Ethiopia

ICCM/Malaria

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Pillar 1- Political Will

• HEP Platform existed with good political well
• HEP optimization road map being developed
• Integration is well managed at all level: particularly Health facility level, district level, PSM, training, planning,
• Prioritization interventions based on data: prevalence of childhood illnesses eg. Pneumonia, guide for interventions.
• Concern on sustainable financing for ICCM and ICCM commodities
• HEW attrition is challenge (expected to be addressed by HEP optimization, carrier development)
• ICCM uptake need to improve through innovative demand creation strategy
• ICCM training is included in the curriculum/ preservice
• HEP to be well adopted to fit pastoralist community
Pillar 2: strategic use of information

• DHIS2 addressed all ICCM components: coverage at health center 95%
• Transition was challenge from HMIS to DHIS-2 as data was lost in-between. Effort should be exerted to address retrospective data.
• LMIS is gap for program managers to get health facility stock level
• Microstratification can be done by health facilities (morbidity, admission, mortality-hospitality)
• Analytical analysis, data utilization- capacity building is required at district level
• Implementation research newborn and young children (enhanced pneumonia Rx, possible serious bacterial infection, Kangaroo mother care, Assessment of HEP, ARIDA)
Pillar 3: Better guidance

- Coordination strengthened between various directorate in FMOH: MNCH directorate, HEP/PHC directorate, Malaria/DPC directorate

- Blanket coverage of ICCM enhanced with CBNC program, commodity distribution is based on consumption and burden. Prioritization for hard to reach and high burden is require further analysis and validation.

- Improvement is required for estimation of childhood illness burden (pneumonia, diarrhea) for drug quantification as drug consumption data is not enough

- Lack of incident data for childhood illnesses

- HEW follow well the guidelines.
Pillar 4: Leadership and coordination

• Strong Government led process
• Joint planning to accelerate child mortality
  • Delayed procurement is challenge (lack of local production for key essential drugs)
  • Planning is bottom up approach and need to strengthened to hear Community engagement
• Partners alignment is positive, need more number of partners.
Recommendation

• Coordination strengthened between various directorate in FMOH
• Capacity building on data use and analysis at district level
• Reduced Procurement led time: early planning, simplify and shorten the bureaucracy, local production of essential drugs
• Increased partners involvement on technical support and documentation
• ICCM financing from donors & increase domestic financing to child health.
• Finalize optimization of HEP strategy
• Strengthening PHC unit linkage
• ICCM uptake need to improve through innovative demand creation strategy/ community engagement
• Improve ICCM quality service through quality improvement initiative (mHealth, eCHIS, innovation, mentorship/coaching, etc)
Recommendation...

• Standardizing community health workers level for PHC for countries to achieve UHC