Integrated Community Case Management /ICCM/

story in Ethiopia

March 3 ,2014

Ghana, Accra

iCCM 2014

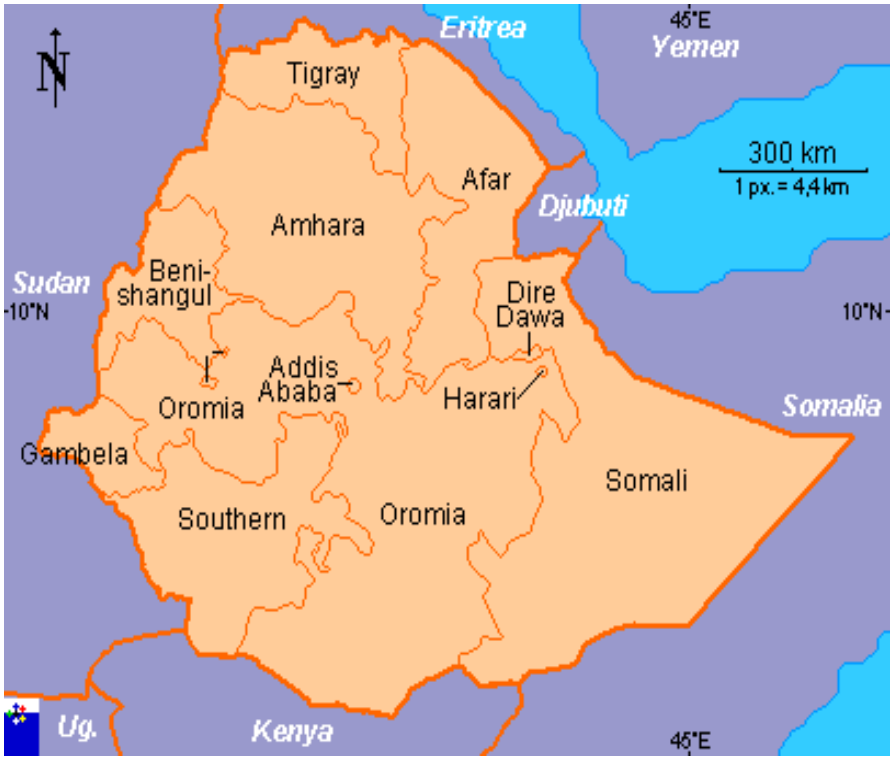
Integrated Community Case Management (iCCM): Evidence Review Symposium

3–5 March 2014, Accra, Ghana

Background

Country Overview

- ✓ 2014 population is 89 million. *(2007 population & housing census)*
- ✓ 9 regions, 2 city administrations, 824 districts, 16,000+ rural kebeles
- ✓ 84% rural
- ✓ 13 million <5s



Background

Health situation

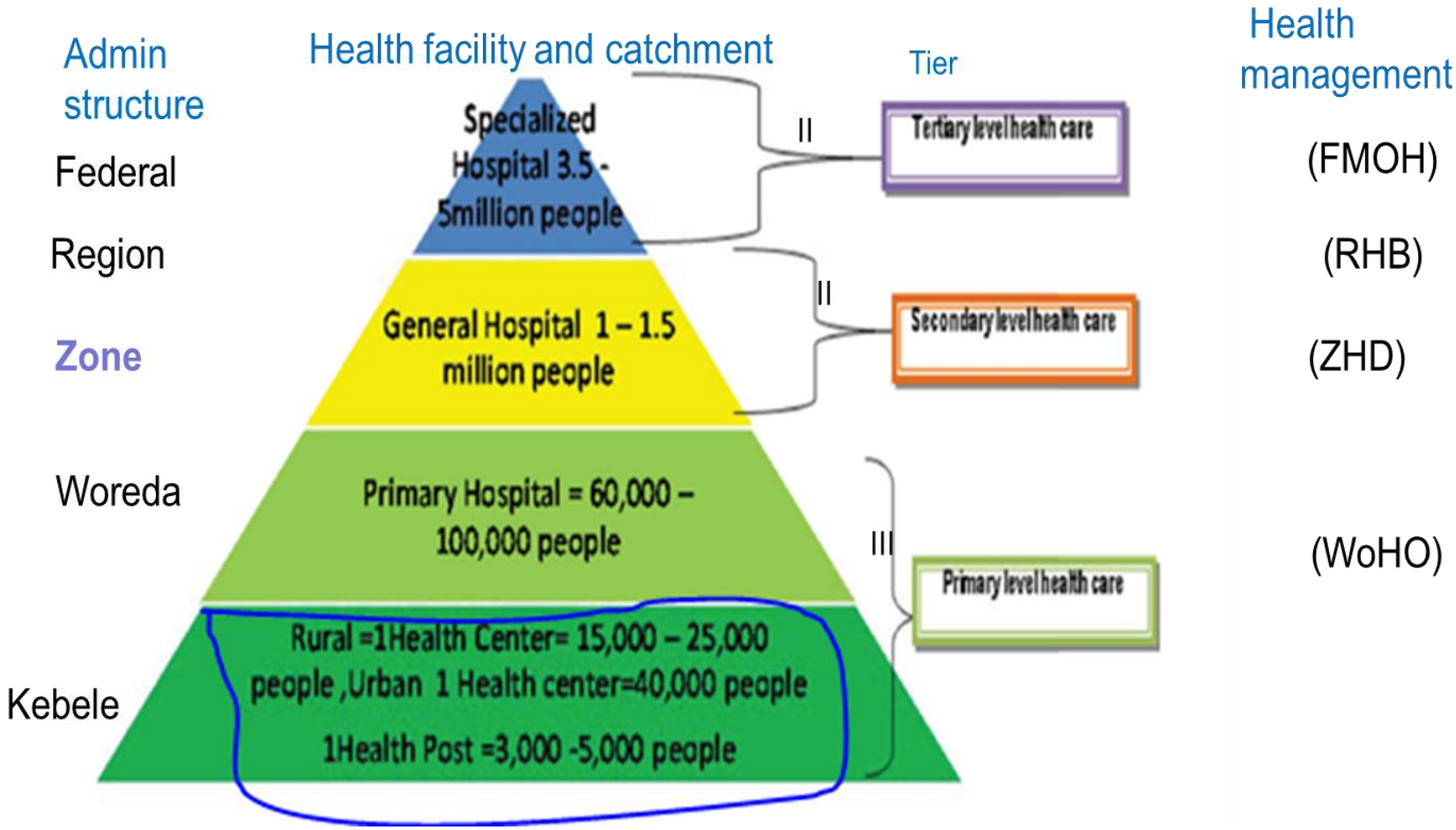
- ✓ Ethiopia achieved MDG4 target by reducing child deaths by 67%, from 204 per 1000 live births in 1990 to 68 per 1000 live births in 2012 *(UN IGME report 2013).*

Background

- ✓ Nearly 205,000 children still die each year mostly from preventable or treatable diseases
- ✓ More than 70% of the deaths due to pneumonia, diarrhoea, malaria, newborn conditions and malnutrition (WHO/CHERG 2010)

	Common contributors of the deaths and illness in Ethiopia			
Type of Illness	**Pneumonia**	**Diarrhoea**	**Malaria**	**Newborn conditions**
death (#, %)	36,000 (18%)	26,000 (13%)	14,000 (7%)	67,000 (33%)
illness (#)	3,500,000	39,000,000	-	300,000

Ethiopian Health System



Integrated Community Case Management (iCCM)

Goal

- Ensure the achievement of MDG 4 by 2015, through Integrated Community-Case Management of Common Childhood Illnesses (iCCM)

- To contribute to the country goal of reducing under five mortality to below 20/1000LB by 2035

Health Extension Program

- Flagship health program
- Introduced in 2003-4
- Philosophy: if the right health knowledge and skills are transferred, households can take responsibility for producing and maintaining their own health.
- HEWs deliver 16 health intervention packages in the community
  - Maternal & child health (5)
  - Hygiene & sanitation (7)
  - Communicable disease prevention & control (3)
  - Health education & communication (1)

History of CCM in Ethiopia

- To decrease under five mortality, Ethiopia initiated CCM before the era of MDG.
- The most appropriate way of increasing access to the rural & poorest families is treating common childhood illness through community-based approach with the human potential available at community level.

Objective

Pneumonia

Malaria

Increase **Access** to case management of common childhood illnesses at the community level

Diarrhea

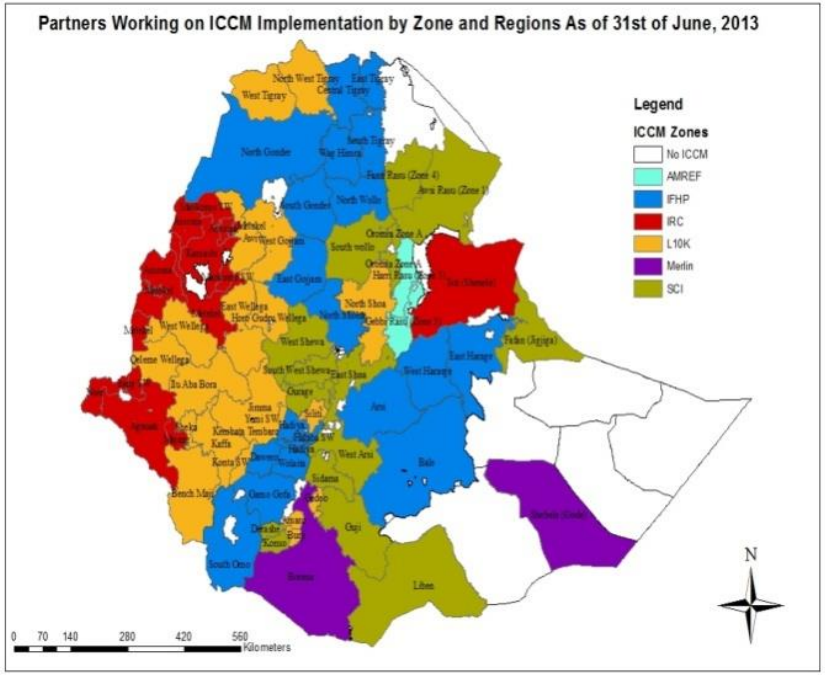
Malnutrition

Major activities

- Establish strong coordination among partners
- Prepare training guides, job aids, and standard list of drugs and supplies
- Train
- Follow up and supervise post-training
- Conduct Performance Review and Clinical Mentoring
- Distribute supplies
- Mobilize communities and communicate for behavior change
- Monitor and evaluate

Achievement

- >**29,900** HEWs (**14,500** health posts) in *Amhara, Oromia, SNNPR, Tigray, BG, Gambella, Afar* and *Somali Regions* started iCCM
- >**8000** health workers equipped with iCCM facilitation & supervision skills and IMNCI skills
- >**36,500** training kits distributed
- **86%** districts covered by iCCM
- **~4.6** million sick children benefited from iCCM between 2011 and 2013



Program learning

- Technical Working Group prioritized 5 operations research questions
- Many have generated evidence, including
  - Johns Hopkins University, Institute for International Programs
  - Medical Research Council of South Africa
  - Implementing Partners (JSI, IRC, IFHP, SC, etc.)
- Under review: a 2014 supplement to *Ethiopian Medical Journal*; a "national case study" of iCCM at scale with 16 papers and 4 editorials

Opportunities

- Strong political commitment and government leadership
- Mature HEP platform with >34,000 salaried rural HEWs can shoulder iCCM
- Primary Health Care Unit linkages (1 health center + 5 health posts)
- Health Development Army (HDA)
- Committed development partners supporting HEP and iCCM

Challenges

- Low service utilization, particularly by sick young infants
- Supply chain management system
- HMIS not yet fully capturing new interventions
- Regular supportive supervision by PHCU and district
- Primary Health Care Unit not yet strong
- Continuous need to train newly deployed HEWs

Lessons learned

- Strong government leadership is necessary for successful implementation monitoring and evaluation
- HEWs can deliver quality iCCM service if well trained, supplied and supervised
- HEWs' commitment and strong community mobilization through the HDA are critical for iCCM use
- Strong national and local partnership helps ensure speed and quality of iCCM implementation at scale
- Clinical mentoring, supervision and review meetings are important for improving quality of services
- Pre-service training is important for sustainability
- iCCM alone will not be enough to reach the young infant population

Next steps

1. Consolidate the iCCM programme in the four big regions, focusing on quality improvement, utilization, supervision and supply chain management
2. Complete iCCM role-out in the developing regions, hand-in-hand with HEP improvement
3. Scale up community-based newborn care, including newborn sepsis management by 2015

Thank you