Federal Democratic Republic of Ethiopia,
Ministry of Health

National Implementation Guideline For Integrated Community Case Management of Childhood Illnesses and Newborn Care

April 15, 2017

Addis Ababa, Ethiopia

Federal Democratic Republic of Ethiopia,
Ministry of Health

National Implementation Guideline For Integrated Community Case Management of Childhood Illnesses and Newborn Care

April 15, 2017

Addis Ababa, Ethiopia

Contributors

1. Dr. Ephrem T. Lamango (Director; MCH Directorate, FMOH)
2. Addis Ashenafi Bogale (Consultant)
3. Tina Asnake (Child Health Case Team; MCH Directorate, FMOH)
4. Yirdachew Semu (Child Health Case Team; MCH Directorate, FMOH)
5. Dr. Abraham Tariku (Child Health Case Team; MCH Directorate, FMOH)
6. Dr. Yared Tadesse (Child Health Case Team; MCH Directorate, FMOH)
7. Melaku Beyene (HEP Directorate; FMOH)
8. Demisse Denebo (SNNPR RHB)
9. Yemane Hadish (Tigray Regional Health Bureau)
10. Hawa Abdu (Afar Regional Health Bureau)
11. Miraf Tesfaye (PLMD; FMOH)
12. Bizuhan Gelaw (UNICEF)
13. Agazi Ameha (UNICEF)
14. Macoura Oulare (UNICEF)
15. Mariame Sylla (UNICEF)
16. Dr. Wegen Shiferaw (WHO)
17. Dr. Yunis Musema (Save the Children International)
18. Dr. Abeba Bekele (Save the Children International)
19. Asayehegn Tekeste (Save the Children International)
20. Hailu Abebe (Save the Children International)
21. Dr. Lisanu Tadesse (JSI/L10K)
22. Adebabay Wale (JSI/L10K)
23. Wuleta Betemariam (JSI/L10K)
24. Dr. Efrem Teferi (TRANSFORM-PHCU)
25. Dr. Brikti Jembere (PATH)
26. Dr. Abebe Gebremariam (MANHEP)
27. Aynalem Hailemichael (MANHEP)
28. Dr. Habtamu Seyoum (Clinton Health Access Initiative)
29. Yewudalem Tesfaye (Results for Development)
30. Merry Harvey (USAID)
31. Yung-Ting Bonnenfant (USAID)
32. Dr Hailemariam Legesse, UNICEF Ethiopia

CONTENTS

List of Acronyms

ANC	Antenatal Care
ARI	Acute Respiratory Infection
ARV	Anteretro Virus Therapy
BEmONC	Basic Emergency Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CBDDM	Community Based Data for Decision Making
CBNC	Community Based Newborn Care
CSTWG	Child Survival Technical Working Group
EDHS	Ethiopian Demographic and Health Survey
FMOH	Federal Ministry of Health
HDA	Health Development Army
HDAL	Health Development Army Leader
HC	Health Center
HEP	Health Extension Package
HEW	Health Extension Worker
HMIS	Health Management Information System
HP	Health Post
HSTP	Health Sector Transformation Package
iCCM	Integrated Community Case Management of childhood illnesses and Newborn Care
IMNCI	Integrated Management of Newborn and Child Illnesses
IPLS	Integrated Pharmaceutical Logistic System
IPRM	Integrated Program Review Meeting
ISS	Integrated Supportive Supervision
JMV	Joint Monitoring Visit
KCP	Kebele Command Post
KMC	Kangaroo Mother Care
MNCH	Maternal, Newborn and Child Health
OHEP	Optimizing Health Extension Program
PHCU	Primary Health Care Unit
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
PRCMM	Performance Review and Clinical Mentoring Meeting
PRRT	Performance Review and Refresher Training
PSBI	Possible Bacterial Infection
RHB	Regional Health Bureau
ToT	Training of Trainers
TVET	Technical Vocational Education Training
UNICEF	United Nation Children Fund
VSD	Very Sever Disease
WHO	World Health Organization
WoHO	Woreda Health Office
ZHD	Zonal Health Department

Executive Summary

Even though Ethiopia has achieved a significant reduction of Under-Five mortality rate to ultimately meet MDG target, about 184,000 children were estimated to die of preventable causes by the year 2015 alone. Moreover, Newborn mortality showed a stagnant decline with Newborn Conditions taking a big share of deaths in children below the age of five years. As proven-lifesaving interventions, iCCM and CBNC were introduced in to the health system platform in 2010 and 2013 respectively as in effort to decline the unacceptable levels of deaths in children and newborns. Coordinated national scale-up was ultimately reached with almost blanket coverage achieved particularly in Agrarian regions with a need for additional effort to reach to all pastoralist areas with both iCCM and CBNC. With successes gained with regard to coverage and quality, areas of shortcomings have been identified in the previous implementation phases of both programs. among the identified gaps are- maintaining quality of care; demand for and utilization of services; supply chain management; Equity; full program ownership and institutionalization over the public health system; and Monitoring and Evaluation. To address the identified gaps and ensure program sustainability, a need appears to have a continued implementation phase of iCCM and CBNC with full integration for the period between August 2017 and July 2022. This particular implementation phase has an objective of 'Strengthening the delivery of quality MNCH services through implementation of integrated community based case management of newborn and childhood illnesses at PHCUs level'. Trainings; supportive supervision; program reviews; M and E; supply chain management; advocacy; coordination and leadership; community mobilization among the intervention areas to be deployed for meeting set-objectives. All the processes, activities and interventions will follow through the key guiding principles of full program integration; PHCU and Woreda centered approach; MNCH continuum of care; sustainability and leadership; partnership; quality of care; and Equity. Children under the age of five years will be direct beneficiary of the program with households and communities to be counted as indirect beneficiaries. An estimated cost of $80,418,478 will be required for the successful achievement of the stated objective

1. Background Information and Context

1.1. Newborn and Child Health Situation and coverage of interventions across the Continuum of MNCH in Ethiopia

Ethiopia moved a remarkable step forward when it achieved a significant reduction in the mortality of children under the age of five years (from 166 to 67 per 1000 live births) and in the Infant Mortality Rate (from 97 to 48 per 1000 live births) between 2000 and 2015[1]. With under-five children constituting 14.6% (13.2 million) of the population[2], the achievement in the reduction of under-5 mortality in Ethiopia can be taken as a milestone-success as far as health development is concerned. A prime factor for this achievement is the successful, coordinated introduction and implementation of key proven lifesaving child health interventions within the Ethiopian health system framework. There is still a need for comprehensive strategies and packages of Newborn and child health interventions with 184,000 children under the age of five years estimated to die in the year 2015 alone.[3] Moreover, Newborn mortality shows slow progress (from 49 to 29 per 1000 live births), with a decline rate of only 42% between 2000 and 2015.

Facts and Figures
Mortality Levels
U5MR: 67/1000LBs
IMR: 48/1000LBs
NMR: 29/1000LBs
MMR: 412/100,000LBs

Major Causes of U5M
Newborn conditions-45%
ARI-18%
Diarrea-9%

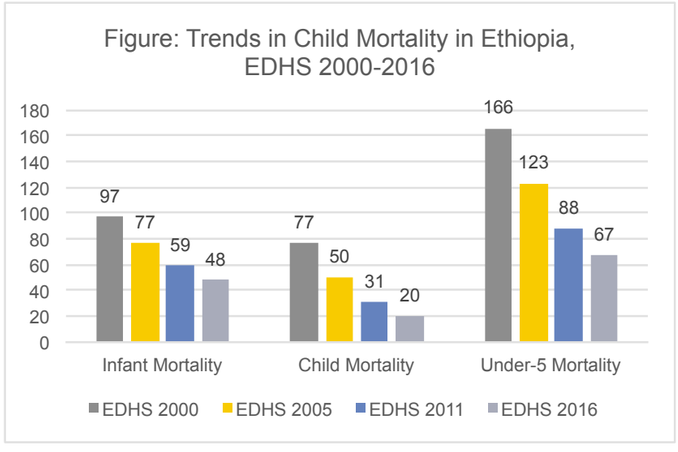
iCCM/CBNC coverage
Year iCCM started-2010
Year CBNC started-2013
iCCM coverage by HP-99.5%
CBNC coverage by HP-93%

iCCM/CBNC Quality
HEWs received competency based iCCM/CBNC training: 98%/95%
Of trained HEWs clinically supervised and mentored for iCCM/CBNC: 97%/95%
iCCM correct management rate: 64%
Sensitivity for VSD: 55%

iCCM/CBNC demand and utilization
PNC within the first 48 hours: 17%
iCCM syndromes treated, 2011-13: 1,265,160
% reached through iCCM:
Malaria:12%
Diarrhea:29%
Pneumonia: 21%
Care seeking-
ARI: 30%
Fever: 35%
Diarrhea: 43%

Key Strategic approaches
MNCH Results framework model
Health System Strengthening and Capacity building
Woreda tier as a target with improved referral linkage
Continuum of MNCH care
Community ownership and engagement
Coordination and Partnership
Sustainability and Ownership
Quality and demand

1 *Ethiopia Demographic and Health Survey, 2016*
2 *CENSUS report*
3 *UN Inter Agency group for Child Mortality Estimation*



At the same time, Newborn conditions contribute the largest share as causes of under-five deaths in Ethiopia. Prematurity, Newborn infections, and birth asphyxia are responsible for 12%,10% and 9% of under-five mortality respectively. Acute respiratory infections (ARI) account for 18% and diarrhoea for 9% of the deaths. EDHS has found 7% of children have ARI symptoms and diarrhoea and fever were present in 12% and 14% of under-five children respectively. The major killers were still reported among the major causes of under-five morbidity at OPD level: with 25% for diarrhoea and 19% for pneumonia[4].

Against the fact that many children are dying of vaccine preventable causes, only 38.5% of eligible children have received all basic vaccinations in 2016. In the same year, about 38% and 10% of children under the age of five years were found to be stunted and wasted respectively.1

The Newborn and child health outcomes are closely associated with the spectrum of maternal health from pre-pregnancy to child birth and raring. The Total Fertility rate in Ethiopia stands at 4.6 children per woman at 2016 with 36% of married women using a method of Family Planning and 22% unmet need among married women. About 62% of women had at least one ANC visit while 28% of births were delivered by a skilled provider in the dame year. While postnatal period is the most crucial period for Newborn and child survival, PNC visit within the first two days after delivery still remains at 17% by 20161.

4 *Health and Health Related Indicators, 2008 EFY*

The Health Sector Transformation Plan (HSTP) has set out a target-reduction of Under-Five Mortality Rate to 44 per 1000 live births and Neonatal Mortality Rate to 10 per 1000 live births. by the year 2020.

The iCCM implementation will be one complementary intervention and contribute to the realization of these HSTP targets.

1.2. Global Newborn and Child Health Initiatives and Program Interventions in Ethiopia

Ethiopia, through the technical guidance of the CSTWG and leadership role of the FMOH has been continuously exploring, adopting, testing and implementation at-scale of of various lifesaving child survival interventions through the health system program delivery platform. The interventions are usually rolled-out as packages of MNCH care and integrated with existing programs. Table 1: Summarizes key global Child and Newborn Health intervention-recommendations against interventions being delivered through the Ethiopian Health System

Table: Existing Child Health Interventions in Ethiopia as adopted from Global Child Health Recommendations

Global Recommended Interventions introduced in to the Ethiopian Health System		Level of delivery	Program Platforms
Newborn Health Interventions			
Immediate Essential Newborn Care	Promotion and provision of thermal care for all Newborns to prevent hypothermia (immediate drying, warming, skin to skin, delayed bathing)	Community PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC (Promotion) BEmONC CEmONC
	Promotion and support for early initiation and exclusive breastfeeding (within the first hour)	Community PHCU (Health Post and Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC IYCF BEmONC CEmONC
	Promotion and provision of hygienic cord and skin care	Community/Household PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC (Promotional) BEmONC CEmONC
	Neonatal resuscitation with bag and mask for babies who do not breathe at birth	PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC (Early identification, initial resuscitation and referral) BEmONC CEmONC
	Newborn immunization	PHCU (Health Post and Health Centre) Primary Hospital General Hospital Specialized Hospital	EPI iCCM and CBNC (Promotional)
Neonatal Infection Management	Presumptive antibiotic therapy for the Newborns at risk of bacterial infection	PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC IMNCI
	Case management of neonatal sepsis, meningitis and pneumonia	PHCU (Health Post and Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC IMNCI
	Initiation of ART in babies born to HIV infected mother	PHCU Primary Hospital General Hospital Specialized Hospital	HCT PMTCT ARV ANC
Interventions for small and ill babies	Kangaroo mother care (KMC) for preterm and for < 2000g babies	Community/Household PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	KMC iCCM/CBNC IMNCI B/CEmONC
	Extra support for feeding the small and preterm baby	Community/Household PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	iCCM and CBNC IYCF IMNCI B/CEmONC
	Prophylactic and therapeutic use of surfactant to prevent respiratory distress syndrome in preterm babies	PHCU (Health Centre) Primary Hospital General Hospital Specialized Hospital	ANC B/CEmONC
	Continuous positive airway pressure (CPAP) to manage pre-term babies with respiratory distress syndrome	Primary Hospital General Hospital Specialized Hospital	NICU B/CEmONC
	Management of Newborns with jaundice	HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	iCCM/CBNC IMNCI B/CEmONC

Global Recommended Interventions introduced in to the Ethiopian Health System		Level of delivery	Program Platforms
	Promotion and support for exclusive breastfeeding for 6 months	Community/Household HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	iCCM/CBNC IMNCI IYCF PNC
	Promotion and support of continued breastfeeding and complementary feeding a) Continued breastfeeding up to 2 years and beyond b) Appropriate complementary feeding starting at 6 months	Community/Household HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	iCCM/CBNC IMNCI IYCF PNC
	Comprehensive care of children infected with or exposed to HIV	Community/Household HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
	Promote and provide routine immunization plus H.influenzae, meningococcal, pneumococcal, and rotavirus vaccines	HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
Childhood and Infancy	Vitamin A supplementation from 6 months of age in Vitamin A deficient population	Community/Household HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
	Management of severe acute malnutrition: a) without complications (all levels) b) with complications (Referral)	HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
	Case management of childhood pneumonia a) Vitamin A as part of treatment for measles-associated pneumonia for children above 6 months b) Vitamin A as part of treatment for non-measles associated pneumonia for children above 6 months	HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
	Case management of diarrhoea: a) Acute watery diarrhoea b) Dysentery	HP and HC (PHCU) Primary Hospital General Hospital Specialized Hospital	
	Case management of meningitis	HC Primary Hospital General Hospital Specialized Hospital	

Moreover, crucial Pre-Pregnancy and pregnancy Newborn and child health interventions within the MNCH continuum of care are clearly outlined in the national strategy for Newborn and child survival and are part of the overall service and care package of the health system at different levels. These include;

a) Pre-Pregnancy Interventions
   - Family Planning

b) Pregnancy
   - Focused ANC- four or more visits
   - Iron Folate Supplementation
   - ART for HIV positives and Pregnant Women
   - Tetanus Toxoid Immunization
   - ITNs for Pregnant women-Malarious areas
   - Antenatal Corticosteroid for Preterm labour
   - Mg sulphate during pregnancy and birth

c) Birth and Postnatal
   - KMC
   - Antibiotics for Preterm rapture of membrane
   - Postnatal visits for mothers and Newborns (the first visit within 48 hours)
   - Antibiotics for neonatal sepsis
   - Early initiation of breastfeeding (within one hour after birth)

iCCM as a comprehensive Newborn and child survival package, will comprehend the child survival interventions through health promotion, case management and establish a referral linkage between communities and the next levels of care.

1.3. Key Newborn and Child Health Policy Breakthroughs and the Health System for continuum of MNCH care

Having high child mortality rates in Ethiopia, there were proven health promotion, disease prevention and curative care- child survival interventions introduced and delivered through the Health Extension Program (HEP) platform prior to the introduction of iCCM to reduce the mortalities. These include;

- Promotion of hygiene and environmental sanitation
  - o Proper and safe excreta disposal and proper and safe solid and liquid waste management

- Water supply and safety measures
- Food hygiene and safety measures
- Healthy home environment
- Arthropod and rodent control
- Personal hygiene

- Prevention and control of major communicable diseases including
  - Prevention, case management and treatment of diarrhea, pneumonia
  - Prevention, case management and treatment of malaria
  - Referral of severe cases of malaria, pneumonia and diarrhea to a higher level
  - Identification and referral of children with other conditions and commu wnicable diseases
- Promoting and providing family health services
  - Maternal and Child Health
  - Family Planning
  - Immunization
  - Adolescent reproductive health
  - Nutrition
- Health education and communication

The Federal Ministry of Health (FMOH) made a policy decision to introduce community-based pneumonia case management through the HEP in 2010 as one key child survival intervention[5], because: (1) about 28% of under-five mortality was due to pneumonia; (2) services through IMNCI at health facilities alone were insufficient; (3) there was a review providing strong global and local evidence; and (4) there was already HEW experience with disease prevention and case management.

The policy breakthrough paved a way for streamlining an integrated package of malaria, diarrhoea, pneumonia and SAM case management complemented by health promotion and disease prevention interventions and with appropriate health system strengthening actions. A national iCCM implementation plan, basically for Agrarian regions, was developed in 2010 by the national CSTWG. An objective of the plan,

5 *HSDP III, Midterm review, 2009*

'Improving Community-based Case Management of Common Childhood Illnesses including pneumonia," used the Health Extension Program as a major vehicle'.[6] Initially iCCM has targeted the four agrarian regions (Amhara, Oromiya, SNNP and Tigray) which comprised 75% of the population. Then it was expanded from four to eight regions (with a step-wise addition of Benshangul Gumuz, Gambella, Somalia, and Afar regions and Harar and Dire Dawa) by 2013 with a total of 13,500 HPs in 600 Woredas and reaching 10,230,450 under 5 children.11

National coverage of iCCM implementation was ultimately achieved with 100% in Agrarian and 95% (in Pastoralist) of Health Posts currently providing iCCM service (monitoring data). This coverage was achieved under the leadership of FMOH, and with coordination responsibility from the CSTWG and the support of implementation partners. Sensitization and orientation; training; supportive supervision; performance review and clinical mentorship; supply chain; coordination and monitoring and evaluation are among the major activities rolled-out to achieve the national coverage of quality iCCM services.

With continued iCCM implementation, a need emerged for a robust-focus on Newborn care given the following situation and need by 2010[7]

- Newborn conditions account for a significant share of under-five mortality
- A large proportion of neonatal deaths can be prevented through achieving high coverage of a few key practices in low income countries: hygienic cord care, thermal care, early and exclusive breastfeeding, community-based care for low birth weight and care seeking for illness
- Availability of strong local and global evidence on the effect of community-based packages with management of neonatal sepsis by community health workers in reduction of Neonatal Mortality Rate R
- Newborn care, being an integral part along the RMNCH-N continuum of care, can be a reinforcing factor to further improve the overall RMNCH-N service package
- Maternal and newborn care made a top priority by HSDP IV
- Limited newborn care services and inadequate health seeking for newborn illnesses, with about 90% births taking place at home

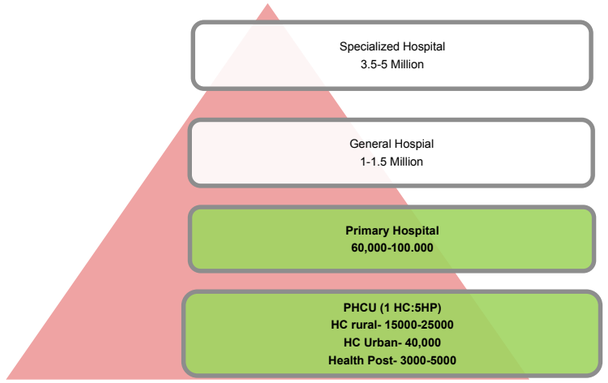
6 *National implementation plan for community based case management, 2010*
7 *Community Based Newborn Care Implementation guideline, 2012*

- Existence of functional HEP and PHCU platforms coupled with strong lessons learnt from iCCM implementation

As a result, Community Based Newborn Care (CBNC) was introduced in 2013 on the existing HEP, iCCM and PHCU platforms with the objective of 'strengthening the Primary Health Care Unit and the Health Extension Program in delivering quality MNCH services through efficient and effective linkages between health centers and health posts'

The Health System Structure for delivering iCCM/CBNC along the MNCH continuum of care

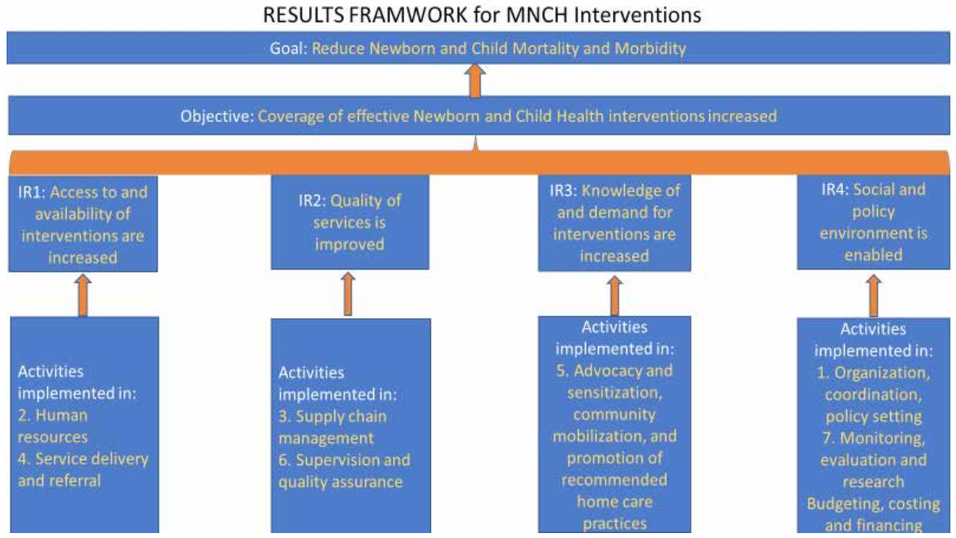
The three-tier health system of the health sector has remained the strategic delivery route for implementing health care and increasing access to and availability of services. Among the tiers is the Woreda Health System, which constitutes a primary hospital and Primary Health Care Unit (PHCU). The PHCU connects a health center with five satellite health posts, and iCCM/CBNC has been and will continue to be delivered through the PHCU.



About 42,336 HEWs have been deployed in 16,447 Health Posts which are key service delivery points and crucial to significantly increase access to MNCH care. The health posts are administratively and technically linked with 3,586 available Health Centers to form a Primary Health Care Unit with 234 hospitals completing the Woreda Health tier by the end of August, 20164

The programmatic approaches for iCCM and CBNC use the 'Results framework for reducing Maternal, Newborn and Child Mortality' model and it will remain the framework of choice for the next phase of iCCM/CBNC implementation.

Fig. The Results Framework Model for MNCH interventions



1.4. Summary of program-assessment findings in reference to Intermediate Results of the Results Framework

a) Access to and Availability of iCCM, CBNC and IMNCI Interventions

Access to and availability of iCCM and CBNC has significantly improved with a huge disparity between Agrarian and Pastoralist areas/regions in terms of timing of program introduction, kickoff and implementation; modality of program rollout and implementation; and quality of interventions. According to the routine program monitoring data, 16,447 (100%) health posts in the four big regions were providing both iCCM and CBNC service by the end of 2016 after being supplied with drugs and commodities and with the HEWs trained and mentored regularly. In Pastoralist areas 95% of health posts are giving iCCM service. The coverage level of CBNC is quite different in pastoralist areas. So far only eight woredas are completely covered for CBNC in pastoralist areas with a coverage level of only 10% by HP

This implies that there is still a need for extensive engagement and partners' support to reach to the uncovered-remaining of HPs and for continuous quality improvement and demand generation for iCCM given the challenging implementation contexts in those areas At the same time, IMNCI services are provided in 93% of the health centers with the Health Post-Health Center referral linkages put in-place. The existence of estab-

lished referral linkages was evident linkage is somehow evidenced by the availability and utilization of referral slips at health posts and health centers during iCCM case management; regular supportive supervision visits to health posts by catchment health centers; and monthly PHCU level performance review meetings at health centers. The referral system goes down to a community level structure where HDALs continuously engage on case identification, linking with HEWs and jointly do regular reviews at their kebeles. This still is dependent on the strength of leadership among kebeles. Areas where there is a strong leadership exists, the performance tends to be better. Hence there is a need for strengthening leadership along the government structure and maintain uniformity. Trainings, supervisions, program review meetings and stocking HPs with iCCM/CBNC drugs and supplies have been key activities to achieve this level of coverage and ensure adherence to high quality-service standards. On the same note, the regular supportive supervisions and program review meetings needs to be further strengthened and established as it is consistently pointed out as one system issue not to have worked at full capacity

But it is only in some better performing PHCUs that have linkages with all the associated processes and tools including referral slips and feedback communication which has been evidenced by low referral acceptance rates for referral of sever PSBI cases from HPs from the preliminary researches in Jimma and Tigray[16]. As indicated above,

b) Quality of iCCM, CBNC and IMNCI services improved

Even though achieving a high coverage of iCCM/CBNC services at scale is a key success, coverage alone is not sufficient to meet the iCCM goal of reducing child and newborn mortalities. The quality of the services implemented should adhere to high quality standards. The activities impacting quality of care include;

- Basic and regular refresher trainings to HEWs on iCCM and CBNC case management
- Basic trainings for Health Workers from Health Centers on iCCM/CBNC case man agement and supportive supervision skills
- Basic and refresher trainings for Health Workers on IMNCI
- Initial follow-up to health posts and health centers within 4-6 weeks after initial iCCM/CBNC/IMNCI trainings
- Regular supportive supervision to Health Posts and Health Centers
- Joint Monitoring visits at all levels along the health system
- Regular performance monitoring and clinical mentoring meetings with HEWs and HWs
- Supply Chain Management to stock health posts and health centers with essential iCCM/CBNC/IMNCI drugs and supplies

The training approach used for both iCCM and CBNC was competency based model to help HEWs have the necessary skill for correct case mangement. The majority (97%) of them are clinically supervised and mentored for iCCM after training[8]. Comparable level supervision is achieved for CBNC as it is reported through monitoring data that about 95% of Health Posts were covered with CBNC-initial follow-up within 4 to 6 weeks following basic training. Though there is no strong data to inform the level of established regular supportive supervision under existing health system structure, gaps and inconsistencies were seen through various observations on the regularity, quality and full institutionalization of regular supportive supervisions that also includes iCCM and CBNC. Structured and holistic checklists, developed through the national CSTWG, has been consistently used during all the supervision processes. Data from the supervision visits have been passing in parallel through multiple levels of the M&E infrastructure to enable program monitoring to inform and improve the performance of iCCM and CBNC programs. The iCCM and CBNC checklists were later consolidated but the product was too detailed to be refined and fully incorporated into the existing health system checklists at the initial phase of implementation. But an initiative has started in some locations to fully integrate the iCCM/CBNC checklist with the overall integrated supportive supervision checklists used by woredas, Health Centers and higher levels. This practice will be adopted and used in the upcoming implementation phase without compromising the quality-intensive support.

The iCCM and CBNC supportive supervisions were found to influence quality of care significantly. Consistency of pneumonia case management through iCCM has increased 3-fold with two or more visits[9] and likewise, quality of CBNC significantly increased with the number of visits[10]. Additionally, about 64% children observed were reported to be correctly managed through iCCM[11]

8 UNICEF, iCCM Brief, March 2014
9 Agazi A. et al, the effect of supportive supervision on quality of iCCM care
10 Gizachew T. et al, Effectiveness of Supportive Supervision Visits on the Consistency of Community-Based Neonatal Sepsis Management Skills of HEWs
11 Hailemariam Legesse, et al: National Scale up of iCCM-Lessons learned, May 2012

On top of the supportive supervisions, Performance Review and Clinical Mentoring meetings (PRCMM) have been a key activity to further reinforce the quality of iCCM and CBNC services. Almost all health posts have participated in PRCMMs with their catchment PHCUs and woredas within 3-6 months after basic training. The PRCMMs were subsequently integrated with the overall PHCU and Woreda level review meetings and have been conducted with full integration but still with irregularities, quality and frequency shortcomings. Like the supervision visits, the PRCMMs were found to significantly increase quality of care.[12]

One key outcome indicator of the quality assurance is the effectiveness of the supply chain system to consistently supply Health Posts with essential iCCM/CBNC commodities. An assessment conducted on December 2012 by Nathan M et al on quality of iCCM service found 69% of the health posts were had all the necessary iCCM drugs. But a number of health posts were also found to have expired or no drugs for CBNC through monitoring visits basically due to low levels of CBNC service utilization.

Despite achieving high iCCM quality, alerts have been ringing at times to do more robust quality improvement activity particularly for CBNC. With all the limitations involved in operationalizing 'quality of care', a midterm CBNC assessment done by IDEAS reported case sensitivity levels of 30% and 55% for very severe newborn disease and local bacterial infections respectively. (Need to show also data compiled from PRCMM about treatment CBNC quality).

Even if about 93% of Health Centers, which are the prime referral destinations from health posts for case management of childhood illnesses, are currently providing IMNCI services, the quality of service has been found to be low through various observations particularly when compared to consistency of case management through iCCM. A study conducted on IMNCI service quality have found the consistency of IMNCI with classification for pneumonia, diarrhea and malaria to be 78, 45 and 67% respectively against the iCCM levels of 86, 80 and 91% for the same[13]. With another observation, only 71% of health centers assessed had functional oral rehydration therapy corner by 2013[14].

With limited quality measurement data available on the quality of health promotion, community mobilization and interpersonal communication activities of HDAs, various quality assurance approaches and tools have been used to reinforce the skills of HDAs on their undertakings. HEWs, after receiving CMNCH training, are expected to provide simplified orientation to HDAs in their kebeles on how to communicate key health promotion and disease prevention message with their catchment households; use family health guide and speaking books to disseminate the messages and improve demand for health services; identify maternal, newborn and child danger signs and refer cases to Health posts/facilities; use data for decision making through CBDDM. The tools used by HDAs, FHG and speaking books, have been under regular review and update to make them effective and user friendly. The CSTWG with other directorates of FMOH has been playing key role in this regard

A quality improvement plan, which will be an integral part of this guideline, was developed through the CSTWG in February 2017 to guide actions for improving the quality of iCCM/CBNC. The document clearly states the role and responsibilities of all key players and was shared to all. The final draft was shared to regions after conoslidation of the feedbacks from all stakeholders and a team of experts from the Child Health case team conducted orientation sessions with all RHBs. The next level orientations are to be rolled down by the respective RHBs with guidance and monitoring of implementation of the plan with established performance monitoring and accountability mechanism as outlined in the guideline. The progress will be closely followed and monitored and follow-on activities will be considered accordingly.

c) Knowledge of and demand for iCCM/CBNC

The establishment and presence of community structures like HDA and Kebele command post is believed to be a key success-factor to mobilize communities; improve demand for MNCH services and increase service uptake. Currently there are active 439,497 HDAL and 2,125,190 1 to 5 networks supported by kebele command posts4. These structures team-up with HEWs and ultimately with PHCUs for the same purpose. But, demand for and utilization of not only iCCM/CBNC but also all MNCH services along the continuum of care have still been a major challenge standing against reducing the envisioned level of mortality. For instance, the coverage for the crucial PNC within 48 hours is stuck

12 *Briktey et al, The effect of PRCMM on quality of iCCM care*
13 *Efrem Teferi and etal: Quality and use of IMNCI services at health centre under five clinics after the introduction of iCCM in three regions of Ethiopia, 2014*
14 *Integrated Family Health Program: End-line Survey summary report, July 2013*

at 17%.

According to EDHS 2016, ANC coverage (at least one visit) was 62% while the proportion of births attended by skilled personnel stands at 28% and PNC within the critical 48 hours after delivery is only 17%. Pentavalent 3 and measles vaccination coverages were recorded to 53 and 54% respectively from the same reference

Demand for and utilization of iCCM and CBNC is no different than treatment rates for malaria, diarrhea and pneumonia -- found to be 11.9%, 29.2% and 21.2% respectively[15]. EDHS 2016 also reported low levels of care seeking with only 30% for ARI, 35% for fever and 43% for diarrhea. Though not satisfactory, many sick newborns and children have been managed through iCCM and CBNC as a major service delivery outlet. About 1,265,160 syndromes (290,950 Malaria; 323,839 Suspected Pneumonia; 562,044 Diarrhea; and 88,323 SAM) were treated through iCCM between 2011 and 2013 alone[11].

The problem of low service utilization gets much lower for sick Newborn and young infant case management. An operational study conducted by Jimma and Mekele University showed that only 91 out the expected 300 were managed for PSBI at PHCUs in Jimma and 395 out of the expected 809 in Mekelle [16]

One positive outcome of the introduction of iCCM is its effect on improving IMNCI service utilization at health centers which could have been reinforced through the referral linkages and the community mobilization activities done in communities. Case load of sick children in 28 observed health centers increased by 16% after the introduction of iCCM between 2010 and 2012. The effect on iCCM introduction had influenced not only the uptake of IMCNI service, but also key health promotion and disease prevention interventions. The following items were found to significantly increase between 2011 and 2013 after the introduction of iCCM[13]

- Four or more ANC visits
- Use of Family planning
- Children fully vaccinated and children who received Vitamin A at six month
- Breast feeding within one hour after birth
- Exclusive breast feeding and proper complementary feeding at six month of age
- Use of bed nets
- Households with appropriate latrine

Both demand and supply side barriers are incriminated for the low service utilization of iCCM and CBNC[17]:

Demand side barriers for iCCM/CBNC service utilization

- Poor knowledge on disease causation and illness recognition
- Lack of awareness on iCCM/CBNC services
- Preference for traditional healers or home remedies
- Perceived poor quality of iCCM/CBNC service
- Perceived capacity or scope of work of HEWs
- Cost of care basically associated with distance and cost of transportation
- Need to obtain husband's permission for seeking and getting care

Supply Side barriers for iCCM service utilization

- Weak iCCM program ownership at different levels
- Service interruption- drug stock-outs, health post operational hours, unscheduled closure. Household survey done IFHP areas (300 woredas) 2015 showed 38% HHs said HP not always open and in 2016, it dropped to 19%[18]
- Limited skill and confidence of HEWs particularly in treating sick Newborns
- Absence of clear performance monitoring and accountability mechanism for newborn and child health services
- Poorly functioning referral mechanisms between levels (health post & health center, health center & hospital)

d) Social and Policy Environment enabled

Introduction of iCCM and CBNC followed policy endorsement and commitment

15 *Yenealem T. et al: Utilization of iCCM services in 3 regions after 2 years of implementation: Oct 2014*

16 *Implementation Research on Management of Sick Young Infants with Possible Serious Bacterial Infections where Referral is Not Feasible in Jimma and Tigray: Review,*

17 *UNICEF and PATH-Optimizing the Health Extension Program to Increase Integrated Community Case Management of Childhood Illness Service Utilization in Ethiopia*

18 *Ethiopian Journal of Paediatrics, 2016: Volume VIII Number 2: Health Service Utilization research, IFHP*

from FMOH after having all the evidence presented and the implementation modality and structure were defined. Child health, including iCCM and newborn care, is supported by key strategic documents like the 'Health Sector Transformation Plan (HSTP)' and 'Child Survival strategy'. Program implementation has enjoyed demonstrated leadership from the FMOH and effective coordination from the CSTWG across all levels. Even though, gaps have been observed of the effective functionality of systems and referral linkages through assessments and monitoring visits, the placement of a well-defined health system structure in general and PHC in particular, complemented outlined referral linkages is a tremendous opportunity to institutionalize and flow the iCCM and CBNC programs down to beneficiaries. if further strengthened. Moreover, the government-led establishment of community /based structures, like HDALs and Kebele Command Posts, has supported the demand creation and community mobilization efforts for the programs. The leadership commitment and support for iCCM is further demonstrated by the incorporation of iCCM and CBNC supply chain management with the national IPLS and willingness of the HMIS to absorb sufficient numbers of iCCM-CBNC indicators which will help reinforce performance improvement and accountability mechanisms. Program monitoring visits are showing utilization of iCCM indicators and data as one key measure for performance monitoring and accountability of PHCUs and subsequent levels. The program-environment at all levels is also made favorable by having a responsible technical focal person at regional, zonal and Woreda levels, even though the assignees are expected to backstop wider thematic areas than iCCM alone. In conclusion, strong MOH leadership, policy support and national partnerships helped successful national iCCM Scale-up[13]

1.5. Denomination of the program

The name integrated Community Case Management of Childhood illness and Newborn Care will be used to identify the integrated community case management of child and newborn health as one intervention package. The acronym of iCCM will remain to be the choice of denomination encompassing the previous-independently mentioned iCCM and CBNC altogether in this document and implementation phase

1.6. Strengths and Weaknesses of iCCM and CBNC implementation

1.6.1. Summary of identified strengths

- Strong policy backup and commitment; demonstrated leadership by FMoH; established coordination through CSTWG
- Streamlining iCCM and CBNC through the existing and structured health system
- Controlled and harmonized scale-up nationally
- Uniformity in cascading iCCM and CBNC training to HEWs with appropriate quality assurance strategies (leadership of the public health sector; strong partnership; competency based training; adequate pool of trainers)
- High supportive supervision coverage for particularly for the initial start-up follow-up supervisions;
- Integration of iCCM and CBNC supervisions. But the initial start-up follow-up required intensive coordination, partner support and engagement for achieving high coverage within short period of time between training and 6 weeks after
- Use of structured checklists
- Strong partnership and collaboration for conducting trainings, supervision visits, performance reviews and supply chain management
- Integrated and focused program review and clinical mentoring meetings
- Holistic focus on MNCH continuum of care
- High quality of services as measured by consistency of case management with established FMOH standards more particularly for iCCM
- Addressing quality of care at PHCU level rather than targeting health posts alone; IMNCI training, CBNC/iCCM orientations/trainings, supportive supervision trainings, referral linkages
- Well-coordinated supply chain management
- Consolidation and documentation of the lessons learnt-iCCM special supplement; systematic utilization of lessons from iCCM implementation for CBNC
- Engaging community structures in the overall implementation processes in general and increasing demand for service utilization

- iCCM as an opportunity to mobilize resources for Community Based Newborn Care

1.6.2. Summary of identified weaknesses

- Low perceived and actual quality of care for CBNC
- Identified gap in case management skills by skill of HEWs for CBNC
- Non-problem solving Integrated supportive supervisions with minimum orientation on quality
- Irregular and unestablished supportive supervision structures and visits with lack of full institutionalization and ownership of the supervision processes
- Inefficient demand generation to increase service utilization
- Sub-optimal quality of, coverage for and utilization of key maternity and newborn services including PNC;
- Insufficient and inconsistent data to monitor and improve performance
- Drug stock out, mismanagement and expiry for both iCCM and CBNC
- Lack of performance monitoring and accountability mechanisms using newborn and child service and coverage indicators
- Parallel and un-integrated monitoring system including supervision visits
- Reduced frequency and regularity of coordination meetings through CSTWG
- Missed realignment of other newborn care packages like BEmONC and iCCM/CBNC
- Poorly functioning referral system for managing sick newborns and children who cannot be safely managed by iCCM/CBNC as well as treatment failures, co-morbidities/complications, and other adverse events
- Absence and/or inadequacy of forums and coordination means to bring together different working groups, task forces and directorates which have the same platform and operational target

1.7. Potential Opportunities and Challenges for the upcoming iCCM implementation phase

1.7.1. Potential Opportunities

- Functional and established common-implementation platform and system structure to foster integration and ownership
- Leadership commitment; presence of supportive national strategies and guides
- Active coordination through the CSTWG
- PHCUs and Health Post Health Center linkages for referral, supervisions, performance reviews, clinical mentoring and administrative support
- Community support groups-HDAs, KCP to support overall implementation processes and demand generation efforts
- The upcoming roll out of competency based Level 1 training to HDAs, which will avail a well capacitated HDA structure
- Integrated Pharmaceutical Logistic system (IPLS) for channeling iCCM/CBNC commodities integrated with all MNCH drugs and supplies
- Potential upcoming resources and funding mechanisms including Global Fund
- School health program to be key platform to integrate demand generation and awareness creation interventions
- Assignment of focal persons at regions and zones
- Use of the developed iCCM/CBNC quality improvement and transition plan
- Opportunity for capturing more numbers of newborn and child health indicators on the revised HMIS
- Emergence and availability of new tested models, innovations and technologies, with partners' support, like OHEP, Community Action Cycle, CBDDM etc
- Availability of evidence from implementation experience, assessments, iCCM and CBNC supplements and operations research including PSBI operation research to recommend treatment regimens for Very Severe Newborn Disease

1.7.2. Potential Challenges

- Reduced funding portfolio and financial uncertainties
- Unavailability of clear and contextualized implementation guideline for rolling out iCCM and CBNC in pastoralist areas
- Insufficient performance monitoring and accountability mechanisms; unsystematic use of data for decision making;

- Incomplete program ownership and institutionalization at all levels
- Institutionalization and sustaining program activities like supervisions and absence of focal person at different levels if not acted up on deployed as planned
- Weak Health Post-Health Center linkages observed . For example, most HC were not using the drug budget for procuring iCCM/CBNC commodities for the HP in the PHCU.
- High burden on and expectations from HEWs;
- Closure of Health Posts during working hours; service interruptions due to stock-outs, structural issues, lack of staff
- Supply Chain management: lack of strong data for effective quantification; drug stock-out and expiry for various reasons including proper quantification, transportation and distribution; source of funding for iCCM drug procurement and management
- Logistical challenges and constraints to carry-out program activities regularly and continuously as planned
- Unfavorable and non-existent Health Post infrastructure for smooth and successful delivery of service

2. Justification for Revision and merging of iCCM and CBNC guidelines

The iCCM and CBNC guidelines used to have separate implementation guidelines to lead the implementation processes of the programs. Currently it is highly recommended to have a revised and merged implementation guideline for the following reasons;

- The implementation guidelines for both iCCM and CBNC have run out of date after adequate implementation period when they were successfully scaled up nationally. A need to have a revised guideline appeared with in-depth focus on full institutionalization, quality, demand, integration and sustainability
- iCCM and CBNC share the same implementation platforms (PHCUs) and target communities/beneficiaries
- Both programs utilize the same activity approaches- Trainings, supportive supervisions, PRCMMs, demand generation activities for the same audience
- There is a need for fostering integration and harmonization of all lifesaving interventions along the MNCH continuum of care
- The merger is believed to leverage resources and improve efficiency
- To build on and maintain the momentum gained during iCCM/CBNC scale up and implementation

3. Goal

Contribute to reduction of Under-five mortality from 2015 levels of 64/1000 to 29; IMR 44 to 20/1000 and NMR from 29 to 11/1000 by 2020[19]

4. Objectives

4.1. General Objective

Strengthen the delivery of quality MNCH services through implementation of integrated community based case management of newborn and childhood illnesses at PHCUs level

4.2. Specific Objectives

Objective I. Ensure equitable and continuous access to and availability of iCCM services to unreached communities

Objective II. Improve quality of iCCM services through MNCH quality improvement approach at PHCU level

Objective III. Intensify demand generation for iCCM and increase the level of service utilization

Objective IV. Ensure adequate and sustainable availability of essential iCCM drugs and supplies at the PHCU level

Objective V. Foster sustainability and ownership of iCCM programs along the public health system with accountability

Objective VI. Enhance the efficiency and effectiveness of the Monitoring, Evaluation and Learning system at all levels

4.3. Key general Strategic-Priorities to be utilized for achieving objectives

- Leadership and program management
- Advocacy and resource mobilization
- Ensuring accountability and ownership at all level
- Health system strengthening and capacity building to have resilient health system-Supply management system
- Referral system and linkage within the PHCU

19 *The prime goal of this particular iCCM implementation-phase is to contribute to achieving target under five, IMR and NMR reductions set-out in the national Child Survival Strategy and HSTP-V. It will be used for realignment of revised target reductions by the year 2022 along side the upcoming strategies after 2020*

- Catchment clinical mentoring approach
- Community mobilization and participation
- IEC and BCC
- Fostering partnership
- Research, monitoring and evaluation
- Woreda led-key activities
- Performance review and clinical mentoring
- Regular catchment based supportive supervision
- Demand creation
- Improving quality of care
- Equity
- Gap filling training – preservice training
- Ownership and sustainability
- Avail job-aids, supplies, equipment and essential medicines

4.4. Guiding Principles

The implementation of iCCM and CBNC activities has been guided with and adhered to key principles that were believed to improve the way of delivering activities and maximizing program outcomes. Lists of the guiding principles were set out in consultation with all key stakeholders. Most of the previous guiding principles will be retained in this particular implementation phase with some additions based on experience and new developments.

The key guiding principles for this program phase include;

i. Full Integration of CBNC in to the Comprehensive Child and Newborn package of iCCM

iCCM, as a comprehensive package of newborn and child survival interventions, should be the sole program of choice to deliver all newborn and child health services including case management for sick newborns and children through HEP in an integrated approach. Even though the two programs have been complementary to each other and use the same delivery-platforms, the required program and process Complete integration between CBNC and iCCM has not been reached for various reasons. This was demonstrated with parallel pieces of implementation guidelines and activities like trainings, monitoring and program review meetings . The phased-in program introduc-

tion/kick-offs and the need for robust focus on newborn care are among the factors.

The incorporation of all CBNC program activities and process under the bigger iCCM will be a frontline priority over this particular implementation period and will strongly facilitate the sustainability and ownership objectives of the same period. Integration starts with having one implementation guideline to provide strategic-guidance for the execution of all newborn and child health activities and case management of newborn and childhood illnesses as one integrated package of interventions. This will be followed by the revision and merging of associated guides and tools like training guides and manuals; supportive supervision and monitoring tools; program review guides; and supply chain system and tools. The leading documents will be structured in a way that the previous separate pieces of iCCM and CBNC activities will be conducted with full integration and delivered through the common PHCU system-platform. The development of the revised guides and tools will be finalized by the end of October 2017 through the CSTWG and the new tools will be in use to lead and support the upcoming program activities under one iCCM program.

Under this principle, this guideline will use iCCM (which includes CBNC) rather than **iCCM/CBNC** for the rest of the document

ii. PHCU and Woreda-Centered Systems approach and Health System Strengthening

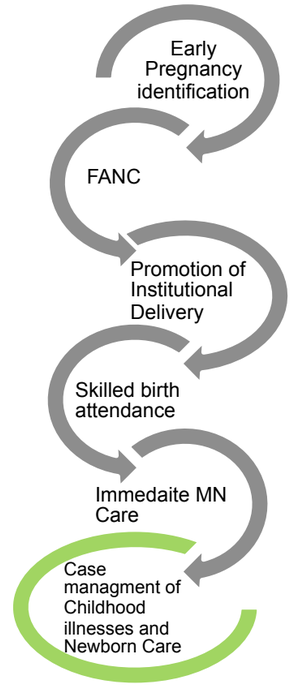
Strengthening the technical and administrative support relationship between Health Centers and Satellite Health Posts has been one of the guiding principles outlined under the previous CBNC and iCCM implementation guidelines. With holistic Health-Systems strengthening, it will remain to be an important guiding principle to help the health sector totally institutionalize and deliver quality iCCM services in an effective and sustainable manner. The associated approaches of establishing interactive and linked performance monitoring and accountability mechanisms; supportive supervisions; integrated catchment program reviews; supply chain system; and administrative cycles will trail the guiding principle. The PHCUs will be empowered to have all the required technical, and logistic support to HPs with appropriate capacity building blocks.

The assignment of Zonal and Regional Technical focal persons will play a key role to effectively stream iCCM though administrative capacities to effectively function as a system that takes control of and lead the delivery of iCCM services with the associated program activity implementation. The Health System Strengthening interventions will flow through all levels from the FMOH down the public health facilities. .

iii. Focus on MNCH Continuum of care

All programs and activities that aim to ultimately reach sick newborns and establish a continuous interaction with households need to take in to account intervening across maternal, newborn and child care from family planning to early pregnancy identification and PNC with uninterrupted encounters. This iCCM implementation phase will focus on the overall MNCH continuum of care rather than management of sick newborns and children alone, and the strategic 4C's (Contact, Capture, Care, Complete) objective will be upheld for increasing the care rate for sick newborns and contact with households. CBNC, as the name implies, will have basically four newborn-targeting components of case management: Caring for Healthy Newborns; Recognition and early management of Asphyxia; Prevention and treatment of hypothermia; Management of Newborn Sepsis. But the crucial maternity care from early pregnancy identification through to PNC will be the target of interventions to reach the highest number of newborns possible. Strong community support (including HDA and KCP) and functional PHCUs will be among key success factors to realize this guiding principle

Figure: Target MNH interventions along the continuum of care to reach sick Newborns with CBNC



iv. Ensuring Sustainability

Implementation of the iCCM program has already matured with extensive partner support. The current program period should thus ensure maximum institutionalization of iCCM within the health system in a way that service will be continuously delivered and sustained. Continued mainstreaming of all program activities along the public health system structure; capacity building; and strong community engagement will be important to achieve the goals of this implementation guideline.

v. Leadership and Ownership by the Public Health Sector

With irregular ownership and institutionalization gaps observed through various means, iCCM and CBNC program activities have been owned and led by the public health sector at all levels from FMOH to PHCUs from their inception. This guiding principle will be followed through this phase with appropriate capacity building interventions from all stakeholders

vi. Partnership

There are built-on experiences with specialized expertise from a number of partners and stakeholders who have been key players over the previous iCCM and CBNC implementation phases. They will be a valuable asset to the public health sector's ambition to fully institutionalize and deliver quality iCCM services sustainably by its own during and after this particular implementation phase. The CSTWGs at all levels will be strengthened to be the prime technical and program coordination body that will engage all key iCCM partners and stakeholders. The CSTWG will continue to coordinate the national program implementation and backup informed decision-making process by the public health sector for continuous performance improvement on a quarterly basis.

Moreover, other dimensions of partnership like Public-Private partnerships will be explored and factored in to ensure maximum stakeholder involvement and increasing access to life saving Newborn and Child Health services

vii. Quality of Care

On top of expanding access to iCCM, quality of service will be at the center of program implementation and will be one basic measurement of program success. This guideline will conform with and complement to the national strategic-focus on quality of care under the HSTP.

viii. Equitable Access and Coverage for Care

With wide and rapid scale-up of iCCM, there are still unreached segments from both hard-to-reach and easy-to-reach communities. All have to be reached out with iCCM service equitably if the desired level and distribution of child mortality is to be attained over the next five years. This guideline outlines the expansion measures as one key objective and that will be adhered-to for helping every newborn and child get iCCM service during illnesses.

ix. Community Participation and Involvement

It has been proven that no community-centered MNCH program can be successful without having communities own and engage on all program components. For iCCM to be successful in providing quality service and reduce mortality, the established principle of ensuring community participation and involvement has to be upheld during this implementation period. Communities will be engaged on the initial program planning to implementation process and monitoring progress. HDAs and KCPs will be strategic links and vehicles to have maximum community involvement and ownership of iCCM.

5. Description of Major activities by Objective

Objective I:

Ensure equitable and continuous access to and availability of iCCM and CBNC services to unreached communities

i. Mapping; Equity and Barrier Analysis and setting up expansion plan

The first action for scaling up iCCM service to unreached communities will be assessment of the coverage and distribution of iCCM services through a mapping exercise, doing equity analysis and identify potential barriers and challenges during expansion including geographical barriers. The CSTWG with respective RHBs will draft a guiding concept not on the overall structure and of the assessment, timeline and roles and responsibilities by December 2017. The assessment should be done as soon possible as thereafter and a report must come out on November 2017. A desk review should support the overall assessment with the identification of equity among different variable-groups. Associated tools and guides will be used to carry out the assessment, compile and analysis the data and produce analysis-report

Using the mapping and barrier analysis report and contextual backgrounds, an expansion plan will be developed through CSTWG and RHBs with a tentative program kick-off timeline of January 2018

ii. Adopt a model to rollout contextualized implementation for communities with different context like pastoralist areas

Given a huge contextual difference of the pastoralist areas with the areas where iCCM is currently implemented, there needs to be a model that will best fit in to the pastoralist set up and facilitates effective iCCM service provision. The CSTWG and the respective regions will engage with all stakeholders and support partners on a one week workshop (on December 2017) to produce iCCM rollout and scale-up model for pastoralist areas' and a 'Detailed Operational Plan'

iii. Costing of Intervention, Resource Mobilization and Partner Mapping

Once the Contextualized Model is developed with the operational plan, all the program scale-up costs will be estimated and business case will be developed. The FMOH, RHBs and Key stakeholders will use the business case to mobilize resource required to achieve full scale up and coverage of iCCM across all communities. Partners mapping will also be done to identify potential partners already involved in supporting the programs on those areas to leverage resource and consolidate the implementation experience and lessons learnt.

The resource mobilization should start as early as December 2017 to ensure immediate program start up to the unreached communities and address equity disparities for iCCM service

iv. Service Kick-off and maintenance

The full scale up of iCCM to all unreached communities is expected to be finalized within one year time from January to December 2018. All iCCM related interventions like trainings, Supportive Supervisions, Program Reviews and Supply management will be put-in-place as part of program scale up process. Associated drugs, supplies and registers will be estimated and factored in the expansion plan. All the processes will be led by the FMOH and RHBs with the coordination role to the CSTWG. There will be a Pastoralist/scale up sub-group under the TWG which will closely coordinate and follow the controlled scale up process and the progress.

Objective II:

Improve quality of iCCM-CBNC services through MNCH Continuum of Care quality improvement approach at PHCU level

I. Trainings

a) Revision and merging of iCCM and CBNC training guidelines

Trainings have been and will remain to be an entry point for enhancing the skill and competencies of HEWs and HWs. Successful training in improving quality of care and services is affected by the effectiveness of its guidelines and tools that have to be regularly revised based on lessons and outcomes. Though the iCCM and CBNC trainings have been working well in making HEWs acquire the necessary skills, they are outdated and missing some key case management competencies and approaches like sufficient practical exposure to sick Newborns, drills, demonstrations and case scenarios. Moreover, training guidelines for iCCM and CBNC, with the associated tools and job aids, have been used in trainings independent of similar activities, guidelines, tools, and job aids for child health targets. The iCCM-HEW training required six days and CBNC four days with both having one additional day of supportive supervisory skills training for health workers. This means about 10 days of HEWs training-attendance is needed for iCCM and CBNC alone.

The full integration of iCCM and CBNC and quality improvement actions will start with having a revised, refined and integrated training guidelines and tools where CBNC will be one key component of iCCM. This will include the revision of facilitator guidelines, exercise booklets, chart booklets (for updated treatment protocol), job aids and video demonstrations. Prior experiences, available global and local evidence and contextual considerations on demand generation, case management (including treatment regimens for VSD and LBI), and supply management will be factored in during the revision processes. Strong emphasis will also be given for Newborn case management, demand generation and increasing service utilization. The new training will not be expected to take more than seven days of basic training. The CSTWG will be tasked with the revision process through involvement of delegates from the health sector at all levels. The new version should be available by the first week of October 1, 2017. All the revised training guides, tools and training model will be pre-tested before used at scale. Technical representatives from all levels and TVET instructors will receive a ToT orientation on the revised modules, guidelines, tools and training approaches.

There will not be stand-alone refresher trainings for iCCM. But the refresher trainings will be part of and delivered with PCHU-based performance review and clinical mentoring meetings. All the associated guides will be developed as part of the overall PRC-MMs/PRRTs.

b) Pre-deployment and Gap filling trainings

HEWs who have already been trained on both iCCM and CBNC will not be required to have another round of training with the new training model unless required with agreed circumstances like a very low case management skill through supervisions and having at least a one-year lap after the last case is managed by the HEW. The first basic iCCM training will target only new-untrained HEWs as part of Pre-Deployment and gap filling skill building activity. The facilitation, conduction and organization of trainings will be planned, led and coordinated by RHBs, WoHOs and respective TVET centres with the support of partners as required.

About 5000 new HEW graduates will be reached through the basic iCCM training and the new integrated and revised manuals, tools and guides will be leading the training processes. The trainings will be expected to have the case management session not more than seven days. They will also have intensive attachments to health centres where they will be practically exposed to adequate child and Newborn cases, and hands-on mentoring will be done for HEWs during case management sessions.

A pool of trainers will be created through ToT of two staffs per each RHB and one staff per ZHD on the revised guides and approach. The existing 23 TVETs, the key delivery point for the pre-deployment trainings, will have 10 tutors oriented on iCCM each and provided with adequate manuals, tools, guides and supplies. The total number of trainers attending ToT on the revised iCCM training will be 321

The training outcomes and the level of skill attained by trainees will continuously be assessed using training evaluation tools and databases. The training content and approaches will be continuously improved as required to meet objectives. The national CSTWG will be expected objective. With proper capacity building and use of cascade approach, full responsibility will lie on RHBs and TVETs to observe at least 25% of rollout the trainings to evaluate and the quality and outcomecontrol task will be taken by the respective regional CSTWGs

The national CSTWG will be expected to observe at least 10% of the trainings for evaluation of the training quality and outcome. The methodology for sampling of the trainings will be decided based contemporary situations and convenience

The iCCM basic training will be addressed through the pre-deployment/gap-filling trainings at TVETs immediately after HEWs' graduation. In line with the pre-deployment and gap filling trainings, effective ways of fully-incorporating iCCM trainings with the pre-service package will be explored, tested and structured over the first three years of this implementation timeline. Full incorporation of the trainings in to the HEW pre-service training package is targeted from first quarter of year-four and all iCCM trainings will be delivered through the pre-service training from then onwards with functional quality assurance mechanism established and used.

c) Training and of Health Workers from PHCUs and Primary Hospitals on Child and Newborn Health Thematic area

The quality improvement approach for Child and Newborn Health services will include PHCUs and Primary Hospitals making the Woreda/District Tier a strategic level of interventions rather than targeting Health Posts alone. The Health Centres, like the HPs, need to have the capacity to maintain quality of care so that cases of sick newborns and children referred from HPs or directly seeking care from the health centres are managed through standard case management protocols. The IMNCI case management protocols at health centres and primary hospitals will be subject to revisions at least once over two years based on emerging local and global evidence.

At least 7160Health Workers, two from each 3560 Health Centres and Primary Hospitals, will be trained on the revised iCCM package for three days and IMNCI with supportive supervisory skill training with revised protocols

i. Program Monitoring visits and Supportive Supervisions

a) Program Specific Supportive Supervisions and catchment based mentorship

Inadequate technical-focus on program and quality of care aspects during the supportive supervisions done by Health Centres to catchment Health Posts is one of the shortfalls identified during the previous iCCM implementation period. Quality and program intensive supervisions will be one crucial activity, alongside the program management-focused integrated supportive supervisions, to attain the highest quality of care possible over this implementation period. The Supportive Supervision guideline developed by HEP directorate will lead the overall processes of the supportive supervi-

sions with adequate orientation of supervisors on the guide. Health Centres will carry out a monthly program specific supportive supervision visits to respective health posts using a unified and structured iCCM checklist. These supervision visits will look at a more comprehensive thematic area of MNCH continuum of care than merely iCCM. Selected PHCUs and HPs will be receiving a technical supervision visits from a joint team of WoHO, ZHD TA and partner staffs through the quarterly Joint Monitoring visits (JMVs). For feasibility constraints, the JMVs can be used to execute both the program-specific and Integrated Supportive supervision with proper planning to allow sufficient mentorship time with HEWs.

Woreda Health Office Technical personnel will also be required to execute program specific supervisions to selected PHCUs quarterly. Catchment based mentorship will be important addition over the program supervisions. It is highly recommended for the Woreda and Primary Hospital technical supervisors to conduct the program supervision alone as it might require sufficient time to spend on on-job mentoring and coaching of HEWs. The program specific supervisions will not be standalone supervisions processes wise but an integral part of existing system supervisions like ISS. They will only have checklist attachment to make sure that quality and program specific details are addressed adequately.

A functional problem solving and feedback mechanism will be established and the process will be led by the checklist. The contemporary checklist has a section to lead feedback communication after all the supervisions. But it will be re liable for regular review to further reinforce problem solving and feedback communication.

b) Integrated Supportive Supervisions (ISS)

Currently ISS is in-place and conducted across all levels to look at HP and PHCU performance against major performance indicators. The ISS basically focuses on level of achievement of key indicators with exploring challenges and putting joint solutions. It is not necessarily required to have in-depth program specific quality assessment and improvement scope through the ISS. But it still is believed to resolve major interactive quality issues as stock availability; service uptake; infrastructure; use of registers and job aids etc. That is why it is highly recommended in the above section to have a quality-intensive supervision. with all the processes integrated with the ISS but with a quality-focused checklist attachment. Even if Newborn and Child health performance indicators are key part of the ISS, further review and revision will be recommended and

done to make sure that iCCM indicators are adequately addressed. The CSTWG will work closely with the Policy and Planning Directorate to complete the task

Health Centres will do a monthly ISS to catchment Health Posts using ISS checklist and WoHOs will also do the same to PHCUs every month. The Woreda Health Offices, PHCUs (with catchment HPs and communities) will receive quarterly ISS visits from the respective Zonal Health Department. A team of experts from the national and regional CSTWG will conduct a biannual ISS to selected Woredas and PHCUs. As stressed earlier, the program-specific supervisions can be conducted at the same time with ISS but with two complementary checklists.

A clear feedback and accountability mechanism will be outlined and utilized to recognize positive performance including ownership and execution of supervision visits and further improve under-performance during the ISS across all levels

c) Joint Monitoring Visits

The catchment based program specific SS and ISS will be complemented to PHCUs with regular Joint Monitoring Visits by a team of supervisors from higher levels. The JMVs will be comprehensive enough to include both program specific mentorship and ISS through ensuring adequate contact with PHCUs to address both quality and program management issues. At least 10% of all PHCUs from a Woreda will be reached every quarter by a team of supervisors including ZHD TA, WoHO and partner staffs. Similarly, a team of RHB/ZHD TA and Partner staffs will select six PHCUs from two woredas of two different zones to conduct regional/zonal JMV every quarter. The national CSTWG will also form teams to conduct national JMV bi-annually to four regions-four zones-eight woredas-16 PHCUs. HCs, HPs, communities and households will be the prime targets of visits during all the JMVs.

ii. Integrated Performance Review and Mentorship Meetings (IPRM)

IPRMs, commonly referred as Performance Review and Clinical Mentoring Meetings (PRCMMs) and Performance Review and Refresher Trainings (PRRTs), have already been established at the Woreda tier and PHCU levels of the health system to review performance; improve quality of services; and address implementation challenges at PHCUs. Currently two IPRMs are expected to be accomplished one at PHCU level on a monthly basis and another quarterly IPRM at the Woreda level. Next to the PHCU and Woreda based IPRMS, existing health sector's regular program reviews will be explored and utilized at the Zonal level (quarterly), regional level (bi-annually) and national level

(annually) to integrate and address quality; program performance and implementation challenges with an output of clearly outlined solutions and plan of action. The existing health sector's plan will be strengthened for the same purpose if already happening. If they are non-existent, they will be activated with the leadership of FMOH structure at all levels. They will basically be high level program reviews with the exclusion of the mentorship. With the current number of health centres, about 3,560 IPRMs will be conducted every quarter at the health centres, iCCM being one top agenda subject for the review and mentorship activities. Similarly, there will be 800 Woreda level IPRMs every month, 75 Zonal level quarterly and 8 regional and national level biannual program reviews. These IPRMs will be strengthened and structured as one of the major quality improvement activities. Their facilitation will be aided by a guideline used to basically lead the facilitation process and structure the review meetings. The detailed program review meeting contents will be established by the respective levels based on context and contemporary program-issues. The structured guideline will be developed regularly through the lead WoHOs and PHCUs with the support of ZHD, RHB and national CSTWG.

iii. Use of innovations and technology for quality improvement

In this era of iCCM, technology can play a significant role to improve and maintain quality of care if properly tested, contextualized and scaled-up. One potential tool can be Mobile technology with inclusion of iCCM components on mHealth to aid HEWs adhere to quality standards during case management where alerts and red signs appear when they diverge from the case management algorithm. This model is recommended to start as a controlled testing in 2017 and scaled up afterwards based on evidence. Existing trials will be explored for additional evidence to make a strong case before wider scale up. These will include cost analyses and technology impact assessments.

Another potential model can be adopting innovative approaches and technologies for iCCM case assessment, classification/diagnosis and treatment including Acute Respiratory Illness Diagnostic Aid (ARIDA).

The iCCM version of ICATT can also be considered for the TVET-based HEW training by adopting and simplifying the IMNCI version and utilization of lessons learnt. It can be tested in some controlled trainings and can be used at scale based on effectiveness and efficiency

The test-contextualize-scale up approach will be the guiding principle to ultimately use the innovations and technologies nationally at scale. But, continuous observation will be paid to global innovation market-places, available resources and platforms to test, adopt and scale up proven high impact interventions. Additional rationalization should include cost analyses and technology impact assessments to ensure that the introduction of innovative approaches are appropriately budgeted and overall Ethiopia maintains a trajectory of continued improvement in newborn and child health without undermining existing interventions.

iv. Documentation and scaling up of localized best-quality-improvement practices

The level of quality of iCCM services is not uniform throughout all HPs and PHCUs. As observed through monitoring visits and PRCMMs, some HPs and PHCUs have gone farther than others in reference to maintaining quality of Newborn and Child health services including iCCM. Exploring and using contextualized quality improvement schemes is one factor among others for the success. But there hasn't been a systematic way of documenting the best practices for consideration and introduction at scale. A mechanism will be established over this iCCM implementation period to capture, document and scale up the best practices learnt from specific PHCUs and HPs. This will include;

- Identifying specific best practices from best performer PHCUs
- Restructuring and pre-positioning the iCCM monitoring tools and database to capture and document the practices
- Joint monitoring visits by high level experts from national and regional levels for proper compilation
- Systematic review by a technical-panel from coordination groups at all levels
- Use of IPRMs as a forum to share practices and recognize the model PHCUs
- Organizing experience sharing visits among PHCUs and Woredas
- Use of existing program review meetings to share best practices and experiences

The CSTWG will come up with an outline to guide the documentation process and vehicles for best practice and their informed and controlled scale up by the end of November 2017.

v. Implementation of 'iCCM Quality Improvement and Transition Plan'Plan'

The 'iCCM Quality Improvement and Transition Plan' was developed in May 2017 with

a clear outline of identified quality issues; major activities; roles and responsibilities; M and E framework and cost. It was circulated down to regions from the FMOH. RHBs, ZHD, WoHOs and PHCUs will be supported to effectively execute the plan with continuous progress monitoring. The plan will be rolled out as an integral part of and under the umbrella of this bigger implementation guideline.

Objective III:

Intensify demand generation for iCCM and increase the level of service utilization

i. Build HEW and Health Post capacity for successful demand generation

a) Improve HEWs' capacity and skill in interpersonal communication (IPC) and community mobilization to perform focused and effective demand generation

Having low demand and care seeking behaviour in communities for iCCM, more effort has to be exerted using all program and health system opportunities maximally. IPC and community mobilization skills will be given a prominent share during all trainings that have HEWs and PHCU staff targets including iCCM basic trainings and IRT. Moreover, mentoring and coaching through the performance review meetings and supportive supervisions will be made to be demand sensitive and guide time spent with HEWs, PHCU and WoHOs to explore demand related challenges and set up doable action plans with monitoring mechanisms. Advocacy activities will also be considered at kebele and woreda level to use service coverage indicators for key MNCH interventions including iCCM as one performance monitoring and accountability criteria.

b) Stocking HPs/HEWs with enabling tools and commodities for promotion of healthy practice in general and for identification and management of sick newborn and child cases in particular

The FHG is a key guide for promoting positive health behaviour and increasing care seeking, and other complementary materials, such as speaking-books, should also be available at all times for new distribution and replacement. Over this particular period, 2,125,190 FHG and speaking books each will be delivered to 1:5 network leaders through the health system structures with partners' support. The HEWs should also have the necessary guides for facilitation of community meetings, dialogues and HDAs forum. The CSTWG will look at what simplified and integrated guides will be required for development and introduction. The HPs should have also back packs with portable register-paper-copy to help them treat sick newborns and children captured during home visits. Hence a total of 42,336 back bags will be supplied to HPs/HEWs for the same purpose. Regular need-quantification will be done by HEWs supported by HCs

and information passed on to the next level for resupply. The delivery will pass through the existing health system channel with efficient stock monitoring means with the support of implementing partners

ii. Strengthening community based structures and forums and maximizing their utilization to reinforce demand generation

There are well-established community structures by the name of 1 to 5 networks, HDA, and Kebele Command Posts which are strategically critical to enhance demand generation and increase service utilization if utilized effectively. Households are linked 1 to five to peer-influence positive household health practices and care seeking behaviour. Five 1 to 5 networks group together to form HDAs, led by a role-model-HDAL. Kebele command posts (KCP), the ultimate kebele-governing body, pursue all development agendas including health in the Kebele. The HEWs, supported by the HDALs and KCPs, increase demand for and utilization of key MNCH services including iCCM at the health posts and health centres. They use key activities of orientation of HDALs and KCP on MNCH thematic area, demand generation, case identification and referral; performance review; regular meetings and social bonding to improve the health outcome of their communities.

In spite of the presence of this structure, the level of service utilization hasn't been high enough to reach to all sick newborns and children with iCCM care by Health Posts and PHCUs. In addition to the established activities, a more tangible way of maximizing the effectiveness of PCHU-HP-HDAL-KCP performance through consolidation of lessons, ad-hoc assessments and robust community engagement and participation with the leadership of the government structures will be given due emphasis. Moreover, existing demand creation models of 'Community Action Cycle'; 'OHEP', 'CBDDM and the likes will be explored for at-scale introduction by the first quarter of this implementation phase.

One bold bottleneck identified as barrier of demand for iCCM is lack of awareness by communities about availability of iCCM service. There are a number of kebele-based entities who have frequent interaction with the same target communities. Having established network and social linkage with communities, HDAs are among the key strategic vehicles, that can be utilized for the highest outcome possible. But they have to be supported by the HEWs and KCP to have the required interpersonal communication skill; capable of promoting disease prevention and health promotion messages with

FHG; have the knowledge and skill on identifying maternal, Newborn and child danger signs and link with service; and jointly overcome challenges and bottlenecks for care seeking. The HEWs training recommended above is meant not only to build their own demand generation skills but also teach ways to work with HDAs and command posts as a team to mobilize their communities. The HEWs will cascade the set of skills and orientations to HDAs and KCP through the regular orientation and meeting platforms happening within their kebeles. About 439,497 HDA leaders will receive orientation from HEWs on key MNCH messages; identification of danger signs and referral; and IPC. The existing 15,000 KCPs will be an integral part of the orientation processes and events and catchment HCs will be providing backstop support. The HDALs will reach 2,125,190 One to Five networks with the same yearly on a regular basis. The advocacy work will leverage KCP and PHCU support for coordination and facilitation of the orientation and performance review meetings with HEWs. The HEW-HDAs interaction should be strengthened and reinforced through the simplified intervention of CBDDM where HDAs update MNCH information of their households regularly on a map, utilize the information for action, establish linkage with HP for care and review their performances. Communities and KCP will also be engaged-on and own community quality improvement action through building their capacities on continuous problem identification; use data for decisions and introduction of local solutions. HEWs with support from catchment health centres will provide on-going coaching of KCPs and HDAs on the same through the already established monthly meetings. CBDDM will also be strengthened to support the process with data and its use for decision making

Another potential disseminator for information on demand and availability of service is Agricultural Extension Agents who frequently interact with households. They can be equipped with the necessary skills, information of interest about danger signs and availability of services and the tools to let their beneficiaries know about danger signs and service availability. The KCP will be advocated to make them involved in all the performance review meetings. For the same reason 15,000 AEAs will be oriented for one day to integrate MNCH service demand generation and community mobilization within their daily scope of interaction with households. The same AEAs will also be involved in the community level and KCP regular review meetings

Families usually tend to be influenced much more by religious leaders and community figures than they are by any other community members. The demand generation effort

will be incomplete if it fails to take them in to account. A half-day 15,000 Kebele-based quarterly dialogue forum will be established targeting religious leaders, community leaders and traditional healers through KCPs and with the objective of promoting healthy practice including care seeking for MNCH services

The pregnant women forum taking place in kebeles can be another opportunity to reinforce the demand and care seeking information. HDAs, KCP and catchment health centres should be part of the estimated 16,447 forums happening in communities to support HEWs and influence the attitudes of the attendants. A simple discussion guide and FHG will be used to lead the conversations and dialogue during the forums.

A Monthly joint meeting between Health Posts and community groups/representatives will be encouraged and established to explore quality of care issues and elements that have to be addressed locally. The KCP is the Kebele governing body to keep HEWs accountable for continuous opening of HPs during working hours and performance of the HP as far as service utilization and quality of services are concerned. The regular review meeting will be linked with KCP's scope of performance management and accountability mechanism at community level. Their discussion structure will be supported via PHCUs forum the forum to be able to continuously monitor performance and establish community level accountability mechanism.

PNC within 48 hours after birth will be given big attention as it is believed to be key intervention to reach to sick Newborns but has very low coverage. The MNCH continuum of care will be the overall strategic target to enhance contact with sick Newborns and children and PNC will be treated within the same umbrella but with a robust intervention. HEWs' lack home visits is not the sole factor for low rate of identification of mothers and Newborns who have to be reached with PNC visits. Even with high commitment and engagement from HEWs on home visits, it has been reported in many cases that they miss new births, the mother and Newborn. The unsystematised and low level of birth notification be a significant factor to low PNC coverage and missing sick Newborns. An established birth notification loop should be put in place and strengthened by;

- Early PNC within the first 48 hours should be consistently given attention and prioritized by PHCUs, HDA, Health workers, program implementers and decision makers
- Active birth surveillance by HEWs and HDAs for home deliveries
- Supporting HEWs to get real, on-time information about births taking place in their catchments
- Devise way of ensuring that HEWs act for the information they receive and link with accountability mechanism. One undertaking can be introducing and using a voucher at households with births to track HEWs' visit
- Improving HDA-Health Post-Health Centre communication channel and referral linkage to update both on births happening, service provided and follow-on actions
- Use of aiding checklist and mobile technology for information sharing and providing comprehensive care for the Newborn and the mothers
- Focus on and strengthening service along MNCH continuum of care
- Identifying potential areas of HAD-HP-HC task sharing and shifting areas on doable tasks across MNCH continuum of care and review of roles and responsibilities
- Improving quality of PNC and interpersonal communication skill at all levels

About 8 million copies of PNC home visit checklist referral slips (for both forth and back referrals), and 24 million birth notification cards (three different coloured types for health posts, for HDAs and for HCs) will be printed and distributed on a quarterly basis. This process will fully be owned and coordinated by respective WoHOs and PHCUs

All these recommendations should be made a crucial and integral agenda within the trainings, supportive supervision and performance review and mentorship activities targeting the whole Woreda level health system tier

iii. Integration of iCCM demand generation with existing School-Health platforms

Schools and school health programs are one of the under-utilized and missed-opportunities to pass on messaging on the availability of iCCM services and promote positive health practice. A large section of households could be reached with school health platforms. Over this implementation period, iCCM will be integrated with existing school health programs. To achieve effective and productive integration, the CSTWG in collaboration with other stakeholders will do a mapping exercise on existing school health platforms and their distribution; design integration strategy with potential areas of integration; outline basic demand generation activities to be part of the school health programs; and establish a monitoring scheme. This task will be finalized by the end

of December 2017 and a guiding document will be developed and disseminated to all actors involved.

In the meantime, about 15,000 primary schools will be reached with targeted messages about Newborn and child danger signs and the availability of accessible services at PHCUs and Primary hospitals.

iv. Use of Media as a vehicle to disseminate demand generation information

Media has been one important outlet to disseminate information on availability of services, disease prevention and health promotion practices. They will remain an important target to flow information to communities with the objective of enhancing community mobilization and demand generation of MNCH services in general and iCCM in particular. The media/channel database will be updated/created with a potential list of media that can reach all communities equitability. Their distribution nationally and locally will also be noted. Targeted messages and radio spots will regularly be developed by CSTWG and communication departments and disseminated to communities through selected outlets. The Media Monitoring system should capture 100% of radio spots/messages disseminated through RHBs, ZHD and WoHOs will be encouraged and empowered to own and invest in the utilization of respective local media in their territories. They will receive continuous support from coordination bodies like the CSTWGs in all the processes involved

v. Ensure opening of Health Posts during working hours

There are various reasons for the closure of HPs during working hours;

- Inconsistency on the flow of HEP directives on the time and scheme HEWs have to spend at the Health Posts and house to house visits
- Uncoordinated and separate pieces of trainings and forums called at places farther than their kebele of assignments
- Frequent demand for HEWs to engage on extra meetings and engagements out of the health sector
- Lack of clear performance monitoring and accountability mechanism
- Inefficiency of the supply chain system to deliver drugs and supplies to the health posts requiring HEWs to travel to health centres and woredas for collection
- Having insufficient number of HEWs for different reasons and mal-assignments across different HPs based on need

A circular has been written and sent out from MOH to RHBs on the HEP directive which requires the opening of Health Posts during working hours and the alternative-round assignments of the HEWs-one at the health posts when the other carries out house to house activities. RHBs have to cascade the communication until it ultimately reaches Health Posts and has to make sure that it is abided by and strictly followed. The accountability mechanism has to be reinforced more to follow its execution and keep everyone involved accountable.

The MOH has decided CMNCH/IRT is a comprehensive package to address the training needs of HEWs on all CMNCH thematic areas. Woreda Health Offices and PHCUs have to make sure that HEWs are not called for multiple separate pieces of trainings and forums. Another circular will be disseminated as above to avoid the closure of the Health Post due to this cause.

One round of advocacy will be planned and completed in 800 Woredas by the end of from October to May 2017 involving Woreda Cabinet and Kebele Command Posts to help relieve HEWs from the high demands of engagement on extra non-health development issues and activities. Moreover, HDAs and KCPs will be strengthened to task-shift and support HEWs on those assignments. The advocacy will also address the insufficiency of HEWs in some kebeles/HPs to increase woreda commitment and investment to train and deploy replacements and review the distribution of HEWs across different HPs in reference to size as soon as possible. This activity will be supported by a mapping exercise on the number and distribution of HEWs within Woredas.

The supply chain has to be efficient enough to continuously deliver drugs and supplies to HPs and the activities to follow are indicated under the 'Supply Chain' Objective

vi. Continuous availability of supplies to avoid service interruption (Activates outlined under Objective III)

vii. Perceived and actual poor quality of care (Activities outlined under Objective I)

Objective IV.

Ensure adequate and sustainable availability of essential iCCM-CBNC drugs and supplies at the PHCU and Woreda levels

i. Strengthen Integrated Pharmaceutical Logistic System and Procurement and Supply Management to effectively and efficiently manage iCCM supplies with all MNCH commodities

IPLS will be the sole delivery-strategy for iCCM drugs and supplies integrated with all MNCH commodities to PHCUs as already established. But there is a need for more reinforcement and support to enable the supply chain system avoid over and under stocking with firm data and regular quantification exercises; placing and use of compressive and functional tools and forms; skill building on Human Resources involved; conducive infrastructure and logistics and active coordination group and forums.

The quantification exercise for iCCM commodities is expected to take place year and has been under way regularly. The iCCM supply need for 2018 has already been executed jointly by the CSTWG and Supply Chain working group. About X43,690,225 sachets of ORS, 1,641,865 and 30,880,050 tablets of 125 mg and 250 mg dispersible Amoxicillin respectively and 830,590 ampules of 20mg/ml gentamycin ampules were estimated for iCCM with a total cost of 3,332,768 USD for the aforementioned supplies and 7,798,022 USD for all iCCM related drugs and supplies. Prevalence estimates of 27% for pneumonia, 3 annual episodes for diarrhoea per child, 9% for malaria, 7.6% for VSD and 10% for PSBI with the dosage requirements in the iCCM chart booklet. Based on the agreed-on quantification interval, the next exercise should be executed on before the end of 2018 with revised data and process jointly by the CSTWG and IPLS task force. The prevalence and dose used for the quantification should be subject to regular review (at least once per two years) based on emergence of new concrete estimate data and changes made on the program. The first data-review needs to be done as early as November 2017 followed by the next on November 2019. EDHS will be the prime reference to estimate prevalence complemented by timely evaluations and evidence. The MOH is currently looking at the possibility of revising the 7-day gentamycin treatment regimen for PSBI to a 2-day regimen based on evidence and the expected recommendations from local operations research done in Oromiya and Tigray regions to assess feasibility of the potential change. If the change is to happen, there will be an immediate need to revise the quantified Gentamycin as it will have huge cost and operational implications.

There was some improper management of iCCM drugs (most importantly gentamycin) due to the low strength of the estimate data and unforeseen poor service utilization. The old estimate data need to be revised and a more concrete and up-to-date estimate has to be generated through various M and E models to make the quantification process more accurate and efficient. The CSTWG and IPLS working groups will jointly come up with a concept note with recommendations for generating stronger and up-to-dated evidence on prevalence estimates with recommendations and responsibilities by October 2017. In the meantime, the gentamycin forecast will be revised if the treatment regimen for VSD is changed to 2 days through one round of ad-hoc quantification exercise. The full successful integration of iCCM with IPLS and effective iCCM supply management requires revised and comprehensive tools. For the same reason, the existing tools and forms including RRF and HPRRM will be reviewed and revised by the Child Survival and IPLS working groups by December 2017 to make sure that they are comprehensive and effective. iCCM guidelines and monitoring tools will be restructured to capture supply chain components as one key section.

Training will be another target to improve the supply chain management system. Drug and commodity management will be part of Pre-deployment/Gap filling orientation of HEWs. IPLS haven't been addressed adequately on the basic iCCM trainings previously. The training approach and manuals will be revised to include a half day basic orientation on IPLS and all the upcoming pre-deployment and gap-filling trainings will be conducted with the revised approach. Trainings will also be considered as key capacity building approach to PFSA hubs, WoHO logistic officers and RHB key staffs to help them have the necessary skill and capacity for proper supply chain management of iCCM and other commodities. As a cascade continuation, PFSA staffs with iCCM technical personnel will conduct the same capacity building training to Health centres and the health centres will provide mentorship for their catchment Health Posts

To further reinforce the supply management skills of woredas and health centers, relevant job aids will be developed jointly with the supply chain actors and used. HEPD has developed 'Drug Management Handbook for Health Extension Workers'. The CST-

WG will work closely with the HEPD to ensure that the handbook is reached to Health posts and iCCM drugs are properly stored and managed. All trainings, supervision and reviews will be used as an opportunity to reinforce HEWs' skill on consistent use of Health Post Monthly Resupply and Request Form. Moreover, the IPLS forms and job aids should be continuously availed at the health posts and health centers.

Warehousing and transportation will remain to be key focus areas for the supply chain management at Woreda, primary hospital and PHCU levels. Woredas and Health Centers need to have the proper warehouse to safely store the supplies and the necessary transportation and collection means to consistently deliver the supplies to the next recipient.

The IPLS integration task force will be a key coordination body as far as IPLS is concerned. MOU has already been developed and being used to guide the structuring, roles and responsibilities and the processes involved with the taskforce. The IPLS taskforce meeting which happens every two month has to be supported to take place regularly. The CSTWG representation is already in-place in the IPLS taskforce meeting to address issues related with iCCM supplies and this will be sustained. The IPLS personnel will also be a regular attendant on the CSTWG meetings.

Domestic/Internal spending needs to increase for procurement of iCCM commodities over this implementation period. MCHD will closely work with PFSA in mapping the financing of iCCM supplies and engage with supply chain partners, stakeholders and funding platforms including CHAI, R4D, SDGP, GFF and GFTAM

At the final point of supply management-the health post, engagement of Kebele Command post and administration in renovation of health posts for proper storage and utilization of MNCH commodities including iCCM will be ensured

ii. Monitoring and Evaluation for Supply chain

There is a Supply and Logistics checklist used by PFSA and WoHOs for corrective support at PHCUs. These checklists will be revised by the IPLS task force to make sure that child and Newborn health drugs and supplies are adequately captured. The supply and logistics information sharing among PFSA, FMOH and RHBs structure need to be set up or strengthened if already existing. The inclusion of iCCM commodity availability as tracer drugs will be ensured on the HMIS through continuous engagement of PPD, IPLS task force and CSTWG. The monitoring and evaluation activity will be supported by complementary operations researches that will continuously be used to improve Supply Chain Management implementation and system strengthening.

iii. Coordination

The key outcome of all the supply chain coordination events will be full integration of supply chain issues in all key program activities and ensuring the highest level of ownership possible by the public sector. Program review forums at PHCU and WoHO levels (IPRMs) will be made to address and discuss supply chain bottlenecks with possible solutions. RHB pharmaceutical and logistics core process owners and units will need to have iCCM supplies as part of their plan and implementation. For all these coordination recommendations to be able to deliver results, there needs to be strong and active supply chain TWGs at all levels and all supply issues should be aligned with security and program TWGs at FMOH and PFSA. The Hub based TWGs will also be revitalized with iCCM commodities being one of their main agenda.

Objective V:

Foster sustainability and ownership of iCCM programs along the public health system with accountability

i. Planning Exercises inclusive of Newborn and Child Health (including iCCM) at all levels

The very first action to fully institutionalize iCCM within the health system and ensure its sustained implementation starts at the planning stage. iCCM should be an integral part of all the operational, annual, quarter and monthly plans from the national level to PHCU and HP levels. Potential areas of recommendation, for instance, include in the plans includes Treatment (and referral) coverage against target for pneumonia, malaria, diarrhoea, PSBI and VSD; Stock availability for key iCCM supplies; key activities under taken; HDAs meetings/orientation and performance. But in the meantime, a catalogue of measurable indicators to be part of the plans will be developed through the CST-WG to support planners with guidance during the planning exercises. But each level will have a flexibility of contextualizing their own plans under the larger frame of the catalogue. A two days' intensive advocacy and orientation forum will be conducted in all woredas involving PHCUs, WoHOs and decision makers to ensure the inclusion of iCCM indicators on their plans and performance monitoring schemes.

For the same purpose 16,447 HPs, 3600 HCs/PHCUs, 800 WoHOs, 75 ZHDs, 8 RHBs and FMOH will adequately include iCCM targets in their Monthly, Quarterly, Bi-Annually and Annual Plans. The process will be supported through existing supportive supervision visits, program review meetings, advocacy forums and Joint Monitoring visits with the engagements of partners and stakeholders

The Woreda-Based Health Sector planning will be another strategic target to position the public health sector sustainably plan for and monitor iCCM indicators. The MCHD will work with PPD on how best sufficient iCCM indicators can be made an integral part of the Woreda-Based Health Sector planning and all the processes involved. Child Health technical experts will support the orientation and planning process of 800 Woreda based planning.

ii. Strengthen the Monitoring and Evaluation mechanism across the public health system to consistently inform and improve iCCM program implementation

a) Adequate inclusion of major iCCM indicators on HMIS and its associated tools

b) Revision of existing checklists at all levels of the health system to include key iCCM variables

c) Ensuring that iCCM agendas are included and addressed in review forums at all levels including Woreda and PHCU based IPRMs

iii. Ensuring the performance monitoring and accountability mechanism is functional enough to address performances on Newborn and child health

The adequate inclusion of iCCM indicators on various plans and M and E system should be linked with and backed-up by a functional Performance Monitoring and Accountability mechanism within the public health sector at all levels to recognize best performers and set improvement plan for under performers. Pneumonia and VSD case management coverage will be key proxy indicators that needs to be inculcated within the accountability mechanism. But generally, RMNCH score cards should be efficient enough to generate the performance-picture and dash board of HPs, PHCUs and Woredas on key Newborn and Child Health interventions. The team of child health experts which will support the worda planning advocacy and orientation forums will make sure that the accountability mechanism sufficiently uses the key iCCM indicators to monitor performance and award/reprimand actions as a result using a contemporary checklist. The PHCU and Woreda based IPRMs will be used as important forum to have a detailed discussion and set up improvement actions on HP and HC specific performances on Child Health interventions in general and iCCM in particular. The IPRM guides will have a guiding section for the same.

iv. Leadership and Coordination

As it has been the case, Communities and the Public Health Sector at all levels will be scoped with the role of leading all iCCM related activities partners are expected to provide technical, logistics and financial support as required with a more intensive support in program expansion areas. The public health sector links the leadership scopes with respective government administrative bodies like Cabinets and KCP. Regions and Zones will be capacitated with the assignment of Technical focal person to resume full

technical leadership and program management roles. For the same purpose 75 ZHD and 8 RHB TAs will be recruited by December 2017 under the respective offices with the emplacement of associated logistic, technical and administrative supports.

The CSTWG will continue to be the coordination body for iCCM program management and technical guidance with the MOH at respective levels chairing the working groups. The working groups will ensure the maximum participation of all iCCM key players as important and regular members. Monthly one national and 8 Regional CSTWG meetings will be conducted to continuously improve and influence iCCM and other Newborn and Child Health programs

v. Continued political commitment and support

For effective increment of service coverage; maximize utilization; maintain quality of care; and improvement of the Supply Chain, engagement of political leaders at all levels and mainstreaming Newborn and Child Health services along political agendas will be required

One National, 8 Regional, 75 Zonal, 800 Woreda and 15000 Kebele level advocacy workshops will be conducted in the first quarter of the implementation phase to leverage political commitment for iCCM program implementation and performance. Political leaders, Health system personnel; community and religious leaders will be addressed through the workshops

vi. Increasing Public-Financing on iCCM

An increased public-financing/spending on iCCM will be key success factor to meet the 'Sustainability and Ownership' objective of this particular implementation phase.

Program costing; resource mapping; gap analysis and FMOH-spending plan will regularly be developed with the investment and expenditure monitoring system put in-place. Moreover National, Regional, Zonal and Woreda Cabinets will be approached with advocacy intervention for understanding the significance increased spending on Newborn and Child Health programs

Objective VI:

Enhance the efficiency and effectiveness of the Monitoring, Evaluation and Learning system at all levels

A functional and comprehensive Monitoring and Evaluation will be among key requirements for the effectiveness of iCCM program in Ethiopia. All pertinent process, input, outcome and impact indicators will regularly be tracked, collected, analysed and used for performance improvement through various existing and ad-hoc mechanisms (M and E framework). Child Mortality trends (under-5, Infant and Newborn Mortality rates) will be the ultimate indicators to evaluate the impact of iCCM, IMNCI and other complementary MNCH interventions in mortality reduction. With the existence of established fact of iCCM saving lives and reducing mortality with high coverage, level of service utilization and coverage will be evaluated for indirect impact measurement. Involved processes and inputs to improve access and coverage will also be continuously observed to ensure that program implementation is effectively established and carried-out.

I. Health Information Management System (HMIS)

HMIS will be used as the prime source to collect and utilize service coverage and delivery indicators. The current HMIS has become more comprehensive to include additional Newborn and Child Health indicators and currently has six key iCCM indicators. The HMIS will serve as the primary health system platform to follow the and improve iCCM related performance through information generated regularly from the system

The lumpsum and disaggregated indicators that will be tracked through HMIS to monitor iCCM are;

- Early neonatal death in the community
- Under-5 Pneumonia Treatment Coverage
- Under-5 Diarrheal Treatment Coverage
- SAM treatment
- VSD/PSBI case management
- KMC service initiation for preterm and low birth weight baby

As part of the health system strengthening contributing pillar, iCCM program activities will be utilized as important opportunity to further reinforce the effectiveness of HMIS On-Job mentoring and coaching will be rendered to HEWs and Health Workers from

PHCUs on HMIS process, definitions, requirements and tools through various existing forums. All the supportive Supervisions and IPRMs will be structured in a way that they address HMIS as one key component. The mentorship will involve orientation and coaching on how to properly use family folders, bin cards, HMIS forms and registers. They will also be guided on correct registration, data compilation, data transfer and use of data for performance improvement. The RMNCH score card will be a reference for performance monitoring and improvement of iCCM as the HMIS now captures more iCCM related data to indicate progress and shortcomings. To achieve the task, the CSTWG will work with the Director of PPD to make iCCM checklists and tools have sufficient sessions and time for strengthening HMIS

Upcoming new iCCM and IMNCI gap-filling and supply chain trainings will be another opportunity to integrate skill building on HMIS and data use for decision making. The final day of the trainings will have a session for the same

The continuous availability of HMIS forms and registers will be ensured through the supportive supervision visits of various forms and action will be taken along the public health system boundary to fill identified gaps.

II. Regular Supportive Supervision and Program Monitoring Visits

The established supportive supervision visits (outlined under the other objectives as a cross-sectional activity) will be used for program monitoring purpose beyond their quality improvement scope. There are a bulk of quality measurement data which can't be obtained through the prime source of HMIS and the program performance picture and improvement will be incomplete unless quality of iCCM service is regularly monitored, improved and maintained. The primary aim of using supportive supervisions to monitor iCCM will be to equip the Woreda and PHCU tiers with the skills and capacities to regularly monitor performance and use data to carryon regular program improvement, but not to establish a parallel M and E system and database. About 8000 PHCU supervisors will be trained how to collect and use data with the supportive supervisory skill trainings. Additionally, data compilation exercise will be done with trainees during the trainings using a spreadsheet-level database to help them carryout simple analysis of data collected through the supervision visits. It will be ensured through the CSTWG that the iCCM program specific checklist will covers and captures key program quality monitoring information. The same will be done to monitor the IMNCI program performance through supervision visits done by supervisors from primary hospitals and Wo-

HOs. About 1200 supervisors will receive a one-day training on supportive supervision skill and program monitoring through the visits.

III. Integrated Program Review Meetings

Program monitoring will be synergized through IPRMs on top of the supportive supervision and monitoring visits. The monthly PHCU based and quarterly woreda based IPRMs will look at quality of service through observation of the iCCM registers with respective HPs. The IPRMs will be supported by simple guide and the spreadsheet database to gather, compile, analyse and use data for performance improvement. The data will be owned locally used by PHCUs and Woredas to do proper program monitoring

In addition to PHCU based IPRMs a quarterly Woreda-based program reviews will be conducted involving all PHCUs and Primary hospitals to compile, share and use program data to look at performance and set-out action plans. ZHDs and RHBs will also be expected to have a bi-annual program review as part of zonal and regional program Monitoring and Evaluation and performance improvement. The national CSTWG will have a yearly execution of the same

IV. Baseline, Midterm and End-line Resources and references

EDHS will be the key reference for establishing time-bound levels for key iCCM impact and outcome indicators of evaluation interest. The EDHS 2016 levels of child mortalities, care seeking and utilization will be taken for establishing baseline levels and EDHS 2021 levels will be compared against to look at the impact and changes brought about with this iCCM program implementation phase. The final EDHS reports don't usually present mortalities disaggregated by regions, zones, woredas and kebeles. The FMOH, RHBs and CSTWG will regularly engage with Central Statistical Authority to obtain raw-data and find ways of doing additional analysis and generate more-informative disaggregated mortalities to evaluate impact at all levels. Other relevant surveys planned and conducted by iCCM stakeholders will be explored and used to look at trends and changes associated with iCCM

V. Operational researches

Operations and implementation research can be one complementary means to contribute to iCCM program Monitoring and Evaluation if well-designed and coordinated through the CSTWG to be able to better produce utilizable information. The group will be responsible for listing potential research questions and areas and tasks and process-leadership can be shared among the technical working group members on the

basis of expertise area, interest and availability of resources.

Potential thematic areas of consideration for implementation research include;

- Adoption and controlled introduction of innovations and technologies for iCCM
- Effect of iCCM activities and interventions on program outcome and impact along the MNCH continuum of care
- Introduction and use of local solutions for community mobilization, demand generation and increasing service utilization
- Redesigning and contextualizing iCCM in pastoralist and hard to reach areas
- Quality improvement and maintenance
- Supply chain management
- Health System and referral linkages
- Equity analysis and program scale-up to unreached communities
- Cost effectiveness of iCCM
- Linkage of iCCM with community support structures
- Public Private Partnership for iCCM
- Broadening and redesigning iCCM based on emerging local and global initiatives
- Leadership, Coordination, ownership and sustainability

Summary of Specific activities by Objectives

Table: Summary of Specific activities under Objective-I

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Adopt a model for contextualized introduction and implementation of iCCM to unreached communities	One Implementation document will be developed	By December 2017	CSTWG, RHBs, Partners	A modified approach, model and implementation manuals/tools will be developed utilizing experience and consideration of contextual factors
2	Costing of Program Scale-up and interventions	One round of costing	By December 2017	CSTWG, RHBs, Partners	
3	Partners Mapping in the unreached communities/areas	A mapping assessment will be conducted	By December 2017	CSTWG, RHBs, Partners	Partners mapping will be done in the unreached areas to establish support system and leverage resource
4	Resource Mobilization for scaling up iCCM to unreached communities	Monthly resource mobilization forums	December-February 2017	FMOH, RHBs, Partners	
5	Program Start-up	Unreached Woredas and Kebeles from report	January 2018	CSTWG, RHBs, ZHDs, WoHOs, PHCUs, Partners	All the expansion interventions will be delivered with the leadership of the health system at all levels, coordination of Pastoralist/unreached communities sub-working group and support of partners from January 2018 to January 2019

Table: Summary of Specific activities under Objective-II

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Merger and revision of iCCM/CBNC training facilitator guidelines, exercise booklets, chart booklets, job aids and video demonstrations	Merged guides, manuals, tools and job aids	December 31st, 2017	National CSTWG	
2	ToT for RHB, ZHD and TVET trainers with the revised iCCM training	321	December, 2017	National and regional CSTWG	
3	Pre-deployment/gap filling Training for new HEWs on the revised iCCM training	5000	Continuous until Year V	RHBs, TVETs, ZHDs, WoHO	FMOH and Partners to support the training process and ensure quality
4	Continuous evaluation of iCCM training	50	Continuous	National and regional CSTWG	25% of all the training sessions will be observed for quality and outcome
6	A 3-day training of HC and Primary Hospitals Health workers on the revised iCCM training	7,600	Year I	CSTWG, RHB, ZHD, WoHOs and partners	Will be completed by the end of Year I
7	Regular revision of case management protocols for HPs, HCs and Primary Hospitals	twice	Year II and V	CSTWG	Will be based on emerging evidences and feasibility
8	Revision and refining of iCCM program specific checklist	Revised checklist will be developed	November 2017	CSTWG	The SS checklist will be comprehensive to include iCCM/CBNC, quality, demand, supply but will be made friendly to use
9	Program Specific supportive supervision to HPs	16,447 HPs	Monthly	PHCUs/HCs	10% of the visits will be joined by Primary Hospitals for the clinical mentorship role 10% of the visits will be supported by Partners to ensure quality and monitoring purposes.
10	Program Specific Supportive Supervision to PHCUs	3,560 PHCUs	Quarterly	WoHO, ZHD TA, Primary Hospitals, Partners	All PHCU will be supervised for quality every quarter by WoHO. They will be supported by Primary Hospitals, ZHD TA and partners
11	Review the Newborn and Child Health sections of the ISS	Newborn and child health sections of ISS checklist will be revised	Once	CSTWG, MCHD, PPD	

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
12	Monthly ISS visit to HPs	16,447 HPs	Monthly	HC, WoHO	HCs to conduct ISS monthly to satellite HPs. WoHO to support the process
13	Quarterly ISS to PHCUs	3,560 PHCUs	Quarterly	WoHO, ZHD TA	WoHOs to conduct the ISS. ZHD TA to support the process
14	Woreda Joint Monitoring visits (JMV)	10% of PHCUs in a woreda	Quarterly	WoHO, ZHD TA, partners	At least 10% of the PHCUs should be visited by the team in a woreda
15	Zonal/Regional JMV	2 Woredas, 2 Zones, 6 PHCUs	Quarterly	RHB/ZHD TA, partners	The 6 PHCUs will be selected from the 2 selected woredas of 2 selected Zones
16	National JMV	4 regions, 4 Zones, 8 woredas and 16 PHCUs	Bi-Annual	CSTWG	The 16 PHCUs will be selected proportional from the selected four zones
17	Development of structured integrated Program Review and Mentoring Meeting (IPRM) guideline	Structured IPRM checklist will be developed bi-annually	Bi-annual (first guideline to be developed on October 2017)	CSTWG	The structure guideline will provide generalized guidance. Woredas and PHCUs will contextualize it to their use

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
18	PHCU level IPRM	3560	Monthly	PHCUs, WoHO, ZHD TA	The IPRMs will be an integral part of the overall PHCU level monthly review. ZHD TA to provide technical assistance with WoHO sequentially
19	Woreda level IPRM	800	Quarterly	WoHO, ZHD/RHB TA, partners	The IPRMs will be Woreda-led and will be supported by ZHD/RHB TA and partners. The program review will address both program implementation and quality issues
20	Zonal level Program Review	75	Quarterly	ZHD/RHB TA, WoHOs, partners	The IPRMs will be Zone-led and will be supported by RHB TA and partners. The program review will address both program implementation and quality issues

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
21	Regional level Program Review	8	Bi-Annually	RHB, ZHD, Partners, CSTWG	The Program reviews will be region-led but will be back-stopped by CSTWG. The program review will address both program implementation and quality issues
22	National level Program review	1	Annually	FMOH/CSTWG	The program review will address both program implementation and quality issues
23	Controlled testing and scaling up of 'Inclusion of iCCM components on mHealth'	iCCM components included on mHealth	Year I for testing and Year III for scale up	CSTWG	
24	Controlled testing and scale up of Acute Respiratory Illnesses Diagnostic Aid (ARIDA)	ARIDA testing and scale up	Year I for testing and Year II-III for scale up	CSTWG	
25	Adaptation of emerging technologies for quality improvement	New upcoming technologies to be adopted	Continuous	CSTWG	Emerging technologies will be discussed on, tested and scaled up if appropriate through the CSTWG

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
26	Documentation and scaling up of localized best quality improvement practices	Proper documentation at PHCUs, WoHOs, ZHD, RHB, FMOH put in place and in use	continuous	PHCUs/WoHO/ZHD/ RHB/FMOH/CSTWG	

Table: Summary of Specific activities under Objective-III

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Revision of iCCM Supportive Supervision, training and IPRM materials and tools to include IPC, Demand generation and community mobilization	iCCM tools and materials updated	December 2017	CSTWG	Demand to be adequately addressed in all activities
2	One-day Advocacy and sensitization workshop on care seeking, availability of services, performance monitoring and accountability on Child Health and leveraging political commitment at all levels	15,000 kebele level workshop 800 Woreda level 75 Zonal 8 Regional 1 National	October-May 2017	HPs and KCPs PHCUS and WoHOs ZHDs FMOH	

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
2	Revise the performance monitoring and accountability mechanism and RMNCH scorecard to include iCCM indicators	RMNCH score card revised to include iCCM indicators	November 2017	CSTWG, PPD, RHBs	HMIS-iCCM indicators to be used for performance monitoring and RMNCH scorecard
3	Transportation and distribution of FHG and speaking books	2,125,190 FHG 2,125,190 speaking books	Year II and Year IV	CSTWG, Partners, RHBs, ZHDs and WoHO	The distribution will follow the health system structure and supported by partners
4	Development of HEW-guide and Job aid to facilitate community dialogue and meetings	HEW-guide and job aid developed	December 2017	CSTWG	This will be a very simplified guide
5	Quantification, Procurement and Distribution of backpacks	42,336 backpacks	Year I	FMOH, partners	
6	Printing of portable register copy for HPs to be used during house to house case management	39,000	Quarterly	WoHOs, PHCUs	All the action will be executed at woreda and PHCU levels
7	Orientation of HEWs on IPC, community mobilization and effectively working with HDALs, KCP and PHCUs as a team	42,336 HEWs	Once	WoHOs, TVETs, RHB, PHCUs, Partners	This will not be a stand-alone orientation. It will be integrated with IPRMs and basic iCCM training

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
8	Support orientation of 439,497 HDALs and 15,000 KCPs on key MNCH messages, community mobilization, identification of danger signs and referral by HEWs	439,497 HDALs 15,000 KCPs	Quarterly	HEWs, PHCUs, WoHOs	This activity will basically be HEW-led, but will be supported by HCs and WoHOs
9	Orientation of 1:5 Networks on 15,000 KCPs on key MNCH messages, community mobilization, identification of danger signs and referral by HDALs and KCPs	2,125,190 1:5 Networks	Continuous	HDALs, KCPs, HPs	The activity will basically be HDAL and KCP-led but will be supported by HEWs and HCs
10	Continuous update of CBDDM Maps	439,497 maps updated	Continuous/ Monthly	HDALs, KCP	Will be followed up and supported by HEWs. Data to be generated through assessment
11	A one day orientation of Agricultural Extension Agents (AEAs) to integrate community mobilization activities with their daily deliverance	15,000 AEAs	By November 2017	PHCUs, KCP	
12	A half day quarterly Kebele based community dialogue in all kebeles to discuss service utilization and quality issues	15,000 dialogues	Quarterly	PHCUs	
13	Support Pregnant Women forum and incorporate Newborn and child health issues in the forums	16,447 forums	Monthly	PHCUs	Existing forums will be strengthened and supported

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
14	Bi-annual Community-PHCU meeting to explore quality of care issues and set up contextual quality improvement actions	3,600 Meetings	Bi-annual/Quarterly	PHCUs, WoHO, TA	
15	Attachment of HP accountability with KCP	All HPs are linked to KCP for accountability	First Quarter	KCPs, WoHOs, PHCUs	
16	Support Active birth surveillance by HEWs and HDAs	All HPs and HDAs conduct active birth surveillance	Monthly	HEWs, HCs, HDALs, KCPs	Estimated number of births will be used for all HPs as target to capture
17	Introduction of home-visit's checklist and mobile alerts for HEWs to capture births and conduct PNC	Home visit checklist and mobile alerts introduced to HEWs	By December 2017	CSTWG, WoHO and PHCUs	The checklist will be a detail of actions that should be performed by HEWs
18	Mapping of School Health Program Platforms and their distribution	One mapping exercise	By January 2018	CSTWG	Primary Schools will be the targets
19	Design and integration of Newborn and Child Health Programs with identified school health programs	Integration guiding document to be developed	By January 2018	CSTWG	
20	Distribution of FHG to Primary schools	15,000 Primary Schools	By January 2018	CSTWG, WoHOs, Partners	

Table: Summary of Specific activities under Objective-IV

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Incorporation and integration of all iCCM supplies within IPLS	All iCCM supplies fully integrated within IPLS	Ongoing July 2017	CSTWG, PFSA and IPLS task force	iCCM SCM is already integrated with IPLS. It will be regularly monitored and all iCCM related supply quantification, procurement and distribution will follow the same
2	MOU development for revision of estimate data and iCCM/CBNC quantification exercise	Once	December 2017	CSTWG, PFSA and IPLS task force	The task group will develop a concept note/MOU to guide the revision of prevalence estimate data and the overall quantification process
3	Revision of iCCM/CBNC prevalence data for estimation of supply quantity	Twice	November 2017 November 2019	CSTWG, PFSA, IPLS task force and PPD	The estimate data should be subject to revision regularly. DHS data will be the prime source but will be complemented with up-to-date data from various sources

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
4	Quantification and costing of iCCM/CBNC supplies using updated estimates	Twice per year	Bi-annually (The next exercise will be conducted on December 2017)	CSTWG, PFSA and IPLS task force	The quantification exercise is expected to happen annually. The last one was conducted for 2018 and the next one will be done after the revision of data and process Gentamycin quantification will be done immediately if the treatment regimen is to be changed to 2 days based on emerging evidence and FMOH guidance
5	Procurement of quantified iCCM/CBNC supplies	Once per year	July of every year	FMOH, Partners, PFSA	There has to be continuous resource mobilization supported by quantification process
6	Revision of IPLS tools and forms including RRF, HPRMM to fully incorporate iCCM/CBNC SCM	Once	By December 2017	CSTWG, PFSA and IPLS task force	
7	Revision of iCCM/CBNC training, supervision and IPRM manuals and tools to adequately address supply chain management	once	By December 2017	CSTWG and IPLS task force	Will be done as part of the overall iCCM/CBNC manuals and tools revision

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
8	Training of new HEW-graduates on IPLS and supply Chain Management	5 , 0 0 0 HEWs	Annually	CSTWG, Supply Chain partners and working group, RHBs, TVETs	All new HEW graduates will be trained/oriented on supply chain management as integral part of Pre-deployment training
9	Orientation of existing HEWs on IPLS and supply Chain Management	4 2 , 3 3 6 HEWs	Quarterly	PHCUs, WoHOs, CSTWG, Supply Chain partners and working group	IPLS and Supply Chain Management orientation and mentorship will be addressed through existing PHCU and Woreda level IPRMs
10	Training of PHCU and Primary Health Workers and WoHO personnel on IPLS, Supply Chain Management and supportive supervision skills	8800	Once By January 2018	CSTWG, IPLS working group, RHB/ZHD, partners	A two-day orientation will be given for 2 HWs per facility and 1 WoHO technical expert. Ways of integration of the orientation with existing training platforms like IMNCI will be devised
11	Supportive Supervision to HPs for Supply Chain Management	16,447 HPs	Monthly	PHCUs, Primary Hospitals, WoHOs, Partners	Will be integrated with existing program-specific supervisions and ISS. The checklists will be revised to adequately address IPLS and Supply Chain Management

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
12	Supportive Supervision to HCs for Supply Chain Management	3,600 HCs	Monthly	ZHD TA, Primary Hospitals, WoHOs, Partners	Will be integrated with existing program-specific supervisions and ISS. The checklists will be revised to adequately address IPLS and Supply Chain Management
13	Adequate inclusion of IPLS and SCM on PHCU and Woreda based IPRMs	All PHCU and Woreda IPRMs address IPLS	Quarterly	CSTWG, RHB/ZHD TAs, WoHO, PHCUs	The IPRM guidelines are expected to be revised regularly to focus on contemporary issues. IPLS and SCM will remain to be one key thematic area in all the IPRMs
14	Regular updating of bin cards by all HPs	16,447 HPs	Monthly	PHCUs, WoHOs and partners	HPs will be supported through supportive supervisions to regularly update their stock level using bin cards and existing tools. SS database will be used as source of data

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
15	Establish stock monitoring and accountability mechanism	16,447 HPs 3,600 HCs	Monthly	KCPs, PHCUs, WoHOs, ZHD, RHB	Stock balance analysis will be done against utilization level every month through the supportive supervisions. The copy of the supervision findings will be shared with KCPs, HCs and WoHOs and will be one basic agenda at Kebele, HC and Woreda based program reviews with established accountability mechanism
16	Regular request for iCCM/ CBNC/IMNCI supplies and drugs and stock data compilation and reporting	16,447 HPs 3,600 HCs	Monthly/Quarterly	HPs, HCs, WoHO	Standard IPLS formats like RRF and HPMRR will be used
17	Regular Quantification, packaging, transportation and distribution of iCCM commodities from National Hub to regional Hubs then down to PHCUs	3 6 0 0 PHCUs 16,447 HPs	Annual	CSTWG, IPLS task force, PFSA, RHBs, ZHDs, WoHOs, PHCUs	All the processes are fully integrated with and follow through the existing IPLS channel

Table: Summary of Specific activities under Objective-V

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Adequate inclusion of iCCM targets in the public Health Sector annual and regular plans	iCCM targets included in 3600 PHCU, 800 Woreda, 75 Zone, 8 Regional and National annual plans	Annual/Quarter/Month	FMOH, RHBs, ZHDs, WoHOs, PHCUs, Partners	The inclusion in the annual plan will be reflected in the broken-down Bi-Annual, quarter and monthly plans
2	Adequate inclusion of iCCM indicators in the Woreda-Based Health Sector planning	iCCM targets adequately included in 800 Woreda-Base Health Sector Planning	Annual	FMOH-MCHD, FMOH-PPD, CSTWG, RHBs, WoHOs	Continuous engagements with all stakeholders and sector leads will be used to ensure the inclusion
3	Support Woreda-Base Health Sector Planning activity	800 Woredas	Annual	CSTWG, RHB/ZHD TAs, Partners	All the planning activities will be supported by iCCM technical personnel
4	Integration of Newborn and Child Health indicators on performance monitoring and accountability mechanism	Key newborn and Child health indicators included adequately	Monthly/Quarterly/Annually	FMOH, RHBs, ZHDs, WoHOs, PHCUs, KCP	
5	Sector-led regular Program Review meetings	1 National 8 Regional 75 Zonal 800 Woreda 3600 PHCU Program Reviews	Annual Bi-Annual Quarter Quarter Monthly	FMOH, RHBs, ZHDs, WoHOs, PHCUs	
6	Assignment of TA to regions and Zones	8 RHB TA 75 ZHD TA	By October 2017	FMOH, RHB, Partners	
7	Regular regional and national CSTWG meetings	1 national 8 Regional	Monthly	CSTWGs, FMOH, RHBs	
8	A one day advocacy workshop to mobilize political commitment and public-funding for iCCM	1 National 8 Regional 75 Zonal 800 Woreda 15000 Kebele	October-May 2017	CSTWG, Public Health Sector, Partners	

Table: Summary of Specific activities under Objective-VI

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
1	Routine data collection, compilation, analysis and reporting through HMIS	16,477 HPs and 3600 HCs will report monthly performance through HMIS	Monthly	PHCUs, WoHO, ZHD TAs	
2	Orientation of HEWs on HMIS and use of data for performance improvement	42,336 HEWs will be oriented	Monthly/Annual	WoHOs, HCs, TAs, RHB, TVETs	The orientation will be integrated with planned trainings and IPRMs
3	Orientation of HC and Primary hospital staffs on HMIS and use of data for performance improvement	8000 Health Workers will be oriented	Quarterly	WoHOs, HCs, TAs, ZHDs, RHB, FMOH	The orientation will be integrated with planned trainings and IPRMs
4	Transportation and distribution of HMIS forms, registers and tools	16,477 HPs, 3600 HCs 270 Primary hospitals	Quarterly	FMOH, RHB, ZHD, WoHO	
5	Regular Supportive Supervisions for program monitoring to HPs	16,477 HPs will be visited	Monthly	HCs and WoHO	HCs to be prime responsible for doing the supervisions, collecting data and use of data for performance monitoring and improvement
6	Regular Supportive Supervisions for program monitoring to HCs	3600 HCs will be visited	Monthly	Primary Hospitals and WoHO	Primary Hospitals to be prime responsible for doing the supervisions, collecting data and use of data for performance monitoring and improvement
7	Regular compilation, analysis and use of supportive supervision data	3600 PHCUs	Monthly	PHCUs, WoHOs	PHCUs to be supported for use of data for program improvement. IPRMs will be used to share and discuss analysis output and set action points
8	Conduct PHCU-based IPRMS	3600 PHCUs	Monthly	PHCUs, WoHOs	IPRMs will be one key forum to collect, share and discuss on program performance

SN	Activity	Target value	Timeline/Frequency	Responsible	Remark
9	Conduct Woreda-based quarterly IPRMs	800 Woredas	Quarterly	WoHO and ZHD/TAs	Woreda and PHCU level performance data will be shared and used during Woreda based IPRMs
10	Conduct Bi-Annual program review at zonal and regional level	75 zones and 8 regions	Bi-Annual	ZHD, RHB/TAs	Will include woreda, zone and region representatives
11	Conduct annual national level program review	1	annual	FMOH, CSTWG	
12	Midterm program evaluation	1	August 2019	FMOH, CSTWG, Partners	Will depend on availability of resources
13	Program Implementation and Operations research		Continuous	FMOH, CSTWG, Partners	Will depend on availability of resources. Research questions will be taken from the implementation guideline and the revised list by CSTWG if any

6. Roles and responsibilities

Roles and Responsibilities of FMOH

- Lead the implementation of the iCCM implementation guideline
- Coordinate regional level sensitization meeting with the regional health bureau heads and program focal person
- Mobilize resources for the ICCM program implementation over the next five years
- Ensure that ICCM activities and indicators are properly addressed in the Woreda-based health sector plan, core plan and comprehensive plan & HMIS;
- Ensure supply of drugs, job aids and equipment for ICCM implementation.
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the iCCM program implementation
- Organize and conduct annual review meetings.

Roles and Responsibilities of PFSA

- Delivery of pharmaceuticals for the management of ICCM to health centres that are responsible to supply HPs
- Provide supply information for RHB, ZHD & Woreda Health office
- Build the capacity of all PHCU that will be involved in ICCM through IPLS training and supportive supervision on pharmaceuticals availability and rational use;
- Assess the performance of HCs in the area of pharmaceutical supply and services and take appropriate intervention;

Roles and Responsibilities of RHB/ZHD

- Recruit the regional and zonal TA and monitor their performance and replace with civil servant worker subsequently.
- Coordinate gap filling trainings on ICCM
- Ensure that ICCM activities and indicators are properly addressed in the Woreda-based health sector plan, supportive supervision checklist and discuss issues of the program in their review meeting;
- Ensure supply of drugs, job aids and equipment for iCCM to ZHD/Woreda Health Offices
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the implementation of iCCM by HEWs.

Roles and Responsibilities of Woreda Health Office

- Ensure that ICCM activities and indicators are properly addressed in the Woreda-based health sector plan, supportive supervision checklist and discuss issues of the program in their review meeting
- Coordinate trainings and follow-up after training to HEWs, PHCU and relevant Woreda Health Office staffs iCCM

- Ensure continuous supply of drugs, job aids and equipment for iCCM at health posts
- Strengthen the referral linkage and communication systems between the primary hospitals, health centre and health posts by capacitating referral points.
- Ensure that the HC and primary hospital staffs conduct regular supportive supervision to enhance capacity of the HEWs and HWs in assessing, classifying and managing Newborn and Childhood illnesses
- Conduct supportive supervision and regular review meetings to enhance iCCM Program management by HEWs;
- Ensure complete and timely reporting of activities on iCCM by HEWs and PHCU Director; and

Roles and Responsibilities of the National Technical Working Group

- Assist in the development or revision of guidelines, job aids and other relevant documents on iCCM;
- Assist the FMoH and RHBs in resource mobilization, optimal utilization and efforts on sustainability of the services;
- Establish/activate ad hoc working groups for specific tasks, when necessary.
- Roles and Responsibilities of the Regional Technical Working Group
- Coordinate the planning, implementation, monitoring and evaluation of ICCM by HEWs in the region;
- Assist the RHB in resource mobilization, optimal utilization and efforts on sustainability of the iCCM
- Adopt/translate/customize iCCM guidelines, job aids and other relevant documents to make them locally appropriate i.e. into the local language/s;
- Advance advocacy on key community based child health interventions.

Roles and Responsibilities of PHCU/ Referral HC

- Train and support HEWs in building their skills to assess and manage common childhood and Newborn illnesses
- Ensure the continuous supply for IMNCI, iCCM and other MNH services;
- Ensure that iCCM implementation is well coordinated, implemented and followed at the kebeles of their respective catchment areas;
- Conduct relevant IPRMs
- Conduct timely and regularly program based supportive supervision and integrated supportive supervision on monthly base
- Establish referral and feedback mechanisms

Roles and Responsibilities of HEWs

- Ensure quality implementation of all the Health Extension Program core packages, while balancing preventive, promotive and basic curative interventions;

- Ensure 24/7 functions of the health post;
- Ensure the availability and proper utilization of necessary supplies (drugs, job aids and equipment) in the health post and request for timely supply to HCs;
- Provide ICCM services, including complete registration and regular update of pregnant women, as well as follow-up, clean and safe delivery, essential Newborn care, manage Newborn with intrapartum asphyxia, scheduled post-natal home visits, and neonatal sepsis management at the community level.
- Properly register sick neonates managed in the kebele and report to the HC in timely manner;
- Build the capacity of HDA, 1 to 5 network leaders, and model families to recognize newborn danger signs and improve the health care seeking behaviours in the community with the support of PHCU;
- Ensure that referred patients actually reach health centres; by giving them proper counselling on the reasons for referral to mothers/care givers, visiting the homes following the referral, addressing reasons for potential hindrance for not going to HCs, and informing the HDA, 1 to 5 network leaders, to conduct close follow-up, in collaboration with community leaders, kebele management and community social organizations;
- Ensure that mothers and sick neonates referred back to the community adhere to the advice given by HCs and comply with the medication;
- Ensure that the iCCM issues are discussed in community conversations in 1 to 5 networks.

Roles and Responsibilities of HDA (1 to 5 network leaders)

- Have the appropriate skills and tools to increase the knowledge, attitude and health seeking behaviour of mothers, caretakers and the community at large;
- Continuously undertake health promotion, counselling and social mobilization activities in the community to improve the knowledge, attitudes and health seeking behaviours of caretakers;
- Timely notification and registration of pregnancy and births as well as recognize Newborn danger sign and refer to HP;
- Regularly meet and report back to HEWs on progress and new information in the community
- Support the caretaker to ensure treatment compliance and home management of sick neonates;
- Ensure that referred cases actually go to HP/HCs, as a result of proper counselling and the creation of enabling conditions for referral.
- Conduct community mobilization on iCCM through HDA
- Facilitate the referral of seriously sick newborns;
- Mobilize local resources for implementation of iCCM

7. Cost of program implementation

The total cost required to execute all program activities over the five-year period will be 80,418,479 USD (1,870,197,185 ETB). The basic cost categories include: M and E and quality improvement and maintenance; Demand generation and community mobilization; Ensuring equity for access to service; supply chain management; and ownership and sustainability (Table). The CSTWG with FMOH's leadership will be responsible to mobilize the finance with the government pre-defined spending commitment on-top of the current level public expenditure on the health system structure

Table: Cost of iCCM program implementation by category; August 2017-July 2022

Cost by category	
Monitoring and Evaluation and Quality improvement and maintenance	608,655,185.00
Demand generation and community mobilization	232,722,000.00
Supply Chain Management	577,200,000.00
Equity	4,500,000.00
Ownership and Sustainability	447,120,000.00
Total	1,870,197,185.00

	Cost line by Objective	*Total Cost (ETB)*	*Total Cost (USD)*	*Year I*	*Year II*	*Year III*	*Year IV*	*Year V*
Objective-I	*Merger and revision of iCCM/ CBNC training facilitator guidelines, exercise booklets, chart booklets, job aids and video demonstrations*	*111,400.00*	*4,790.20*	*111,400.00*				
	ToT for 321 RHB, ZHD and TVET trainers with the revised iCCM training for 5 days	*1,693,285.00*	*72,811.26*	*1,693,285.00*				
	Pre-deployment/gap filling Training for new 5000 HEWs on the revised iCCM training	*15,680,000.00*	*674,240.00*	*3,136,000.00*	*3,136,000.00*	*3,136,000.00*	*3,136,000.00*	*3,136,000.00*
	A 3-day training of 7600 HC and Primary Hospitals Health workers on the revised iCCM training	*19,507,200.00*	*838,809.60*	*13,004,800.00*	*6,502,400.00*			
	Regular revision of case management protocols for HPs, HCs and Primary Hospitals	*222,800.00*	*9,580.40*		*111,400.00*		*111,400.00*	
	Program Specific supportive supervision to HPs and PHCUs (Monthly logistic support)	*273,600,000.00*	*11,764,800.00*	*54,720,000.00*	*54,720,000.00*	*54,720,000.00*	*54,720,000.00*	*54,720,000.00*
	Woreda Joint Monitoring visits (JMV)	*48,000,000.00*	*2,064,000.00*	*9,600,000.00*	*9,600,000.00*	*9,600,000.00*	*9,600,000.00*	*9,600,000.00*
	Zonal/Regional quarterly JMV	*568,000.00*	*24,424.00*	*113,600.00*	*113,600.00*	*113,600.00*	*113,600.00*	*113,600.00*
	National Bi-annual JMV	*896,000.00*	*38,528.00*					
	PHCU level IPRM (uses exisiting PHCU level meeting-No cost involved)	-	-					
	Woreda level Quarterly IPRM with 3800 HWs, 16,447 HEWs and 1600 WoHO staffs)	*177,882,000.00*	*7,648,926.00*	*35,576,400.00*	*35,576,400.00*	*35,576,400.00*	*35,576,400.00*	*35,576,400.00*

	Cost line by Objective	Total Cost (ETB)	Total Cost (USD)	Year I	Year II	Year III	Year IV	Year V
Objective-I	Zonal/Regional level Program Review (75 Zones and 8 regions to participate)	2,442,000.00	105,006.00	488,400.00	488,400.00	488,400.00	488,400.00	488,400.00
	National level Annual Program review (50 participants)	302,500.00	13,007.50	60,500.00	60,500.00	60,500.00	60,500.00	60,500.00
	Controlled testing and scaling up of 'Inclusion of iCCM components on mHealth'	2,000,000.00	86,000.00		2,000,000.00			
	Controlled testing and scale up of Acute Respiratory Illnesses Diagnostic Aid (ARIDA)	6,000,000.00	258,000.00			3,000,000.00	3,000,000.00	
	Adaptation of emerging technologies for quality improvement	5,000,000.00	215,000.00	-	2,500,000.00		2,500,000.00	
	Documentation and scaling up of localized best quality improvement practices	5,000,000.00	215,000.00	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00
	Subtotal	558,905,185.00	24,032,922.96	119,504,385.00	115,808,700.00	107,694,900.00	110,306,300.00	104,694,900.00

	One day Advocacy and sensitization workshop on care seeking, availability of services, performance monitoring and accountability on Child Health and leveraging political commitment at all levels (800 Woreda, 75 Zonal, 8 regional and 1 national=884 sessions)	7,502,200.00	322,594.60	7,502,200.00				
Objective II	Support transportation and distribution of FHG and speaking books twice for one to five networks	212,519,000.00	9,138,317.00		106,259,500.00		106,259,500.00	
	Quantification, Procurement and Distribution of backpacks for HEWs	12,700,800.00	546,134.40	12,700,800.00				
	Subtotal	232,722,000.00	10,007,046.00	20,203,000.00	106,259,500.00	-	106,259,500.00	-
	Controlled testing and scale up of Acute Respiratory Illnesses Diagnostic Aid (ARIDA)	6,000,000.00	258,000.00			3,000,000.00	3,000,000.00	
	Adaptation of emerging technologies for quality improvement	5,000,000.00	215,000.00	-	2,500,000.00		2,500,000.00	
	Documentation and scaling up of localized best quality improvement practices	5,000,000.00	215,000.00	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00	1,000,000.00
	Subtotal	558,905,185.00	24,032,922.96	119,504,385.00	115,808,700.00	107,694,900.00	110,306,300.00	104,694,900.00

	Revision of iCCM/CBNC prevalence data for estimation of supply quantity	*200,000.00*	*8,600.00*	*100,000.00*	*100,000.00*			
Objective III	*Quantification and costing of iCCM/CBNC supplies using updated estimates*	*2,000,000.00*	*86,000.00*	*1,000,000.00*	*1,000,000.00*			
	Procurement of quantified iCCM/CBNC supplies	*575,000,000.00*	*24,725,000.00*	*115,000,000.00*	*115,000,000.00*	*115,000,000.00*	*115,000,000.00*	*115,000,000.00*
	Subtotal	*577,200,000.0*	*24,819,600.0*	*116,100,000.0*	*116,100,000.0*	*115,000,000.0*	*115,000,000.0*	*115,000,000.0*
	Controlled testing and scale up of Acute Respiratory Illnesses Diagnostic Aid (ARIDA)	*6,000,000.00*	*258,000.00*			*3,000,000.00*	*3,000,000.00*	
	Adaptation of emerging technologies for quality improvement	*5,000,000.00*	*215,000.00*	-	*2,500,000.00*		*2,500,000.00*	
	Documentation and scaling up of localized best quality improvement practices	*5,000,000.00*	*215,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*
	Subtotal	*558,905,185.00*	*24,032,922.96*	*119,504,385.00*	*115,808,700.00*	*107,694,900.00*	*110,306,300.00*	*104,694,900.00*

Objective IV	*Concept note development for iCCM service Equity-mapping, Barrier analysis and setting-up expansion plan*	*500,000.0*	*21,500.00*	*500,000.00*				
	Adopt a model for contextualized introduction and implementation of iCCM to unreached communities	*1,000,000.0*	*43,000.00*	*1,000,000.00*				
	Costing of Program Scale-up and interventions	*1,000,000.0*	*43,000.00*	*1,000,000.00*				
	Partners Mapping in the unreached communities/ areas	*1,000,000.0*	*43,000.00*	*1,000,000.00*				
	Resource Mobilization for scaling up iCCM to unreached communities	*1,000,000.0*	*43,000.00*	*1,000,000.00*				
	Subtotal	*4,500,000.0*	*193,500.0*	*4,500,000.0*	*0.0*	*0.0*	*0.0*	*0.0*
	Documentation and scaling up of localized best quality improvement practices	*5,000,000.00*	*215,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*	*1,000,000.00*
	Subtotal	*558,905,185.00*	*24,032,922.96*	*119,504,385.00*	*115,808,700.00*	*107,694,900.00*	*110,306,300.00*	*104,694,900.00*

Objective V	Midterm Program Evaluation	44,000,000.00	1,892,000.00		44,000,000.00			
	Operations research	5,750,000.00	247,250.00	1,150,000.00	1,150,000.00	1,150,000.00	1,150,000.00	1,150,000.00
	Subtotal	49,750,000.00	2,139,250.00	1,150,000.00	45,150,000.00	1,150,000.00	1,150,000.00	1,150,000.00
	Subtotal	577,200,000.0	24,819,600.0	116,100,000.0	116,100,000.0	115,000,000.0	115,000,000.0	115,000,000.0

	TA assignment	447,120,000.00	19,226,160.00	89,424,000.00	89,424,000.00	89,424,000.00	89,424,000.00	89,424,000.00	
Objective VI				-	-				
				-	-				
	Subtotal	447,120,000.00	19,226,160.00	89,424,000.00	89,424,000.00	89,424,000.00	89,424,000.00	89,424,000.00	
	Subtotals		1,870,197,185.00	80,418,478.96	350,881,385.00	472,742,200.00	313,268,900.00	422,139,800.00	310,268,900.00

Annex

Cost

M and E framework

SS checklist

PRCCM guide

Line #	Entity	Description	Indicator	Numerator and Denominator	Data source	Means of Data collection	Frequency	Critical Assumptions
Impact indicators/Mortality								
1	**Maternal, Newborn and Child Mortality**	Underfive mortality rate	Point reduction of underfive mortality rate from baseline	**Numerator:** Total number of deaths of children under the age of five years **Denominator:** Total Number of Live Birhts	EDHS 2016 for baseline EDHS 2021 for endline	The level reduction of under-five mortality reduction will be computed from endline against baseline	Once- Year V	EDHS 2021 report will be available timely
2		Infant Mortality mortality rate	Point reduction of Infant mortality rate from baseline	**Numerator:** Total number of deaths of infants under the age of one year **Denominator:** Total Number of Live Birhts	EDHS 2016 for baseline EDHS 2021 for endline	The level reduction of under-five mortality reduction will be computed from endline against baseline	Once- Year V	EDHS 2021 report will be available timely
3		Neonatal mortality rate	Point reduction of Neonatal mortality rate from baseline	**Numerator:** Total number of deaths of newborns within 28 days after birth **Denominator:** Total Number of Live Birhts	EDHS 2016 for baseline EDHS 2021 for endline	The level reduction of under-five mortality reduction will be computed from endline against baseline	Once- Year V	EDHS 2021 report will be available timely
4		Maternal mortality ratio	Point reduction of Maternal mortality ratio from baseline	**Numerator:** Total number of deaths of women due to pregnancy, child birth and related factors **Denominator:** Total Number of Live Birhts	EDHS 2016 for baseline EDHS 2021 for endline	The level reduction of under-five mortality reduction will be computed from endline against baseline	Once- Year V	EDHS 2021 report will be available timely
Objective I: Improve quality of iCCM-CBNC services through MNCH Continuum of Care quality improvement approach at PHCU level								
1	Training guides	Revision and integration of iCCM training guides, mannuals and tools	iCCM and CBNC training Mannuals Revised and integrated	NA	Availability of Revised and integrated training Mannuals	Desk review of the training mannuals	Once in the first quarter	The reference document will be the revised and integrated training mannuals and guides
2	Incorporation of iCCM training with HEW Pre-service training package	Revision of iCCM/IMNCI training pakcages incorporated with HEW Pre-service training package	iCCM training fully incorporated on HEW level X pre-service training caricullum	NA	Level X HEW trainining module	Desk review of the training modules and curriculum	First Quarter of Year 4	Inter-directorate effort and engaging TVETs and RHBs will be crucial success factors
3		Training of 321 Trainers for RHB, ZHD and TVET staffs/tutors on revised iCCM ToT	Proportion of RHB, ZHD and TVET trainers trained on revised iCCM ToT	Numerator: Total number of trainers trained on revised iCCM ToT Denominator: Total numbers of trainers targeted on revised iCCM ToT	Training database (Form A1) for the numerator. Targeted number of trainees from database	Regional and Zonal iCCM TA to compile training data and update database		Regional and Zonal TA to be deployed in all regions and zones and will lead program activities and collect and compile data
4		Predeployment/Gap-filling Training of 5000 HEWs on the revised iCCM/IMNCI training	Proportion of targeted HEWs trained on the revised basic iCCM training through predeployment/gap filling training	Numerator: Total number of HEWs trained on revised basic training on iCCM. Denominator: Total number of new HEWs graduates	Training database (Form A1) for the numerator. Mapping of new graduate HEWs (TVET, RHB, WoHO)	RHBs to track new HEW graduates. TA to lead task	Yearly	Regional and Zonal TA to be deployed in all regions and zones and will lead program activities and collect and compile data
5	iCCM training	iCCM training coverage by HP	Percentage of HPs with all HEWs trained on basic iCCM training	Numerator: Total number of HPs with all HEWs trained on basic iCCM trainings	Training database (Form A1) for the numerator. HMIS for total number of HPs Baseline and Endline Surveys	Regional and Zonal TA will compile training data after completion of each training session; which will be aggregated centrally. Training coverage by HP will be part of program surveys	Quarterly Year I and Year VI for surveys	HMIS will update the total number of HEWs and HPs Baseline and Endline surveys will be conducted
6		Woreda Technical Personnel trained	Proportions of woredas with at least 1 staff who is trained on iCCM/IMNCI	**Numerator:** Number of woredas with at least one staff who is trained on CBNC **Denominator:** Total number of CBNC implementing woredas	Training database (Form A2) for the numerators	TA to compile training data after completion of each training .	Annual	This assumes that program woredas have iCCM /IMNCI trained staff that can be trained on CBNC as this is a prerequisite for CBNC training.
7	Quality of iCCM training maintained	Hands-On clinical mentorship provided to HEWs with adequate exposure to sick cases at HCs	Proportion of trainings having practical sessions at HCs with exposure to at least 10 VSD and PSBI cases	**Numerator:** Total number of training sessions having practical attachements at HCs with exposure to at least 10 VSD and PSBI **number of basic iCCM training sessions**	Training database (Form A2) for the numerators Training database (Form A2) for the denominator	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	All new basic iCCM trainings will have practical attachements to HCs Training database to capture number of cases seen during clinical sessions at HCs
8		Number of Facilitator to Trainee ration maintained at 1 to 5	Proportion of basic HEW iCCM trainings with facilitator to trainee ration maintained and used at least to 1 to 5	**Numerator:** Total number of training sessions with basic HEW iCCM trainings with facilitator to trainee ration maintained and used at least to 1 to 5 **Denominator: total number of basic iCCM**	Training database (Form A2) for the numerators Training database (Form A2) for the denominator	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	Training database to capture facilitator to trainee ration Regional and Zonal TA will be assigned

				training sessions				
9	Health Worker Training and Orientation	Orientation of 7,600 Health Workers from Health Centres and Primary hospitals on the revised iCCM/CBN training for 3 days	Proportion of targeted HWs trained on revised iCCM /CBNC training	**Numerator:** Total number of HWs oriented on revised iCCM /CBNC training	Training database (Form A2) for the numerators	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	Target denominator will be updated from HMIS Regional and Zonal TA will be assigned
				Denominator: total number of HWs targeted for iCCM /CBNC revised	HMIS and target (7600) for the denominator			
10		Training of 7,600 Health Workers from Health Centres and Primary hospitals on revised IMNCI and supportive supervision skill training	Proportion of targeted HWs trained on revised IMNCI and supportive supervision skill training	**Numerator:** Total number of HWs trained on revised IMNCI and supportive supervision skill training	Training database (Form A2) for the numerators	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	Target denominator will be updated from HMIS Regional and Zonal TA will be assigned IMNCI protocol and training package will be
				Denominator: total number of HWs targeted for revised IMNCI and supportive supervision skill	HMIS and target (7600) for the denominator			
11		IMNCI and Supportive Supervision skill training coverage by HCs	Percentage of HCs with at least two staff trained on revised IMNCI and Supportive Supervision skill training	training Total number of HCs with at least two staff trained on revised IMNCI and Supportive Supervision skill training	Training database (Form A2) for the numerators	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	subject to at least two Target denominator will be updated from HMIS Regional and Zonal TA will be assigned Regional and Zonal TA to regularly map and assess IMNCI training need
				Denominator: Total number of HCs in the catchment area.	HMIS and target (3586) for the denominator			
12		IMNCI and Supportive Supervision skill training coverage by Primary Hospital	Percentage of Primary Hospital with at least two staff trained on revised IMNCI and Supportive Supervision skill training	**Numerator:** Total number of Primary Hospital with at least two staff trained on revised IMNCI and Supportive Supervision skill training	Training database (Form A2) for the numerators	RHB and ZHD TA will compile training data after completion of each training session; which will be aggregated centrally.	Quarterly	Target denominator will be updated from HMIS Regional and Zonal TA will be assigned Regional and Zonal TA to regularly map and assess IMNCI training need
				Denominator: Total number of Primary Hospita in the catchment area.	HMIS and target (224) for the denominator			
13	Program-specific Supportive Supervision	HPs reached with start up follow up after basic iCCM training	Percentage of HPs with newly trained HEWs reached for post training follow up visit with in 4-6 weeks of iCCM training	**Numerator: Total number of HPs with newly trained HEWs reached for post training follow up visit with in 4-6 weeks of iCCM training**	Supportive Supervision data. Completed Form C (Supportive Supervision) checklist	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	once after basic training	Post training follow ups to HPs will be conducted by HCs with the support from WoHO and Partners
				Denominator: Total number of HPs in the catchment area.	Training database for newly trained HEWs (Denominator)			
14		HCs reached with start up follow up after basic iCCM training	Percentage of HCs with a post training follow up visit with in 4-6 weeks of IMNCI/CBNC training	**Numerator:** Total number of HCs with a post training follow up visit with in 4-6 weeks of IMNCI/CBNC training	Supportive Supervision data. Completed Form G (Supportive Supervision) checklist	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	once after basic training	Post training follow ups to HCs will be conducted by WoHO with the support from ZHDs and Partners
				Denominator: Total number of HCs in the catchment area with new IMNCI trained health worker	Training database for newly trained HWs (Denominator)			
15		HPs receiving regular program-specific supportive supervision	Percentage of HPs reached with a program-specific regular Supportive Supervsion	**Numerator:** Total number of HPs reached with a program-specific regular Supportive Supervsion	Supportive Supervision data. Completed Form C (Supportive Supervision) checklist	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	Monthly	The program specific SS will be conducted by HCs with a support from partners. (partners will involve in at least 10% of the visits) One HP will be visited monthly with program specific checkist
				Denominator: Total number of HPs in the catchment area.	HMIS for total number of HPs (denominator)			
16		HCs receiving regular program-specific supportive supervision	Percentage of HCs reached with a program-specific regular Supportive Supervsion	**Numerator:** Total number of HCs reached with a program-specific regular Supportive Supervsion	Supportive Supervision data. Completed Form G (Supportive Supervision) checklist.	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	Monthly	The program specific SS will be conducted by WoHO with a support from partners (partners will involve in at least 20% of the visits). One HC will be visited monthly with program specific checkist
				Denominator: Total number of HCs in the catchment area.	HMIS for total number of HCs (denominator)			
17		PHCUs supervised and monitored through Zonal Joint Monitoring visits (JMVs)	Percentage of PHCUs reached through Zonal JMV by a team of supervisors consisting of ZHD TA, WoHO and partner staffs	**Numerator:** Total number of PHCUs reached through Zonal JMV by a team of supervisors consisting of ZHD TA, WoHO and partner staffs	Supportive Supervision (JMV) data. Completed Form G and database Targeted PHCUs (10% of PHCUs in a Woreda)	Zonal TA and WoHO will coordinate the JMVs and compile data	Quarterly	A team of ZHD TA, WoHO and partner staff will conduct a quarterly JMV to selected 10% PHCUs in a woreda
				Denominator: Total number of targeted PHCUs				
18		PHCUs supervised and monitored through regional Joint Monitoring visits (JMVs)	Percentage of PHCUs reached through regional JMV by a team of supervisors consisting of RHB and ZHD TA and partner staffs	**Numerator:** Total number of PHCUs reached through regional JMV by a team of supervisors consisting of ZHD TA, WoHO and partner staffs	Supportive Supervision (JMV) data. Completed Form G and database	Regional and Zonal TA will coordinate the JMVs and compile data	Quarterly	A team of RHB and ZHD TA and partner staff will conduct a quarterly regional JMV to targeted 6 PHCUs from 2 woredas of 2 different zones every

				Denominator: Total number of targeted PHCUs	Targeted PHCUs			quarter
19		PHCUs supervised and monitored through national Joint Monitoring visits (JMVs)	Percentage of PHCUs reached through national JMV by a team of supervisors from national CSTWG	**Numerator:** Total number of PHCUs reached through JMV by a team of supervisors from national CSTWG	Supportive Supervision (JMV) data. Completed Form G and database	CSTWG and Regional/Zonal TA will coordinate the JMVs and compile data	Bi-annually	A team from the national CSTWG will conduct JMV to 8 PHCUs from four regions-four zones-four woredas bi-annually
				Denominator: Total number of targeted PHCUs	Targeted PHCUs			
20	Integrated Supportive Supervisions (ISS)	Integrated Supportive Supervision (ISS) done to HPs	Percentage of HPs reached by PHCUs with ISS	**Numerator:** Total number of HPs reached by PHCUs with ISS	Routine Monitoring data/HMIS and Form C	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	Monthly	Every HP will be reached for ISS by PHCUs every month
				Denominator: Total number of HPs in the catchment area.	HMIS for total number of HPs (denominator)			
21		Integrated Supportive Supervision (ISS) done to PHCUs	Percentage of PHCUs reached by WoHO and Primary Hospitals for ISS	**Numerator:** Total number of PHCUs reached by WoHO and Primary Hospitals for ISS	Routine Monitoring data/HMIS and Supportive Supervision data. Completed Form G (Supportive Supervision) checklist.	Regional and Zonal TA will tally conducted SS, conduct data entry of complete forms.	Monthly	Every PHCU will be reached for ISS by WoHO and Primary hospital every month
				Denominator: Total	HMIS for total number of			
22	Integrated Program Review and Mentoring Meetings (IPRMs)	Monthly PCHU-based Integrated Program Review and Mentoring Meetings (IPRMs) by HCs and satellite HPs	Percentage of PCHU-based IPRMs	**Numerator:** Total number of PHCU-Based IPRMs	IPRM report and database	Zonal TA and WoHO to complie IPRM data	Monthly	Monthly IPRMs will take place at catchment HCs IPRM database and tool will be used
				Denominator: Total number of PHCUs in the catchment area.	HMIS			
23		Quarterly Woreda-based Integrated Program Review and Mentoring Meetings (IPRMs) with WoHO and PHCUs	Percentage of Woreda-based IPRMs	**Numerator:** Total number of Woreda-Based IPRMs	IPRM report and database	Zonal TA and WoHO to complie IPRM data	Quarterly	Quarterly IPRMs will take place respecive woredas involving all PHCUs IPRM database and tool will be used
				Denominator: Total number of planned Woreda-based IPRMs	Target			
24		Quarterly Zonal level Program Review Meetings with ZHD, Woredas and PHCUs	Percentage of Zonal level Program review meetings	**Numerator:** Total number of Zonal level Program review meetings	Program review meeting report	Zonal/Regional TA to complie data	Quarterly	Quarterly program review meeting will take place in respecive zones with ZHD, WoHOs and PHCUs IPRM database and tool will be used
				Denominator: Total number of planned Zonal level meetings	Target			
25		Bi-annual regional level Program Review Meetings withRHB, ZHDs, Woredas and PHCUs	Percentage of Regional level program review meetings conducted	**Numerator:** Total number of regional level Program review meetings	Program review meeting report	Regional TA to complie IPRM data	Bi-annually	Bi-annually regional program review meeting will take place in respecive regions with RHB, ZHD, WoHOs and PHCUs IPRM database and tool will be used
				Denominator: Total number of planned regional level meetings	Target			
26		Annual National level Program Review Meetings with FMOH, RHB, ZHDs, Woredas and PHCUs	Percentage of National level program review meetings conducted	**Numerator:** Total number of National level Program review meetings	Program review meeting report	CSTWG to complie IPRM data	Annual	Annual program review meeting will be organized through the CSTWG
				Denominator: Total number of planned regional level meetings	Target			
27		HPs participating in IPRMs	Percentage of HPs attending PHCU-based IPRMs	**Numerator:** Total number of HPs participating PHCU-Based IPRMs	IPRM report and database	Zonal TA and WoHO to complie IPRM data	Monthly	all HPs to participate in monthly PHCU-based IPRMs
				Denominator: Total number of HPs in the catchment area.	HMIS			
28		PHCUs participating in IPRMs	Percentage of PHCUs attending woreda-based IPRMs	**Numerator:** Total number of PHCUs participating woreda-based IPRMs	IPRM report and database	Zonal TA and WoHO to complie IPRM data	Quarterly	all PHCUs to participate in quarterly woreda-based IPRMs
				Denominator: Total number of PHCUs in the catchment area.	HMIS			
29	Supply Chain	iCCM/IMNCI/MNCH Stock	Proportion of HP supervised with stock out ofiCCM/IMNCI/MNCH supplies	**Numerator:** Total number of HPs supervised in the catchment area with stock out of iCCM/IMNCI/MNCH	Form C	Form C is completed by TA and IP during HP visits.	Quarterly	Data is computed from supervised HCs/HPs.
				Denominator: Total number of HPs supervised in the catchment area	HMIS, Surveys			
30		IMNCI Stock	Proportion of HC supervised with stock out of IMNCI/CBNC supplies	**Numerator: Total number of HCs supervised in the catchment area with stock out of iCCM supplies**	Form G	Form G is completed by partners, project staffs during HC visits.	Quarterly	Data is computed from supervised HCs/HPs.
				Denominator: Total number of HCs supervised in the catchment area	HMIS/Surveys			
31	Quality of Case Management		Proportion of sick cases of children under the age of five years correctly-classified for Pneumonia by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-classified for Pneumonia	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done

				Denominator: Total number of children assessed for Pneumonia				
32			Proportion of sick cases of children under the age of five years correctly-classified for Diarrhea by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-classified for Diarrhea **Denominator:** Total number of children assessed for Diarrhea	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
33		iCCM case classification by HEWs	Proportion of sick cases of children under the age of five years correctly-classified for Malaria by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-classified for Malaria **Denominator:** Total number of children assessed for Malaria	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
34			Proportion of sick cases of children under the age of five years correctly-classified for SAM by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-classified for SAM **Denominator:** Total number of children assessed for SAM	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
35			Percent of identified sick newborns correctly-classified for VSD by HEWs	**Numerator:** Total number of sick newborns correctly-classified. For VSD **Denominator:** Total number of identified sick newborns.	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
36			Percent of identified sick young infants correctly-classified for PSBI by HEWs	**Numerator:** Total number of sick young infants correctly-classified for PSBI **Denominator:** Total number of identified sick young infants.	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done

37		iCCM case management	Proportion of sick cases of children under the age of five years correctly-Managed for Pneumonia by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-managed for Pneumonia **Denominator:** Total number of children classified for Penumonia	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
38			Proportion of sick cases of children under the age of five years correctly-Managed for Malaria by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-managed for Malaria **Denominator:** Total number of children classified for Malaria	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
39			Proportion of sick cases of children under the age of five years correctly-Managed for Diarrhea by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-managed for Diarrhea **Denominator:** Total number of children classified for Diarrhea	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
40			Proportion of sick cases of children under the age of five years correctly-Managed for SAM by HEWs	**Numerator:** Total number of sick cases of children under the age of five years correctly-managed for SAM **Denominator:** Total number of children classified for SAM	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
41			Percent of sick newborns correctly managed by HEWs	**Numerator**: Total number of classified sick newborns who are managed correctly **Denominator:** Total number of classified sick newborns by HEWs	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
42			Proportion of VSD cases who received adequate /complete treatment at a facility	**Numerator:** Total number of newborns classified by HEW/HW as having VSD who received adequate/complete antibiotic treatment **Denominator:** Total number of newborns classified by HEW as having VSD	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done

				Denominator: Total number of newborns classified by HEW as having VSD				
43			Proportion of treated VSD cases whose treatment outcome has improved	**Numerator:** Total number of newborns sepsis cases whose treatment outcome has improved in a given catchment area in a given period of time.	Form C, G, RSS tool/IPRM Surveys and operation researches	Form C/G is completed by partners, TA during facility visits. CSTWG	Quarterly Year I, III and V	Data is computed from supervised facilities and recent cases. Midterm and Endline assessments will be done
				Denominator: Total number of VSD cases who are treated at health post.				
44	Maternal Health		Proportion of pregnant women who received at least one ANC by HWs	**Numerator:** Number of pregnant women that received at least one ANC by HW (at HC) in the	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal persons.	Quarterly	
				Denominator: Total number of expected pregnancies in a catchment area.				
45			Proportion of pregnant women who received at least one ANC by HEWs	**Numerator:** Number of pregnant women that received at least one ANC by HEWs in the catchment area.	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal persons.	Quarterly	
				Denominator: Total number of expected pregnancies in the catchment area.				
46			Proportion of women who attended 4+ ANC during their most recent pregnancy	**Numerator:** Number of women who delivered in the last six month period who attended 4+ ANC visits with a skilled provider	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal persons.	Quarterly	
				Denominator: Total number of women surveyed who had a live birth in the catchment area.				
47			Proportion Births attended by (facility-based) HWs	**Numerator:** Total number of deliveries attended by (facility-based) HWs	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal persons.	Quarterly	
48			Percent of mothers who received early (within 48 hours) postnatal home visits by HEWs and HDAs.	**Numerator:** Total number of newborns who received an early (within 48 hours) PNC home visit by HEW in	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal	Quarterly	
			visits by HEWs and HDAs.	PNC home visit by HEW in the catchment area.		woreda HMIS focal persons.		
				Denominator: Total number of expected live births in a given catchment area.				
49			Percent of mothers who received PNC in 7 days	**Numerator:** Total number of mothers who received PNC visit in 7 days in the catchment area.	HMIS	HMIS summary form is will be completed by partners on a quarterly basis from woreda HMIS focal persons.	Quarterly	
				Denominator: Total number of expected live births in a given catchment area.				
	Referral							
Objective II: Intensify demand generation for iCCM and increase the level of service utilization								
1			Proportion of Households which knows the availability of iCCM service at HP	Numerator: Number of Households which knows availability of iCCM service	Midterm and Endline surveys	Midterm and endline surveys will be conducted	Year III and V	
				Denominator: Total Number of Households				
			PNC coverage within the first 48 hours after delivery	**Numerator**: Number of PNC visit within the first 48 hours after delivery	EDHS Midterm and Endline Surveys	EDHS 2021 will be used Midterm and endline surveys will be conducted	Year III and V	
				Denominator: Total Number of births				
		Household knowledge and practice	Proportion of mothers who correctly identify newborn and sick younf infant danger signs	**Numerator**: Number of mothers who correctly identify newborn and sick young infant danger signs	Midterm and Endline Surveys	Midterm and endline surveys will be conducted	Year III and V	
				Denominator: Total Number of households				
			Proportion of mothers who correctly identify Child	**Numerator**: Number of mothers who correctly	Midterm and Endline Surveys	Midterm and endline surveys will be conducted	Year III and V	

			infants from HP and Health facility	infants from HP and Health facility				
				Denominator: Total Number of households with sick newborns and young infants				
	Adequate and Sustainable Availability of Child Health (ICCM) Commodities at Appropriate Levels of Care (Health Post)	Increased sustained availability of Zinc 10mg at appropriate levels of care	Percentage of HPs with Zinc 10mg in- stock on the day of the visit		Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Increased sustained availability of paracetamol at appropriate levels of care	Percentage of HPs with Zinc paracetamol in- stock on the day of the visit	**Numerator**:Total number of HPs with paracetamol in stock	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Increased sustained availability of gentamycin 85mg/ml ampules at appropriate levels of care	Percentage of HPs with Zinc gentamycin 85mg/ml in- stock on the day of the visit	**Numerator:**Total number of HPs with gentamycin 85mg/ml in stock	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Increased sustained availability of gentamycin 20 mg/ml ampules at appropriate levels of care	Percentage of HPs with Zinc gentamycin 20 mg/ml in- stock on the day of the visit	**Numerator:**Total number of HPs with gentamycin 20 mg/ml in stock	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Conducted quantification exercise to incorporate ICCM Commodities	Percentage of quantification exercises conducted at PFSA and FMoH levels	Numerator: Number of quantification exercises conducted incorporating iCCM Commodities	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of Planned quantifications				
	Improving and Maintaining Functional Supply Chain Management System for iCCM Commodities	Functional SCM system in place to sustainably deliver essential child commodities	Percentage of HPs submitting HPMRR every month to the respective HC	**Numerator:** Total Number of HPs submitting HPMRR every month to the respective HC	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Revised and comprehensive iCCM SCM tools (HPMRR, iCCM guideline) in place	Percentage of HPs with updated bin-card for ICCM Commodities on the day of visit	Numerator:Total number of HPs with updated bin-card for iCCM Commodities	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		Health Facilities with trained/oriented HEWs on SCM/IPLS tools of iCCM commodities	Percentage of HPs with HPMRR forms updated with iCCM/ CBNC commodities on the day of visit	Numerator:Total number of HPs with HPMRR forms updated with iCCM on the day of visit	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
		iCCM handbooks and developed job aids are available in HPs	Percentage of HPs with trained HEWs on IPLS Tools (Bin Card, HPMRR, Product Handling)	**Numerator:**Total number of HPs with trained HEWs on SCM/IPLS Tools (Bin Card, HPMRR, Product Handling)	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HPs				
			Percentage of HCs with iCCM handbooks and job aids on the day of visit	**Numerator:**Total number of HCs with functional DTC	Supportive supervision database Surveys	Supportive Supervisions will sufficiently address stock levels of iCCM drugs Midterm and Endline surveys to examine the supply chain	Quarter Year III and Year V	
				Denominator: Total Number of HCs				
	Regular Technical Support and M&E on iCCM Commodities		Supportive supervisions (SS) conducted					
			Bi-annual performance review meetings conducted					
Objective IV: Ensure equitable and continuous access to and availability of iCCM and CBNC services to unreached communities								
		Equity mapping and barrier analysis	Equity mapping and barrier analysis report developed			Assessment/Survey	Q-2 of year I	
		iCCM program scaled-up to unreached communities	National iCCM and CBNC program coverage			HMIS and program database	Quarterly	
Objective V: Enhance the efficiency and effectiveness of the Monitoring, Evaluation and Learning system at all levels								
Objective VI: Foster sustainability and ownership of iCCM programs along the public health system with accountability								
		Inclusion of all key iCCM indicators on HMIS	All key iCCM indicators are included on HMIS		NA	HMIS	Wth the revision timeline of HMIS	
		Inclusion of all key iCCM indicators on Woreda base plan	% of Woredas with iCCM indicators on their Woreda base plan		Numerator: Number of WoHOs with iCCM indicators on their woreda base plans		Wth the revision timeline of HMIS	
			All key iCCM indicators are included on HMIS		NA	HMIS		
		Inclusion of all key iCCM indicators on annual, quarter and monthly plans	% of WoHOs with iCCM indicators on their annual/quarter/monthly plan		Numerator: Number of WoHOs with iCCM indicators on their plans Denominator: Total Number of WoHOs			
			% of PHCUs with iCCM indicators on their annual/quarter/monthly		Numerator: Number of PHCUs with iCCM indicators on their plans Denominator: Total Number of WoHOs			

Support Woreda-Base Health sector planning	% of Woreda base health sector planning supported by Child Health Expert	Numerator: Number of Woreda base health sector planning supported by Child health expert Denominator: Total Number of Woreda base planning	Program data		Annual	
iCCM indicators used in RMNCH score card for performance monitoring and accountability	% of WoHOs using iCCM indicators on RMNCH score card	Numerator: Number of WoHOs using iCCM indicators on RMNCH score card Denominator: Total Number of WoHOs				
Sector-led review meetings that address iCCM program performance	Number of National Review meeting with iCCM addressed	NA	Program data		Program database	
	Number of Regional Review meeting with iCCM addressed	NA		1 National		
	Number of Woreda Review meeting with iCCM addressed	NA		8 Regional		
	Number of PHCU Review meeting with iCCM addressed	NA		75 Zonal 3600 PHCU Program		
Assignment of Zonal and Regional TAs	Number of Regional and Zonal TA s assigned			Reviews 8 regional and 75 zonal TA s will be assigned		
Public Spending on iCCM				800 Woreda		

ICCM\CBNC FOLLOW-UP CHECKLIST: HEALTH POST (HP)

I	**Background Information**
1.1	Date: ___ ___ / ___ / _ __ ___ (use Ethiopian calendar) DM M Y YYY
1.2	Region: ___ ___ ___ Zone: ___ ____Woreda: ___ _____Supervising HC _____ HP Name : ___ ___ ____ # HEWs____ ICCM/CBNC trained___
1.3	Was Direct Case Observation made? Yes__ No _____ Total number of sick U5 observed: ____; Number of Sick Children (2 -59 months)___ Number of Sick Young Infant (0 up to 2 months)__ *(if you get sick children during your visit do direct case observation while the HEWs assess and treat)*
1.4	# of sick children reviewed (2-59 months): __ __# of Young Infant reviewed (0-2 months): __ __
1.5	Kebele Population:__ __ __ # <5 years _____# of newborns_____

II **HEW Quality reviews:** 2 most recent cases for each classification from registration book (completeness & consistency)

		Agreement between case management tasks				Treatment outcome					Check		
		# Seen	Assess & Classify # Agree	Classify & Treat # Agree	Classify & Follow # Agree	Improved	Same	Worsened	Died	Visit done before FUD	Immunization for Age	Vitamin A	Deworming
	Age below 2 months (YI)												
2.1	Very severe disease referred to HC												
2.2	Very sever disease treated at HP												
2.3	Pre-term /LBW												
2.4	Local bacterial infection												
2.5	Feeding problem /Underweight												
	Age between 2 - 59 months (SC)												
2.6	Severe pneumonia or Very												
2.7	Pneumonia												
2.8	Malaria												
2.9	Very severe febrile diseases /Complicated measles												
2.10	Diarrhoea :No/some dehydration												
2.11	Severe dehydration/ Dysentery /persistent/												
2.12	Sever complicated malnutrition												

2.13	Severe uncomplicated malnutrition												
III	**Community mobilization and outreach service**												
3.1	How many H.D.A. members exist in the kebele?												
3.2	Are they Mobilizing families to seek ICCM/CBNC services? Verify by looking at minute for discussion about the issue	1. Yes 2. No											
3.3	Do you have Pregnancy registration book?	1. Available and using it 2. Available but not using it 3. Not available											
3.4	Does the HC notify birth to HP using birth notification (check for documentation of birth notification card)												
3.5	Do WDAs notify birth to the HP using birth notification card (check for documentation of birth notification card)												
3.6	Do the WDAs identify & link newborn/child for iCCM/CBNC service												
3.7	Do the HEWs provide outreach iCCM/CBNC service during home visit	1. Yes 2. No											
IV	**Maternal, Newborn and Child performance**												

	Activities	**Performance**		
		Monthly/ Quarterly plan	Monthly/Quarterly achievement	Coverage %
4.1	# pregnant mother identified			
4.2	# mothers who have referred for 1st ANC to HC			
4.3	# mothers who have their 4th ANC at HC			
4.4	# of delivery attended by HWs (HC/HOSP)			
4.5	# of PNC visits within 48 hours of delivery by HEWs			
4.6	# of PNC visits 4 to 7 days			
4.7	# of neonatal sepsis managed			
4.8	# of pneumonia cases in under five children treated			
4.9	# of diarrhea cases in under five children treated			
V	**Family folder**	**1 = Yes 2 = No**		
5.1	Do you regularly using family folder for service all users and patients? Verify			
5.2	Do you regularly tracking service user through tickler filing system? Verify			

VI	**Drugs and supplies, unexpired**								
	Drugs	**Available** Yes=1 No=2	**Out of stock** Yes=1 No=2	Days**		**Drugs**	**Available** Yes=1 No=2	**Out of stock** Yes=1 No=2	Days**
6.1	ORS					6.8	Gentamicin		
6.2	Zinc tablets					6.9	Chlorhexidine		
6.3	ORS/Zinc co					6.10	Examination gloves, carton		
6.4	Coartum tablets					6.11	2 cc syringe and needle		
6.5	Chloroqine syrup,					6.12	RDT reagent, test kits		
6.6	ORT Corner					6.13	Amoxicillin dispersible		
6.7	ORT Corner functional					6.14	(jug, 2 cups, spoon, water)		

** # of days since stocked out
FUD= Follow up date

Modified Performance Review Clinical Mentoring Meeting (PRCMM) guide

Introduction

ICCM/CBNC training is only an entry point to the implementation of the program. ICCM/CBNC is the main clinical service that HEWs are providing. For such program to be successful, giving quality training alone will not be enough; conducting follow up, supportive supervision, performance review and mentoring will be of critical importance. There is a need for simple PRCMM approach that can be easily integrated into the existing health system at PHCU and woreda level. Such approach will ensure ownership and sustainability. Thus this guideline is developed modifying the previous woreda level PRCMM guide version which was indicated as having high cost implication and challenging for sustainability.

Objective

- To review iCCM/CBNC registers from each health post for consistency and completeness
- To review performances of iCCM/CBNC service delivery and demand creation activities
- To mentor the HEWs and participants on the identified skill/knowledge gaps
- To review follow up issues (improvement action points) from the previous CBNC/iCCM supportive supervisions/follow up visits

SECTION 1: General Direction

A productive and effective PRCMM needs good planning and preparation ahead of time. It is envisioned that the PRCMM will take place every quarter (monthly 'if possible'). It should be conducted on a different day from the monthly performance review of the PHCU to give ample time for review of the registers and clinical attachment in the facility. To facilitate the clinical attachment in a cost efficient manner, the meeting should be conducted in the health center.

Duration of the meeting: 1 day

Participants: This modified PRCMM, that aims to improve sense of ownership at Woreda, PHCU level and improve technical skill and knowledge of Health workers and HEWs, should accommodate a number, which is adequately handy.

- Primary Health Care Unit (PHCU) director
- PHCU Health Extension Program (HEP) coordinator,
- IMNCI trained under 5 OPD service providers
- Midwives
- Health extension workers (HEW) from catchment HP who received CBNC & iCCM training and have been working in a health post for at least six months will be eligible. To avoid closure of the HP, it is preferable if the HEWs from a specific HP attend the meeting alternatively.
- HC staffs who are assigned to supervise HP/HEWs
- Other PHCU staff (optional)
- Woreda Health office MCH head (optional),
- If there is a ICCM/CBNC implementing partner, its project officers could support technically

Who is responsible for what?

- The PHCU director oversees the whole process
- The IMNCI focal person in the facility serves as the organizer of the meeting coordinating the activities
- Other IMNCI trained1 health workers would supervise skill practice and review of the registers serving as facilitators. 6-8 HWs/HEWs need one facilitator
- HEWs bring their respective iCCM/CBNC register, service delivery and demand creation performance report for review during the meeting

In advance Preparation

Facilitators need to have a preparatory meeting to become conversant with each process and coach the participants comfortably.

a) **Invitation**

- Check with the relevant people that there are no other competing tasks on the same date and identify a date that works, this day should preferable be a working day with less case load in the facility so that people will have

1 *The 7day course of IMNCI that includes the supervisory skill*

time and there will be opportunities for case observation in the facility

- Using invitation letter or equivalent means of communication from the PHCU invite participants well ahead of time. It is also crucial to check and follow through telephone or any other means of communication to make sure that the message has reached the intended participants or their institutions.
- Ensure that HEWs from selected HPs should come with both iCCM and CBNC registers, integrated pregnancy identification ANC, delivery and PNC registers, chart booklets, iCCM/CBNC service delivery and demand creation report.

b) **Venue**

A large room with chairs and tables is required in which all participants can sit comfortably. Space is also needed for small group exercises/discussions and demonstrations. This venue should be within the premise of the HC.

d) Logistics needed for the CBNC/ iCCM modified PRCMM

Ensure you have all the materials before the beginning of the modified PRCMM. Use the checklist below.

TABLE 1. LOGISTICS CHECKLIST

S.N	Type of Activity	Qty	Responsible
1.	Registration form	1	organizer
2.	Pre-prepared flip chart- presentation on objectives, expected outcomes, and conversion factor calculation	1 per session	organizer
3.	Flip chart and markers	2	organizer
4.	Modified PRCMM guide	1 for each facilitator	organizer
5.	PHCU MNCH plan(copy)	1/PHCU	organizer
6.	Planning format for HEW , PHCU & HPs	2 copies for each participants	Organizer
7.	CBNC/ICCM case management performance (quality of care) assessment Form C	1 for each HP/HC	organizer
8.	IMNCI case management performance (quality of care) assessment Form G	1 for each HP/HC	organizer
9.	IMNCI Chart booklet for HCs	1 per HC	organizer
10.	HC delivery registration book and IMNCI register	2 per HC	organizer
11.	Copy of HC to HP birth notification	For all deliveries	facilitator
12.	ICCM/CBNC Chart booklet for HPs	1 for each participant	Participants
13.	CBNC , sick child and	2 per HPs, 1 per HC	HEWs, HWs
14.	Pregnancy and newborn identification registers	from selected HPs	HEWs
15.	Demand creation and community engagement performance report (community client/case identification and service linkage by WDAs, traditional healers/ TBAs…)	From all HPs	HEWs

Table 2. Meeting Agenda

Time	Activity	Responsible Facilitator
8:00-8:30	**Activity 2.1:** Registration	
8:30-8:40	**Activity 2.2:** Introduction & welcoming speech, presenting the agenda	IMNCI focal person
8:40-8:50	**Activity 2.2:** Opening speech	PHCU Director
8:50-9:05	**Activity 2.3:** Presentation of the objectives, rationale and expected outcomes of the ~~modified~~ PRCCM/mentoring *–Flip chart 1*	IMNCI focal person
9:05-9: 30	**Activity 2.4. Introduction of** CBNC/ICCM and IMNCI case management performance (quality of care) assessment of selected cases (1 page) on selected HP & HC registration	IMNCI focal person
9: 30-10: 00	**Activity 2.6. Introduction of Woreda and PHCU MNCH (CBNC/CBNC and maternal) service utilization tracking templates and group work by HP (Annex A, B,& C)**	
10:00-10:20	**Health break**	
10: 20-11:30	**Activity 2.7**: Review of CBNC/ iCCM, pregnancy identification registration books from each health posts for completeness and consistency –using ~~modified~~ PRCMM form- and discussion on demand creation activities done so far by the HEWs, community engagement (WDAs ….) and the HC	Group work
11:30-12:15 (the timing for this may change base d on available case in the facility)	**Activity 2.8**: Visit the IMNCI Clinic in the facility to observe case and review of selected HC delivery registration book to watch over the linkage between HC and HP whether it matching with birth notification registration books	Group work
12:15- 1:15	**LUNCH BREAK**	

1:15-3:30	**Activity 2.10:** Summary presentation of CBNC /iCCM/, some maternal components Pregnancy identification & PNC findings of PHCU and woreda health office plan (analysis Annex A, B, & C and form C) focusing on service utilization, strengths and challenges – and quality grid	Group representative
3:30-3:45	**Health Break**	
3:45-4:00	**Activity 2.11:** Discussion on presentation & identified strength and gaps on review of different activities above	Coordinator
4:00-4:30	**Activity 2.12** Planning a 3 month (monthly*)activity focusing inculcating ICCM/CBNC indicators at all level to ensuring Ownership and Sustainability of the program, and demand creation and community engagement activities	WrHO representative or PHCU director
4:30-11:30	**Activity 2.13: Final discussion and direction**	
11:30-11:40	**Activity 2.14 C**losing	

*for Health Centers which can conduct the PRCMM monthly

SECTION 2: Modified PRCMM session

INTRODUCTION AND OPENING

2.1 Registration of participants

- Register all participants per their Kebele by using a standard form prepared for this meeting.
- If the participants know each other they may not necessarily get introduced in this meeting. Let the participants tell their name and position while they are participating; otherwise if someone is new from the facilitators/participants, it is good to introduce him/herself. Otherwise, don't spend much time on introduction.

2.2 Presentations of the meeting agenda and announcing any administrative arrangements

- Discuss with participants the rules to follow during the review and mentoring meeting time.
- Agree on:
  - Finishing time, tea/lunch break time
  - Punctuality, active participation, no side-talks etc.

- Explain if there are any administrative arrangements (tea, coffee and lunch breaks)
- Present the agenda of the meeting briefly.
- Opening speech will be done by PHCU Director

2.3 Presentation of the objectives and the expected outcome of the performance review and mentoring meeting

- Using a flip chart prepared ahead of time present the objectives and rationale of the performance review and mentoring meeting. This will be done for the first round, otherwise can be skipped
- Ask participants if they have any question or comment on what you have presented

Flip Chart # 1: Rationale, objectives and major activities

A) Objectives:	B)Expected outcomes
1. Reinforce integrated case management skills and assist HEWs & HWs to transfer these skills to actual practice; 2. Identify challenges & opportunities of MNCH program and make recommendations. 3. To inculcate CBNC/ICCM activities in to routine public health sector ensuring ownership C) Summary of major activities • CBNC/iCCM/IMNCI registers from selected HPs will be reviewed for consistency and completeness • Case observation at OPD • Feedback and mentoring given to HEW • iCCM/CBNC demand creation activities will be reviewed • Summary of previous CBNC/iCCM supervision result or PRCMM result will be presented	At the end of this meeting: • HEWs and HWs would be able to identify issues related with consistency and completeness • HEWs and HWs would improve their skills of assessing, classifying and treating sick newborns and children • Able to provide quality of maternal health services • Action plan will be developed or ICCM/CBNC /MNCH collaborative work • Solutions to weaknesses identified and agreed

Activity 2.4 Introduce CBNC/ICCM /IMNCI case management performance (quality of care) assessment of selected cases.

Distribute printed 4A size quality grid assessment format

Prepare flip chart or Post 3A size of quality gird assessment format in visible area for each group

Present summary of supervisory skill note

Activity 2.7 Review of CBNC/iCCM/ registration, Pregnancy and new born register, delivery, PNC demand creation and community engagement (community client/case identification & service linkage by WDAs….) performances

Step 1: Brain Storming: Ask the participants to present their experiences based on the following questions.

- How does HC work with the HP to improve the performance?
- What support do PHCU staffs provide to each Health Post? (Probe: Which health center staffs support the health post, Frequency of visits, To what depth they provide the support , What tools they used during the visit etc)
- How does each PHCU to HP review performance? (probe: Who participated in meetings, how frequent, the tool/guide they used, major topics discussed, lessons learned etc)

Form groups by their service catchment and HEWs with their registers and demand creation reports. Assign one experienced facilitator who will guide how to review CBNC/ ICCM/ registers for completeness and consistency and also review Pregnancy and new born register, delivery, PNC, demand creation and community engagement (WDAs….) performances. Ensure that all participants have the format and track registers independently which will help them to orient their respective HP when they go back

Exercise 1: review the SC and SYI registers for completeness and consistency

- Explain to HEW and HW that this session is a continuation of the previous PRCMM and they should not take it as an exam or evaluation; encourage them to be ready to ask, comment and learn more,
- Explain and demonstrate what completeness and consistency means
- Facilitator reviews the registers of SC and SYI-using form C for each HP recording, review of Pregnancy and new born register, delivery and PNC performances.
- Encourage the HEWs and HWs to refer to the chart booklet for all CBNC/ iCCM tasks respectively
- Record information for selected two recent classification of other common child hood illnesses for each health post on the form
- Give feedback –start from the strengths and then the weaknesses
- Sign the date of the review on the register-at the end of the last case as this will allow starting place for the next review meeting or supervision

Exercise 2: Review demand creation and program implementation

- Facilitator explain the importance of demand creation and review of the its performances
- Facilitator reviews the HEWs/Kebele's demand creation activity report and facilitate discussion on the key demand creation activities conducted during the review period
- Record discussion points and drawn action points
- Identify strength and weaknesses
- Review demand creation follow up issue from the previous PRCMM, supportive supervision and follow up visits
- Discuss experience in CBNC/iCCM implementation successes and challenges (with special focus on 4 Cs e.g. early pregnancy identification, PNC, early identification of sick newborn, etc.)
- Develop agreed action points for improvement during the next period

Note for the facilitator:

Do the above activities by health post and HC until all the health posts & HC are finished; while HEWs/HWs from a specific health post/HC get their relevant registers reviewed and receive feedback the other HEWs will observe the process until their turn comes and until the activity is over.

- The subsequent review meetings will start on reviewing previous plan performance
- During the group discussion let one HEW be a note taker and present it to the plenary

Activity 2.8 Visit the facilities IMNCI clinic to observe cases and review of selected HC delivery registration book to watch over the linkage between HC & HPs whether it matches with birth notification of HC to HPs

Observe cases available in the facility for under five years and select demonstration of assessing, classifying and managing the cases by the HEWs and the HWs. Also discuss on the skills for these activities using the chart booklets for both ICCM and IMNCI

Identify & have the list of each kebele delivery in specific time.

Collect copy of birth notification format from HC and compare with the list of births on HC delivery registration book.

Oversee if lists of mothers who delivered at HC are registered on HP PNC follow up registration book.

If not registered discuss the reason with HEWs and PHCU staff

For those mothers who are registered at HP after HC birth notification, how many of them got PNC 1, 2 and three?

For those mother who received PNC was their newborn assessed and classified on CBNC registration book for sick young infants and field/note book for well babies?

Identify other births with or without notifications from private clinics and public hospitals

Identify if home births were registered in HP follow up registration book

How many of newborns were assessed and classified on CBNC registration book?

Fill important figures on the annex below and evaluate the strength and weakness

Annex D

Delivered mother, birth notification and HP follow up for mother and New born

Name of Kebele _____ Period it covers_____/__/___ to ____/___/_____

		HC profile			HP profile					
			Birth notification to HP available		were delivered mother name registered on HP RB ?		PNC done for mother at HP		Was NB Assessed?	
SN	Name of mother	Date of delivery at HC	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**	**Yes**	**No**
Total										

Activity 2.9 Review PHCU MNCH activity plan to oversee the inclusion of proper indicators (Use flip chart for this presentation to brief indicators)

Develop and agree on next month activity plan (this would be optional based on the pace the previous plan went and the need to have a quarter or bi annual plan)

The planning session shall be facilitated by the PHCU director & staff and provide the following basic information for planning:

- Use regional conversion factor to calculate the target (Note: the conversion factors will vary every year)

Reorient on the national and regional conversion factors.

- Example 1: ANC and PNC
  - Expected pregnancy and delivery 5,000*3.36% =168
  - Expected VSD (5000x3.36%) x 7.6% =16.8
  - Assuming equal monthly distribution or ignoring seasonal variation there will be about 14 deliveries and PNC cases per month (168÷12)
- Example 2: VSD
  - Expected VSD cases: 168 x 7.6% =12.7
  - Assuming equal monthly distribution or ignoring seasonal variation there will be about 1neonatal sepsis (VSD) cases per month(12.7÷12); about 6 cases per 6 months
- Example 3: Pneumonia
  - U5 821 (16.43% x5,000)
  - Expected pneumonia cases: 821 x .27 cases per child/per =221
  - Assuming equal monthly distribution or ignoring seasonal variation there will be about 18 cases per month(221 ÷12); and about 111 cases per 6 months
- Example 4: Diarrhoea
  - U5 821 (16.43% x5,000)
  - Expected diarrhoea cases: 821 x 3 episodes per child/per =2,464 diarrhoea cases/episodes
  - Assuming equal monthly distribution or ignoring seasonal variation there will be about 205 cases per month (2464 ÷12); and about 1323 cases per 6 months
  - Present next six-month planning

See PHCU MNCH plan and observe the inclusion of CBNC/ICCM and IMNCI in the plan as per the national set of estimate.

If deviate from estimated conversion factor correct it and plan for next period.

Discuss with PHCU how to monitor of each planned activity.

How can we ensure ownership and sustain CBNC/iCCM activities?

How can we ensure ownership and sustain CBNC/iCCM activities?

- CBNC/iCCM activities are integral part of the MNCH plan of the HP, HC, WorHO, ZHD, RHB, FMoH; not a separate partner's program…
- Include CBNC/iCCM/IMNCI activities into Plan, supportive supervision, and Review Meeting at all levels
- Support HPs in CBNC/iCCM supplies availability and management (HPs as one of their work departments of the HC)
- Community mobilization towards CBNC/iCCM services using WDAs and other community networks effectively to increase service utilization

Collect, analyze and interpret as well use CBNC/iCCM monthly reports from HPs and use this data for decision making

Annex I: PHCU plan from _____to_____

Woreda_____ Health Center_____

HC population_____

Number of HPs _____

Annex I: Planning template for PHCU & woreda on key MNCH indicators

Indicator (PHCU)	Plan for next 3 month: Target	Plan for next 3 month: Plan	Plan of action for Major findings observed: Major findings to be improved	Action	Time line	Responsible body
MNCH						
ANC 1						
ANC 4						
Skilled delivery						
Early 1st PNC attendances 0-48 hrs (0-2 days)						
Early 1st PNC attendances49-72 hrs (2-3 days)						
Early 1st PNC attendances 73hrs-7days (4-7 days)						
0-2 months young infants (equal to delivery)VSD of YI (Delivery * 7.6%)						
Total local bacteria cases seen(half of VSD)						
Expected pneumonia cases in U5 Children (27%) and plan						
Expected diarrhea cases in U5 Children (3 episode /year /child) & plan Expected malnutrition cases Demand Creation						
Pregnant women identified & linked to ANC service						
Birth notification made by HC to HP						
Birth notification made by WDAs to HP						
# of sick newborn and U5 children identified and linked to HP by the WDAs/Traditional healers/TBAs						
# of WDAs/leaders actively engaged in identification and linkage of sick newborn/child to HP						

Activity 2.10 Present the summary of CBNC/iCCM/, maternal components …… using compilation format which collected from form C, Annex A, B, & C

- Present a summary of findings of CBNC/ ICCM/ completeness and consistency collected from form C
- Present issues related to planning of PHCU (the strength and weakness)
- Ask other friends to add if missed points.
- Summarize the discussion

Activity 2.11 Discussion on the presentation of CBNC / ICCM and others service related issues and direction.

Activity 2.12 The way forward and closing

Photo credit: Bizuhan Gelaw Birhanu/UNICEF Ethiopia