



MINISTRY OF HEALTH

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS

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IMCI UNIT
MINISTRY OF HEALTH
P. O. BOX 30377,
CAPITAL CITY,
LILONGWE

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1 List of abbreviations

| | |
|----------|--|
| CMED | Central Monitoring and Evaluation Division |
| COVID-19 | Corona Virus Disease 2019 |
| CVDs | Cardiovascular Diseases |
| DHA | Department of HIV and AIDS |
| DHIS2 | District Health Information Software Version 2 |
| EPI | Expanded Program on Immunization |
| FP | Family Planning |
| GAVI | Global Alliance for Vaccines and Immunisation |
| HIV | Human Immunodeficiency Virus |
| HPV | Human Papillomavirus Vaccine |
| HSAs | Health Surveillance Assistants |
| HSSP 2 | Health Sector Strategic Plan 2 |
| HTC | HIV Testing and Counselling |
| LA | Lumefantrine Artemether |
| MNH | Maternal and New-born Health |
| MoH | Ministry of Health |
| mRDT | malaria Rapid Diagnostic Tests |
| ORS | Oral Rehydration Salts |
| TB | Tuberculosis |
| WHO | World Health Organization |

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4 Introduction

Integrated Management of Childhood Illness (IMCI) recognizes the importance and efforts towards interventions that contribute to the reduction of under-five mortality from all stakeholders in child health. The IMCI unit has been scaling up a package of evidence-based high-impact child health interventions since 2000 through the Child Health strategy 1 and II. The leading causes of child deaths in Malawi have continued to be malaria (14%), HIV related causes (14%), pneumonia (12%), diarrhoea (8%) and neonatal conditions e.g., prematurity (12%), Birth asphyxia and intrapartum complications (10%), with neonatal sepsis, meningitis and neonatal pneumonia at 5% and 3% respectively (MDHS 2015-16).

The IMCI Unit which coordinates Child Health interventions ensures that routine data that is reported is used at all levels of care and for program strengthening purposes. The Unit therefore reports data on under five children who access care from health facilities and community level village clinics. This bulletin shows performance of the IMCI unit data from January to June 2022. This has been compared with the immediate corresponding past three years of 2021, 2020 and 2019.

5 Methodology

A compilation of DHIS2 child health data for malaria, pneumonia and diarrhoea are collated to generate zone and district level analysis on performance. Explain how determination of completeness, and timeliness is compiled on what period of reporting time?

5.1 Facility IMNCI level childhood illnesses data

Explain this data briefly and show how compilation is done

5.2. Community Case management through Village clinics

Explain this data briefly and show how compilation is done

6 Data Quality

Good quality data is data that is fit for purpose. That means the data needs to be good enough to support the outcomes it is being used for. Data values should be right, but there are other factors that help ensure data meets the needs of its users. Good quality means: good design, having the right values in your data, processing that data well, forming it into good quality datasets accompanied by metadata and analysing the data properly This will be easier to

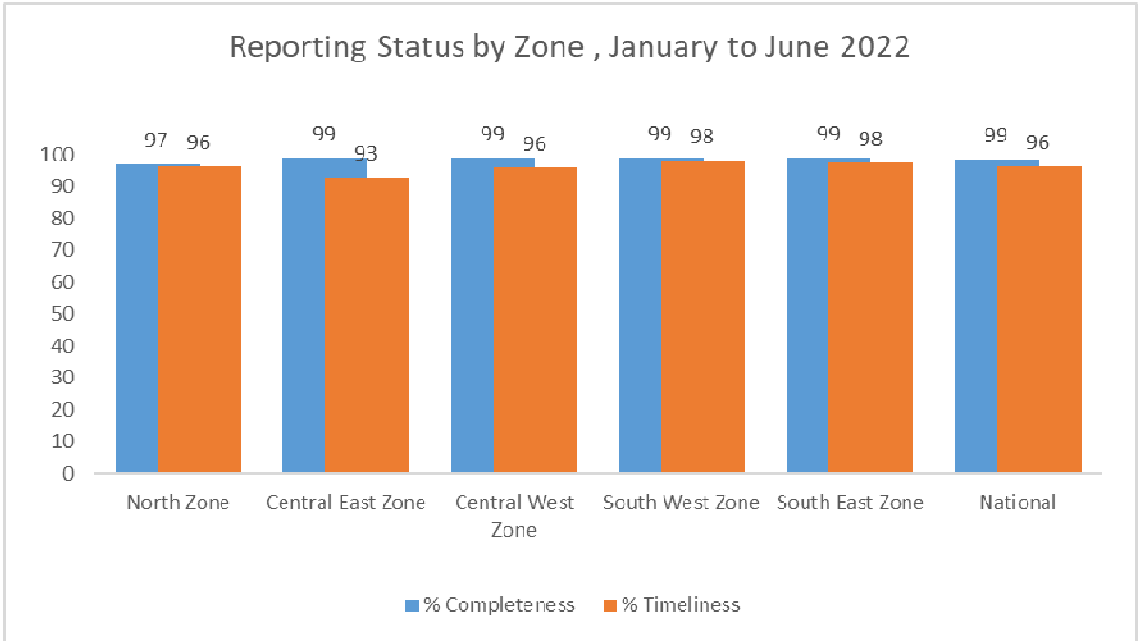
achieve if you have the right governance, information and data management, and standards in place.

Accuracy, Consistency, Validity and Uniqueness would be identified through Data Quality Audits which happens in the facilities through supportive supervision and Data Quality Assessments. This has been taking place on a slow pace because of inadequate resources of which needs to be intensified and has been planned to be taking place quarterly in the coming periods.

Completeness and Timeliness

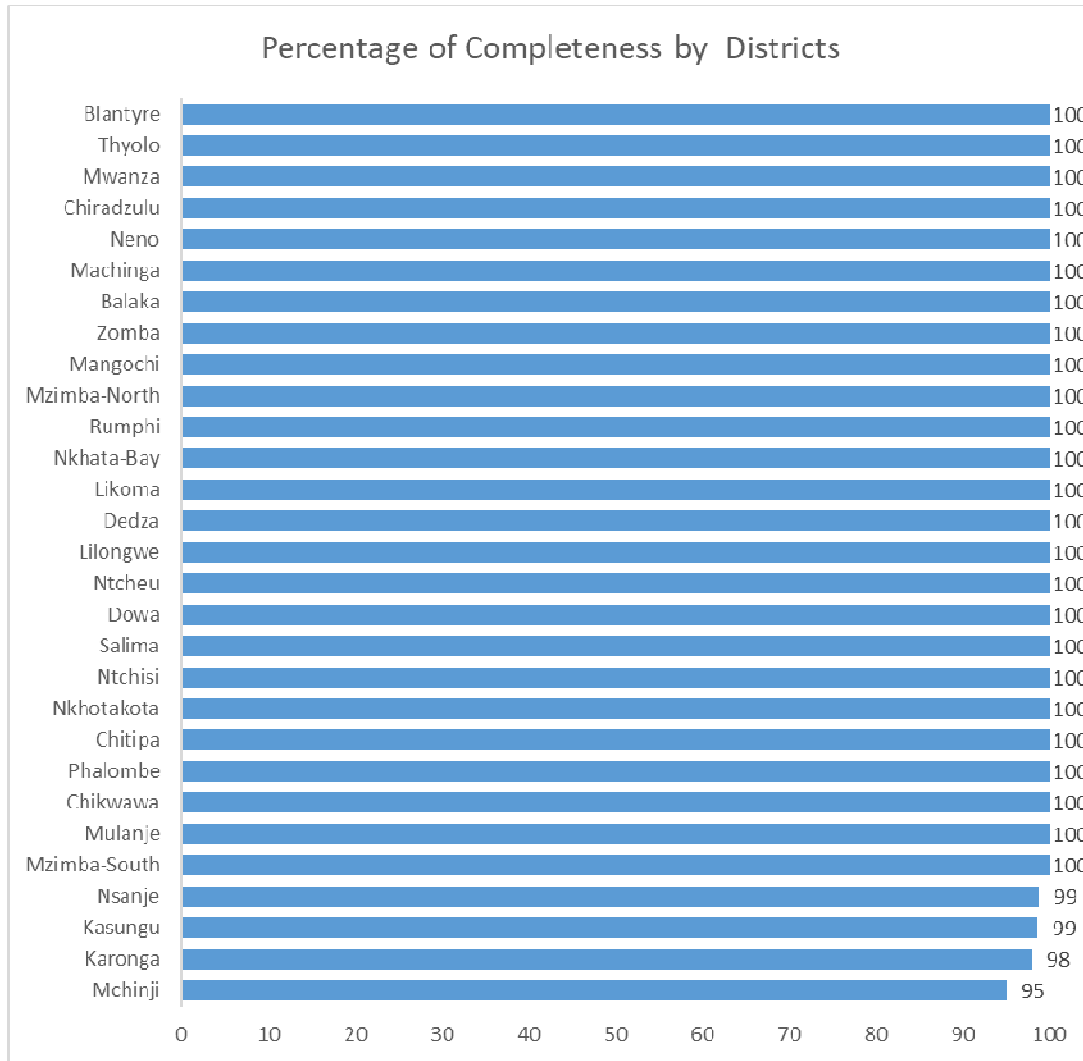
Completeness is defined as expected comprehensiveness of the data to be reported. This involves that all required entities have reported while timeliness is defined by all entities supposed to report have reported within the specified period. These two dimensions help to come up with comprehensive decision with adequate data and timely decision making.

Figure 1: National Reporting Status



In the period under review completeness of reporting has increased from 91% to 99% in the semi-annual under review while timeliness has also increased from 63% to 96%. There is passion and commitment by the program coordinators in the districts hence the improvements.

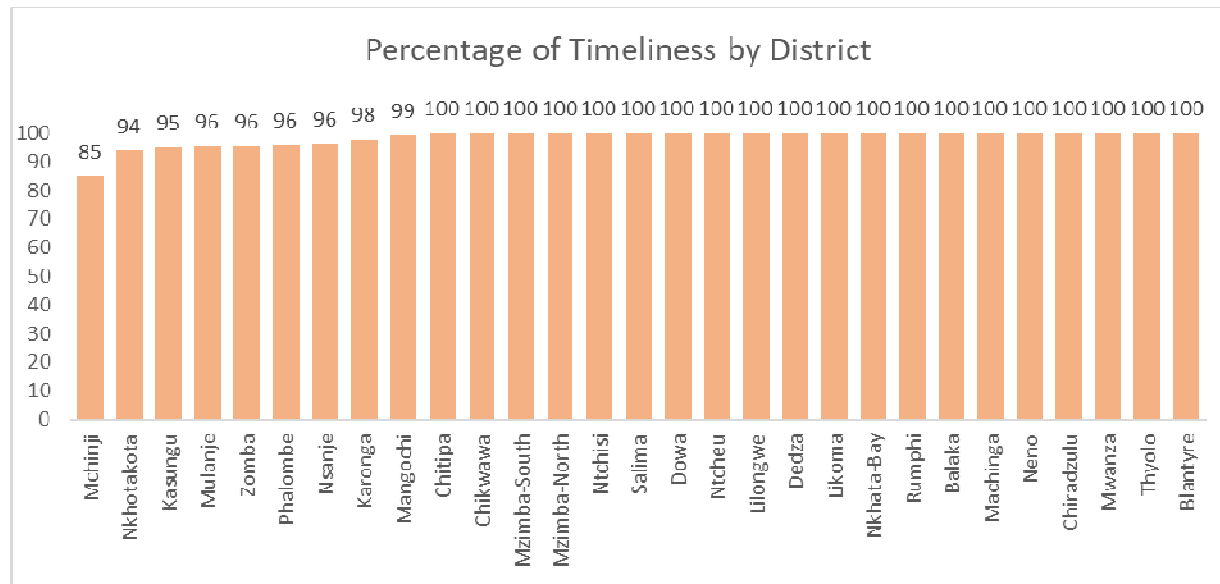
Figure 2: Completeness by District



The target is to have a completeness of above 90% as a country. Referring to figure 2 above shows districts have reported above 90%. The completeness range from 95% in Mchinji to 100% in most districts.

With this performance, districts need to continue encouraging facilities to report. This could be done by either creating a platform where all facilities would be reminded to report.

Figure 3: Timeliness by District



The timeliness of reporting is ranging from 85% in Mchinji to 100% in most districts in the country. Districts are encouraged to work hard to improve on timeliness more specific with Mchinji which is below the 90% target.

7 Capacity Building

The Unit has trained nurses and clinicians on facility Integrated Management of New-born and Childhood Illness, (IMNCI) in 29 districts across the country representing 100% coverage. Two health workers were targeted per facility in the initial phase of the trainings. The first phase is to be finished by the end of June 2022.

There was an issue as regards to supplies in the village clinics, therefore the unit carried reorientation to all providers in community cases management and pharmacy staff in cstock management. This facility has been revamped to solve the issue of overstocking by the village clinics. So far 11 districts have been re-oriented in the first half of the year. The staff oriented come from the following districts Chitipa, Karonga, Rumphi, Mzimba North, Mzimba South, Nkhatabay, Mchinji, Dowa, Ntchisi, Dedza and Balaka. Plans are underway to orient the other districts.

Data management is another issue that was considered to be done so far all districts in north and Central regions have been trained in IMCI data management. The target participants were IMCI District Coordinators and HMIS Officers, total trained are 32 participants in 16 health districts. The southern region is remaining and plan are also underway to have this on. As soon as support is identified this will take place.

8 Service Delivery

Diarrhoea Cases among Children under Five

Data presented is for under-five children who sought care for diarrhoea from facilities and village clinics which were reported and captured in DHIS2. The graphs below show number of under five children with diarrhoea cases that were seen and treated with ORS. The graph below shows trends of cases seen and treated from 2019 to 2022 in the period of January to June in each year.

Generally, there is a decline in number of cases seen and treated in 2022 from 106,308 in 2021 to 89,054 in 2022 reporting period. The cases were rising from 2019 January to June to same period in 2021. Refer Figure 1 below.

Figure 4: Trend of Diarrhoea Cases seen Jan to June

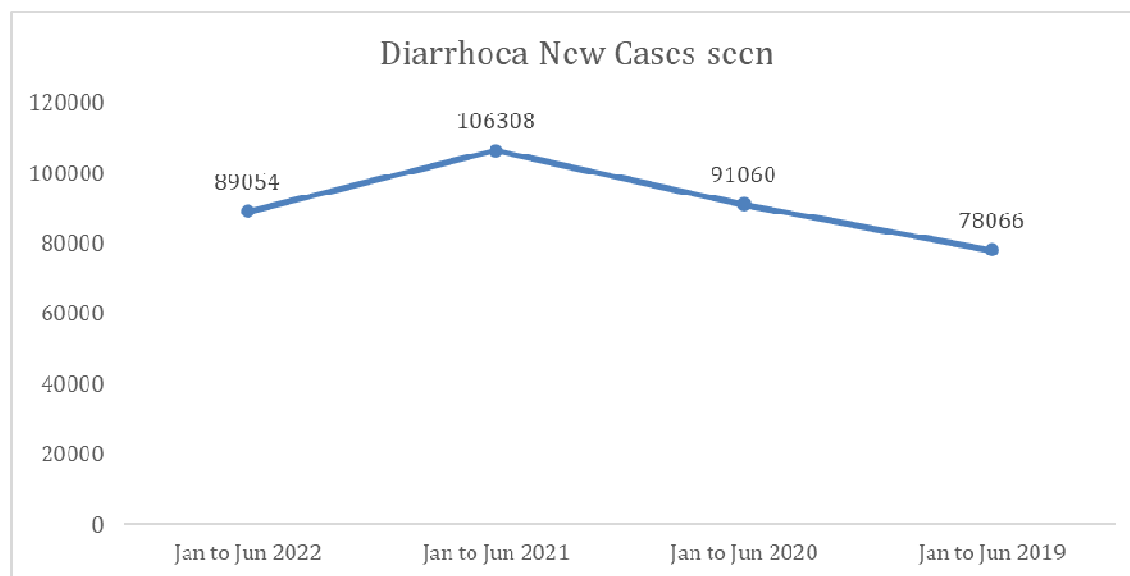


Table 1: Diarrhoea Referrals

| Variable | Jan to Jun 2022 | Jan to Jun 2021 | Jan to Jun 2020 | Jan to Jun 2019 |
|-------------------------------------|-----------------|-----------------|-----------------|-----------------|
| Diarrhoea Referrals Danger Signs | 2846 | 2794 | 3789 | 2619 |
| Diarrhoea Referrals Drug Stock Outs | 20743 | 12428 | 16884 | 51272 |

Table 1 above, shows that cases referred due to Drug stock out are more than those referred due to danger sign. This is an indication that the village clinics are inadequately supplied with medicines as such there is a need of increasing the supply of the commodities.

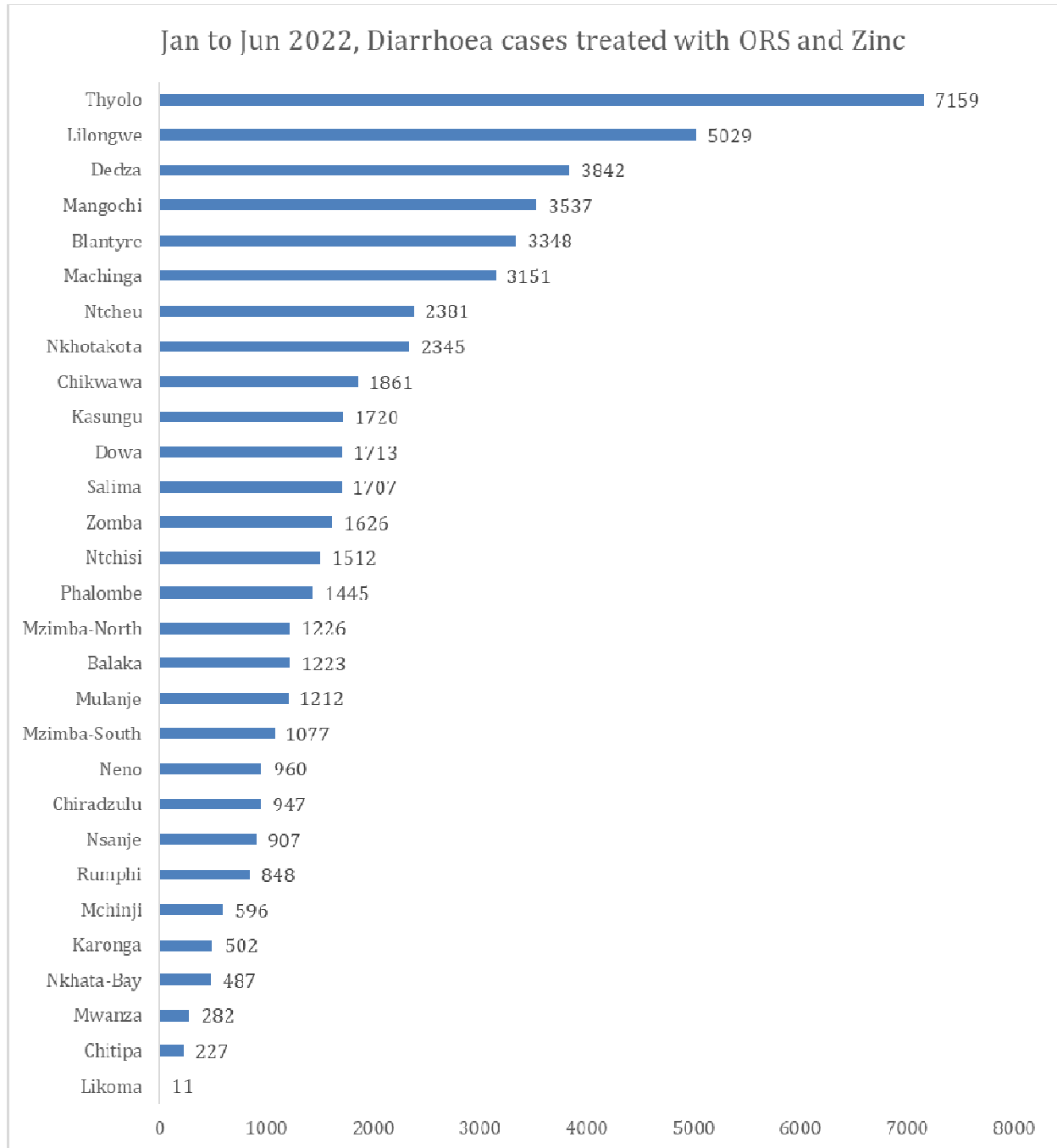
Table 2: Referred Cases of Diarrhoea by Reason and by District from village clinics

| Diarrhoea Referrals Danger Signs, January to June 2022 | | |
|---|--------------------------------------|---|
| District | Referrals due to Danger Signs | Referrals due to Drug Stock Outs |
| Blantyre | 66 | 193 |
| Chikwawa | 52 | 1801 |
| Chiradzulu | 16 | 59 |
| Mwanza | 7 | 104 |
| Neno | 61 | 12 |
| Nsanje | 30 | 232 |
| Thyolo | 54 | 83 |
| Balaka | 103 | 441 |
| Machinga | 27 | 736 |
| Mangochi | 450 | 1907 |
| Mulanje | 133 | 902 |
| Phalombe | 69 | 106 |
| Zomba | 178 | 647 |
| Chitipa | 40 | 145 |
| Karonga | 21 | 637 |
| Likoma | 0 | 0 |
| Mzimba-North | 17 | 75 |
| Mzimba-South | 131 | 1423 |
| Nkhata-Bay | 59 | 156 |
| Rumphi | 11 | 47 |
| Dedza | 198 | 423 |
| Lilongwe | 356 | 4288 |
| Mchinji | 149 | 847 |

| | | |
|------------|-----|------|
| Ntcheu | 78 | 452 |
| Dowa | 66 | 1140 |
| Kasungu | 317 | 2146 |
| Nkhotakota | 78 | 290 |
| Ntchisi | 58 | 385 |
| Salima | 21 | 1066 |

The above table is depicting the problem of referrals by district in the period under review, with a lot of referrals in Lilongwe which reported 4,288 cases due to drug stock outs. As explained earlier, there are more cases referred because of drug stock out.

Figure 5: Diarrhoea cases treated in Village clinics by District



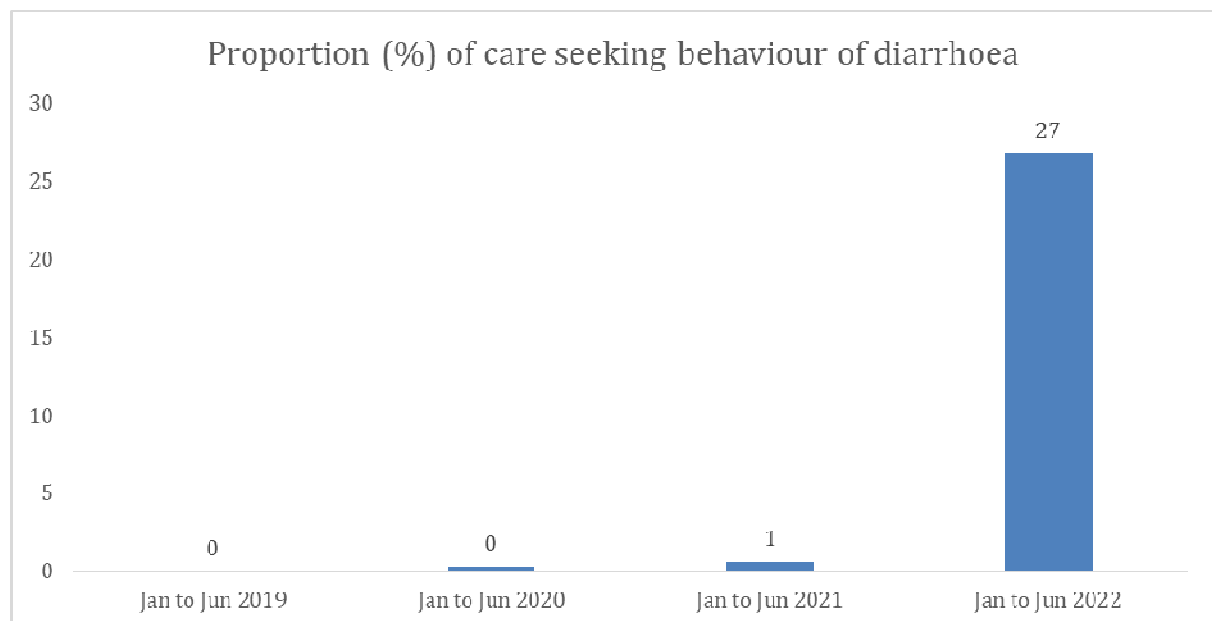
Thyolo district has reported to have treated more cases than any other district with 7,159 in the village clinics seconded by Lilongwe with 5,029 cases in the country with Likoma reported the fewest in the country with 11 cases being treated.

Care seeking behaviour for Diarrhoea Cases

Social and Behaviour Change Communication (SBCC) seeks to engage audience and addresses people not as recipients, but as knowing subjects, to achieve a deepening awareness both of the socio-historical reality that shapes their lives and of their capacity to transform that reality. This activities aims at promoting health knowledge and awareness to increasing motivation, providing skills, addressing social and gender norms, and creating a supportive environment for the adoption of key behaviours.

Any child presenting with diarrhoea is supposed to seek health services within 48 hours (2 days) from the first time the child presents diarrhoeal disease. This activity was intensified in 2021 in July where all HSAs were oriented on this such that they should also tell their communities on the importance of early seeking behaviour of health services. *Figure 2 below explains*

Figure 6: Diarrhoea SBCC



The graph above shows that care seeking was poor in the last three years and after the orientation that took place in July 2021 has promoted the behaviour from 0% in 2019 to 27% in 2022 same period country wide.

Fast breathing among Children under Five seen in the Village clinics

Fast breathing can be a sign of an infection of the lower airways, such as bronchiolitis or pneumonia. All children are different, but as a rough guide, fast breathing can be defined as: more than 50 breaths per minute for infants (2 months to 1 year), more than 40 breaths per minute for children (1-12 years) and more than 20 breaths per minute for children over 12 and adults.

The main thing to watch out for is if your child is breathing persistently faster than usual. Wheezing is a high-pitched sound that comes from the chest when your child is breathing out. Wheezing is a common symptom of asthma. However, wheezing can have many causes, so it does not necessarily mean your child has asthma. “British Lung Foundation Report new version”

The graph below show number of under five children with cough and fast breathing that were seen and treated with antibiotics. Cough and fast breathing are cardinal signs for childhood pneumonia. The graph shows trends of cases seen and treated from January to June 2019 to January to June 2022 semi-annual years.

Generally, there is a decline in number of cases seen and treated throughout the periods. A total of 110,975 new cases were seen in 2022, the period under review, which is a drop from 242,719 in 2019 same time. The decrease came about because care givers stopped from visiting the village clinics due to stock outs of antibiotics. *Refer to figure 4 below*

Figure 7 Trend of Fast Breathing cases in Village Clinics country wide

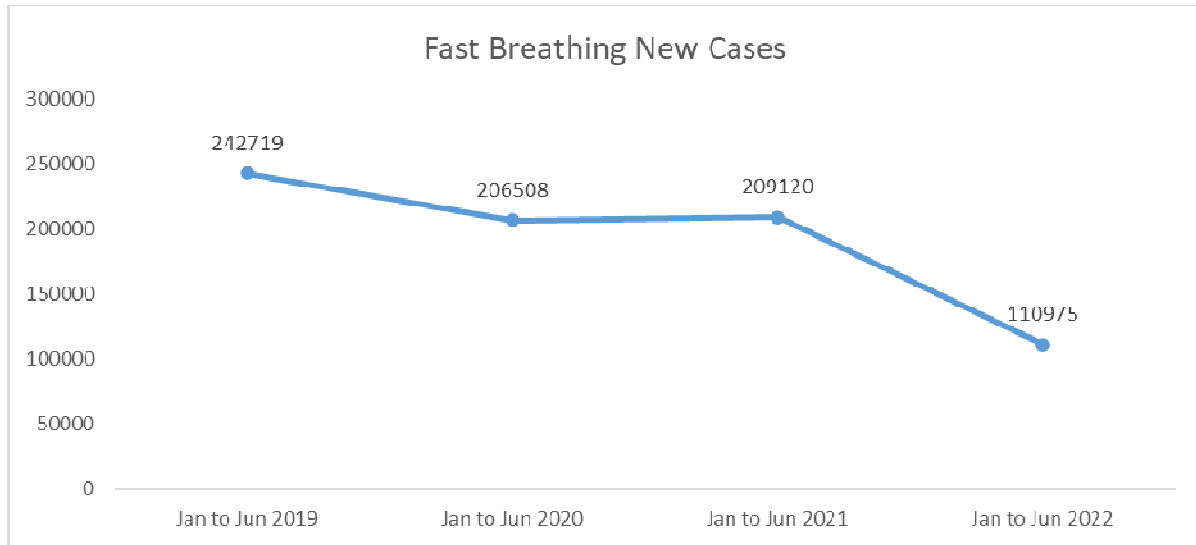


Table 3: Fast Breathing Referrals

| Period | Referrals Danger Signs | Referrals Drug Stock Outs |
|-----------------|------------------------|---------------------------|
| Jan to Jun 2019 | 5508 | 51688 |
| Jan to Jun 2020 | 9229 | 49426 |
| Jan to Jun 2021 | 7261 | 52786 |
| Jan to Jun 2022 | 5345 | 66909 |

Table 3 above shows that there were more referrals of fast breathing cases due to medicines stock outs. 66,909 cases were referred in the period January to June 2022 and is more than the referred cases during same time in 2019 with 51,688 cases.

Figure 8: Fast Breathing Cases seen in Village clinics

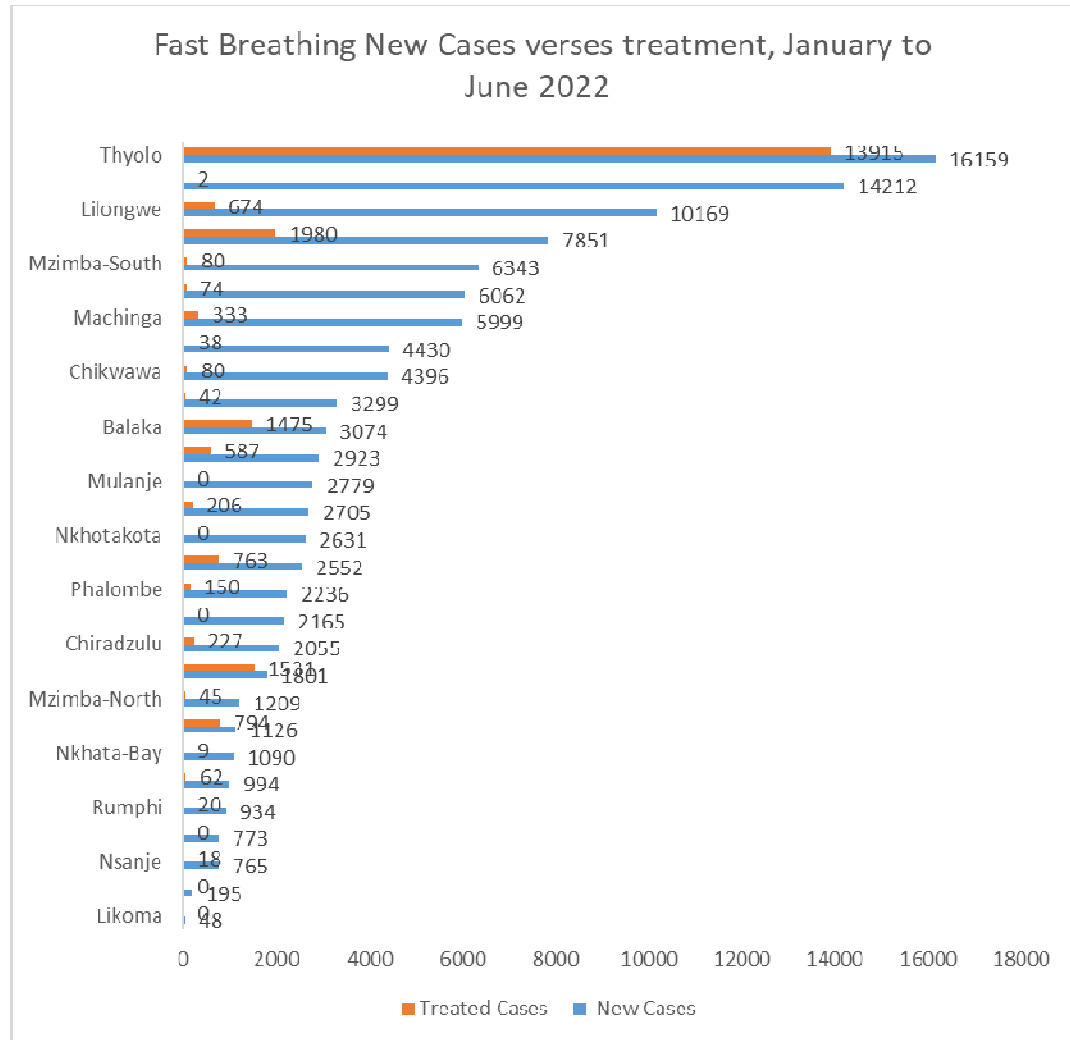


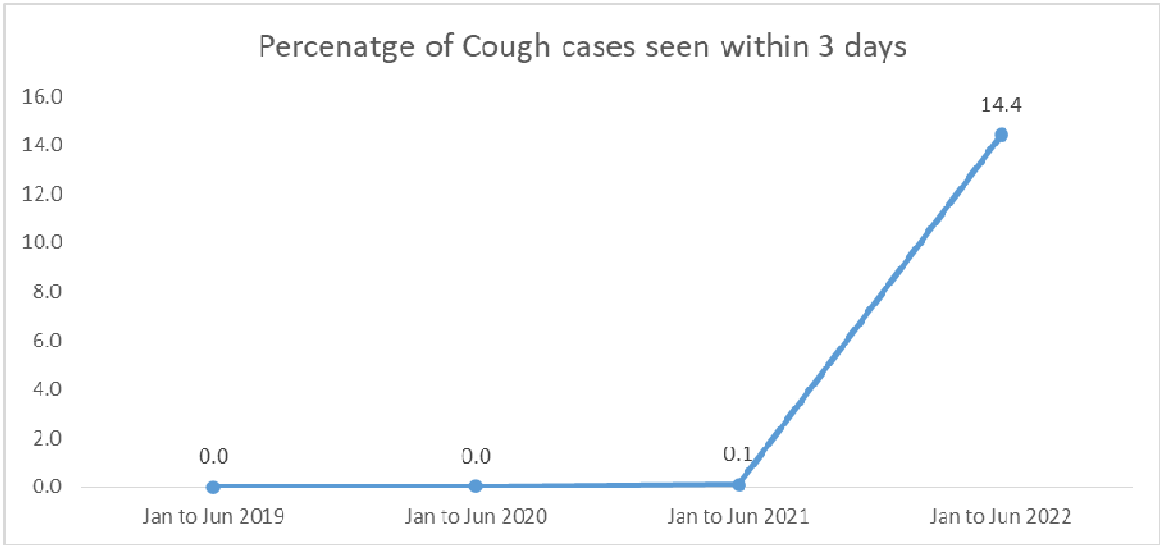
Figure 5 above shows the relationship between total cases seen and case treated. Thyolo treated more cases than any other district because of the assistance from Save the Children who supplied them with Amoxicillin in the period under review. Total new cases seen for Thyolo 16,159 and cases treated were 13,915 representing 86% of the cases seen were treated. In most districts new cases were not treated hence referred them to the Health Centre.

Care seeking behaviour for Cough Cases

Any child presenting with cough is supposed to seek health services within 72 hours (3 days) from the first time the child presents cough. This activity was intensified in 2021 in July

where all HSAs were oriented on this such that they should also tell their communities on the importance of early seeking behaviour of health services.

Figure 9: Trend of Care seeking Behaviour for cough

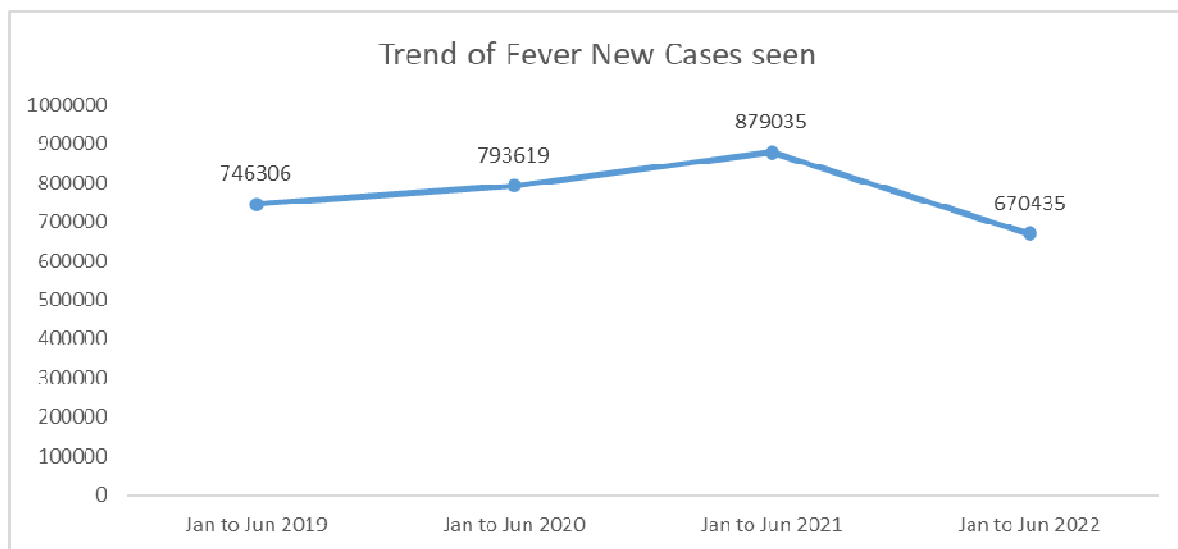


The graph above shows that care seeking was poor in the last three years and after the orientation that took place in July 2021 has promoted the behaviour from 0% in 2019 to 14.4% in 2022 same period country wide.

Fever and mRDTs at Village clinics by HSAs

Trained HSAs continue to assess children who present with fever. Malaria policy recommends that any child who present with fever must be checked with an RDT for malaria. HSAs are trained to treat fever cases with an RDT positive. Figure below is showing the trend of Fever cases seen among children who presented at village clinics. This data is showing the trends of fever cases seen in semi-annual years of January to June from 2019 to 2022. The trend has been in a downward pattern from 2019 which had 746,306 new cases seen to 670,435 new cases seen in 2022. *Refer figure 7 below.*

Figure 10 Fever Cases



Some of the contributing factors to the trend is because of experience drug shortages in the village clinics. There was a sharp increase from January to June of 2020 793,619 to 879,035 new cases seen in the clinics.

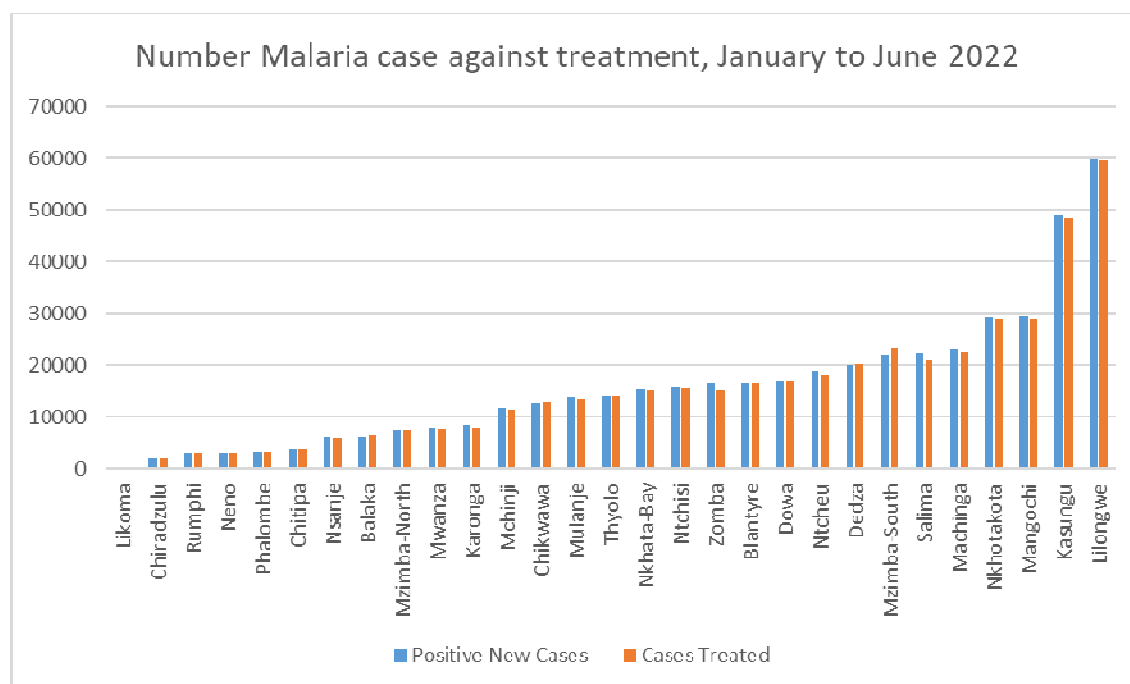
Table 4 Fever New Cases and positivity rate in the village clinics

| Fever Positivity Rate by District for January to June 2022 | | | |
|---|--|--|----------------------------|
| Districts | Fever New Cases Jan to Jun 2022 | mRDT Positive New Cases Jan to Jun 2022 | Positivity Rate (%) |
| Blantyre | 23844 | 16595 | 70 |
| Chikwawa | 23103 | 12684 | 55 |
| Chiradzulu | 3883 | 1994 | 51 |
| Mwanza | 11671 | 7954 | 68 |
| Neno | 5368 | 3139 | 58 |
| Nsanje | 8925 | 6025 | 68 |
| Thyolo | 23803 | 14215 | 60 |
| Balaka | 10345 | 6204 | 60 |
| Machinga | 31562 | 23141 | 73 |
| Mangochi | 44526 | 29325 | 66 |
| Mulanje | 19415 | 13701 | 71 |
| Phalombe | 6010 | 3435 | 57 |
| Zomba | 25247 | 16513 | 65 |
| Chitipa | 6011 | 3765 | 63 |
| Karonga | 13294 | 8510 | 64 |
| Likoma | 66 | 46 | 70 |
| Mzimba-North | 12424 | 7555 | 61 |
| Mzimba-South | 33836 | 22261 | 66 |
| Nkhata-Bay | 19716 | 15489 | 79 |
| Rumphi | 6113 | 3091 | 51 |
| Dedza | 27834 | 20183 | 73 |
| Lilongwe | 83353 | 59822 | 72 |
| Mchinji | 18620 | 11721 | 63 |
| Ntcheu | 27302 | 18810 | 69 |
| Dowa | 28226 | 16771 | 59 |
| Kasungu | 68508 | 49062 | 72 |
| Nkhotakota | 36234 | 29134 | 80 |
| Ntchisi | 22827 | 15794 | 69 |

| | | | |
|--------|-------|-------|----|
| Salima | 28369 | 22421 | 79 |
|--------|-------|-------|----|

80% positivity rate was achieved in Nkhotakota seconded by Salima and Nkhatabay with 79%. This means that almost over three quarters of the cases seen in the mentioned district are malaria positive. These areas have one common characteristic of lakeshore districts. Most districts are between 51% and 80%. The average positivity rate is 69% across all the 29 healthy districts.

Figure 11 Treated Cases



On average the treatment rate against positive cases is 99% this means that case management and decision making by HSAs is perfect. The providers are following the treatment guidelines and protocols of IMCI in as far as malaria decision making is concerned.

Table 5: Fever Referrals by reason by District from Village clinics

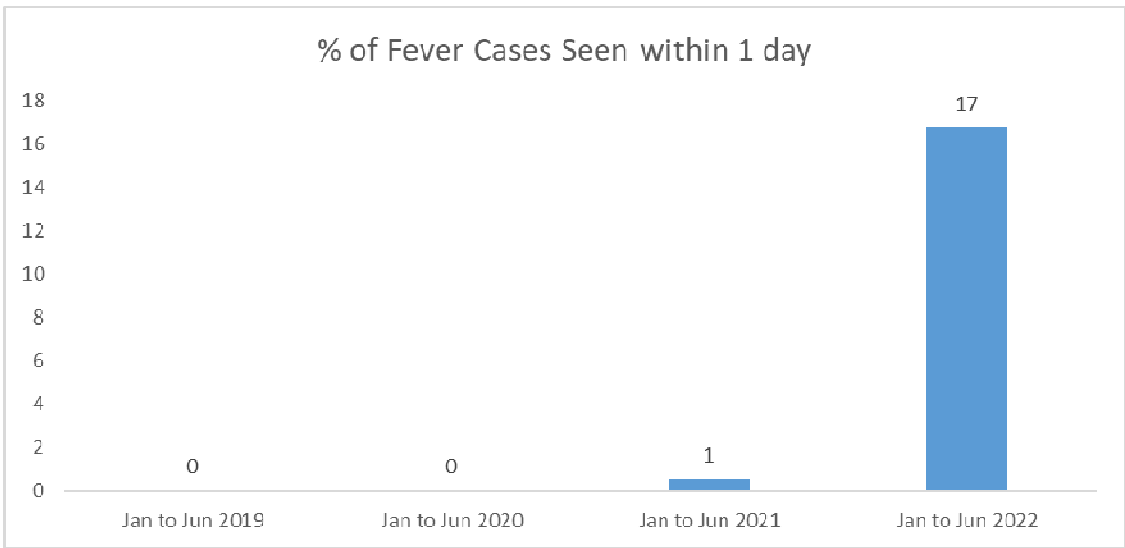
| Fever Referrals, Jan to Jun 2022 | | |
|---|---------------------|------------------------|
| Districts | Danger Signs | Drug Stock Outs |
| Likoma | 0 | 0 |
| Mwanza | 8 | 14 |
| Neno | 8 | 56 |
| Nsanje | 11 | 0 |
| Phalombe | 15 | 41 |
| Chitipa | 27 | 4 |
| Blantyre | 42 | 20 |
| Rumphi | 54 | 17 |
| Salima | 55 | 43 |
| Mchinji | 59 | 25 |
| Mzimba-North | 78 | 7 |
| Chiradzulu | 84 | 15 |
| Machinga | 91 | 67 |
| Nkhata-Bay | 97 | 125 |
| Nkhotakota | 108 | 77 |
| Chikwawa | 119 | 204 |
| Dowa | 146 | 100 |
| Karonga | 147 | 12 |
| Balaka | 172 | 78 |
| Mzimba-South | 192 | 449 |
| Ntcheu | 209 | 37 |
| Zomba | 215 | 65 |
| Thyolo | 267 | 34 |
| Mulanje | 295 | 625 |
| Kasungu | 334 | 642 |
| Ntchisi | 443 | 230 |
| Dedza | 505 | 517 |
| Lilongwe | 731 | 185 |
| Mangochi | 1067 | 751 |

In most districts there are more cases that were referred because of danger sign than refer due to drug shortage. However, there few district which referred more cases because of inadequate stocks. Such districts are Kasungu (642), Mulanje (625), Mzimba South (449), Chikwawa (204) and Nkhatabay (125) cases respectively against fewer cases referred because of danger signs.

Care seeking behaviour for Fever Cases

Any child presenting with cough is supposed to seek health services within 24 hours (1 day) from the first time the child presents fever.

Figure 12: Proportion of care seeking for fever



The graph above shows that care seeking was poor in the last three years and after the orientation that took place in July 2021 has promoted the behaviour from 0% in 2019 to 17% in 2022 same period country wide.

Table 6: All other conditions

| |
|-----------------------------------|
| Malnutrition and other conditions |
|-----------------------------------|

| Variables | Jan to Jun 2022 | Jan to Jun 2021 | Jan to Jun 2020 | Jan to Jun 2019 |
|--|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| Other Conditions New Cases | 10821 | 9971 | 9905 | 10731 |
| Palmar Pallor New Cases | 507 | 608 | 318 | 515 |
| Malnutrition New Cases | 124 | 1334 | 1684 | 2765 |
| Red eye new cases | 9404 | 25 258 | 24 602 | 24 029 |
| Malnutrition Referrals Danger Signs | 85 | 4367 | 1096 | 1752 |
| Other Conditions Referrals Danger Signs | 4353 | 4342 | 3809 | 5132 |
| Other Conditions Referrals Drug Stock Outs | 1 | 21 | 0 | 0 |

The above table shows that other conditions are also seen at the village clinics which means that there is need to expand the broad of case seen and treated in village clinics. The main aim was to deal with the major under-five killer diseases. Other conditions new cases could range from burns, skin lashes and others apart from Red Eye and Malnutrition. Almost 10,821 other conditions cases were seen in the village clinics and over 4000 of them were referred due to danger sign.

There were 9404 cases of Red eye seen and treated in 2022 in the village clinics a decline from 25,258 in 2021.

Table 7: New entries in IMCI

| Variable | Jan to Jun 2022 |
|--|----------------------------|
| Red MUAC Tape with complication | 1243 |
| Oedema +++ | 50 |
| Oedema +/-++ with medical complication | 144 |
| Oedema with IMCI danger sign | 99 |
| Marasmickwashiokor | 53 |
| HIV new cases | 118 |
| At risk of HIV | 57 |
| TB new cases | 25 |
| At risk of TB | 9 |

With support from UNICEF the IMCI is piloting the inclusion of the above variables in the delivery of services in the village clinics with an aim of looking at a Child wholesomely. Table 7 above shows number of cases that were seen and treated in the community case management from January to June 2022. A total of 1,243 children were diagnosed with malnutrition after an assessment with MUAC tape. For other assessments are also shown in the table like cases with plus 2 and plus 3 oedema and others.

The new reporting tools do also capture issues of HIV/AIDS and TB among children of under-five.

Drug and medical supplies

Medicines are the integral part in the delivery of services in community case management. Village clinics are supplied with different sort of medicines as tabulated below in table 8. The medicines supplied to the village clinics are anti-malarial drugs, Anti-biotic drugs, diarrhoeal drugs, pain killers and antibacterial drugs.

Table 8: Medicines Supplied

Medical Supplies

| Stocks | Jan to Jun 2022 | Jan to Jun 2021 | Jan to Jun 2020 | Jan to Jun 2019 |
|---------------------------------|------------------------|------------------------|------------------------|------------------------|
| LA 6X1 Quantity Received | 1,624,234 | 2,367,848 | 2,016,678 | 1,890,994 |
| LA 6X1 Quantity Dispensed | 1,292,198 | 1,935,070 | 1,814,085 | 1,610,422 |
| LA 6X2 Quantity Received | 2,748,804 | 4,019,717 | 3,462,906 | 3,221,390 |
| LA 6X2 Quantity Dispensed | 2,860,071 | 4,238,177 | 3,746,680 | 3,327,069 |
| Amoxicillin Quantity Received | 425,616 | 1,570,007 | 1,261,436 | 1,385,193 |
| Amoxicillin Quantity Dispensed | 462,050 | 1,709,734 | 1,267,425 | 1,579,157 |
| ORS Quantity Received | 156,648 | 240,793 | 202,627 | 76,836 |
| ORS Quantity Dispensed | 158,644 | 251,651 | 179,585 | 153,419 |
| Eye Ointment Quantity Received | 13,268 | 32,979 | 35,237 | 33,826 |
| Eye Ointment Quantity Dispensed | 17,776 | 28,533 | 27,837 | 28,455 |
| Paracetamol Quantity Received | 1,481,624 | 2,112,473 | 1,705,503 | 1,799,300 |
| Paracetamol Quantity Dispensed | 1,375,219 | 2,074,926 | 1,636,608 | 1,784,639 |

Table 8 above show the quantities supplied to community case management and quantity dispensed by the community case management to clients.

9 Supervision and Mentorship

Monitoring and Evaluation (M&E) is used to assess the performance of projects, institutions and programmes set up by governments, international organisations and NGOs. Its goal is to improve current and future management of outputs, outcomes and impact. Monitoring is a continuous assessment of programmes based on early detailed information on the progress or delay of the ongoing assessed activities. An evaluation is an examination concerning the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives. Monitoring and evaluation processes can be managed by the donors financing the assessed activities, by an independent branch of the implementing organization, by the project managers or implementing team themselves and/or by a private company.

As a primary activity the IMCI conducts supervision to assess quality of care in order to improve current and future management of outputs, outcomes and impact of the program. Where gaps have been identified, mentorship is embarked to avert the situation. The program has supervisors and mentors who take the tasks to the care givers in the communities.

Figure 13: Supervision and mentorship

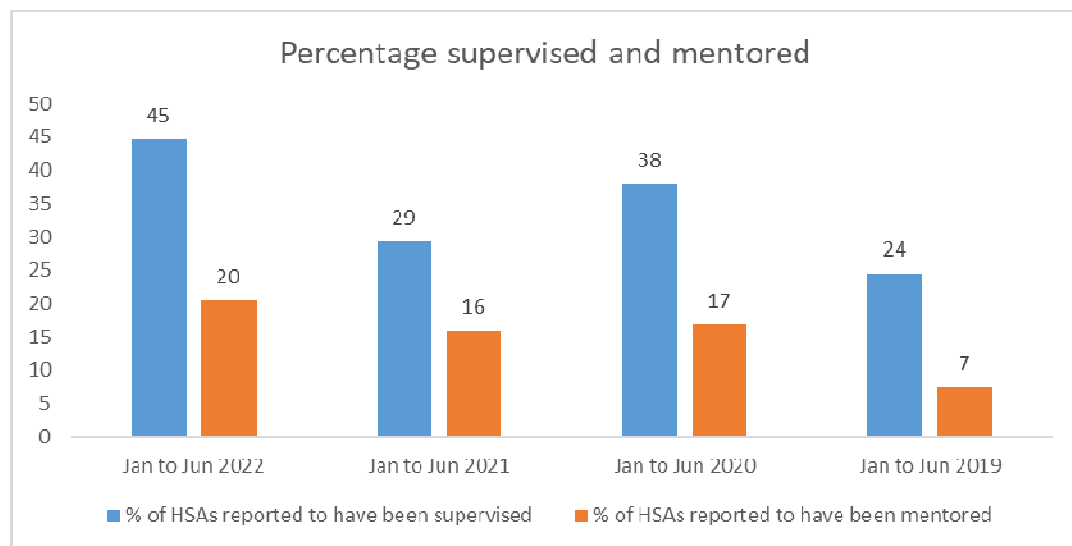
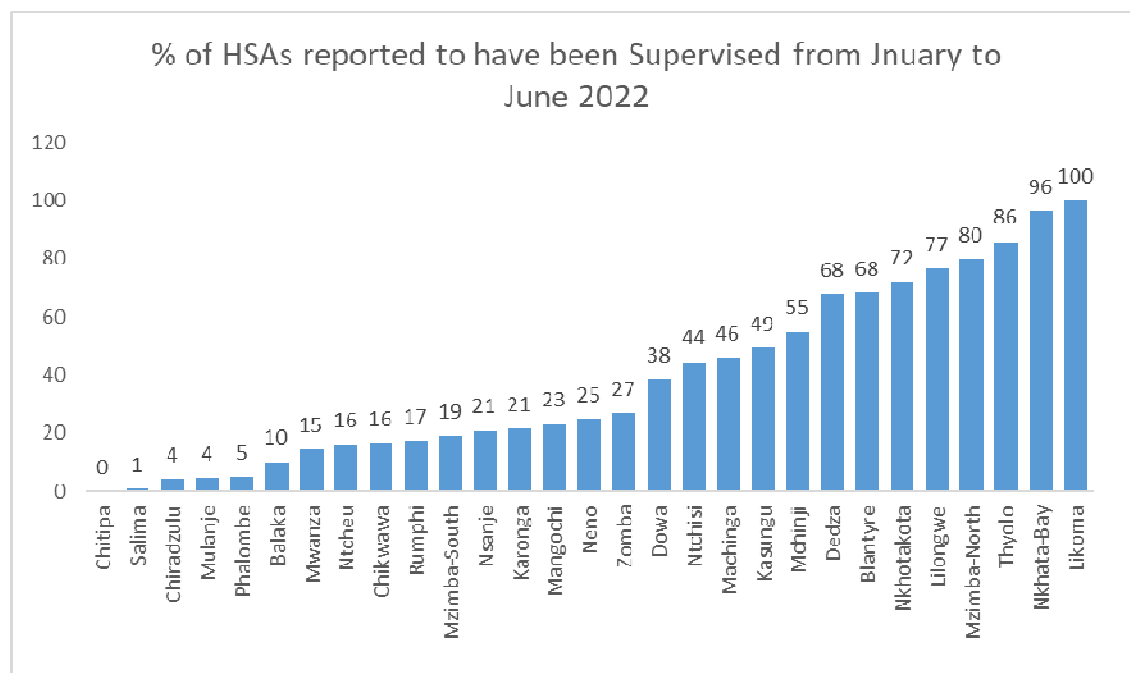


Figure 10 above shows on average the supervision performance stand at 45% and Mentorship at 20% nationally from January to June 2022 compared with same time subsequent years past. Both supervision and mentorship have improved in the period under review showing an increase from 24% and 7% in 2019 respectively.

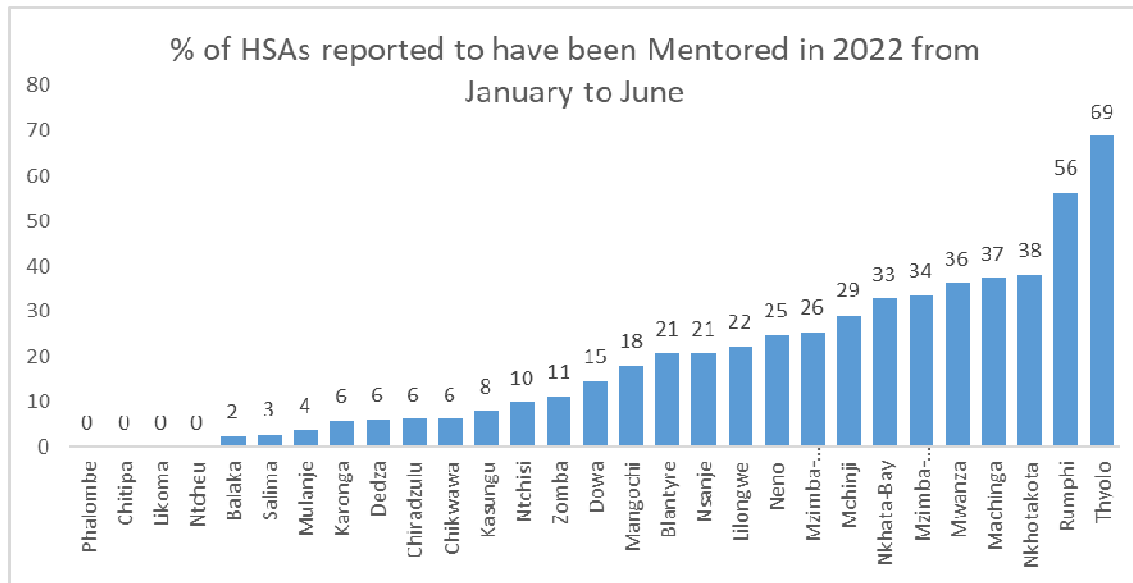
Figure 14 Supervision by District 2022



From January to June we had three supervisions one supported by Global Fund, one supported by Impact Malaria and one supported by UNICEF. The supported by Global Fund covered all district targeting two facilities per district and two HSAs per facility. The one supported by Impact Malaria targeted their impact area of Mchinji, Kasungu and Nkhatabay while the one supported by UNICEF targeted thirteen Districts which happens to be their implementation areas, the districts are Nsanje, Chikwawa, Chiradzulu, Phalombe, Mangochi, Balaka, Dedza, Lilongwe, Mzimba South, Mzimba North Karonga, Kasungu and Ntcheu.

The supervision coverage ranged from 0% in Chitipa and 100% in Likoma in the period under review.

Figure 15 Mentorship by District



Mentorship ranged from 0% in Phalombe, Chitipa, Likoma and Ntcheu to 69% in Thyolo. There is an improvement in both supervision and mentorship but still more there is room for improving further. It has been observed that despite being mentored some staff are not documenting in the reporting system.

There is need to improve in the performance of this section in order to achieve the intended outcomes and deliver effectively and efficiently. The supervision coverage has improved from 29% to 40% on average while mentorship from 16% to 20% on average respectively.

If resources are put in place in the delivery points and in supervision and mentorship, great improvement might be registered as it has been proven that community case management brings the services closer to the communities. It also help to decongest our facilities apart from the proximity that reduces travel distance by health service seekers.

10 Achievements

- Managed to establish village clinics across the country where care givers seek services
- Trained service providers both at facility level and community level
- Conducted supportive supervisions every quarter in the past years
- Revamped cStock services which were suspended in the past years
- Secured support from partners

11 Challenges

- Competing priorities among service providers at facility and HSAs at community level continue to affect continuous access of affordable child care services e.g., low numbers available workforce, and meetings outside duty stations
- Inconsistent documentation of statistical and logistics data due to inadequate availability of reporting and monitoring tools/booklets
- Inadequate availability of essential medicines for example; ORS, Zinc and dispersible Amoxicillin almost zero in all the districts except Balaka, Mangochi and Rumphu where a few were available.
- Inadequate supervision, data and clinical mentorship, data management and refresher training

12 Conclusion

Going forward, the IMCI Unit would like to encourage all Districts to capture, aggregate and intensify reminding the facilities on reports. Almost all reports shall be published based on data from DHIS 2.

IMCI looks forward to engaging with various Districts and Program coordinators plus facilities to streamline reporting of IMCI data in order to gear up for data quality in the DHIS2 environment. Also, worthy emphasising is that coordinators should have time to monitor data entry and quality in DHIS2 in collaboration with HMIS officers.