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

22 July, 2019

Presenter: Dr. Abraham Tariku, Child Health case team leader
Contributors: Mr. Yirdachew semu, Solomon Gebeyehu, Dr. Kebede Etana, Ashenafe Berhane
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
Currently all districts regardless of their hardship status are implementing iCCM program (824/824 = 100%)

Treatment in numbers

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>1,930,161</td>
<td>1,748,723</td>
<td>1,206,891</td>
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<tr>
<td>Pneumonia</td>
<td>1,025,235</td>
<td>1,584,637</td>
<td></td>
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<tr>
<td>Diarrhoea</td>
<td>1,713,075</td>
<td>2,129,431</td>
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<tr>
<td>Malaria Positivity rate</td>
<td>29.8%</td>
<td>25%</td>
<td>17%</td>
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HUMAN RESOURCES: COMMUNITY HEALTH WORKERS

**Status**

❖ HEWs are Cadres for providing iCCM services
❖ Criteria for recruitment
  o Female, age >18 yrs
  o Completed 10th grade and above
  o Speak local language and Resident of the village

❖ Training:
  o 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
**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 ICMNCl services
  - Conduct PRRT/PRCMM quarterly in their 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
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 is 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.
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 7-day course of appropriate antibiotics even when referral is not possible.
THANK YOU