice as health assistants, many of whom are the main providers of primary health care in rural areas. They usually base in rural health center.

**Midwife (MW):** Sub-rural health centre and rural health centre are staffed with midwife to provide health care for rural population. MW is the backbone for maternal and child health care services. To be certified as MW, one has to complete 2 years training course provided at midwifery school.

**Rural Health Centre (RHC):** In each township, there are 4-7 RHCs based on township population to provide promotive, preventive and curative health services to the rural population. RHCs are usually staffed with Health Assistant, Lady Health Visitor, Midwife and Public Health Supervisor Grade II. Each RHC has four sub-centres covered by a midwife and Public Health Supervisor grade 2 at the village level.

**Township Health Nurse (THN):** THN is mainly responsible to supervise public health activities being implemented in the township. THN works under close supervision of TMO and assists TMO in compilation and submission of township report.

**Township Medical Officer (TMO):** TMO is a medical doctor who is responsible for promotive, preventive, curative and rehabilitative health of the population in assigned township. TMO is the key player in improving township health coordination among various implementing partners.

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4 Health in Myanmar 2007
ACKNOWLEDGEMENTS

The Ministry of Health recognizes the need for a Community Case Management Implementation Guide; and is grateful to UNICEF who have effectively contributed in the initial phase, and also to Technical Working Group for their valuable contribution in the development and production of this document which will serve as an important tool for the implementation of CCM in the Republic of the Union of Myanmar.

Our sincere gratitude also goes to the Australian Aid for International Development, AusAID for providing financial and technical support through UNICEF for development of these draft national standards.
INTRODUCTION

Topography and administrative divisions of Myanmar

Myanmar is a country with 676,578 square kilometers area which has borders with the Republic of India and People’s Republic of Bangladesh on its west, People’s Republic of China on the north and north east, Lao People’s Democratic Republic and the Kingdom of Thailand in the south and south east. The topography of the country is quite varied comprising of hilly areas, plains, coastal areas and deltas on the Andaman Sea in the south and the Bay of Bengal in the west. The terrain is hilly in the north, west and east, coastal lowlands and the central valley region (Please refer to the map for details). The states of Shan, Chin, Kachin, Kayin and Kayah are in the north and eastern part of the country. The terrain in many areas in these states is hilly. The central plains comprise of Mandalay, Sagaing and Magway while Yangon, Bago and Ayeyarwady are in the delta region. Mon and Rakhine States and Tanintharyi Regions are located in the coastal areas. The country is divided administratively into 14 States and Regions, 67 districts 330 townships, 2891 wards, 13,698 village tracts and 64,817 villages. There are three major rivers in the country. Natural resources comprise of land, water, forest, minerals, coal, natural gas and petroleum and marine resources. The climate is predominantly tropical with three distinct seasons (summer, rainy and cold).

Demographic situation

The population of the Union of Myanmar is estimated to be 58.38 million in 2008-09 with a population growth rate of about 1.52% annually. The sex ratio was 98.91 males per 100 females in 2008-09 (Source: Health in Myanmar 2010). Rural population is nearly 70% of the total population in the country while the rest of the population is in the urban and periurban areas. About 60% of the population of the country comprises of women and children and the estimated population of children under the age of 5 years was 6.6 million which is about 11.7% of the total population (Source: Statistical Year Book 2007 CSO). There are 135 national groups who speak more than 100 different languages and dialects. The major ethnic groups are Bamar, Chin, Kachin, Kayah, Kayin, Mon, Rakhine and Shan. The large majority of the people are Buddhist, while the rest are Christian, Hindu and Muslims.

Socioeconomic development

For economic development, top priority has been accorded to agriculture. Encouragement for the development of the industrial sector has been provided since 1995. In order to support and encourage small and medium industry throughout the country a total of 19 industrial zones have been established by the government in the states and regions. The government of the Republic of the Union of Myanmar has also carried out liberal economic reforms to ensure participation of the private sector in every sphere of economic activity as a part of economic reforms. The gross domestic product showed a favorable growth rate between 1998-2005 from 5.8% in 1998-1999 to 13.1% in 2006-2007 (Source: Statistical Year Book 2007, CSO). The development of social sector has kept pace with economic development. Continuous efforts have been made by the government to ensure equity and access to health, education and social services.

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5Ministry of Health, Department of Health, Women and Child Health Development Section. Five-year strategic plan for child health development in Myanmar 2010-2014.
Health Status of under-five in Myanmar

Under-five child mortality in the Republic of the Union of Myanmar shows declining trend in the last two decades. Inter-agency Group for Morality Estimation report 2012 shows under-five mortality 62/1,000 live births with a range of 45-84.\(^6\) MICS 2009/10 estimated under-five mortality at 46.1/1,000 live births, and infant mortality at 37.5/1,000 live births at national level. However, there are large variations in child mortality rates: rates are substantially higher in rural (42.8 infant and 52.9 under-five mortality) as compared to urban areas (24.5 and 29.1 respectively), higher amongst children with mothers having lower education level, and among children from families in the lowest socio-economic quintile. Major causes of deaths among under-five are acute respiratory infection (21.1%), brain infection (13.9%), diarrhoea (13.4%), septicaemia (10.7%) and prematurity (7.5%) according to the Under 5 Mortality Survey 2002-2003.\(^7\) Leading causes of Mortality according to causes of death verification study in Pyinmana township in 2007 by DHP found that the leading causes of under-five mortality were Pneumonia (45%) followed by diarrhoea (10%) and birth asphyxia (7%).

Most of the deaths among under-five children investigated by verbal autopsy\(^3\) (85.5%) occurred at home. This serious situation may be due to difficult access to quality health care and medicines, ignorance of danger signs and low involvement of the community. Malnutrition was considered to be a direct cause of death only in 1.0% of all deaths investigated but it was a contributing factor in vast majority of deaths.

Reducing mortality requires implementation of preventive, curative and promotional activities involving not only the health system but also the community, whose active participation is indispensable. To achieve its objective, Myanmar has prioritized strengthening of community-based health care services and CCM is one of the three thrust areas identified in the Five-year Strategic Plan of Child Health Development (2010-2014).

What are the issues to be solved by CCM? The first factor is the GEOGRAPHIC INACCESSIBILITY (distances and natural barriers). Indeed, CCM providers are based in villages or communities located away from a health facility or cut by natural barriers, giving priority to larger townships in order to cover as many children as possible. The second factor is THE CIRCULATION QUALITY MEDICINES IN THE COMMUNITY, used for 1st care in households. CCM provides the population with essential generic medicines (EGD) of good quality for children’s health care. The third factor is the SOCIOECONOMIC BARRIERS. The communities primarily receive quality health care free of charge in their vicinity and it reduces disparity in accessing health care services among wealth quintiles.

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CHAPTER - I
CONCEPTS OF COMMUNITY CASE MANAGEMENT

1.1. Concept of CCM establishment
One or more villages or communities with difficult access to a health facility receive health care provided by volunteers who is trained and supervised by health care providers to handle common childhood illnesses specifically non-complicated pneumonia and diarrhea without severe dehydration among under-five children (2-59 months).

1.2. Objectives
1.2.1. General Objective
Improve access to correct case management of pneumonia and diarrhoea (and malaria in some highly endemic villages in linkage with malaria program for under-five children who live far from health facilities or who have a difficult access to them.

1.2.2. Specific objectives:
- Ensure early diagnosis and treatment for pneumonia, and diarrhea among under-five without any geographic and socioeconomic difficulties
- Ensure timely referral of cases with danger signs or cases with complications
- Improve the availability of quality essential generic medicines (EGD) in the community and their rational use
- Improve the key family practices related to child survival

1.3. Intervention package.
The package for under-five children delivered by CCM volunteers comprising following key components;
- Provision of treatment for non-complicated cases of pneumonia and diarrhea
- Referral of cases with danger signs or cases with complications
- Communication for behavior change with special reference to home care and care seeking of a sick child

It would also be important for CCM volunteers to keep recording and reporting of the interventions delivered as per guideline.

1.4. Delivery of CCM package
CCM volunteers primarily operate from their home. Regarding hours of operation, they do not work full-time. They have to attend their own business/professional activities but dedicate part of their time to CCM activities. It should then be discussed with the community to agree on the hours in which they can be contacted.
### 1.5. Stages (or Components) of CCM implementation

The stages of implementation of CCM in identified townships are summarized in the table below:

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<th>Stages</th>
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<td>1. Drugs and supplies order</td>
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<td>2. Advocacy with state/region/township</td>
<td>Central Level</td>
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<td>3. Identification and selection of villages</td>
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<td>4. Selection of volunteers and supervisors</td>
<td>Township, Health Center, Community,</td>
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<td></td>
<td>Implementing Partners</td>
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<tr>
<td>5. Training of trainers</td>
<td>Central Level</td>
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<tr>
<td>6. Training of supervisors</td>
<td>Township, State-Region</td>
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<tr>
<td>7. Training of volunteers</td>
<td>Township, Health Center</td>
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<tr>
<td>8. Official introduction of volunteers to communities mobilization and</td>
<td>Health Center, Implementing Partners</td>
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<tr>
<td>social</td>
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<tr>
<td>9. Supportive supervision for implementation quality assurance</td>
<td>Basic Health Staff</td>
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<tr>
<td>10. Monitoring, data collection, compilation and sharing of progress</td>
<td>DOH, Implementing Partners</td>
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<td>reports</td>
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CHAPTER II
MEDICINES AND SUPPLIES MANAGEMENT

Medication management is one of the pillars that support CCM implementation since without them; health care becomes impossible at the community level.

2.1. List of medicine and supplies for CCM volunteers

2.1.1 Medicines
- Paracetamol 500 mg/100 mg tablets (or) Pediatric oral solution 125 mg per 5 ml
- Amoxicillin 250 mg tablets (or) Pediatric oral suspension 125 mg per 5 ml (or) 125 mg dispersible tablets
- Cotrimoxazole 480 mg tablets (or) Pediatric oral suspension 240 mg per 5 ml
- ORS (Oral Rehydration Salts) Low Osmolarity sachets
- Zinc Sulphate 20 mg tablets

2.1.2 Supplies
- Respiratory Timers
- Digital Thermometers
- Plastic Drug Box for easy carriage of medicine
- Plastic Bags for dispensing medicine
- Standard Patient register book (See Technical Supplement 1)
- Standard Patient treatment record form (See Technical Supplement 2)
- Standard Medicine stock record book (See Technical Supplement 3)
- Standard Monthly reports forms (See Technical Supplement 4)
- Information, Education, Communication (IEC) materials (See Technical Supplement 5)

Ensure CCM Volunteers learn how to fill out various management tools/supplies included on the list.

2.2. Medicines and supplies order
Annual stock of medicines and supplies to be used by the health volunteers are made available at township level at the start of training sessions for three reasons:

- There is a long lead time for some supplies
- There are supplies and equipment to which the CCM Volunteer should be familiar from their training session
- There shouldn’t be a gap between the end of the training session and the start of actual activities, otherwise the CCM Volunteer would lose the newly acquired knowledge and skills for taking care of sick children.
Generally, on a two monthly basis supplies are collected from township level by Rural Health Center's staff e.g through Health Assistant and the supervisor, **CCM Volunteer** will be provided with a two months’ stock of medicines to start with; assessed taking into account the following:

- The population of less than 5 years expected at the site.
- The number of episodes of illness per child per year (2.5 for diarrhea and 0.43 for pneumonia)
- The utilization rate of health care at the **CCM Volunteer** estimated initially at approximately 50%
- The total dose of tablets to be administered for each episode of illness.

For the **CCM Volunteers** to know MONTHLY CONSUMPTION as well as the MINIMUM STOCK LEVEL for their responsible areas, the facilitators can demonstrate the necessary calculations during the training session. This is not included in the currently suggested training manual and facilitator’s guide for keeping the training as simple as possible.

Each **Supervisor**; Basic Health Staff as well as concerned staff from higher level (township, state/region or central level) shall make sure necessary medicines are available to the **CM Volunteer** in a way that guarantees effectiveness of health care for 2-59 month old children with non-severe, uncomplicated pneumonia and diarrhoea without dehydration. It is strongly prohibited **CCM volunteers** from treating children under two month old as they are very liable to change and need skilled care. Also they are not trained to manage over five year old with ARI/pneumonia as well as adult.

Based on local situation (e.g difficult geographical terrain, heavy rainy season interfering transportation) some modification in refilling supplies should be considered to ensure no stock out of supplies at **CCM Volunteers**. For example prior to long rainy season villages with difficult access need to receive at least 4-5 months’ supply. Pre-packed drugs distribution to **CCM Volunteers** could also be considered to simplify drug dispensing and drug consumption recording.

**Note:**
Consider providing stock of Amoxicillin and Co-trimoxazole in a ratio of 4:1 to volunteers. Amoxacillin still will be first choice in treating under-five with suspected pneumonia while co-trimoxazole will be used in children with increased respiratory rate with diarrhoea.

**2.3. Receipt and storage of medicines**

Upon receipt of medication, **CCM Volunteer** with support from supervisor will be responsible for:

- Counting the amount of medication received
- Checking the expiry date of medicines
- Checking the external appearance of each product (color, smell, shape ...)
Medications should be kept:
   a) **Clean and well maintained**: regular sweeping and dusting of storage space and keep the medicines off the floor as well
   b) **Ventilated**: the room or the storage box must be ventilated so as not to expose the medicines to high temperatures and keep them away from direct sunlight
   c) **Dry**: the storage place should be dry as moisture can affect product quality
   d) **Secure**: the medicines box should always be locked to prevent losses…
   e) **Well-organized**: i.e. a good medicines organization which makes them easier to find at the time of distribution.

2.4. **Physical inventory of medicines**

The inventory of medicines is a task that the *CCM Volunteer* will perform each month to ensure that the quantities recorded match those they have physically counted. The supervisor will support the carrying out of inventory of medicines before refilling the medicines.

Expired medicines or the medicines affected or damaged must be delivered to supervisor and returned to the township office for destruction. In such a rare event these medicines can be recorded as losses.

2.5. **Dispensing of medicines**

When medication is given, it is important that the patient receives:
   - The appropriate medication with its name
   - The correct information on how to take the drug, i.e.:
     - The exact dosage of the medicine
     - How many times per day the drug is to be taken
     - The number of days of treatment
     - How to administer the drugs to sick child

The steps in the dispensing of medicines are described in detail in the *CCM Volunteer* training module. It is very important for *CCM Volunteers* to understand these different steps in order to have a correct administration of medicines. These are verified by simulation exercises during the training and needs to be strictly followed.
CHAPTER - III

ADVOCACY AND SOCIAL MOBILIZATION AT VARIOUS LEVELS

Advocacy is a fundamental step at the beginning of the implementation at new location/site. At each level of the health system, it will precede the actual beginning of the intervention on the field. It will be done in cascade.

3.1. **Purpose of the Advocacy**

The advocacy of senior management teams will have the following goals:

- Provide information to local authorities and leaders on CCM.
- Obtaining the support of local authorities, local leaders and partners for their involvement in the implementation process.
- Prepare various trainers and supervisors of intermediate and peripheral levels on the tasks.

3.2. **Advocacy meeting levels**

Advocacy meetings will be held in cascade at the following four levels:

- **National level** Participants will be the national level authorities, state/region/township senior staff, and other stakeholders. The central team will facilitate this advocacy.

- **State/Region level** Participants will be the State/Region level authorities, influential leaders, partners, and state/region health staff. The training team from the national level and state/region will facilitate this meeting. Advocacy at this level needs more emphasis as decentralization is taking place.

- **Township level** Participants will be the local authorities of the townships, influential leaders, INGOs, Local NGOs working in the township (Myanmar Maternal and Child Welfare Association, Myanmar Women Affair Federation, Myanmar Red Cross society, etc.), Basic Health Staff and hospital staff of health facilities. The training team from the state/region/township will be the ones to facilitate this Advocacy.

- **Village level** Participants will be the local authorities of villages, village health committee members, faith-based leaders, influential people of the village and community where CCM Volunteer will operate.

3.3. **Social Mobilization**

The social mobilization of community at the village level where CCM Volunteer operates is one of the key components for successful implementation of CCM.
The social mobilization has following goals:

- Raise awareness of the community particularly care givers of under-five children on CCM initiative in their village
- Create community demand and improve utilization of delivery package for sick child
- Ensure community participation and support towards CCM Volunteers

Channels and types of communication: Social mobilization will be done through various channels. For example, through the religious institution like Churches, Monasteries, through the care giver to care giver, through the regular villagers meeting, through BHS and through the volunteer themselves.

Communication materials: The significant reduction in mortality and morbidity from common childhood illnesses; pneumonia and diarrhea can be achieved to a large extent through community case management in combination with adoption of recommended key family practices such as appropriate home care of sick child, early recognition of danger signs and in-time care seeking from appropriate health care providers. Complementary to CCM training package IEC on Danger Signs of pneumonia and diarrhea (Technical Supplement 5) would be used till the specific communication for development package has been produced.
CHAPTER - IV
SELECTION PROCESS

First of all, township where CCM will implemented need to be identified in collaboration with the Ministry of Health at national and/or State/Regional level. There are pockets of hard to reach areas even in the townships which are apparently considered to be reachable (e.g. Pyinmana, Magway) and this should be considered during township selection.

After identification of township for establishing CCM initiative, the selection of eligible villages and volunteers need to be done by/in consultation with township health team and community. This can be initiated by mapping of unreached or underserved villages. The place where the CCM will be installed should help improve access to health care for a number of distant villages/populations or those cut away by natural barriers. The identification on the map is not enough. Thus the support of the local community should thereafter be obtained for the selection of the villages, during field visits to inform local people and their leaders including village health committee in the ordinary course of a meeting.

4.1. Village Selection

Village selection will be done according to certain process standard to ensure quality. Avoid unnecessary duplication with other implementing partners and to implement it in peripheral of the health care catchment area covered by BHS. These will be:

4.1.1 Eligibility criteria
The eligibility criteria for villages are:

- **Geographical accessibility**: population of the village have difficult access to the health facility; either because of the distance or a natural barrier (erosion, rivers, forests…)

- **Existence of health care providers**: Exclude villages where midwife/BHS is residing and/or those which have access to an existing trained CCM provider/ the same intervention to avoid any duplication and wastage of scarce resources. Villages could not reach at all by midwife/BHS should also be included with some assurance for supervision in place.

- **Size of under-five population**: Priority given to villages with larger under-five population in order to have the mutual benefits; CCM Volunteers could well practice their skill and be motivated if there were enough cases to serve as well as more under-five could benefit from services provided by CCM provider.

4.1.2. Identification of potential villages
The identification of villages follows the following procedure:

- Make a sketch of the area (mapping of the area)
- Show all health facilities, both government and other health care available in the area
- Display villages located more than 5 km or hard to reach due to natural barriers: rivers, mountains, ravines, etc.
- Indicate the number of inhabitants for each of these villages
Indicate the distance of each village in relation to the HC and any health facility close to each of these villages

Indicating the other villages covered by the identified village and the distance between villages

Indicate the distance between the identified villages and the health center

### 4.1.3 Mapping elements for an area by Rural Health Centers

<table>
<thead>
<tr>
<th>Sub-Rural Health Centers</th>
<th>Villages under Sub-RHC</th>
<th>Village population</th>
<th>Distance between village and Sub-RHC</th>
<th>Village selected for CCM volunteer</th>
<th>Population covered by CCM volunteer</th>
<th>Natural obstacle</th>
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### 4.1.4 Stages in selection

There are three recommended stages in the selection.

1) First identify villages by midwife/BHS with involvement of community and obtains the consent of the township health authority on the identified villages before informing the target population and select volunteers who want to be.

2) Mobilizes only villages/communities that have received the endorsement of the township health authority for further activities and make arrangements for the key people in the village including village authority/village health committee to attend meeting for the selection of volunteers.

3) Involve township health authority, community and the partner in the selection of *CCM Volunteer* to ensure that the selection criteria are met.

### 4.2. Volunteers Selection

For successful implementation of CCM, the right selection of volunteer is a corner stone and following are criteria taking into account during selection.

- Being a promotional *health volunteers* e.g in malaria or AMW or CHW
- Willingness to work as CCM Volunteer at least for 3 years
- Have a known resident of the village, preferably the one who is likely to stay in the village.

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9Annual head counts by health staff can be used as reference to indicate the number of inhabitants in villages.
Ensure availability; less mobile and less traveler
Know how to read and write in Myanmar with numerical skills, preferably secondary education
Have good relationships with other community members
Age between 18-50 years

**HOW IS THE SELECTION DONE?**
A meeting for the selection of the volunteer should be arranged and mobilize community members including village leaders and village authority to attend the meeting.

- Identification of volunteers would lead by responsible midwife/BHS of the above selected village in close consultation with concerned community.

- The nomination and final selection of the volunteer can be done in the same meeting or in a subsequent meeting after ensuring nominated volunteer meet above-mentioned criteria to the extent possible. It is desirable that a supervisor from township health department be present during the selection.

- Ask the volunteer if she/he agrees to work as a volunteer for at least 3 years? If she/he agrees, ask the community to support him and cheer.

- Announce to the community the next steps such as:
  - Volunteers training
  - Beginning of CCM in the village
  - Motivation of volunteers and free access to medicines during illness episode
  - Setting up a plan for urgent referrals.
This chapter deals with the conduct of various types of trainings to introduce CCM in selected areas. The following three types of trainings are intended for the CCM implementation in cascade:

1) Training of trainers (3 days)
2) Training of supervisors/BHS (3 days)
3) Training of CCM Volunteers (5 days)

5.1 Training of trainers

5.1.1 The Role of Trainers
Trainers will facilitate training of supervisor and the CCM Volunteers in the selected townships. They are also responsible for state/region level advocacy and township level advocacy. Effective program management including monitoring, supervision as well as providing higher quality clinical care for referred cases are also the important function among the others.

5.1.2 Selection of Instructors to be trained as trainers
Given that the CCM deals primarily with treatment of sick children, trainers are selected among government professionals and health care providers who have patients’ health care in their basic training e.g. pediatricians, medical officers, nurses, health assistants etc. Primarily they are selected from selected Townships, District and State/Region. Attention needs to pay here that pediatrician involvement and guidance at district/township level is critical. In addition, prior knowledge in IMCI/Integrated Management of Common Childhood Illnesses given by WCHD section of the Department of Health is recommended. In the absence of this prerequisite; a prior IMCI/Integrated Management of Common Childhood Illnesses knowledge and skill upgrade session is recommended.

5.1.3 Training materials for trainers
The following Myanmar specific training materials have been developed, field tested and evaluated for training of trainers in Myanmar. These are available with WCHD section of DOH and all implementing partners are encouraged to use the standard materials to ensure standard materials and methods:

- Trainer’s guide
- CM Volunteer guide
- CM Volunteer job-aids
- Video
- Instructions on the selection of villages and volunteers
- Assessment tools for the CCM Volunteer during the training session
- Supervision tools and the data processing form for evaluating the quality of health care provided by CCM volunteers.
5.1.4 Conduct of training of trainers

The training of trainers lasts for 3 days. Train all potential trainers at central level (or) train only pediatricians at central level and then Pediatricians in turn will train TMO, Medical Officers and training team from township as trainers.

The following events are described at the training session:

- The advocacy of local authorities at the opening of the training session
- The orientation of trainers to village and volunteer selection related information
- The introduction to facilitation techniques for CCM volunteer course
- The familiarity with program management including monitoring, supervision tools
- The familiarity with CCM volunteers supplies including:
  ♦ Patient register book
  ♦ Patient treatment form
  ♦ Medicine stock record book
  ♦ Monthly reports forms

The training of trainers (TOT) schedule is enclosed in Technical Supplements 6.

5.1.5 Trainer’s Guide

To enable the trainers to better accomplish their assignment as facilitators, a trainer’s guide is available to them. This phase of training focuses on giving them familiarity with the trainer’s guide, which they are supposed to keep handy (and have it in front of them) during the training session.

This guide is a combination of CCM Volunteer guide and trainer’s instructions. It is presented in two parts: TRAINER’s methodological guide to the course lecturing at each stage of the session and in the boxes is the Contents of CCM VOLUNTEER guide. We recommend the trainers to STICK their GUIDES to themselves throughout the session.

**Important Note:**

At the end of their training, trainers must be able to immediately facilitate the training of supervisors and CCM Volunteer under the supervision of the central level.
5.2 Training of supervisors in Supportive Supervision (Basic Health Staff)

5.2.1 The role of supervisors
Supervisors are responsible for proving supportive supervision on regular basis to CCM Volunteers operating in their responsible areas using a standard checklist. In the various training sessions of *CCM Volunteer*, supervisors and volunteers participate as a team, are positioned together to ensure bonding and to get immediate feedback on CCM knowledge and skills.

5.2.2 Selection of supervisors
BHS basically midwife from areas planned for CCM integration are automatically selected for training as supervisors to provide supportive supervision to *CCM Volunteer*. Prior knowledge in IMCI/Integrated Management of Common Childhood Illnesses is a recommendation. However, in the absence of this prerequisite; knowledge and skill upgrade in this technical area is necessary.

5.2.3 Training materials for supportive supervisors
The following tools are used for training of supervisors:
- CCM Volunteers’ Handbill
- CCM Volunteers’ Guide
- Vinyl sheet on management of common childhood illnesses
- Photo Album
- Video
- Treatment record form
- Patient register book
- Drug stock book
- Supervision check-list
- Instructions on the selection of villages and volunteer

5.2.4 Conduct of training
The supervisors would have a 3-day training facilitated by the township training team and supported by the District/State/Region following TOT. However, many other circumstances will help provide an ongoing training, not to mention the subsequent visits and supervision of teams of supervisors. In a formal way; the three selected training opportunities are:
- At the township level advocacy, the supervisor will be oriented to prepare the selection of villages and volunteers (see Chapter 4).
- During their training, supervisors will be introduced to the management of cases by CCM Volunteers and will receive a technical knowledge and skill upgraded as well as introduced to the supportive supervision.
- During the training of *CCM Volunteer* led by the training team of township and state/region, the supervisor will be given opportunity to perfect their skills by facilitating *CCM Volunteer* training during the 5 days of their theory and practical training sessions.
The training of Basic Health Staff in Integrated Management of Common Childhood Illnesses or upgrade of knowledge and skill in this matter is recommended to be planned as part of capacity building of health staff at facility level of implementation area. In addition to the technical knowledge, logistical capabilities of supervisors including on supportive supervision can be improved as required.

The trained supervisors will be able to ensure the immediate supervision of CCM Volunteer in their responsible area, under the coordination of the township training team. The state/region level and central level will then perform their supervision according to an established schedule.

The supervisor’s training schedule is enclosed as Technical Supplement 7

5.3 **Training of CCM Volunteer**

5.3.1 **The Role of CCM Volunteers**
CCM Volunteers are responsible to deliver CCM package for under-five children comprising of following key components in their resident/assigned areas;

- Provision of treatment for non-complicated cases of pneumonia and diarrhea without dehydration for the children age 2-59 months
- Referral of cases with danger signs or cases with complications or less than 2 months old
- Communication for behavior change with special reference to home care of a sick child and recognizing danger signs for sick children

It would also be important for them to keep recording and reporting of the interventions delivered as per guideline

5.3.2 **Selection of CCM Volunteers**

comprising of following key components in their resident/assigned areas;

Please see chapter III for selection process details. In order to facilitate the CCM Volunteer to learn about case management, it is recommended that the training as AMWs and CHWs precedes that of as CCM Volunteers. However, this does not constitute a major constraint, because the prerequisite may also depend on other previous health knowledge or experience of the potential candidate for being a CCM Volunteer.

5.3.3 **Training materials for CCM Volunteers training**

All teaching materials for the training of CCM Volunteer must be prepared before the session to facilitate their theoretical and practical learning, the video study, examination of sick children, dispensing of medication and communication with the mothers for pneumonia and diarrhea,. 
Training materials and aids used for training *CCM Volunteer* are listed below:

- CCM Volunteers’ Guide
- CCM Volunteers’ Handbill
- Photo Album
- Video
- Treatment record form
- Patient register book
- Drug stock book
- Monthly reports forms
- Respiratory Timers
- Digital Thermometers
- Life-saving medicines (samples of each product used by *CCM volunteers*)

### 5.3.4 Conduct CCM Volunteer training

**Trainer:** *CCM Volunteers* are trained by the township training team supported by the state/region, under the supervision of the central level, when needed, especially at the beginning of the process. During training, *CCM Volunteers* are also supervised by their respective BHS/midwife who accompany them throughout the session and assist them with understanding training materials, solving the case studies’ exercises, assisting them with clinical exercises, etc. and establishing linkages with them for continuum of care from home to health facility when needed.

**Duration and location:** The training of the *CCM Volunteer* lasts 5 days, according to the national standard training agenda and schedule. It is recommended that facilitators stick to the national guide and abide by the training methodology throughout the session. Any convenient place will be used for training, if it provides an environment suitable for the achievement of objectives according to the timeframe and the methodology adopted. It may thus be the health area central office, a health facility, which offers the environment.

**Methods:** The mix of training methodologies should be used to develop confidence and skill among *CCM Volunteers*. It includes (a) Brief presentation (b) Group work and discussion using handbill, vinyl, photos and video, and (c) Individual exercise using treatment record form with the support of facilitators; (d) case examination and skills included were (a) History taking, (b) Looking for the danger signs, (c) Taking the temperature, (d) Counting the respiratory rate using respiratory timer (e) Checking the signs of dehydration and (f) Checking the signs of severe pneumonia.

During practical sessions in training, the recruitment of sick children will be done either in health facility (if there are enough sick children for the *CCM Volunteer*) or in the surrounding households (in case there is not enough sick children at the health facility).

The *CCM Volunteers’* training schedule is enclosed as *Technical Supplement 8*. 
5.3.5 CCM Volunteer’s Guide

A 5 day’s training module developed by a technical group in MOH will be used for CCM Volunteers’ training. It was developed with reference to National CHW manual and IMCI Manual for BHS. It was finalized, printed, and piloted by MOH with support of UNICEF in 2010-2011.

The subjects covered in the training of CCM Volunteer are;

- **Simple Case Management component:** It includes the simple assessment chart / algorithms for pneumonia and diarrhoea, as well as management of non-complicated, non-severe cases of pneumonia and diarrhoea
- **Danger signs and symptoms:** Focus given to examining danger signs and make early referral of complicated/severe cases
- **Medicine prescription:** Dosage of ORS and Zinc tablets for diarrhea and antibiotics for pneumonia.
- **Communication to mothers:** for adequate home care and recognizing danger signs for sick children
- **Patient registration, record keeping and reporting:** (not included in CCM Volunteers’ Guide)

Bring following points into CCM Volunteers’ attention;

**Follow up appointments of sick children treated:** Indeed, if the mother does not come to a follow up appointment given, the CCM Volunteer is required to follow up on the child at home.

**Compliance:** When monitoring the child treated, the CCM Volunteer looks for signs and symptoms on whether the child’s health is improving or not, on the respect of given advice by the child’s mother and verifies if the child has received his/her dose as prescribed.

5.3.6 Training Evaluation and Follow up Actions are both during training and at the end of the training.

This is the knowledge and skill based training. To ensure that the minimum levels of knowledge and skills are achieved on a daily basis, at the end of each day there is assessment of the knowledge and skills of volunteers and those who have gaps in the same are required to be given additional “tuition” on the specific area e. g. use of handbills, use of treatment record form, diagnosis, and treatment and skills like counting the respiratory rate using respiratory timer, taking the temperature. A set of assessment questionnaires is enclosed as Technical Supplement 9.

There is the final examination after 5 days wherein five case scenario based simulation exercise needs to be individually administered and scored. Low scores or mistakes in diagnosis and treatment are marked unsatisfactory and volunteers who fall in this category will receive an additional 2 days of intensive training followed by a repeat examination using different simulation exercises.
It is also critical to organize annual refresher training for CCM volunteers at township level to update their knowledge and skill as well as to share experiences among themselves.

Important Reminder: In order to prevent the CCM Volunteer to forget the lessons learned due to inactivity, it is recommended that the township training team provides a sufficient quantity of medicines and supplies for CCM Volunteers to start functioning immediately after the training session. (See Chapter 2).
CHAPTER - VI
SUPERVISION

The supervision of CCM Volunteers is one of the most important elements of the CCM implementation. It can only be successful only if regular supervision is provided. The supervision should be supportive in its nature, not to blame on what has done.

6.1. Objectives

The supervision of CCM Volunteers aims to improve the technical and logistical capacity of the CCM Volunteer for optimum performance. More specifically, activities to be done during supervision are the following:

1) Ensure the availability of life-saving medicines, and other supplies including treatment record form necessary to maintain their functionality
2) Ensure correct diagnosis and appropriate treatment are given to sick child as instructed and trained
3) Interview and assess the knowledge of mothers on danger signs and taking medicines to ensure the mothers are thoroughly counseled
4) Actively collect data and reports not yet transmitted by the CCM Volunteer.
5) Any other support required by CCM Volunteer e.g. talking to village leaders/ elders

6.2. Supervision mechanism

The supervision of CCM Volunteer, in the first place is the responsibility of the sub-rural and rural health center staff; midwife supported by other Basic Health staff and then of the township health staff; Township Health Nurse (THN) and Township Health Assistant (THA). Other executives of the state/region and central level are responsible for the technical support to the midwife as well as the THN/THA to enhance their ability to conduct supervision. This was put in place similar to malaria CCM but more intensive for first few months. In collaboration with TMO, the actual transportation cost and standard daily allowances for supervisors requires to be considered to materialize supervision.

Basically supervision will be Two Tier supportive supervision mechanism.

Tier 1- Township Level Supervision: Township level supervision team comprising 8-10 members including the trainers e.g TMO, MO (MCH), THN, HA is formed. Two persons are assigned for each RHC area. The fixed geographic area of responsibility ensures continuity and each volunteer – supervisor pair can know the progress and jointly solve the challenges if any.

Tier 2- Rural Health Center Level Supervision: All midwives from Sub RHC supported by BHS from RHC level are assigned for supervision. Similar to township level, geographic area is fixed and each midwife supervises 2 to 3 volunteers in her geographic area.
6.3. Supervision Checklist

The supervision checklist for CCM is enclosed as Technical Supplement 10. This supervision checklist covers five key areas as per the Tanahashi Model mentioned below in order to assess both quantitative and qualitative indicators.

1) The availability of life-saving medicines and supplies
2) The availability of trained providers
3) The utilization of the services of CCM Volunteers by community
4) The complete utilization of services by community through involvement in the strengthening of referral of severe cases and follow up visits to child treated
5) The quality of services including record review for diagnosis and treatment consistency and interview with a few mothers who have utilized the service to verify their knowledge about danger signs and home care.

6.4. Supervisors’ Tasks

The supervision will make easy to gather information that will help better focus the issues to be discussed and solved for effective CCM implementation. The key tasks to be completed by supervisor during their routine visit are outlined as the following:

- Review of all treatment record forms filled by the CCM Volunteer, with immediate individual feedback.
- Observe management of cases of illness by the CCM Volunteer and individual feedback. (Only in case a sick child is present)
- Review record and register filled by CCM Volunteer
- Check the availability of medicines, charts and other supplies at CCM Volunteers
- Verify medicine preservation conditions
- Build capacity of the CCM Volunteer in health care and medicines management
- Interview with some mothers who have utilized and who have not utilized the service for verification of their knowledge about danger signs and home care, and to get a sense of their awareness, perceived satisfaction and relevance of the services.
- If required meet village authority, village leaders etc) on the utilization of CCM Volunteer’s service,
- visits to monitor children treated by CCM Volunteer and problems faced.
- Collect data/reports required for processing and analysis.
6.4. Tips for Reviewing Treatment Record Form

When the RHC level supervisor is carrying out supervision, the recommendation is to first go through all the treatment record forms with the CCM Volunteer, which the latter has completed, in order to give them immediate feedback on the errors (misclassification, mismatch in diagnosis and treatment etc) they committed and to congratulate them for the tasks well performed.

The supervisor will then quickly process at least last three treatment record forms to review how the CCM Volunteer has completed the entire problems of the child, including: assess, classify, choosing the treatment and giving treatment related to danger signs, cough/cold, diarrhea, and other problems and to better understand the weaknesses of the CCM Volunteer in general as well as identify areas on which to focus during the next supervision.

COMPLETENESS OF THE TREATMENT RECORD FORM BY SECTION AND MONTH SINCE STARTING DATE

Here, there is a need to analyze the completeness of filling of the treatment record form, item by item and look through the whole form to see if the CCM Volunteer has completed the following sections of the treatment record form:

- Identification
- Complaints
- Danger/Warning signs
- Cough/cold
- Diarrhea
- Treatment & Remedial advice
- Follow up instructions
- Advice on referral

REMARKS:

1. At this stage of the evaluation of the completeness of the treatment record form filling by the CCM Volunteer, DO NOT JUDGE if the CCM Volunteer has well or poorly filled out, as you would be judging the quality (this will follow later). Now, you only worry about the fact that the CCM Volunteer has filled out the form or not.

2. Regarding the follow-up visit. Use new sheet of treatment record form if the sick child returns to the patient appointment but tick in the identification part as Follow-up visit for both cases whether the mother came back herself to the appointment or the CCM VOLUNTEER made a home visit to monitor the child. There is a need to conduct the whole examination as described in follow up visit chapter and fill the treatment record form.
RECONCILIATION BETWEEN SIGNS / SYMPTOMS AND CLASSIFICATION

It is a matter to consider whether the classification is consistent with the signs/symptoms evaluated or encircled by the CCM Volunteer. For example, signs/symptoms suggest a referral but the CCM Volunteer has classified it as a simple case, or vice versa.

It is therefore necessary to analyze in turn the following problems:

1. Cough/cold: Is there correlation between the signs / symptoms and the classification?
2. Pneumonia. Is there correlation between the signs / symptoms and the classification?

To ensure that the CCM Volunteer mentioned in the corresponding blank space the number of BREATHING movements she/he counted on the child. That she/he made the right decision that it is FAST OR NORMAL BREATHING (in relation to age of the child), to decide whether it is happened to be pneumonia or a COUGH / COLD.

3. Diarrhea: Is there correlation between the signs / symptoms and the classification?

RECONCILIATION BETWEEN CLASSIFICATION AND TREATMENT/ACTION

In each case, analyze the treatment/action that the CCM VOLUNTEER noted down under the treatment portion of treatment record from, check whether this is consistent with the classification used. At this point, verifies the NAME OF THE DRUG and/or THE ACTION taken, without considering again the dose by the age of the child.

RECONCILIATION BETWEEN AGE AND THE DOSE OF DRUG

Here needs to verify if each dose, frequency and duration of medication that the CCM VOLUNTEER has recorded corresponds to the age they had mentioned in the identification of the child and according to treatment guideline.

RECOMMENDED PATIENT FOLLOW-UP VISIT

Here, note only if the child has been examined again at the follow up visit or not.

RECONCILIATION BETWEEN SIGNS/SYMPOMTS, CLASSIFICATION AND ACTION AT THE FOLLOW-UP VISIT

During the follow-up visit, there are 2 things to check:

- Danger signs. Did the CCM Volunteer reassess the danger signs or not?
- Cough/cold. During his first visit, if the child had presented the symptom cough/cold (including pneumonia), did the CCM Volunteer count again the respiratory rates of the child or not? Did he make the right decision after recount of the breathing movements?

REMARKS;
The RHC level supervisor requires to compile reports on the activities of the CCM Volunteers within
the area they oversee, to ensure their completeness before forwarding them to the township level. The supervision of a CCM Volunteer takes a minimum of 3 hours. Thus, good planning cannot have more than 2 CCM Volunteers per day to supervise.

The Township level supervisors must plan their supervision to CCM Volunteers along with the RHC supervisors. In case the RHC supervisors did not accompany them, the township level supervisors required to keep the RHC level supervisor informed on the conclusions of their supervision. Indeed, the township level supervisors must ensure that CCM Volunteers are functioning properly, supplies are available, relations with the community are good, service is utilized by the community, the CCM Volunteer does well their follow-up visits to children treated by them, and the monthly reports are regularly collected for processing and analysis.

6.5 Frequency of supervision

- **The RHC/Sub-RHC level staff must supervise the CCM Volunteers once a month regularly.** At the beginning of the implementation at least for 3 months, staff at RHC level should frequently go for supervision probably weekly to ensure adequate skills and to help with local problem solving. If the CCM Volunteers have too many problems, the RHC staff may hold more frequent supervisions, either by going on the field themselves, or by inviting the CCM Volunteer at the health center for follow up. It is envisaged that the frequency will be reduced gradually and can be aligned to routine outreach work as the volunteers build up their capacity. Once things work well, once a month visit by RHC/Sub-RHC level staff is recommended.

- **Supervision by the township level staff to RHC/Sub-RHC staff and the CCM Volunteers will be done on quarterly basis.** At the beginning of implementation, more frequent visits might need with the focus on CCM Volunteers needing more support to improve performance. Once things work fairly well, the schedule of supervisions will be aligned to routine supervision of the township on quarterly basis.

- **Supervision by the central, state/region level to the area where CCM has been implemented, the RHC level staff and the CCM Volunteers will be on annual basis.**
7.1 Records and Status

Basically two types of records are maintained by the volunteers;

(a) Patient Register and treatment record by using Patient Register Book and Treatment Record Form

(b) Medicine and supplies stock related by using Drug Stock Book

7.2 Compilation of data and Reporting

Data compilation and reporting needs to be undertaken by implementing partners with health system at various levels from village to central level on the lines of national Health Management Information System (HMIS).

Compiling data and preparing a monthly summary on patient treated and drug utilization at the end of each month will be done by CCM volunteers with support from supervisor. The data can easily be picked up from the patient register and drug stock book as it is updated on daily basis by CCM volunteers. The suggested reporting format has been kept simple as per evaluation findings and is available in the Technical Supplement 4a.

RHC level supervisors will then compile monthly report collected from CCM Volunteers. Based on CCM volunteer report as well as supervisory checklist, they will prepare monthly report as per the sheet used in the Dawei pilot and the same is available as Technical Supplement 4b.

Then, RHC compiled report shared with the township training team on monthly basis will be compiled in a sheet enclosed as Technical Supplement 4c. The township medical officer (TMO) is responsible for the regular functioning of the CCM activities as well as responsible for the completeness and timeliness of data for submission to the central level initially. With decentralization in place, compilation at state/region level might be later considered as it can produce useful information for state/region to closely guide implementation.

7.3 Monitoring and Use of data

The implementing partners could contribute valuable inputs to the monitoring process. Monitoring is primarily concerned with aspects of the programme and its work that can be counted, whereas supervision deals with performance of health volunteers, including giving them support and assessing conditions in the health facility. Monitoring activities would help TMOs to track progress and to identify and solve problems before they cause further delay in implementation. To find effective solutions to problems identified in monitoring (or in supervision), the likely causes of the problems need to be identified. It is also important for TMO to give feedback to staff involved on the findings of monitoring.

The monitoring data needs to be summarized and indicators require to be calculated. Calculating indicators involves identifying the correct numerator and denominator, determining a current value for each from the data, and doing the mathematical calculation.
When indicators are calculated, implementing partner could also support the TMO in analyzing progress by making comparisons, such as:

- For all indicators for which targets were set, compare the level of achievement for the indicator to the target.
- Compare levels of achievement to a past level, such as last month, or last quarter, or last year.
- Determine trends over time.
- Compare the level of achievement to that in other facilities or another district.

Data from various reports both monitoring and supervision will be collated to draw conclusions on the objectives pursued by the implementation of community case management. Data will be also used to take evidence-based decision and fine-tuning day-to-day operation at grass-root level as well as to improve programmatic action at higher level.
CHAPTER - VIII
MOTIVATION AND RETENTION OF VOLUNTEERS

**Medicines and other supplies:** these are provided to *CCM Volunteers* right after completion of training to start their work and practiced their learning immediately.

**Visibility items:** such as cap, T-shirt, badge and bag to properly identify themselves to member of communities as having been trained to provide treatment to children.

**Acknowledgement:** award a training completion certificate in Myanmar (recognized as CCM volunteers) signed by concerned body or TMO or a group photo with training team would be one of the options to be considered. Quarterly feedback mechanism can also be used to explain a good work undertaken by CCM Volunteer.

**Career path:** experience of working as CCM Volunteer (any volunteers if eligible and working as AMWs, CHW) could be a door way for career advancement and should have long-term career incentive or perspective to become certified Basis Health Staff in line with national human resource (HR) development strategy.

**Standardized reward/compensation package:** currently, there is no standard nationally accepted reward package leading to a wide disparity amongst the volunteers. This is a critical issue for sustainability and needs to be standardized. Taking Ghana (northern region) as an example and based on evaluation study findings in Myanmar, it is suggested that standard reward package for volunteers may include small amount of cash payment e.g. Kyats 3,000 as well as lunch and actual transportation cost when the volunteers attend regular meeting at the health centers and the same for supervisors. Additionally, *CCM Volunteer* and their immediate family could be considered for entitlement of free preventive and some curative services from referral levels whenever required.

**Knowledge enhancement:** conduct on the job training with real or hypothetical cases during regular supervision, arrange six monthly exchange visits to other rural health center catchment to observe service delivery by peer volunteers, organize annual refresher training for CCM volunteers at township level, and when possible allow outstanding CCM volunteer to share their experience at national level event.

**Expansion of their role:** health promotion and prevention could also be integrated into their role in order to have frequent contact with responsible health staff and build better linkage with community.

 Estimates Developed by the UN Inter-agency Group for Child Mortality Estimation 2012: pg 18


Annual head counts by health staff can be used as reference to indicate the number of inhabitants in villages.