Ethiopia

Country experiences from scaling up iCCM within community health systems

Institutionalising integrated community case management (iCCM) to end preventable child deaths Meeting, Addis Ababa

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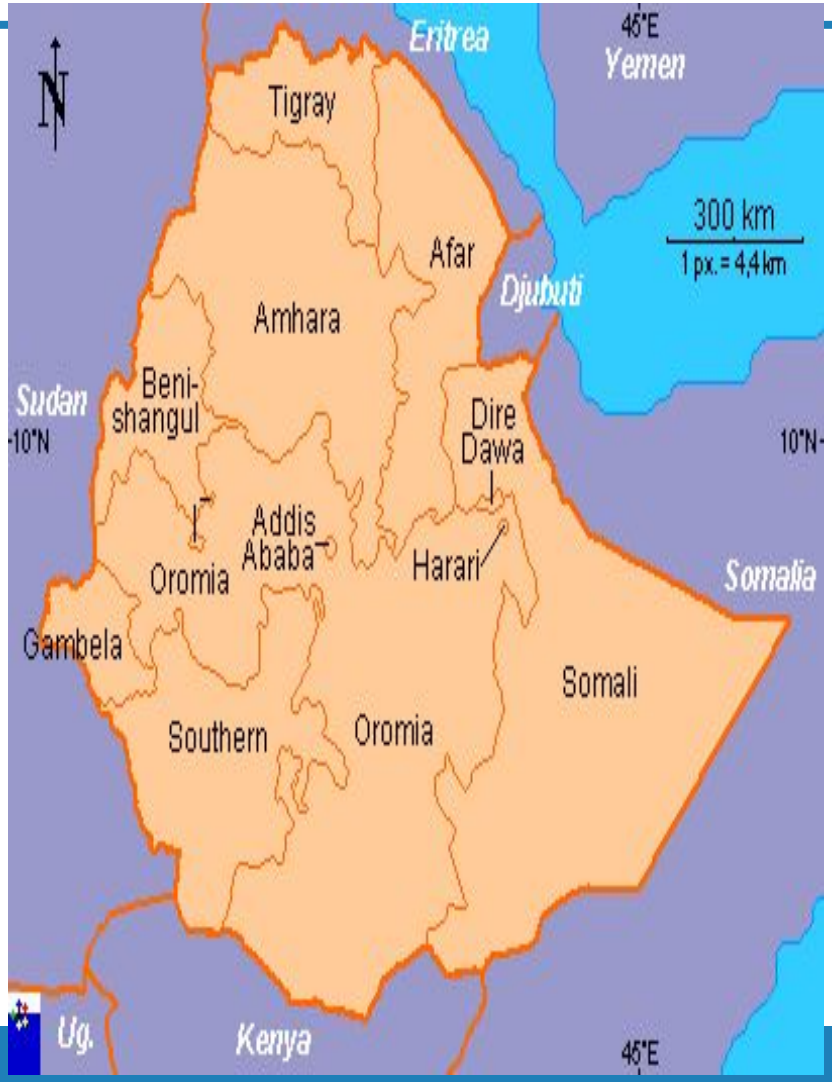
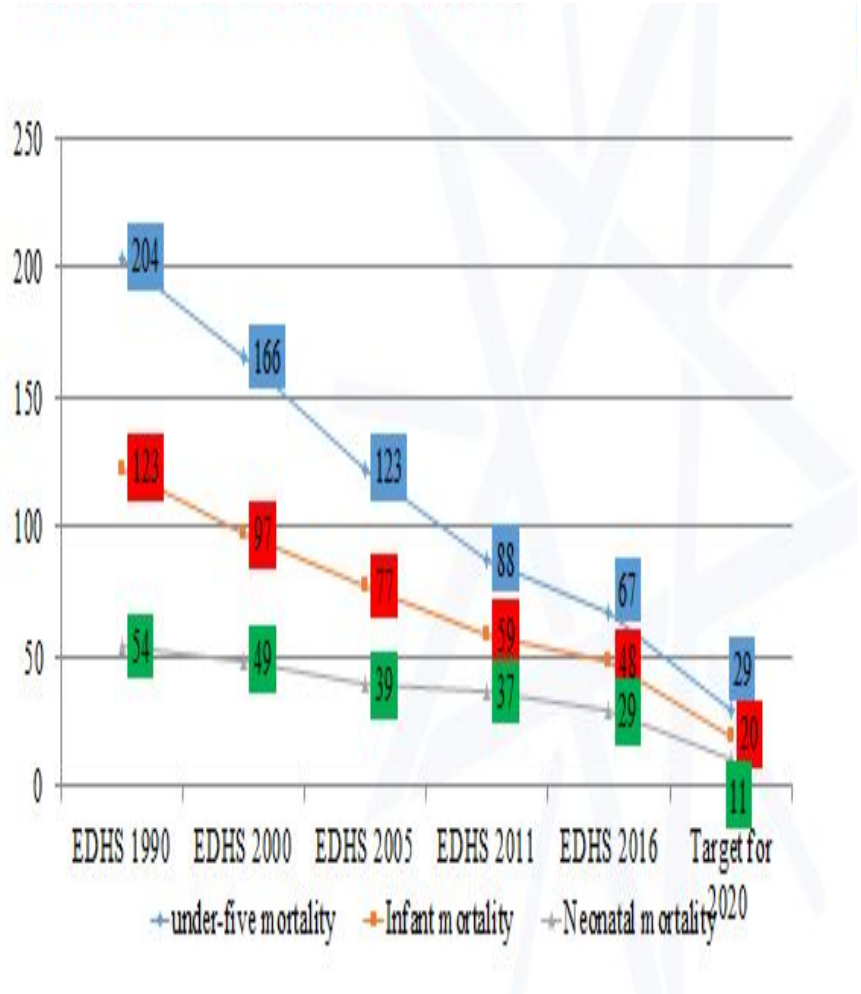
Country profile

- Estimated total population = 98.5 million
  - under 5 pop 14.3 million
- Administrative/governance structure
  - 9 Regional administrations &
  - 2 city administration
  - 824 Woredas/districts



Country profile

- Major causes of child mortality
  - **Neonatal conditions**, **ARI mainly pneumonia, Malaria**, **Diarrheal diseases, Measles and HIV/AIDS** .
  - Underlying cause **malnutrition**
- proportion of under five deaths due to
  - Malaria –3%
  - pneumonia –16%
  - Diarrhea---9%



OVERVIEW OF NATIONAL ICCM PROGRAMME

Year of introduction

- Introduced in 2010 and Interventions at the time of introduction are Diarrhea malaria, pneumonia and Malnutrition.
- Under the guidance of Ministry of health , child health case team
- initially two districts covered
- UNICEF,USAID & Global Funds were the major donors and IFHP,JSI/L10k,SCI, Emory university and others were implementing partner
- ICCM is being implemented at national scale with full coverage of all regions

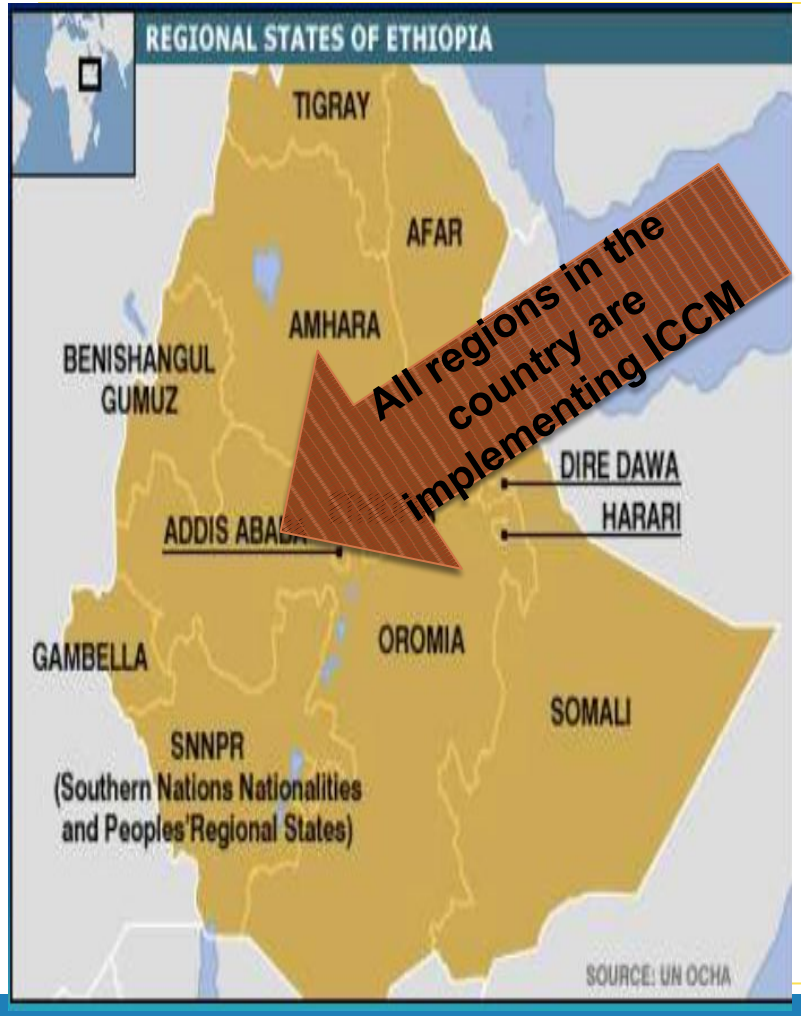
OVERVIEW OF NATIONAL ICCM PROGRAMME

- **Scale-up**
  - currently 824 districts covered (100%)
  - On the package of interventions currently Essential Newborn care and newborn Sepsis management were added
- **Governance**
  - The lead Management Unit is MNCAH-N Directorate
  - The lead Technical Unit is child health case team
  - Child health technical working group is a technical Committee lead by child health case team
- **Protocols and Guidelines**
  - The country have standardized training protocols and guidelines , treatment registers and reporting tools
  - The Source of the protocols and guidelines are WHO and other global and national documents

ICCM COVERAGE

- Currently all districts regardless of their hard ship status are implementing iCCM program (824/824=100%)
- Treatment in numbers

	2016	2017	2018
Malaria	1,930,161	1,748723	1,206,891
Pneumonia		1,025,235	1,584,637
Diarrhoea		1,,713,075	2,129,431
Malaria Positivity rate	29.8%	25%	17%



HUMAN RESOURCES: COMMUNITY HEALTH WORKERS

Status

- HEWs are Cadres for providing iCCM services
- Criteria for recruitment
  - Female, age >18 yrs
  - Completed 10th grade and above
  - Speak local language and Resident of the village
- **Training:**
  - One-year course training at TVET centres or Health Science colleges (Course work 30 % + Field work 70%)
- **Deployment**
  - MOH lead formal Deployment
  - 2 HEWs/5000 people, currently > 38,000 HEWs
  - Permanently salaried
  - Medicines and supplies are **procured** and **distributed** to the HPs by the FMOH, RHBs and District Health Offices-through HCs.
  - Attrition rate around 5-7%

Challenges

- Regional Inequity (Pastoralist Areas)
- Lower ratio of HEWs / population
- poor Housing condition
- Delayed professional development of HEWs

FINANCING/COSTING

- Status
  - Program (ICMNCI) costing exercise conducted
  - have a costed ICMNCI implementation plan
  - the source of funding have been both Domestic and external.
    - HEWs salaries --- Domestic (MOH)
    - Training ----- Both domestic & external
    - Medicines and supplies (MOH or Donor)
- Challenges
  - Lack of domestic sustainable source of funding especially for Medicines

HEALTH FACILITY ROLE IN ICCM IMPLEMENTATION

- **The role of PHCU is**
  - Ensure the continuous supply for ICMNCI services
  - Conduct PRRT/PRCMM quarterly in there catchment
  - Conduct timely and regularly program based supportive supervision on a monthly basis
- **Readiness of referral facilities** were assessed prior to introducing iCCM in the district through filed visit.
- Quality of care at referral facilities have been regularly assessed using a standardized checklist.

Challenges

- ❖ High turn over of trained human resource
- ❖low utilization of chart booklet

Referral facility:

- ❖lack of trained providers,
- ❖poor coordination with health facility/HEWs

SUPERVISION

- ICCM supervision skills training given for supervisors from catchment HCs on how to supervise the HEWS on monthly base
- Supervisors were not incentivized
- Use interview, real case observation and register review to fill the supervision checklists
- The supervisors themselves were supervised by ICCM trained district Health office program focal person on quarterly base

Challenges

- ❖Supervision skills
- ❖Low motivation
- ❖Workload
- ❖Lack of transport for field supervision
- ❖Quality of supervision

SUPPLY CHAIN MANAGEMENT

- HEWs supply requirement quantified as part of health facility requirement not stand alone and procured
- procured as part of overall child health commodities' procurement
- Use MOH storage and distribution system (EPSA) .
- HPs were replenished through pull system on monthly base

Challenges

- Irregular supplies from Health centers to health posts
- Not filling RRF while requesting for Drug
- Delay in procurement

MONITORING AND HMIS

- The national District Health Information System (DHIS2) include monitoring indicators for ICCM
- ICCM data collection and reporting system is a part of MOH HMIS system
- Routine data quality assessment (RDQA) have been implemented to ensure data quality
- There are structured mechanisms for use of ICCM data for program improvement.
  - **EDHAP**
  - **RAC**
  - **RMNCAH score card**

Challenges

- Shortage of resources for printing registers
- suboptimal use of data at all level
- lack of equipment for data entry and analysis at HP level

COMMUNITY ENGAGEMENT

- There a national community engagement strategy which helps to enhance demand creation
- There are strategies in place to engage communities in:
  - In planning of the program
  - HEW selection
  - HEW supervision
  - M&E of iCCM programmes

Challenges

❖Limited budgetary allocation for the implementation of community engagement strategies (HAD)

BEST PRACTICE: *integrated service package*

-Pneumonia,

-Diarrhoea

-Malaria

-Malnutrition (SAM)

-Essential Newborn care and newborn Sepsis management

Community based Newborn care (CBNC)

- aimed at reducing newborn mortality at community level
- is a package of nine different interventions delivered to the community by the health extension worker.

Community based intervention cont`d…

The CBNC package of interventions

- Early Identification of pregnancy
- Provision of focused Antenatal Care (ANC)
- Promotion of institutional delivery
- Safe and clean delivery including provision of misoprostol in case of home deliveries or deliveries at health post level.
- Provision of immediate newborn care, including application of Chlorhexidine gel on cord,
- recognition of asphyxia, initial stimulation and resuscitation of the newborn
- prevention and management of hypothermia.
- Management of preterm and/or low birth weight neonates.
- Management of neonatal sepsis/very severe disease at the **community level**

Community based intervention cont`d… *(CBNC)*

The four C's approach

- In implementing the intervention packages;

(1) Prenatal and postnatal **Contact** with the mother and newborn;

(2) **Case** identification of newborns with signs of possible severe bacterial infection;

(3) **Care**, or treatment that is appropriate and initiated as early as possible;

(4) **Completion** of a full 7day course of appropriate antibiotics even when referral is not possible.

THANK YOU