

Integrated Community Case Management /ICCM/

story in Ethiopia

March 3 ,2014

Ghana, Accra

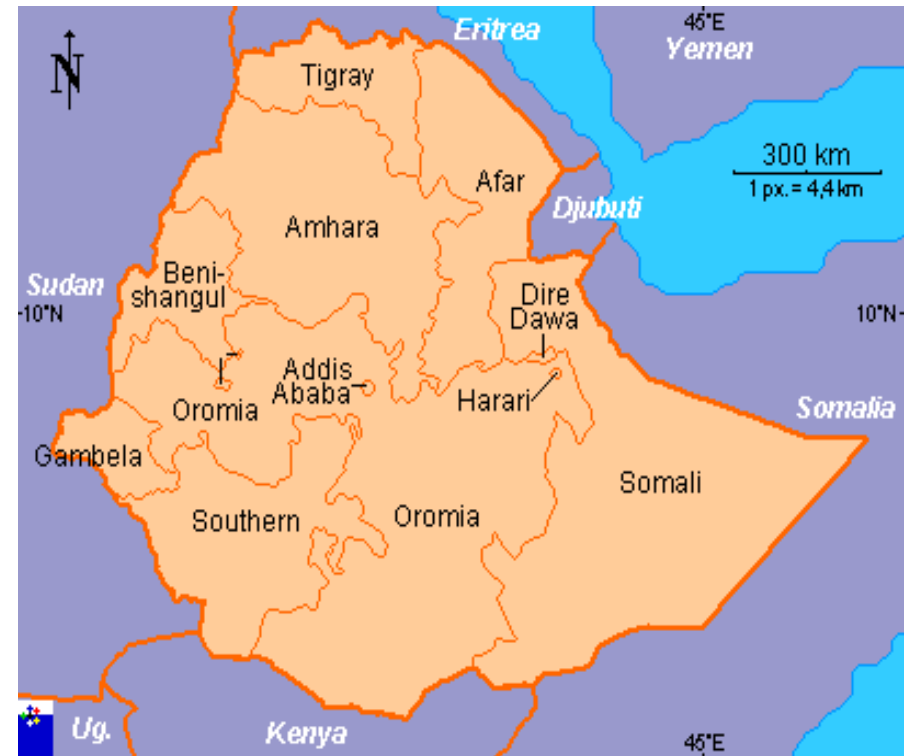
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**Integrated Community Case Management (iCCM):
Evidence Review Symposium
3-5 March 2014, Accra, Ghana**

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



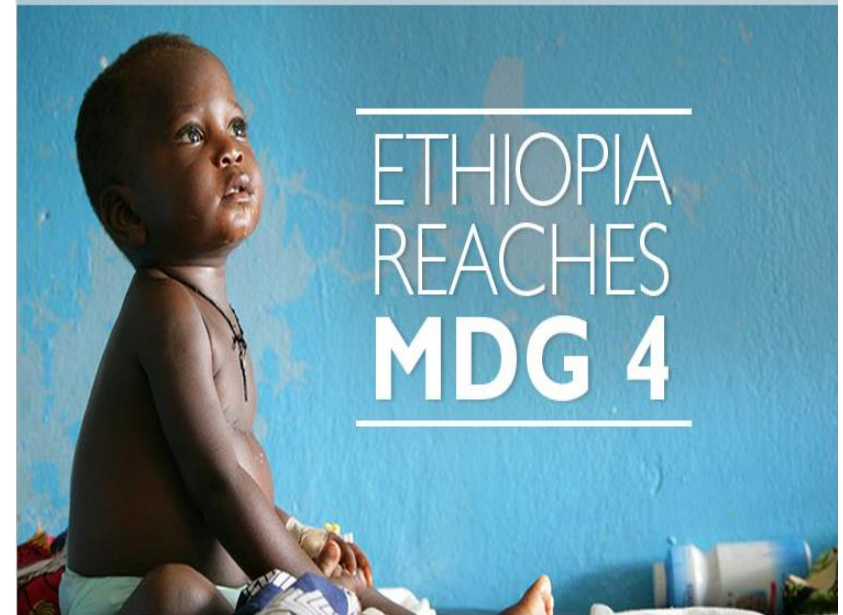
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Health situation

- ✓ 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*).



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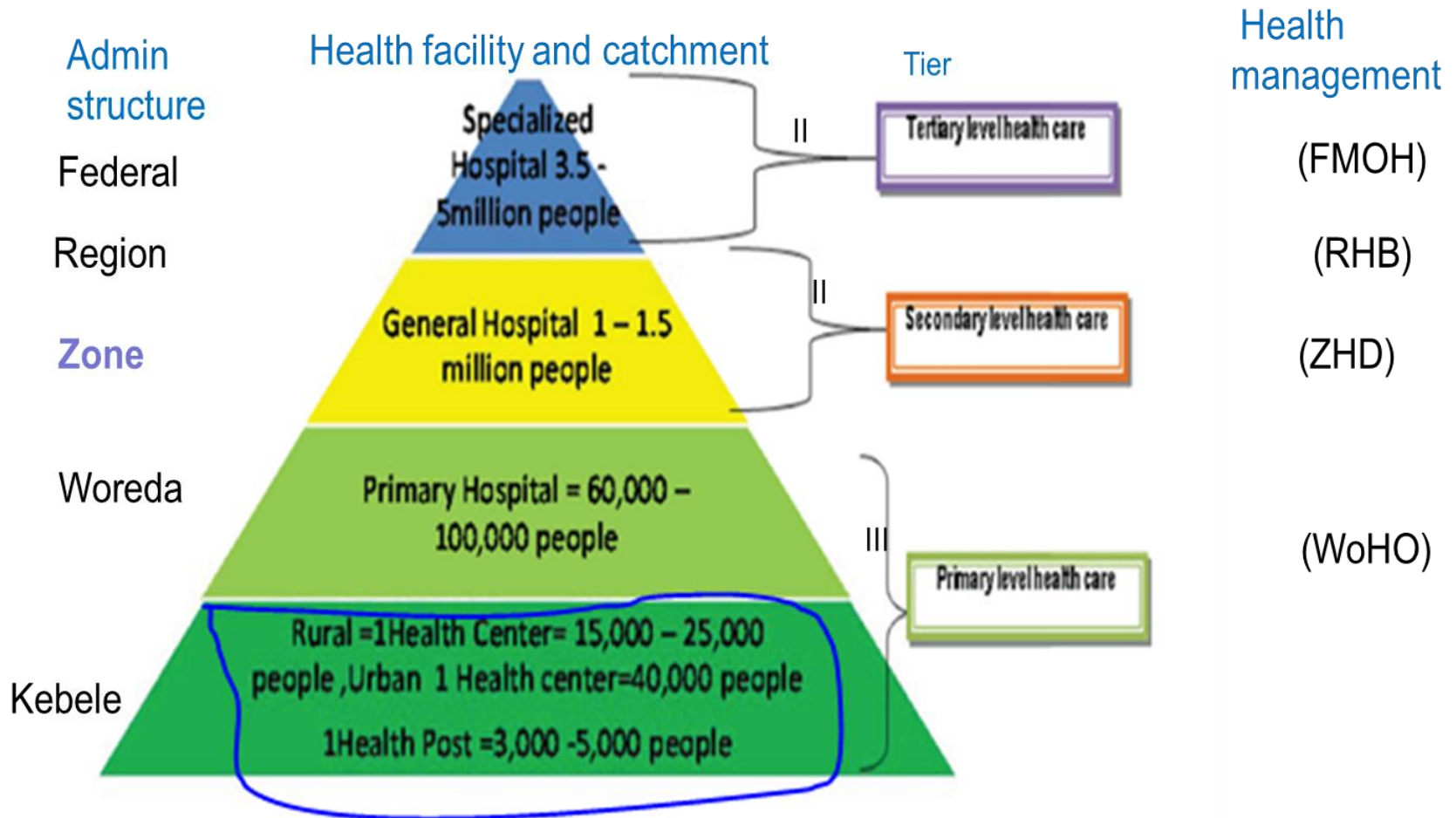
- ✓ Nearly 205,000 children still die each year mostly from preventable or treatable diseases
- ✓ More than 70% of the deaths due to pneumonia, diarrhoea, malaria, newborn conditions and malnutrition (WHO/CHERG 2010)

	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

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Ethiopian Health System



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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

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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)



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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.

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Objective



Pneumonia

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



Malaria



Diarrhea



Malnutrition

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Major activities

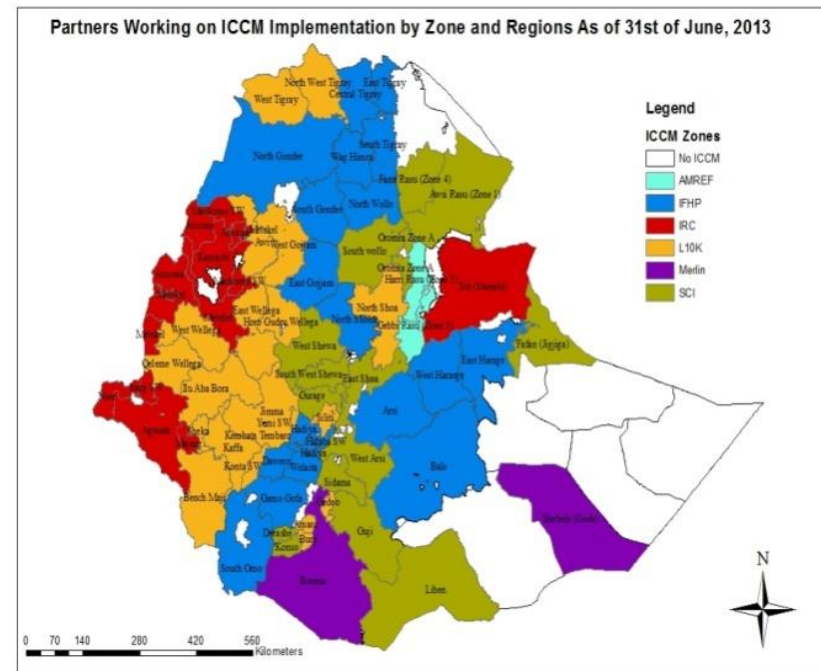
- Establish strong coordination among partners
- Prepare training guides, job aids, and standard list of drugs and supplies
- Train
- Follow up and supervise post-training
- Conduct Performance Review and Clinical Mentoring
- Distribute supplies
- Mobilize communities and communicate for behavior change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

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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



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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

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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

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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

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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

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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

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Thank you

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