

Operations Research Subgroup Teleconference Minutes

Wednesday, September 16, 2015, 10am EST

Participants: Anna Bryant (MCSP), Nate Miller (UNICEF), David Hamer (BUSPH), Stefan Peterson (Uppsala University), Rashed Shah Mohammed (STC), Nick Oliphant (UNICEF), Dyness Kasungami (MCSP), Vikas Dwivedi (MCSP)

Agenda Item	Notes	Action Items
iCCM utilization in Ethiopia (Nate Miller)	<ul style="list-style-type: none"> • Working on a literature review of iCCM and community based newborn services and care-seeking. The review isn't quite complete yet (30 documents). Will share the full report and presentation later. • Looked at levels of care-seeking and utilization. DHS and JH Eroni evaluation, QoC survey, South African Medical Research Council (MRC), program data from STC and JSI last 10k program. Baseline from LSHTM and local university data. <p>Care seeking/utilization</p> <ul style="list-style-type: none"> • Sources: <ul style="list-style-type: none"> ○ EDHS ○ JHU Oromia iCCM evaluation QoC and implementation strength ○ JHU Oromia iCCM evaluation baseline and endline ○ SA MRC iCCM evaluation ○ Save the Children routine program data ○ L10K routine program data ○ LSHTM CBNC evaluation baseline ○ Mekele U., Umea U. • Utilization of iCCM is consistently low <ul style="list-style-type: none"> ▪ 16 consultations/month in Oromia survey one year after start of implementation ▪ Routine data from various regions showed even lower utilization ▪ In SC areas, HEWs saw 60% more children 2-59 months and 73% more SYIs in 3rd quarter 2012 compared to same period in 2011 <p>Service provision and HEW time allocation</p>	Nate Miller to share final report

	<ul style="list-style-type: none"> • Findings: <ul style="list-style-type: none"> ○ High availability of commodities, much better than pre-iCCM ○ 64% of children correctly managed for all iCCM illnesses ○ Most HEWs not from kebele in which they work ○ HEWs spend about 6 hours on work activities per work day (plus about 5.5 hours on weekend) • Barriers to care seeking • Findings: <ul style="list-style-type: none"> ○ Barriers to care seeking from HEWs <ul style="list-style-type: none"> ▪ Preference for home-based or traditional treatment first ▪ Not aware of services ▪ Perceived cost of treatment ▪ Fear of referral to health center (cost and distance) ▪ Distance to HP ▪ Lack of/cost of transportation ▪ HP not always open/absence of HEWs ▪ Lack of drugs at HP ▪ Religious leaders/traditional healers may not approve of using HP ○ Factors significantly associated with utilization of iCCM services; <ul style="list-style-type: none"> ▪ Higher density of HEWs ▪ Living closer to HP ▪ Far from health center ▪ Having a road for vehicle access to HP ▪ Wealth quintile significant for all providers, but not for health post • Findings are that care-seeking is low. Rural careseeking for ARI, diarrhea and fever from 29-22%. There are large differences in care-seeking by wealth quintile. Similar levels of care-seeking in intervention areas. Found that • Utilization is also consistently low. In Oromia, the routine data showed very low implementation in areas. Did see low increase over time. 	
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	<ul style="list-style-type: none"> • Use of newborn cares services increased. • Commodities are generally available, and much better than pre-iCCM availability. Quality of Care is good – better than we see in health facilities. More HEWs are not from the district in which they work, which might affect their presence in the community. • Major barriers to care-seeking – preference for home-based to traditional treatment. Many people still unaware of services available. There is a perceived cost of treatment (cost of services and travel). Distance to health posts are also a barrier. There is a lack of transportation and access to transportation. HEWs may be absent. There is a perceived lack of drugs. Religious healers do not believe in health posts, as family planning services are offered. Women also often need to ask husbands for permission. • Having HEWs/Comm • Looking at time spent between preventive and curative interventions. If the HEWs are out spending time doing prevention, is another doing curative services? • HEW workers are doing a lot of tasks. Are there community groups that can do some of the messaging BCC that would improve the outcomes you mentioned? • Data on referral systems: there weren't any data on this. 2 studies on Uganda and W. African country on referral compliance. Some evidence. • In yesterday's GHSP there were two articles on care groups linking services (social action groups). Rwanda has been implementing this. 	
<p>Pneumonia formulations (David Hamer)</p>	<ul style="list-style-type: none"> • David is a part of the CCM of Pneumonia Innovations Team (run by Leith Greenslade, MDG Health Alliance, Office of the UN Special Envoy for Financing the Health MDGs). Several groups presented new forms of amoxicillin: <ol style="list-style-type: none"> 1. UC Berkley has a peanut-butter based form of Amox: Similar to Ready-to-Use Therapeutic Food (RUTF) with Amox embedded in it, hopefully improving nutrition in addition to treatment. Does not interfere with the absorption of Amox 	<p>Dyness will follow up with Samira to find out where the implementation of the global action plan (GAPPD) stands.</p>

	<p>and does not require refrigeration.</p> <ol style="list-style-type: none"> 2. Rectal suppository form of Amox. This is helpful if a child is vomiting, which is a common symptom in childhood illness. 3. Oil-based delivery method: Amox suspension that wouldn't require refrigeration and would reduce contamination risk. Would be able to withstand high temperatures (30-50C) and appears to be relatively stable in humid conditions. The oil would also provide some calories. <ul style="list-style-type: none"> • Phase II of these new delivery methods is to ensure the therapeutic viability remains the same. There's a group in Singapore that are developing Vixatropid system for oral delivery of amoxicillin to block the unfavorable taste of the drug. Leads to special encapsulation of the particles that make it more palatable. • It will likely be 3-5 years before we can compare these methods with dispersible Amox. 	
<p>Potential to market iCCM as a Rational Drug Use intervention and linking up to WHO and the new Action Plan for Antibiotic Resistance? (Stefan Peterson)</p>	<ul style="list-style-type: none"> • http://www.who.int/drugresistance/global_action_plan/en/ • Given the wide availability and easy access to antimicrobials in many countries, it can be argued that training CHWs will reduce the need for care givers to go to the shops/private sellers and that trained and supervised CHWs will increase rational drugs use. • We need the evidence/documentation of how iCCM has changed practices especially in the private sector, e.g. the Uganda report • <u>Need to establish how and who will lead the process of developing action plans at country level and link them with the child health/iCCM technical working groups. Find out role of WHO country offices.</u> • Figure out how the global group- CCM TF- can support countries that want to use the iCCM argument. 	<p>We will get to this next time to define next steps.</p>
<p>AOB</p>	<ul style="list-style-type: none"> • Next time we will discuss community care groups and their [potential] role in increasing utilization of iCCM services. • Nick Oliphant, who is heading the systematic review, heard back from Cochrane that they accepted the concept note. He is moving forward with the process and will update the group. • We'll have a discussion on Quality of Care in November to be led 	<p>Next meeting at 10am EST on November 11th</p>

	<p>by Florence Nyangara, ICFI</p> <ul style="list-style-type: none">• David can report on ASTMH symposium that is happening in last week of October.	
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