|  |  |
| --- | --- |
| **Message 1** | The MAMaZ Against Malaria (MAM) pilot project in Serenje District provided proof of concept that rectal artesunate (RAS) administered at community level is a highly effective intervention for severe malaria among young children (6 months to 6 years old). The severe malaria mortality rate in this age group fell by 94.6%. It is recommended that community RAS is scaled up across the country as part of Zambia's strategy for reducing severe malaria mortality. |
| **Message 2** | RAS is not yet widely available in Zambia. It is recommended that development partners work with the Ministry to Health to expedite procurement of RAS through the national system so that the intervention can be scaled up to other rural districts in 2019. Once procured, it will be important to ensure timely quantification and procurement of stock to prevent stock outs. |
| **Message 3** | Effective case management of severe malaria in young children requires access to RAS, injectable artesunate, and commodities such as rapid diagnostic tests and disposable gloves. It is important to ensure an uninterrupted supply of these essential severe malaria drugs and commodities as community RAS is scaled up in Zambia.  |
| **Message 4** | MAM demonstrated that different cadres of community health volunteer (CHV) can be successfully trained to administer RAS and mobilise communities around a child health agenda. Training a variety of CHVs (SMAGs, i-CCM, CHWs) builds on existing structures, increases coverage, promotes equity of access to severe malaria services, and is low-cost. It is recommended that the MOH follows this approach and incorporates good practice from MAM's RAS training approach into i-CCM and other CHV training manuals.  |
| **Message 5** | Training a small number of CHVs (i.e. 1-2 per community) in severe malaria case management is unlikely to substantially increase communities' access to RAS and severe malaria treatment. Distances within communities are large and the reach of individual CHVs is small. It is recommended that the MOH considers moving towards 1 CHV: 250 population to increase coverage, a ratio that MAM has found to be very effective.  |
| **Message 6** | MAM trained CHVs to mobilise their communities in support of a severe malaria agenda and to set up and manage community systems to address the access and affordability barriers to use of services. As community RAS is rolled out in Zambia, it will be important to ensure that CHVs receive adequate training on community mobilisation and supportive community systems, drawing on good practices from MAM including the use of innovative participatory training tools (e.g. communication body tools).  |
| **Message 7** | Whole community approaches are needed to change social norms in favour of improved child health care seeking. It is therefore crucial that CHVs are trained to promote male involvement in health. CHVs also need to be trained to promote social inclusion. Reaching the least-supported women in the community is essential since they and their children usually carry the highest burden of ill-health. |
| **Message 8** | The link between communities and lower level health facilities is often the weakest in the health referral chain. Community-managed emergency transport systems (ETS) can significantly reduce travel times to the health facility and be a positive factor in encouraging prompt referral of very sick children. ETS will be an important part of the RAS intervention as it is scaled up across Zambia. It is recommended that the MOH and districts budget for replacement ETS vehicles after four or five years, and to support ETS riders via routine supervisory processes. |