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

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Presenter: Humphreys Nsona, IMCI Unit, Program Manager- MoH
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)

4% Rural access to power

61yrs Life expectancy

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61yrs Life expectancy
Trends in Childhood Mortality

- 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

Source: MDHS 2015/2016
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**: 2008
- **Milestone 2**: 2010
- **Milestone 3**: 2011
- **Milestone 4**: 2012
- **Milestone 5**: 2014
- **Milestone 6**: 2017

Timeline:
- **October 2008**: Introduction of iCCM
- **January 2010**: Phased scale up
- **June/July 2011**: Supply chain
- **October 2011**: ORS + Zinc for diarrhea
- **October 2011**: Nationwide scale
- **April 2012**: DHIS2
- **May 2012**: mRDTs and Rectal Artesunate
- **November 2014**: Amoxillin
- **April 2017**: TB/HIV
- **October 2017**: 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):

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
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<tbody>
<tr>
<td>Malaria</td>
<td>742,627 (pr+mRDT)</td>
<td>924,515 treated</td>
<td>1,064,796 treated</td>
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<tr>
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<td>486,329 (mRDT)</td>
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<tr>
<td>Pneumonia</td>
<td>443,759</td>
<td>477,393</td>
<td>401,873</td>
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<tr>
<td>Diarrhoea</td>
<td>161,175</td>
<td>177,875</td>
<td>120,335</td>
</tr>
<tr>
<td>Malaria</td>
<td>48.9%</td>
<td>70.4%</td>
<td>73.3%</td>
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<td>Positivity rate</td>
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</table>
ICCM Caseload for key childhood Conditions

Source: Routine data from DHIS2
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
HSAs exist as the 1st service delivery point at community level

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

Source: CHSS17-22
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
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.
<table>
<thead>
<tr>
<th>MONITORING AND HMIS</th>
<th>SUPERVISION</th>
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<tr>
<td><strong>Challenges</strong></td>
<td><strong>Status</strong></td>
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<tr>
<td>• Incomplete data elements on reporting forms from HSAs</td>
<td>• Supervision done by ICCM trained immediate supervisors called senior HSAs</td>
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<td>• On monthly basis</td>
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<td>• Each HSAs supervised</td>
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<td>• Unprecedented increase in printing costs of reporting tools - versions updated</td>
<td>• Quarterly supervision is done by district level ICCM trained focal persons and supervisors</td>
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<tr>
<td>• Delayed submission of reports from HSAs</td>
<td>• National level teams conduct quarterly supervision to HSAs</td>
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<tr>
<td>• Difficult to access</td>
<td>• No specific incentives for supervisors rather get lunch allowance and per-diems as they go out</td>
</tr>
<tr>
<td>• Other HSAs engagements</td>
<td>• Developed checklists for ICCM immediate supervisors</td>
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<tr>
<td></td>
<td>• Developed Checklist for ICCM supervisors as well</td>
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<td></td>
<td>• On quarterly basis by IMCI coordinator and national trainers</td>
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<td><strong>Challenges</strong></td>
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<tr>
<td>• Inadequate conduct of supervision exercises</td>
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<td>• Competing priorities (work load)</td>
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<td>• Supervision competencies</td>
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## COMMUNITY ENGAGEMENT

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<td>Weak data feedback loops to community level</td>
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<td>Child Health Strategy</td>
<td>Inadequate community sensitization on their roles</td>
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<td>iCCM Road map for Malawi</td>
<td>Limited budgetary allocation for the implementation of community engagement strategies</td>
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<td>IMCI approach policy for Malawi</td>
<td>National malaria strategic plan</td>
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- **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
## 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