MALAWI

SCALING UP ICCM WITHIN COMMUNITY HEALTH SYSTEMS

MONDAY, 22 July 2019

Institutionalising integrated community case management (iCCM) to end preventable child deaths

Addis Ababa, 22-26 July 2019

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Country demographics make integrated community case management (iCCM) critical to the health system

Malawi's population is **17,931,637**

Under 5 population is **3,048,378**

84%

Rural

+24%

Not within 5km of health facility

53%

Of deaths caused by top 4 illnesses
(Pneumonia, Diarrhea, Malaria, undernutrition)[1]

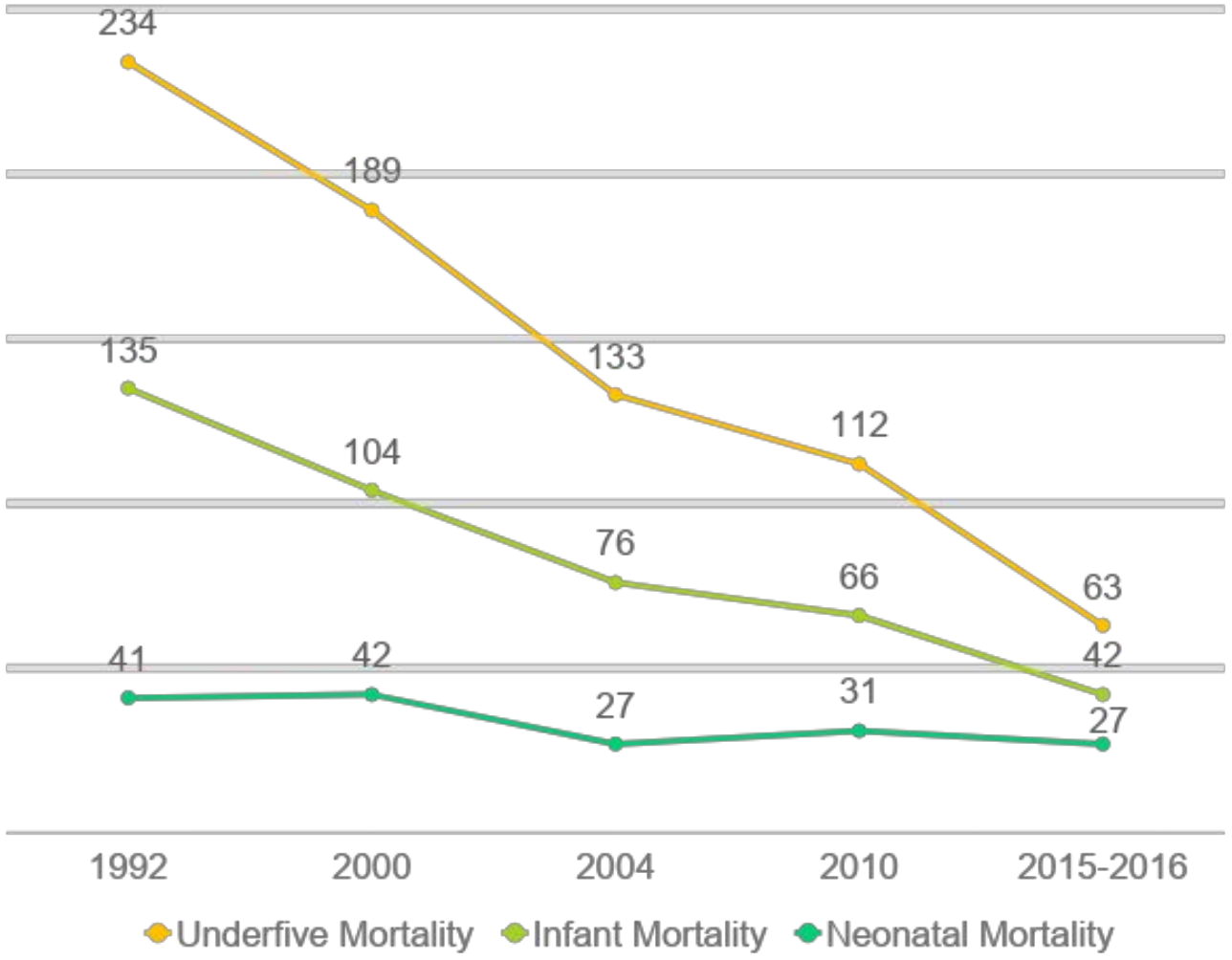
4%

Rural access to power

61yrs

Life expectancy

Trends in Childhood Mortality



Source: MDHS 2015/2016

-Administrative/governance structure:

-Regions, Districts and Health Zones

-Financial decision making is decentralized

-Not fully operational

-Major causes of child mortality

-Malaria, Pneumonia and Diarrhea

iCCM – Introduction and Coverage

- 2008 introduced
  - Through Community Health Workers called Health Surveillance Assistants (HSAs)
  - WHO simplified algorithms and adaptation to country context
    - Fever(malaria), diarrhea, fast breathing(pneumonia), red eye, malnutrition
  - Started with 10 districts supported by World Health Organization
- 2010 scaled up to 8 more districts
- 2011 nationwide scale up – all 29 districts covered

- iCCM services exists within an MoH governance structure
  - IMCI unit - MoH coordinates iCCM implementation and convenes a national IMCI sub-Technical Working Group
    - Operationalized by District Health Management Teams
  - Use standardized training protocols and guidelines , treatment registers and reporting tools
    - *Adapted from the generic WHO protocols, tools and guidelines*

iCCM Journey

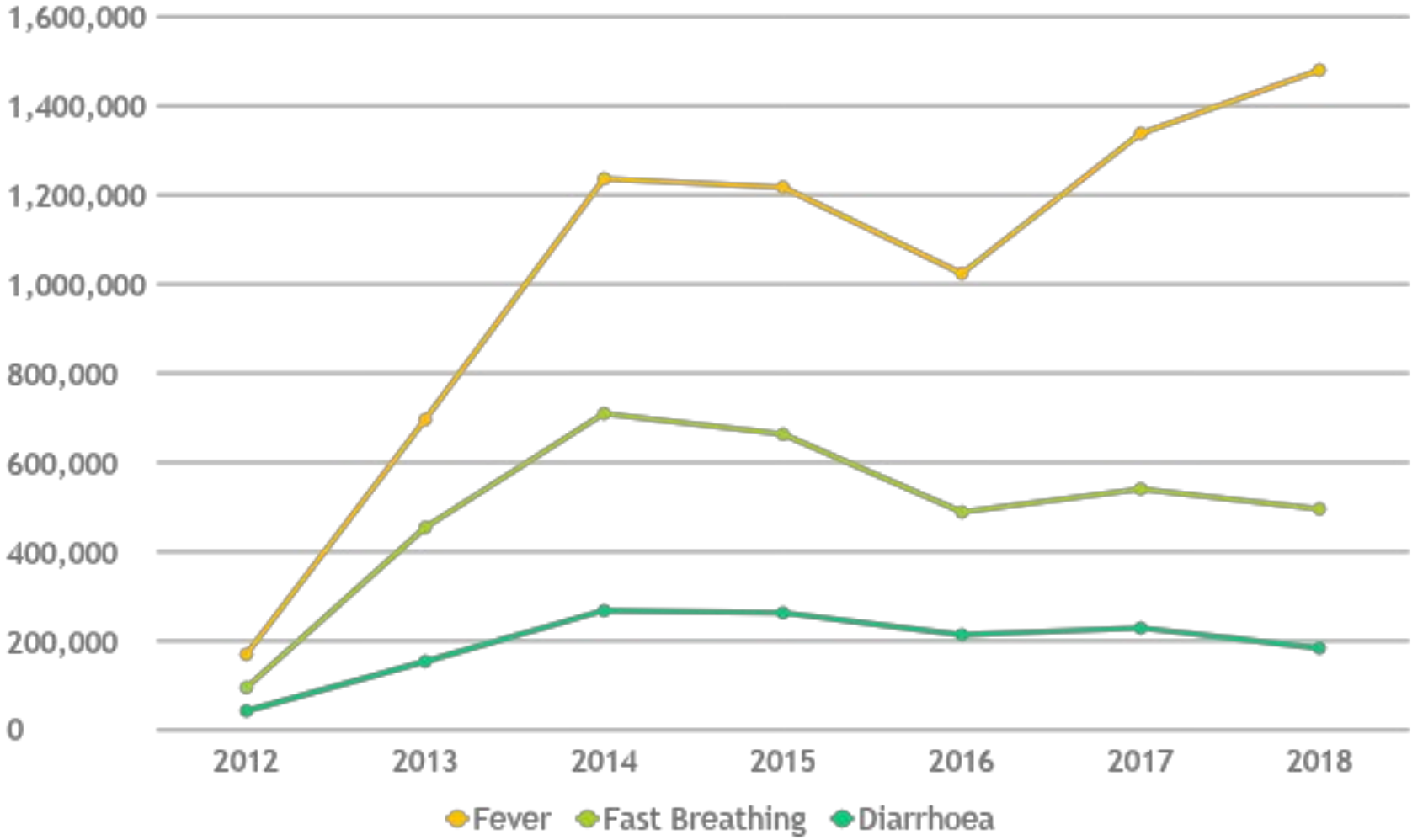
Milestone 1	Milestone 2	Milestone 3	Milestone 4	Milestone 5	Milestone 6
2008	2010	2011	2012	2014	2017
October	January / June/ July / October	January	April	May / November	April / October
Introduction of iCCM	Phased scale up; Supply chain; ORS + Zinc for diarrhea	Nationwide scale	DHIS2	mRDTs and Rectal Artesunate; Amoxillin	TB/HIV; Child Protection

ICCM COVERAGE

- Number of Hard to reach areas mapped **4,592**
- Number of functional clinics: **4,240**
- Proportion of hard to reach areas served by iCCM CHWs: **92.3%**
- Number of districts implementing iCCM **(28/28)**
- Treatment numbers (Source - DHIS2):

	2016	2017	2018
Malaria	742,627 (pr+mRDT) 486,329 (mRDT)	924,515 treated	1,064,796 treated
Pneumonia	443,759	477393	401,873
Diarrhoea	161,175	177,875	120,335
Malaria Positivity rate	48.9%	70.4%	73.3%

ICCM Caseload for key childhood Conditions



Source: Routine data from DHIS2

HUMAN RESOURCES: COMMUNITY HEALTH WORKERS

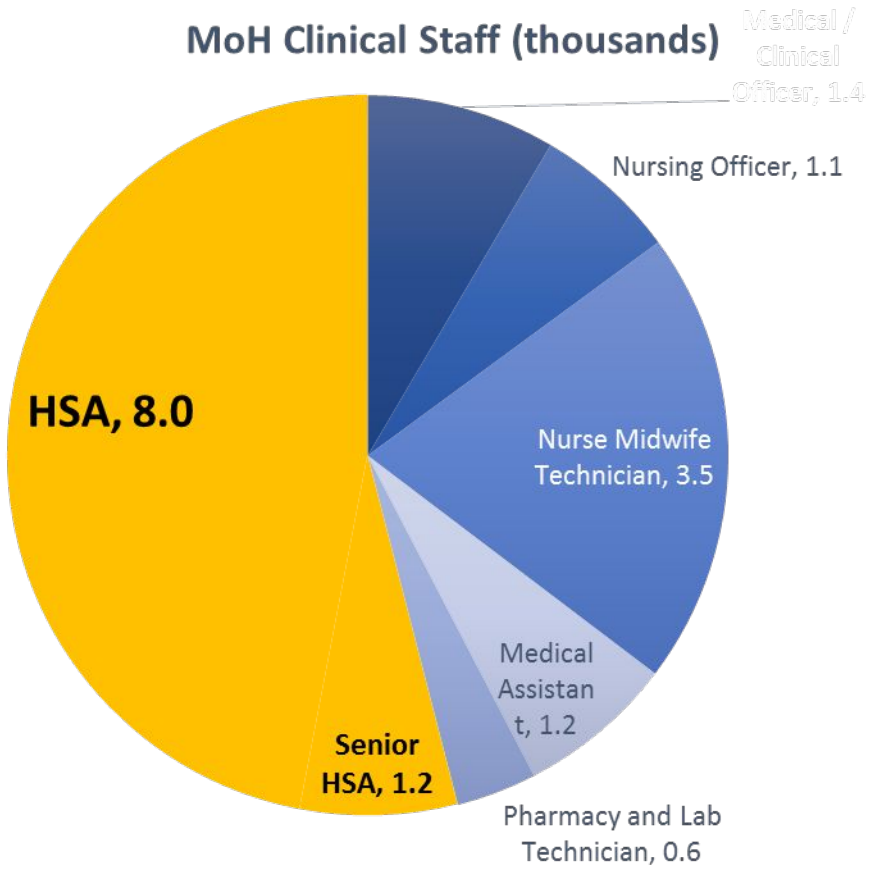
Employed and Salaried by Government
- Education – grade 12
- Recruited and trained for 12 weeks as HSAs

HSA to population ratio is 1:1,000 people

HSAs meant to reside in their catchment area

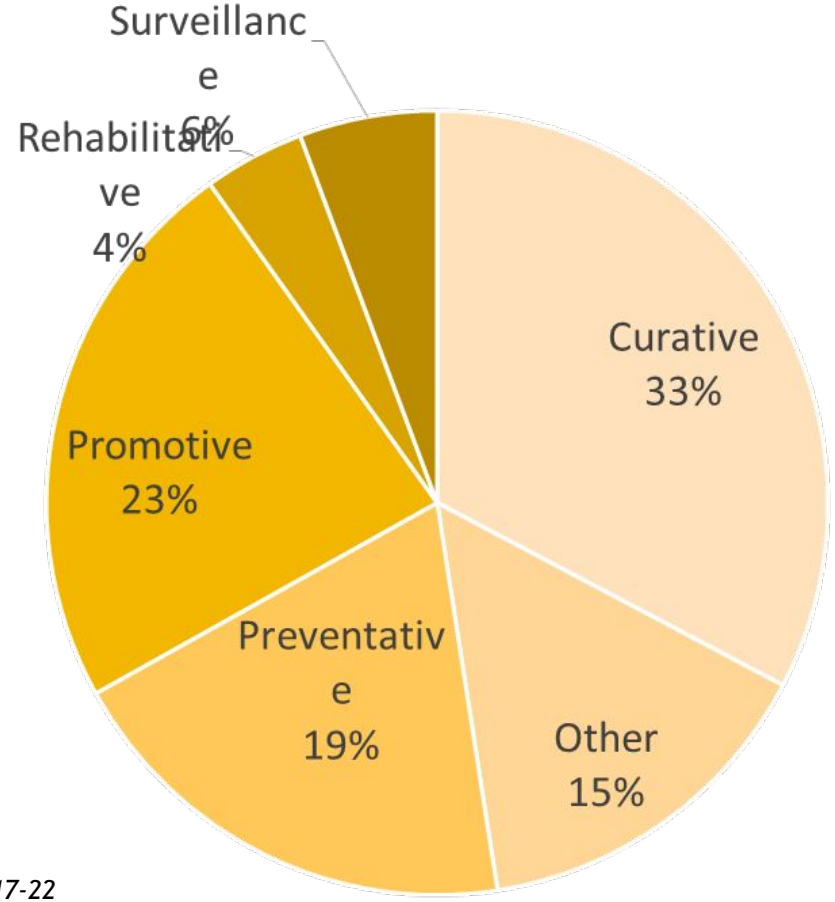
ICCM HSAs pack (minimum) 6 days training
- Wooden drug box, registers, reporting booklets, Bicycle, backpack, uniform, ORT equipment and medicines supplies

HSA's & Senior HSA's are over half of MoH's health workers



HUMAN RESOURCES: COMMUNITY HEALTH WORKERS

HSAs exist as the 1st service delivery point at community level



Source:CHSS17-22

Tasks include:

- Community case management including malaria, diarrhea, pneumonia treatment for under-5s
  - Establishing and coordinating Village Health Committees
- Supervise Health Volunteers/committees
  - Distributing and promoting family planning
- Providing outreach EPI services
  - Vitamin A supplementation etc
- Conducting Home visits
  - Sanitary inspections
- Health campaigns

HEALTH FACILITY ROLE IN ICCM IMPLEMENTATION

- Health facility Roles on ICCM
  - Mentorship on ICCM by the Health Centre Nurse or Medical Assistant
  - ICCM Medicines replenishment/resupplies
  - Point of collection for data reporting tools for ICCM
  - Supervision by Senior HSAs
  - Venue for ICCM review meetings
- Majority of Health centre staff are oriented on ICCM
  - Readiness and referral is taken as an existing role.
- Quarterly data quality assessments and supervision have helped in monitoring quality of care

Challenges

- Health facility Mentorship:
  - Frequency to conduct mentorship is affected by few number of health workers at facility level
  - Poor mentorship competences and skills from non oriented facility staff
  - Inconsistent availability of medicines at facility affects re-supplies for ICCM
- Referral facility:
  - Wireless/radio messaging equipment is not functional in many facilities
  - Lack of transportation means to aide quick referral

FINANCING/COSTING

Status

- Government/MoH funding
  - Human resources
  - Medicine supplies
- Child Health strategy for Malawi
  - ICCM costed as part of the strategy (not separate)
  - Does the country have a costed iCCM implementation plan?
- Source of iCCM funding
  - ✔ Government responsible for CHWs salaries
  - ✔ Government and partners support Training
  - ✔ Medicines (malaria and non-malaria) Donor – Global Fund

Challenges under financing

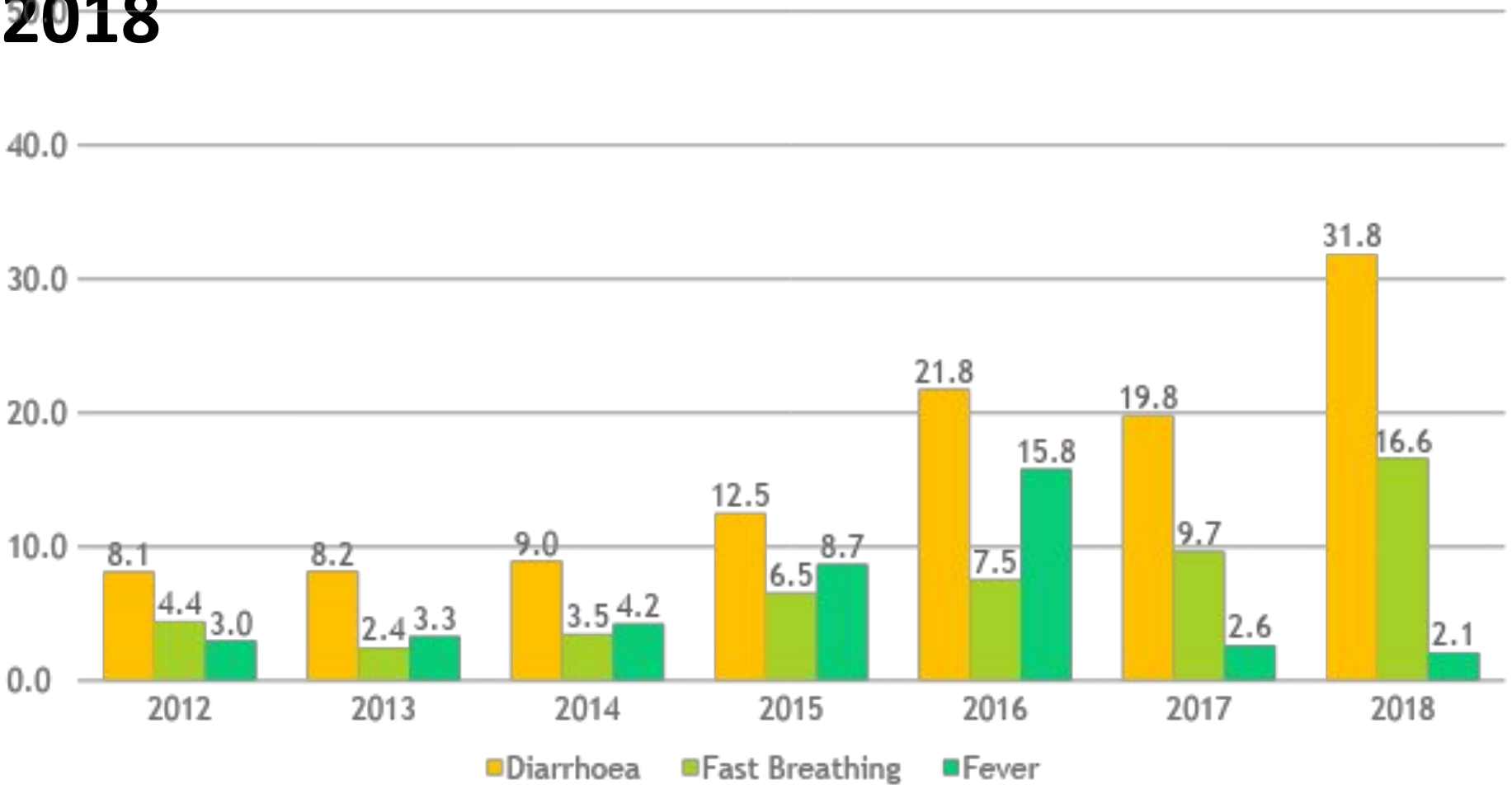
- Lack of intensiveness and aggressiveness of implementation to further increase access

SUPPLY CHAIN MANAGEMENT

Status

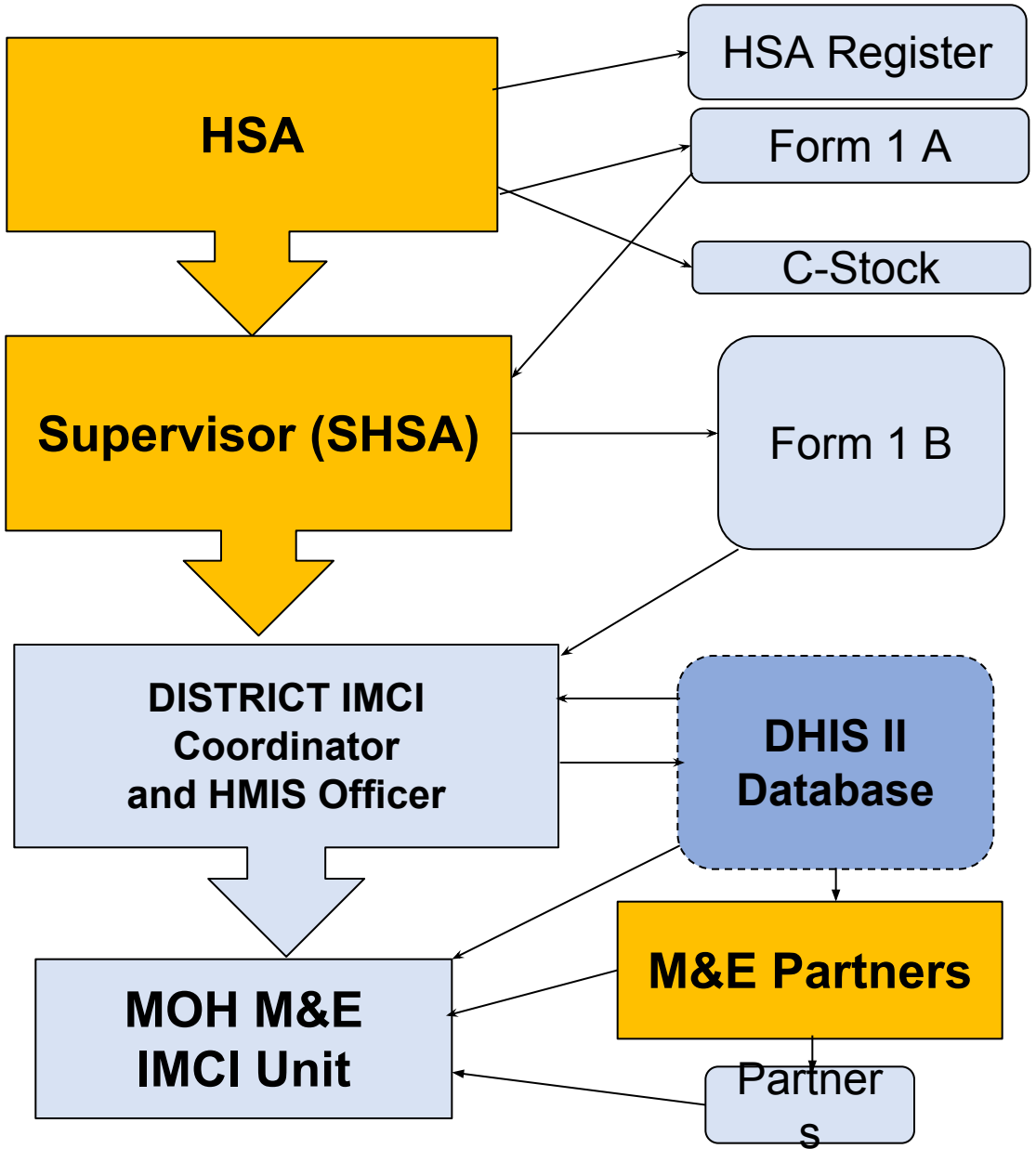
- Medicines for ICCM are quantified for the whole district
  - Takes into account all ICCM HSAs commodities
- Antibiotics for Pneumonia, Anti-malarials, and ORS and Zinc are procured and distributed as part of the MoH supply chain system
  - Partners compliment the medicines availability
- Medicines resupply is through pull system using the cStock via SMS method to the nearest Health facility
  - Orders every 4 – 6 weeks
- **Challenges**
  - Delayed stock replacement mechanism for non fast moving drugs eg zinc to avoid expiry
  - Inconsistent availability of medicines at district level
    - Inadequate drug budget from Government

Referrals due to Medicine Stock outs 2012 - 2018



Source: Routine data from DHIS2

Current ICCM Data Flow



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**

MONITORING AND HMIS

Challenges

- Incomplete data elements on reporting forms from HSAs
- Unprecedented increase in printing costs of reporting tools - versions updated
- Delayed submission of reports from HSAs
  - Difficult to access
  - Other HSAs engagements

SUPERVISION

Status

- Supervision done by ICCM trained immediate supervisors called senior HSAs
  - **On monthly basis**
  - **Each HSAs supervised**
- Quarterly supervision is done by district level ICCM trained focal persons and supervisors
- National level teams conduct quarterly supervision to HSAs
- No specific incentives for supervisors rather get lunch allowance and per-diems as they go out
- Developed checklists for ICCM immediate supervisors
- Developed Checklist for ICCM supervisors as well
  - On quarterly basis by **IMCI coordinator and national trainers**

Challenges

- Inadequate conduct of supervision exercises
  - Competing priorities (work load)
  - Supervision competencies

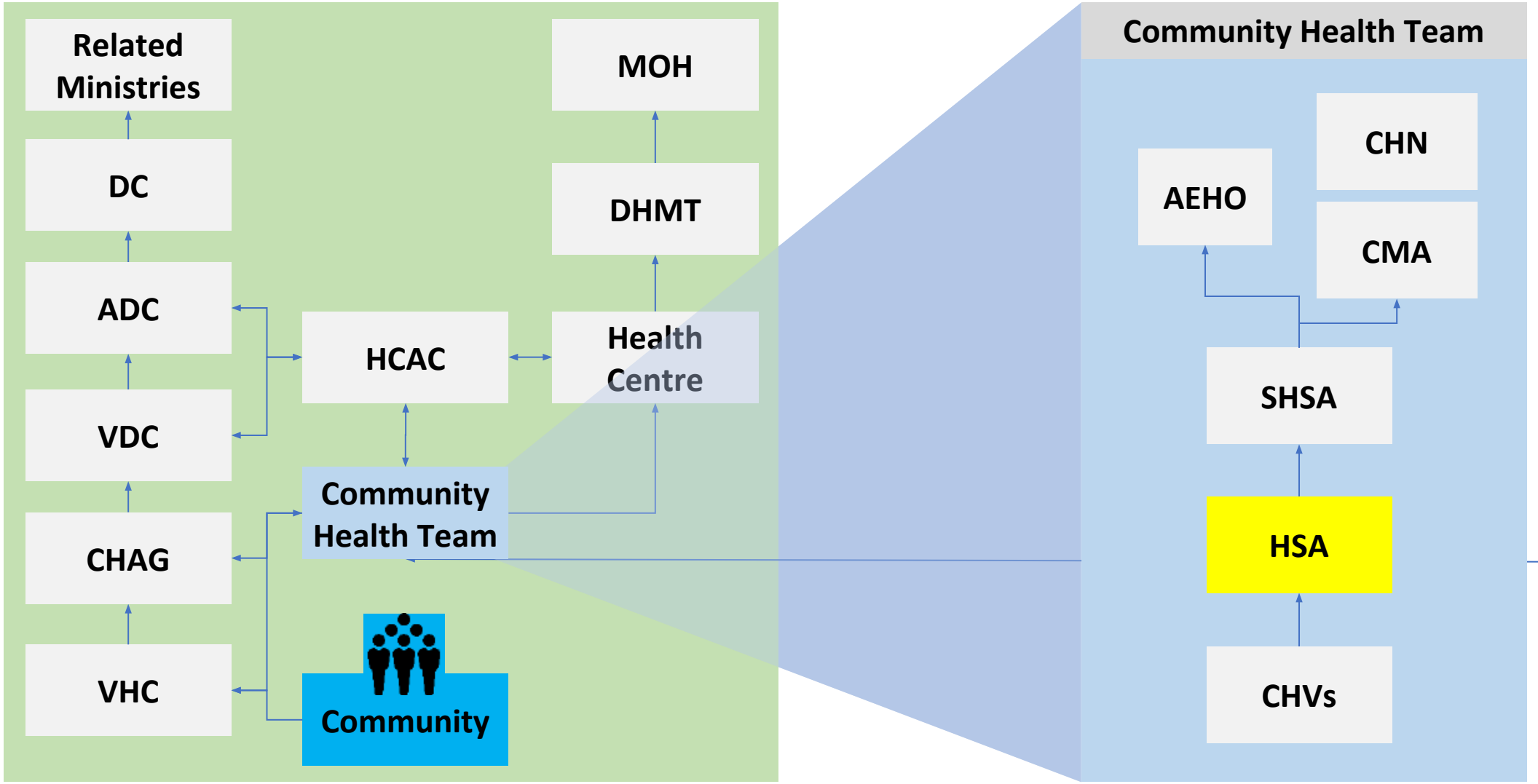
COMMUNITY ENGAGEMENT

- Policy environment
  - Community Health Strategy
  - Child Health Strategy
  - iCCM Road map for Malawi
  - IMCI approach policy for Malawi
  - National malaria strategic plan
- Community health strategy clearly spell out strategies in place to engage communities in;
  - Design of Community programs including iCCM
  - Role clarity guidelines for HSAs, and selection
  - Supervision
  - M&E of community programs plus iCCM

Challenges

- Weak data feedback loops to community level
- Inadequate community sensitization on their roles
- Limited budgetary allocation for the implementation of community engagement strategies

HSAs play a key role in linking communities to the health system and local governance structures



Data Management

- Introduced for ICCM in 2012
  - Started with the WHO - RAcE program in 8 districts
  - Scaled up
  - Training of HSAs
  - Development of data display templates for HSAs and Health facility
  - Printing
  - Used mainly by HSAs and HSAs supervisors (Senior HSAs, Environmental Health Officer, District trainers and focal person)
  - Oriented all functional HSAs on data management and data displays

Village Clinic at a Glance

Village clinic name: _____
HSA name: _____
HSA supervisor name: _____
Facility name: _____

Background information:

Catchment population: ____

Estimated # children U5: ____

Support and supervision monthly summary (tick if received):

Month:	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
Supervision Visit												
Mentoring												

1) Number of malaria positive cases treated in children aged 5-59 months by month

# of stock-out days LA

# of referrals due to stockout

2) Number of fast breathing cases treated in children aged 2-59 months by month

# of stock-out days Cotrim

# of referrals due to stockout

3) Number of diarrhea cases treated in children aged 2-59 months by month

# of stock-out days ORS

# of referrals due to stockout

4) Total number of sick child cases treated in children aged 2-59 months by month

# of days VC operated

# of U5 deaths reported

Notes/Comments:

Instructions: Plot monthly data using shaded bars to make data more visible.

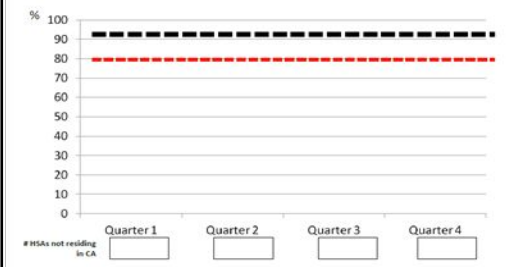
Save the Children

iCCM at a Glance

Health facility: _____ **HSA supervisor:** _____

Under-five catchment population: _____ **# CCM trained HSAs:** _____

1) Percent of CCM-trained HSAs residing in their catchment area

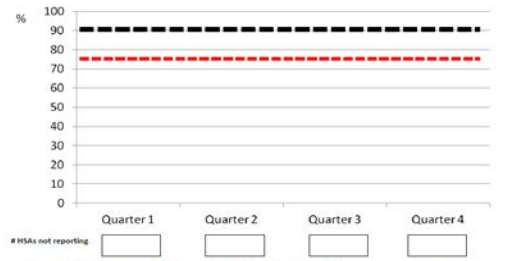


HSAs not residing in CA

Target ≥ 90% of CCM trained HSAs residing full-time in their catchment areas during quarter
Action threshold: <75%

Denominator = total # of HSAs trained in CCM (targeted) in facility
Numerator = total # of CCM trained HSAs residing in their catchment area
Percentage = numerator / denominator x 100%

2) Percent of CCM-trained HSAs submitting reports complete and on time

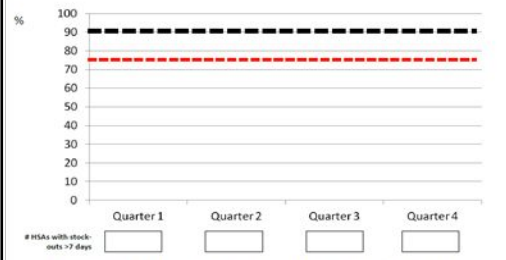


HSAs not reporting

Target ≥ 90% of targeted CHWs trained in iCCM submit monthly reports complete and on time; Action threshold: <75%

Denominator = total # of CCM trained HSAs reporting in facility
Numerator = total # of HSAs submitting reports complete & on time
Percentage = numerator / denominator x 100%

3) Percent of CCM trained HSAs with medicines

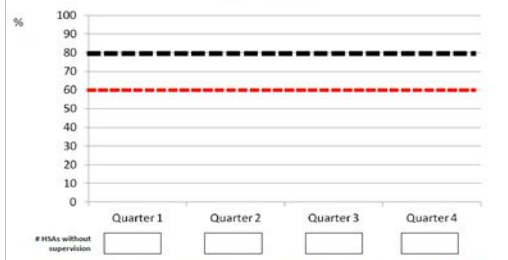


HSAs with stock-outs >7 days

Target ≥ 90% of targeted HSAs trained in iCCM report no stock-outs of LA (or all essential meds) lasting >7 days in quarter; Action threshold: <75%

Denominator = total # of CCM trained HSAs (targeted) in facility
Numerator = total # of CCM trained HSAs with medicines
Percentage = numerator / denominator x 100%

4) Percent of CCM trained HSAs receiving routine supervision

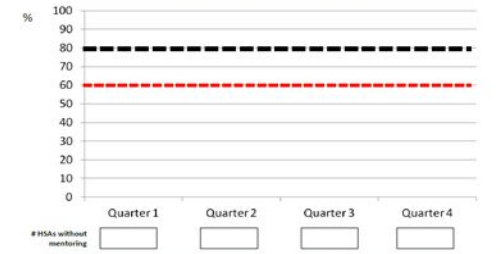


HSAs without supervision

Target ≥ 80% of targeted iCCM-trained HSAs receive ≥ 1 routine supervision/quarter ; Action threshold: <60%

Denominator = total # of CCM trained HSAs (targeted) in facility
Numerator = total # of CCM trained HSAs receiving routine supervision
Percentage = numerator / denominator x 100%

5) Percent of CCM-trained HSAs receiving clinical supervision (mentoring)

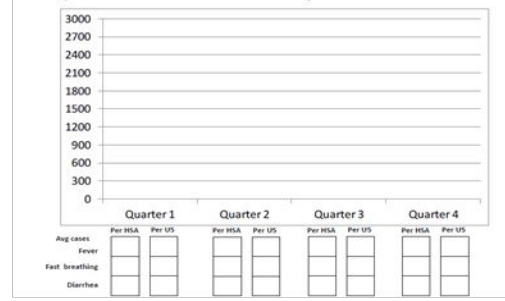


HSAs without mentoring

Target ≥ 80% of targeted CCM-trained HSAs receive ≥ 1 mentoring session during quarter ; Action threshold: <60%

Denominator = total # of CCM trained HSAs (targeted) in facility
Numerator = total # of CCM trained HSAs receiving mentorship
Percentage = numerator / denominator x 100%

6) Number of cases treated by CCM-trained HSAs



Instructions: Plot monthly data using shaded bars to make data more visible.

Save the Children

Enabling factors – for Malawi

Supervision	• **Assignment of specified responsibilities to various cadres of staff (senior HSA, environmental officer, community nurse)** • **Development of integrated checklists incorporating key elements of sick child recording form** • **Training supervisors in iCCM and supervisory skills** • **Creation of a mentorship program for periodic skills reinforcement of trained HSAs**
Medicines and supplies	• **DHMTs provision of medicines to HSAs** • **Guidance on quantification of medicines to DHMTs** • **Roll-out of Standard Operating Procedures for Logistics Management Information Systems to strengthen utilization and management of medicines and other supplies**
Referral	• **Designation of health centre where HSA should refer** • **Use of referral note and feedback** • **Engagement of VHC in finding solutions to facilitate referral , such as bicycles or ox cart as transport, and escorts at night**

Next steps

- Packaging of child care services using ICCM sites as central point of service delivery
  - Service integration at community level
    - Case management; Malaria, pneumonia, diarrhea, Childhood TB/HIV
    - EPI
    - CBMNC
    - HSAs PSBI follow up
    - Child protection
    - Nutrition
    - Wash
    - Early learning and stimulation
- Strengthen Management of the sick young infants (PSBI HSAs follow up)
- Medicines availability
  - Ensuring that DHMTs order dispersible amoxicillin from CMST
  - Promotion of rational use of medicines
- Strengthen, mentorship, follow up and supervision

THANK YOU