iCCM Experience Malawi

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iCCM Country Overview

- iCCM introduced in June 2008 through the IMCI unit of the MOH
- iCCM for malaria, pneumonia and diarrhea delivered through Health Surveillance Assistants (HSAs), a paid, multi-purpose cadre of CHWs
- MOH IMCI unit coordinates CCM implementation and convenes a national IMCI Technical Working Group
  - IMCI unit has introduced standardized treatment registers and reports for iCCM
  - Referral assisted mostly from Village health committees

Scale of coverage and Coordination

- Nationwide program (28 districts)
- ~4,000 hard-to-reach areas (>8km from health facility) targeted for CCM
  - CCM sites set at 8km radius (1 hour) from the nearest Health facility
  - Policy reviewed now using 5km radius distance
- Coordination mechanism
  - IMCI heads and chairs
- Key stakeholders:
  - IMCI-MoH, NMP-MoH, WVI, USAID, UNICEF, WHO, NGOs, Academic Institutions

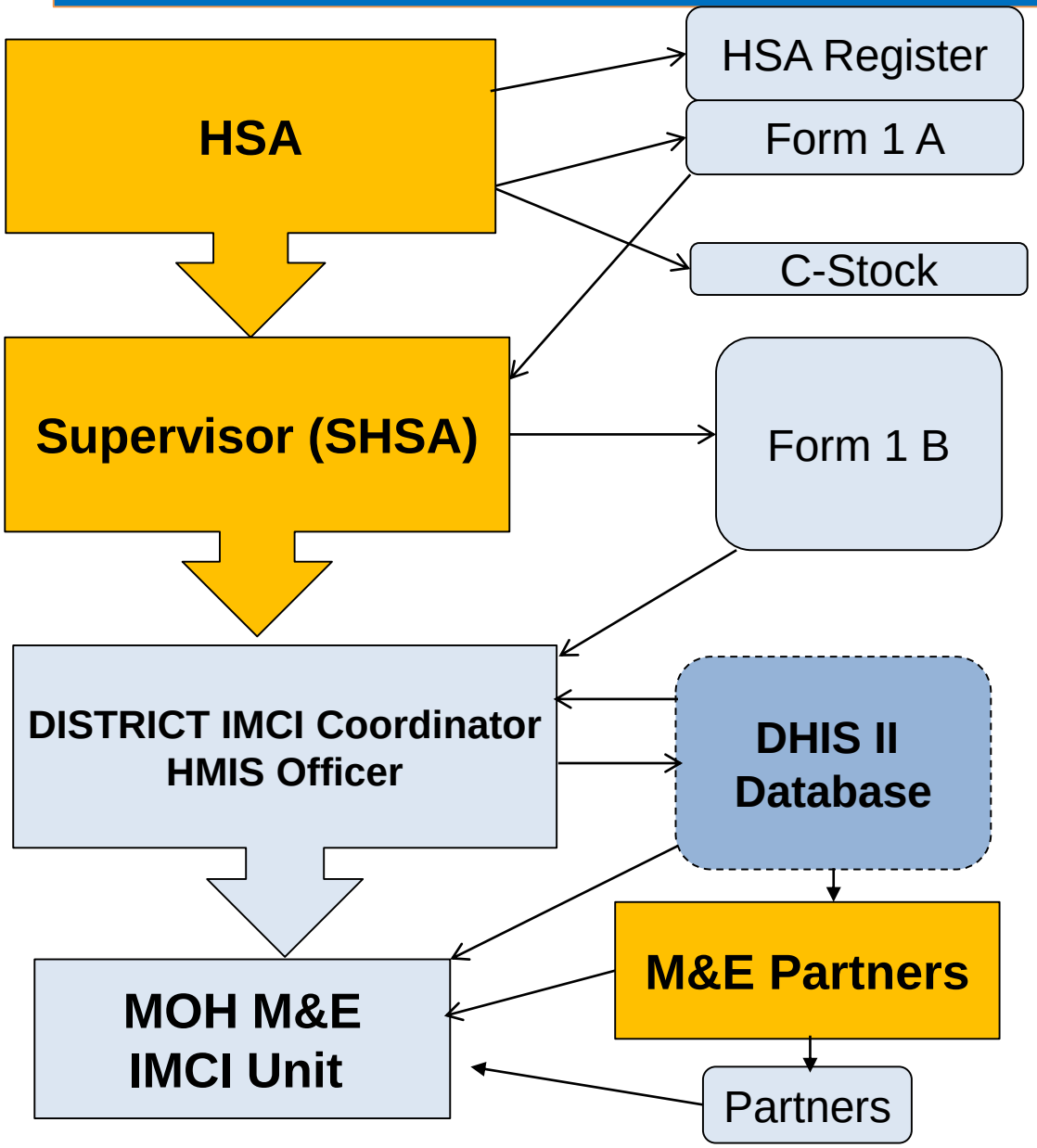
What we have done

- Bottom up microplanning is in place
- Revised iCCM guidelines with inclusion of Amoxicillin, mRDTS and its accompanying waste disposal management, Rectal artesunate as pre-referral, New vaccines
- Use of job aide (WHO -IMCI adapted) to identify, assess and decide what to do; treat or refer
- District level capacity and skills building with expansion of village clinics
  - Current iCCM training coverage of >84%
  - Mentorship, at least one in each respective health facility (512)
  - Supervision
    - Carried out by senior HSAs- HSAs supervisors
    - District focal persons

Monitoring & Evaluation

- DHIS2
  - Reporting forms
    - Captures statistics data
    - Introduced data tools and have started orienting HMIS district folks
    - Health Centre consolidates these data before sending to district (HMIS)
    - Basis for actionable supervision and follow up
- cStock
  - Captures logistics data,
  - Improves medicines visibility and availability
- Introduction of implementation strength indicators for routine monitoring on quarterly basis

Current ICCM Data Flow in Malawi



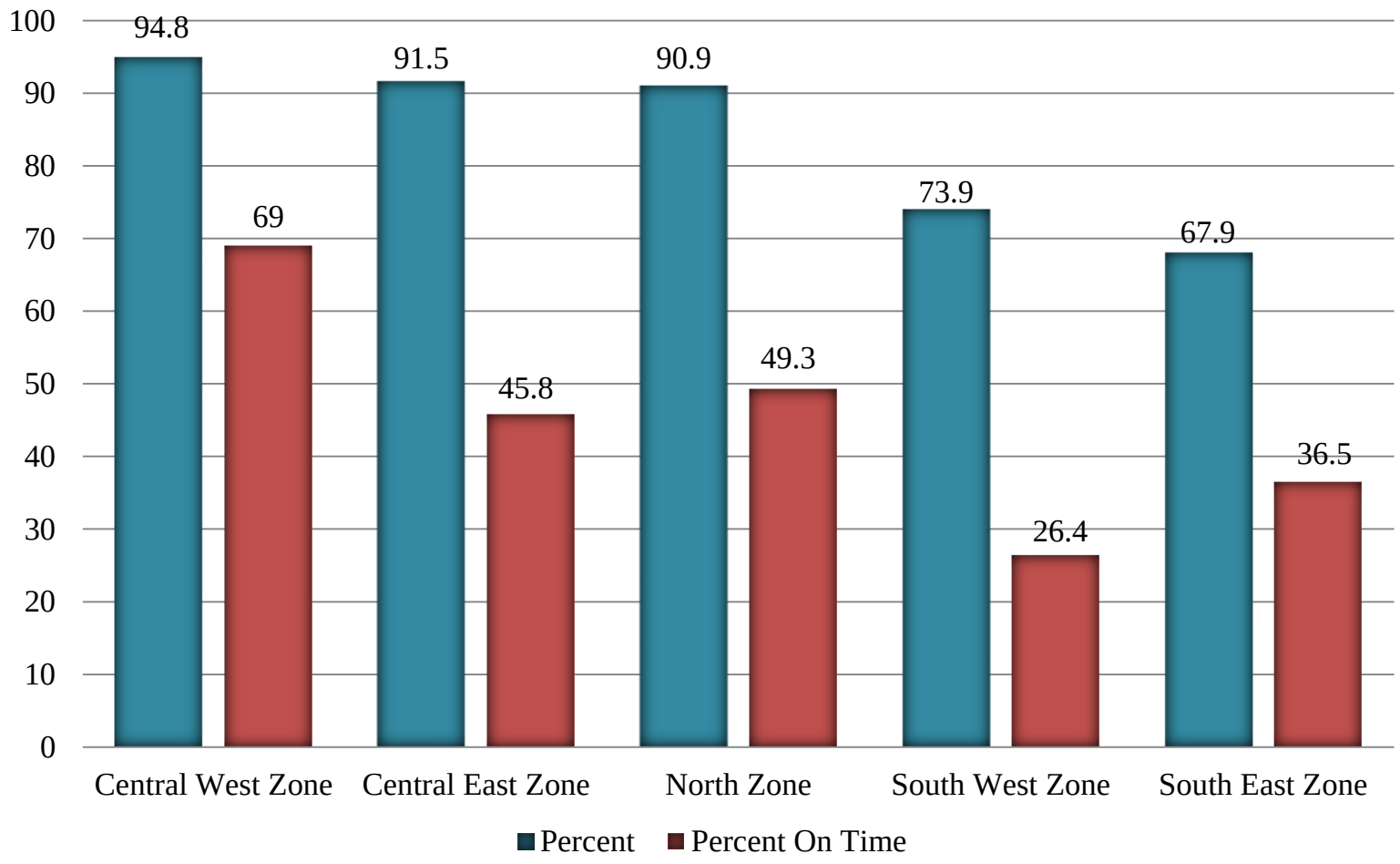
HSAs completes **Village Clinic Register – monthly** summarizes information into ***Form 1 A***.

The **SHSA** collates the **HSA** information and summarizes into ***Form 1 B and submits to the district***.

The **District** enters the data from **form 1 B into the DHIS II database** by **facility**

MoH and all other partners access data from **DHIS II**

Facility Reporting Rates By Zone



Global Fund support for iCCM

Country Action Plan and Progress:

- Proposal with Action plan for two years period (2016-2017) developed and submitted
- Planned for 100% coverage in districts (28 districts)
- World Vision International and Government are SRs and PRs for grant

- Financing: Country plan US$ 9.58 million (2016-2017)
  - Global Fund : 67% of total plan (5,521,160)
  - Funding gap : 33%

- The plan was revisited by Country Team in January 2016 to analyze actual need and the funding gap

Global Fund support for iCCM

Challenges	Solutions
• Inadequate budget allocation for pre-service training of newly recruited 1400 HSAs	• Request for GF allocation
• 90% of HSAs are not trained on RDT & RA. Funding gap for this training is 69%	• Request for GF allocation
• Use of personal mobile phones by HSAs for cStock	• Request for GF allocation
• Residency and Housing for HSAs	• Request for support

Lesson Learnt

- Clear leadership of the Ministry of Health strengthens coordination among partners
- Engagement of the national IMCI technical working group in the process
- Development of integrated checklists incorporating key elements of sick child recording form
- Training supervisors in iCCM and supervisory skills improves performance
- Creation of a mentorship program for periodic skills reinforces HSAs competence
- District based village clinic review meetings to strengthens implementation
- C-stock system improves drug availability, data visibility and reporting

What Next?

- Rolling out of mRDTs and rectal artesunate at community level
- Refresher training for HSAs
- HSAs basic training
- DHIS2
- Strengthening cStock
  - through District product availability team and Health Centre product availability team meetings
- Expansion on the establishment of Village clinics following the revised guidelines on distance

Way forward

Packaging and Integration of child care services at Community level for delivery by CHWs (HSAs)

Thank You