



Federal Democratic Republic of Ethiopia,
Ministry of Health

National iCCM-CBNC Quality Improvement and Transition Plan July 2017-June 2020



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Addis Ababa, Ethiopia



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National implementation guideline for Integrated community case management of childhood illnesses and newborn care



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List of Acronyms

ARI	Acute Respiratory Infection
CBNC	Community Based Newborn Care
CIFF	Children investment fund foundation
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
HEP	Health Extension Package
HEW	Health Extension Worker
HSTP	Health Sector Transformation Package
iCCM	Integrated Community Case Management of childhood illnesses
IMNCI	Integrated Management of Newborn and Child Illnesses
IPLS	Integrated Pharmaceutical Logistic System
PRCMM	Performance Review and Clinical Mentoring Meeting
PRRT	Performance Review and Refresher Training
RHB	Regional Health Bureau
ToT	Training of Trainers
UNICEF	United Nation Children Fund
WHO	World Health Organization
WoHO	Woreda Health Office
VSD	Very sever disease
ZHD	Zonal Health Department

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Executive Summary

Despite the fact that a remarkable achievement has been made in the reduction of mortality in children under the age of five years in Ethiopia, many children and newborns are still dying of preventable causes. Various proven packages of lifesaving Newborn and Child Health programs and interventions have been introduced and rolled-out at scale, which ultimately help reduce childhood mortalities and morbidities. iCCM and CBNC programs are among the key interventions introduced, in 2010 and 2013 respectively, along the health system structure to reach out to sick children with services at the Health Post level. The interventions are providing treatment for childhood illnesses since 2010. Parallel to the accomplishments delivered through iCCM and CBNC, shortfalls and challenges have been recorded through routine program monitoring activities and various assessments. The major findings include poor quality of care; low level of service utilization; poor accountability and inadequate integration and institutionalization of the programs. To address the identified gaps, the FMOH-MCH directorate has developed an initiative to introduce a two-year 'iCCM-CBNC Quality Improvement and Transition Plan (QITP)' to reinforce the quality of care with associated areas of intervention and put in-place a transition plan for the fully-institutionalized/integrated phase of iCCM-CBNC implementation in the agrarian regions. The objective of the QITP is 'To improve the quality of care and performance of integrated iCCM and CBNC programs and in-place transition plan to the next level of implementation'. Integrated Trainings, Supportive Supervisions, Performance Reviews with Clinical Mentoring/Refreshers and strengthening and utilization of the performance monitoring system will be key activities and the lead role will be fully given for the public sector. There is also some change on modalities of implementation specifically on performance review and refresher training. The desired outcome is to improve the quality of care, increase service utilization and strengthen the supply chain management and performance monitoring for iCCM-CBNC. RHBs, ZHDs, WoHOs and PHCUs will be empowered to fully-institutionalize and lead the proposed implementation processes with clear Performance Monitoring, Accountability and Responsibility system established and utilized. An estimated cost of 12,815,098 USD will be required to rollout and implement the quality improvement plan until June 30th, 2020.sp

1. Background Information

Even though about 184,000 children under the age of five years were estimated to die in the year 2015 alone, Ethiopia has recorded remarkable achievement of dropping under-five mortality by 67% by 2014 from 1990. There has also been a recorded reduction of under-5 deaths globally from 12.7 million in 1990 to 5.9 million in 2015. But the current 16,000 deaths occurring every day worldwide signals the need for continued effort to reduce the unacceptable number of child deaths with effective child and newborn health programs and interventions. With the under-five age segment constituting 14.6% (13.2 million) of the population, reduction of under-5 mortality in Ethiopia can be taken as a major success for Ethiopian development.

The successful, coordinated introduction and implementation of key proven lifesaving maternal, newborn and child health interventions along the health system framework is among the prime factors for the achievement to date. The three-tier health system has remained a strategic delivery route for rolling-out health care including implementation of child and newborn health interventions. Among the tiers is the Woreda Health system which constitutes a primary hospital (1 to 60,000-100,000 people) and a Primary Health Care Unit which connects a health center (1 to 15,000-25,000) with five satellite health posts (1 to 3000-5000).

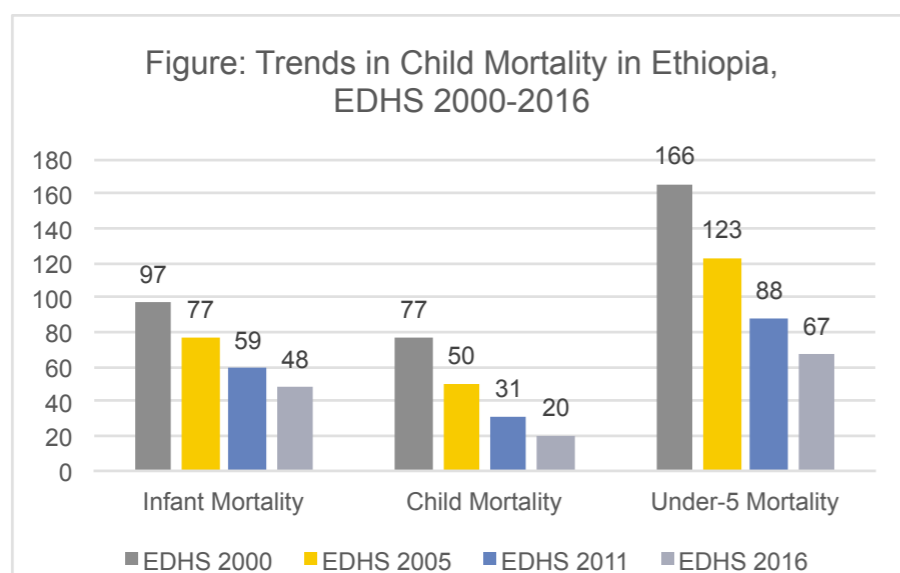


Figure 1 Health Tier System,

The success of many child and newborn health interventions must factor in accessibility to care and target PHCUs as a key focal point as significant members of the community

utilize health centers and their satellite health posts as their primary point of health care. Moreover, the HCs and HPs are the primary outlets for access to a comprehensive package of health promotion, disease prevention and curative care services. Currently about 3562 health centers provide health services including child and newborn health care. They render technical and administrative support to 1:5- linked 16,480 health posts which have about 30,521 trained and deployed health extension workers as a nation. Specific to the four agrarian regions currently about 2,956 health centers and 14,128 health posts are providing both the ICCM and CBNC service and a total of 28,057 health extension workers were also trained on both programs. On top of the support they receive from catchment health centers, the HEWs also team-up and work closely with a network of 439,497 Health Development Army Leaders (HDALs), who in turn work with 2,125,190 networks of 5 households with one leader. Community based support groups, such as the Command Post and kebele administrative body, also provide support and oversight to the HEWs and health posts to effectively provide health promotion and disease prevention services under the 16 element health extension package. In addition to the disease prevention and health promotion scope, the health posts are also expected to provide curative care for select manageable child and newborn illnesses after a policy breakthrough of MOH deciding to introduce newborn and child case management through integrated community case management (iCCM) in 2010 and Community Based Newborn Care (CBNC) in 2013. The HEW-HDAL-Community support group team carries on demand generation, case identification, and referral and follow up, with HEWs assuming the role of case management for childhood illnesses.

2. Introduction and the situation

Ethiopia represents an estimated 184,000 deaths of children under the age of five years of the 2,947,000 under-five deaths in Sub-Saharan Africa in the year 2015 alone¹. Newborn, infant and under five mortality rates were reported to be 29, 48 and 67 per 1000 live births respectively. Contrary to the significant reduction of mortality rates in children under the age of five years, the neonatal mortality rate showed a low near-stagnant rate of decline². Neonatal causes contributed to 45% of the under-five mortality in 2015 with neonatal sepsis, prematurity/low birth weight and intrapartum causes/birth asphyxia being the cause of the majority of neonatal conditions pointed

¹ UN Inter Agency group for child mortality estimation

² EDHS 2016

as cause of death. Other common causes of under-5 deaths in sub-Saharan Africa include; ARI (16.6%), diarrhea (10%) and malaria (10%), while malnutrition intersects with 45% of the mortalities³

Despite improvements in the utilization of health services for key MNH care, there are still many mothers, newborns and children who don't receive care from health care providers. According to the EDHS 2016, about 62% of eligible women received ANC care from a health care provider at least once for their last birth. The proportion of births delivered by a skilled provider remained virtually unchanged over five years at the level of 28% in 2016. Despite the fact that many maternal and neonatal deaths occur within the first 48 hours after birth, the proportion of women who received a PNC visit during the same period still remains at 17%. Only about 38% of eligible children have received all basic vaccination and only 53% were vaccinated for Pentavalent 3 by 2016. About 56%, 49%, 56% and 54% were vaccinated for Polio3, pneumococcal 3, rotavirus and measles respectively.

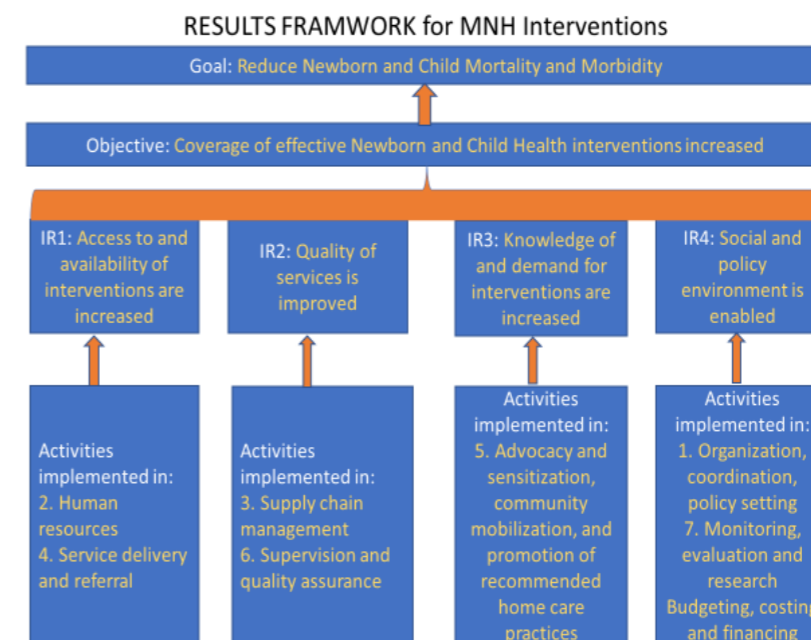
With the high level of childhood and newborn mortality in Ethiopia, The Federal Ministry of Health decided to integrate the proven intervention packages of Integrated Community Case Management (iCCM) in 2010 and Community Based Newborn Care (CBNC) in 2013 into the existing HEP and PHCU/three-tier health system platforms.

2.1. iCCM and CBNC: Coverage, approach, successes and challenges

With the policy-endorsement of antibiotic management of childhood pneumonia by Health Extension Workers in 2010, iCCM has emerged as a strategic and integrated package to increase access to life saving childhood interventions and to effectively and efficiently manage common causes of illnesses in children under the age of five years. Relevant implementation processes with implementation guidelines, training manuals and guides, and M&E tools were put in place through the coordinated effort of the national Child Survival Technical Working group. All the activities related to structuring and rolling out iCCM were coordinated from the national level down to the lowest service delivery point. Partners have been tasked in supporting the program in their already existing program areas with close collaboration and leadership from respective RHBs, ZHDs, WoHOs, and PHCUs.

³ Global Health Observatory data

iCCM and CBNC interventions and activity-rollout was designed in line with the WHO-recommended Results Framework for Maternal, Newborn and Child Health Interventions.



2.1.1. Coverage

The cascade training of both CBNC and iCCM started with creating a pool of trainers through master and regional ToTs organized and conducted by MOH/RHBs with the support of iCCM/CBNC partners. The trainings for iCCM covered case management and supportive supervisory skills for subsequent HEW and supervisor trainings. About 332 trainers were trained through the Masters and Regional Training of Trainers (ToTs). Intensive quality assurance activities like Selection of the right trainees for TOT and engage them in skill based training to facilitate cascade of trainings in the same manner & adherence to the standard training guidelines during training and preparation (duration, facilitator to trainee ratio, method of training, type and number of training materials) were among the principles utilized which later contributed to a uniform standard and outcome for the subsequent HEW and supervisor trainings.

Accordingly, 99.4 % coverage for iCCM was achieved by 2017 with 16,376 health posts providing the service and 98% of HEWs receiving competency based in-service training complemented with the distribution of essential job aids, medicines and supplies as a nation and specific to the agrarian regions 96% coverage for iCCM/CBNC was achieved by the same year as iCCM with 14,479 health posts providing the service in the four regions .

Apart from HEWs, their supervisors and iCCM focal persons were also trained on 6-day case management and one day supervisory skills training as part of establishing supervision and support networks to HPs and institutionalizing the program. For the same purpose about 4,671 (100%) supervisors and public health sector staff were trained during the first phase of iCCM⁴.

The CBNC program scale up and training followed in 2013. This utilized lessons from previous iCCM implementation to incorporate a phased and controlled introduction along the iCCM platform, following the continuum of care approach- the 4'Cs (Capture, Contact, Care, Complete), to ultimately reach out to mother/baby pairs with sensitization and treatment activities. Currently 27,673 (95.8%) HEWs have been trained on CBNC and 13,980 (96.5%) HPs have been covered as a result. To establish support mechanisms, 5,905 (99.4%) health workers were also provided orientation on CBNC and supervision skills.

As part of the guiding principle of addressing quality of care at the whole PHCU and strengthening referral linkages, 6,138 health workers have been trained on IMNCI with supervision skills.

2.1.2. Approaches/Key Activities

The core activities of iCCM and CBNC put forward in the iCCM and CBNC National iCCM implementation plans include:

- Post-training follow-up to HPs within 4-6 weeks after training
- Regular follow-up to HPs by supervisors and from catchment health centers and the WoHO
- Performance review meetings
- Supply chain management optimization
- Coordination, ownership and sustainability
- Monitoring and evaluation

The successful rollout of iCCM and CBNC trainings and national scale up is followed by an initial post-training follow up to HPs/HEWs within 4-6 weeks after training. A team of experts from WoHO, PHCU and partners have been engaged in doing the initial follow up using a structured checklist. Ultimately, those follow up visits were inculcated in to the system to be done regularly. About 97% of trained HEWs were

⁴ UNICEF, *Integrated Community Case Management Brief*, March 2014

supervised and provided with clinical mentoring for iCCM through the same approach. A comparable proportion of health posts was also consistently reported to be reached with post-training follow-ups in the intervention woredas of Jimma and West Harerge Zones, with 87% of HPs receiving at least one supervision visit with clinical mentoring against 19% of HPs in control woredas⁵

The supportive supervision visits were found to significantly improve the quality of iCCM case management as measured by consistency with the iCCM algorithm during management of sick children. HP management consistency in pneumonia, malaria, and diarrhea increased by 3.0, 2.7 and 4.4-fold in a study conducted to assess the effect of supportive supervision on the quality of iCCM care⁶

Performance review and clinical mentoring meetings are other key activities that improve the performance of the iCCM and CBNC programs. Almost all health posts were covered through performance review meeting and clinical mentoring PRCMM within 3-6 months after initial training and then regularly. After the introduction of CBNC, the iCCM and CBNC PRCMMs were integrated with each other and other PHCU reviews. PRCMM guidelines were used consistently after development and field testing by the CSTWG. The meetings have been an opportunity to identify and address implementation challenges and to mentor HEWs.

Like the supportive supervision visits, PRCMMs were also found to significantly improve quality of case management⁷. Low exposure to sick newborns has been a shortfall and needs improvement with PRCMMs to better be done at PHCUs/HCs with on-the-job coaching and mentorship.

The supply chain system has been effectively delivering key iCCM and CBNC drugs and commodities to health posts with continuous coordination among MOH, PFSA, UNICEF and partners.

HEWs were supplied with startup kits after training to help them kick start service. Ultimately iCCM commodities were included in the essential drugs and commodities to be channeled through the existing system and the ministry is struggling to do the same for CBNC commodities. Currently the CBNC commodities were distributed by the PFSA

⁵ Miller et al: *Implementation of iCCM in Ethiopia: Implementation strength and quality of care*

⁶ Agaze et al: *effectiveness of supportive supervision on the consistency of integrated community cases management skills of the health extension workers in 113 districts of ethiopia*

⁷ Briky et al: *effect of performance review and clinical mentoring meetings (prcmm) on recording of community case management by health extensionworkers in ethiopia*

. Regular quantification, procurement and distribution means have been functional to regularly stock HPs.

Millet et al have found 69% of HPs have all the essential iCCM drugs and supplies while the proportion of HPs with stock in of individual iCCM supplies varies between 99 and 80%.

2.1.3. Successes

Quality of Care

Quality of care often has been measured in reference to consistency and correctness of case management as key outcome indicators for both iCCM and CBNC. As indicated above, the quality of iCCM has been reinforced and maximized through different activities like supportive supervision, PRCMM and on-the-job mentoring and coaching. More than three quarters of HEWs are consistent with national case management algorithms during iCCM case management.

However, given the extensive need for practical sessions and the low case flow for CBNC, robust action to further improve management of very severe disease (VSD) and other newborn conditions through CBNC is required.

A midterm assessment done by IDEAS reported the case sensitivity rate of 30% for very severe disease and 55% for local bacterial infection, which measures the power of HEWs to correctly identify newborns and infants with very severe disease and local bacterial infection respectively.

Rapid scale up of iCCM and CBNC

Despite the existence of quality gap's the service coverage by health posts were above 90% for both the ICCM and CBNC program in the agrarian region.

PHCU being a focus target than HPs alone and linkage improved

The implementation of community based child health program (CBNC/iCCM) creates an opportunity to further strengthen the linkage between health center and catchment health posts and to be seen as a unit.

2.1.4. Challenges

- The service utilization status for both iCCM and CBNC specifically at health post level were low and this may occur due to :-

- Unaware of service availability, perception of poor quality of service at health post level and poor newborn illness perception and disease causation recognition from the user side.
- Interruption of service hour, poor social mobilization/Advocacy for the service and lack of confidence in providing injections like gentamicin , lack of properly assigned and accountable focal person, Futility of the supportive supervision undergoing and lack of regular monitoring and evaluation from the provider and organizational side.

- Poor postnatal service coverage
- Case identification and management of newborn problems particularly is very low
- Maintaining quality of case management and care particularly for CBNC (exposure to adequate cases continuously has been one big challenge)
- Stock mismanagement for CBNC supplies (expiry and over estimation)
- Institutionalization and sustaining program activities like supervision
- The level of linkage established between health posts and health centers were not much matured.
- Inadequate or inconsistent integration of ICCM and CBNC into the annual planning and budgeting processes
- None of standardized referral mechanism from the community to the health post, health post to health center and health center to hospital.

2.1.5. Rationale for the iCCM-CBNC Quality Improvement plan

a) Rationale for Quality Improvement

The iCCM quality of care and case management in reference to consistency of case management has shown improvement, however, concrete plans for the continuity, institutionalization and effective integration with CBNC and all other MNCH interventions are needed. Management of potential serious bacterial infections (PSBI) in newborns and young infants is relatively new, still being scaled up and institutionalized. CBNC quality of care and the number of cases managed per health posts were found to be inadequate through assessments and regular program supervision visits. There is a need for a robust quality improvement plan for CBNC as an integral part of iCCM and other MNCH packages for the following reasons:

- FMOH focus on the development and operationalization of a National Quality Strategy
- Low quality of newborn case management by HEW as found in the IDEAS mid-term review
- Newborn conditions contribute to half of the deaths in children under the age of five
- Extremely low level of utilization of the CBNC service specifically for the sick newborn case management components.
- Overemphasis on newborn sepsis management and a strong need to address all four strategic components of CBNC (4C's) by using PNC as an entry point.
- Improper child and newborn drug and commodity distribution management system
- Quality of care being one key intermediate result proposed within the result framework
- Excellence in quality improvement and assurance is one of the four pillars of excellence set out by the HSTP

b) Rationale for Transition

iCCM and CBNC have been implemented with sufficient maturation through government commitment, strong partner support, coordinated approaches and a focused health systems strengthening lens. The public health sector must fully institutionalize and lead all the implementation processes effectively and sustain the delivery of quality iCCM-CBNC services. A three year iCCM-CBNC implementation guideline is under development. The QITP, with the associated guidelines, is required to clearly outline the transition activities and plan until the fully institutionalized, integrated and sustained phase.

3. Objectives

3.1. General objective

Improve the quality of care, performance of the integrated iCCM and CBNC programs, awareness of the community on utilization of the service and transition these programs to the next level of implementation, which is embedded within the GOE's public health infrastructure.

3.2. Specific objectives

- a) To ensure ownership and mainstreaming of ICCM and CBNC within the GOE's public health planning, programming, financing and monitoring/evaluation systems.
- b) To strengthen performance monitoring and accountability on child and newborn health.
- c) To improve HEWs, HWs, and supervisors' competencies in the management of sick newborn and common childhood illnesses within the PHCU level.
- d) To improve sick newborn and children service utilization within the PHCU level.
- e) To ensure a continuous and uninterrupted supply of commodities and improve the efficiency and effectiveness of the supply chain management system for child and newborn health commodities.

4. Major activities

The following section highlights the major activities to be accomplished under each objective for the robust improvement of the quality of the iCCM-CBNC program

Objective 1: Improve HEWs, HWs, and supervisors' competencies in the management of sick newborn and common childhood illnesses at the PHCU level

Key deliverable-1: Capacity building

Training will remain the entry-point for the entire quality improvement action. 5000 new HEWs will be reached with pre-deployment iCCM-CBNC training before their assignment to health posts. The training modules, facilitator's guide, chart booklets and job aids will be revised to address current quality and integration issues. All CBNC guides and tools will be simplified and merged into the bigger iCCM guides and tools. The health science colleges will be key points for the delivery of the pre-deployment trainings, and 10 tutors from each health science college will be trained on the iCCM ToT as a result and other trainings like IPLS, HMIS and safe injection practice will be given with integration. Moreover, the health science colleges will be provided with the necessary training supplies and the revised training materials based on a brief

inventory. To accomplish the task a detailed action plan will be developed on cascading the pre-deployment trainings to HEWs as per the revised and standard manuals and guides. By doing so the tutors will develop the capacity to train health workers on the program as it was included in the curriculum of the health extension workers.

The health worker attrition rate and their low supportive supervision skills have contributed to compromised quality of care for both iCCM and IMNCI. IMNCI case management, iCCM-CBNC orientation and supportive supervision skill training to PHCUs, WorHOs, ZHDs and RHBs will be conducted to address the effect of attrition and low quality supportive supervision. Furthermore the existing opportunities for non financial incentives like education (up grading) will be strengthened by including the program indicators in the specification of the evaluation criteria for health workers and health extension workers.

Key deliverable-2: Supportive Supervision/Catchment based mentorship

Supportive supervision will remain a strategic activity to reinforce the quality of case management for newborn and child health problems. The supervision checklists in-use have been cumbersome and time consuming for serving the purpose. Existing program-specific IMNCI and ICCM-CBNC checklists will be revised to efficiently and effectively address quality issues and be utilizable by PHCUs, Primary Hospitals, Woreda Health offices, ZHDs and RHBs. In the meantime, inclusion of the supportive supervision plan in the woreda based health sector annual work-plan linked with costed budgets (monthly for program specific SS and quarterly for ISS)) will be ensured. Trained health workers from health centers will conduct monthly integrated supportive supervision and iCCM-CBNC program-focused mentorship to their catchment health posts and Woreda health offices will do the same to PHCUs. Bi-annual integrated supportive supervision will be conducted by FMOH, RHBs and ZHDs to selected sites of the next level.

Key deliverable -3: Performance review and refresher training (PRRT) and Integrated Review meetings

The supportive supervision will be complemented with regular performance review and refresher trainings at PHCUs as part of the robust quality improvement action. The existing PRRT guidelines and tools will be revised with a focus on improving quality of care and enhancing iCCM-CBNC service utilization. The woreda based PRRTs will be taken down and decentralized to health centers where integrated PHCU-level

review meetings are currently taking place and adequate exposure to sick newborns and children will be ensured. At the initial undertakings, zonal level orientation will be conducted on the revised PRRT guides and approaches for woreda health office and health center staff who will ultimately cascade the process to their respective woredas and PHCUs. The PRRTs will be conducted monthly and integrated with and as part of the overall PHCU level monthly review meetings. The integrated and program based supportive supervision visits from each level to the health centers and health posts will oversee for the regular implementation of the PRRT at the PHCU level and its outcome at the service delivery point, health posts.

The FMOH will organize bi-annual Integrated Community Case Management of Newborn and Childhood Illnesses (iCCM-CBNC) and IMNCI review meetings with RHB focal persons. RHBs and ZHDs will organize the review meetings quarterly with zonal and woreda focal persons respectively and the woreda health offices will conduct the same quarterly meetings with PHCUs. Similarly the health extension worker will conduct review meetings with the kebele command posts and the health development army team leaders' at least once in a month.

Objective 2: To improve service utilization for sick newborn and children at PHCU level

Key deliverable-1: Supply side interventions

Health posts must be open every day to provide HP based services as per the revised HEP guideline. To ensure this, a monitoring and accountability mechanism between PHCUs and respective kebele command posts will be established. The accountability and monitoring mechanism will also consider the inclusion of 'very severe diseases /neonatal sepsis', pneumonia, diarrhea, management of low birth weight newborn ,management of birth asphyxia , Early PNC for both & 'severe acute malnutrition treatment' indicators as part of performance evaluation indicators for health posts, health centers and Woreda health offices. In line with the aforementioned activities, the CSTWG will work to ensure inclusion of key newborn and child case management indicators in the revised HMIS so that they will be an integral part of the health system's monitoring and accountability mechanism. Similarly the woreda RMNCH score card will include indicators for the management of sick newborns –VSD and childhood illnesses –pneumonia.

Key deliverable-2: Demand side interventions

There has been reported a low level of awareness about the services provided at health posts from the community side. To address this, Orienting kebele command post members, women development army leaders, teachers, faith based organization and community based organization leaders and traditional influential persons on the importance of community based newborn care services provided and having their active participation and support is crucial for the program implementation. The orientation will be provided by health center staffs in collaboration with the health extension workers. Since HDALs play a key role in interacting with and raising the awareness of communities, their competency based training will be supported to increase their awareness and improve their skills and knowledge on newborn and childhood danger signs through a systematic orientation utilizing the existing Family Health guide. Home visits, outreach services and pregnant women conferences are other good opportunities for mobilizing the community to utilize the service. Local media will also be targeted for the same purpose with the development of key targeted messages.

Schools will be considered as an integral part of the demand generation and awareness creation activity, and school children will be reached with key messages on danger signs and services for sick newborns and children. iCCM-CBNC will also be integrated within existing school health and nutrition program platforms established to manage common childhood disease and disorders.

Key deliverable-3:- Strengthening the referral linkage among facilities

In order to provide patient centered service having strong and standardized referral linkage is mandatory. As there is no standardized referral forms, Standardized referral forms from the community to the health post and from the health post to the health center or Hospital will be developed. Orientation on the referral slip will be given integrated with the PRCMM cascades. Furthermore to make the service provided at the health center more reactive for the referred cases from health post basic iCCM / CBNC/IMNCI and supervisor skill training will be given for health workers. Additionally trainings like essential newborn care (for health centers and hospitals) and neonatal intensive care (for Hospital)will also be given based on gaps identified so as to improve the overall sick young infant case management system.

Objective 3: To ensure continuous availability of supplies and commodities and improve the efficiency and effectiveness of the supply chain management system for child and newborn health commodities

Key deliverable-1: Integrated Pharmaceutical Logistics System (IPLS)

IPLS is the main strategy to be used as far as quantification, procurement, consumption, monitoring and management of the supply chain management of iCCM and CBNC commodities is concerned. All iCCM/CBNC drugs and commodities will be integrated with the overall supply chain management for MNCH supplies and drugs.

With appropriate capacity building activities, the existing channel will remain the prime delivery route for iCCM and CBNC drugs and commodities integrated with other MNCH supplies. iCCM and CBNC commodities have been delivered through PFSA led supply chain system. With the knowledge of the Woreda health offices, the quality improvement plan recommends the delivery of iCCM/CBNC drugs directly to health centers and in some cases WoHOs which ultimately supply their satellite health posts.

Strengthening Health Post-Health-Center-Primary Hospitals linkages on IPLS will be a key intervention under the deliverable. Health centers will provide continuous support to their satellite health posts on IPLS with appropriate interventions such as supportive supervision, performance review, stock monitoring and stocking accordingly. Primary hospitals will be required to do the same for health centers within their peripheries. All the checklists and tools being used will be revised for adequate inclusion of supply chain agendas. The linkage will be expected to promote smooth flow of drugs bi-directionally across the health post-health center-primary hospital lines.

Training will be another target to improve the supply chain management system. Drug and commodity management will be part of the pre-deployment/Gap filling orientation of HEWs. Previously, IPLS has not been addressed systematically in the basic iCCM/ CBNC trainings. 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.

Regular revision of quantification and forecasting exercises/documentation of commodities will also be considered as key quality improvement actions. Previous experiences on quantification exercises showed that there is a need to have more accurate prevalence/incidence estimates to prevent mal-distribution of iCCM/CBNC

commodities to health posts. The next revision process should involve all key iCCM/CBNC stakeholders at all levels. A communication has been sent out to the regions to use estimates of 27% prevalence for pneumonia, 3 annual episodes for diarrhea per child and 7.6% for neonatal sepsis. But this has to be regularly reviewed and supported by evidence.

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

To 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 a 'Drug Management Handbook for Health Extension Workers'. The CSTWG will work closely with the HEPD to ensure that the handbook is distributed to Health posts and that iCCM/CBNC 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 Forms. Moreover, the IPLS forms and job aids should be continuously availed at the health posts and health centers.

The IPLS integration task force will be a key coordination body as far as IPLS is concerned. A MOU has already been developed and is being used to guide the structuring, roles and responsibilities, and the processes involved with the taskforce. The IPLS taskforce meeting which happens every two months 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/CBNC supplies and this will be sustained. In the other way round, IPLS personnel will be a regular participant in the CSTWG meetings. MCHD will closely work with PFSA in mapping the procurement funding till 2020. The time-line for the integration be finalized by the task force within the next two months.

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/CBNC will be ensured.

Objective 4: To strengthen Performance Monitoring and Accountability Mechanism on Newborn and Child Health

Key deliverable-1: HMIS

The implementation of this accelerated quality and coverage plan for iCCM/CBNC will be monitored through established monitoring mechanisms of the health system, i.e routine HMIS .Program outcome and output indicators will be identified by the national child health technical working groups and then the MCHD and CSTWG will work closely with PPD for the inclusion of adequate/critical iCCM/CBNC indicators on HMIS. The included indicator will be reported from all facilities/ units starting from September 2017.

Key deliverable-2: RMNCH Score Card

Once the iCCM/CBNC indicators are included in the HMIS, the data generated will be part of performance evaluation and will inform the development of a zonal/woreda level RMNCH scorecard.

Key deliverable-3: Woreda Based Health Sector Planning and Performance Review

Inclusion of iCCM/CBNC/IMNCI targets in the annual woreda base plan has to be ensured. The MCHD will write and circulate a letter to regions on the Woreda Based Health Sector Planning guide on ICCM/CBNC to plan for iCCM/CBNC an activity integrated with the overall woreda level interventions and takes the issue on agenda in the regular meeting with the regional health bureau heads. The woreda level reviews will be used as a forum to recognize best performers; experience sharing and discuss challenges. The command post will be involved in those activities including the woreda based review meetings.

Key deliverable-4: Regional and Zonal Technical Assistant

Assignment of newborn and child health program focal persons at zonal levels to ensure accountability is crucial to effectively lead iCCM-CBNC implementation and ensure quality of care. The recruitment of TA at district level will be carried out by the regional health bureaus but the financial support will be provided by partners. The TA's will be replaced by civil servants after two years of support to ensure local ownership and sustainability.

S.No	Objective	Key Strategy	Activities	Expected date of completion												Responsible
				Year 1				Year 2				Year 3				
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
			conducting Monthly CBNC/ICCM/IMNCI RM with the PHCU program focal person at Woreda level	x	x	x	x	x	x	x	x	x	x	x	x	WHO
		Assigning Regional and Zonal technical Assistant	Recurting 52 Zones, 4 Regions & 1 National Technical Assistant	x												FMOH & partners
			Orientation training for Zonal and Regional level technical assistant	x	x											FMOH & partners
			Provide Technical support for Regions in the recruitment of TAs	x												FMOH & partners
			Provide financial support for regions for Salary, PD and Vehicle rent	x	x	x	x	x	x	x	x	x	x	x	x	FMOH & partners

S.No	Objective	Key Strategy	Activities	Expected date of completion												Responsible
				Year 1				Year 2				Year 3				
				Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
	To improve sick newborn and children service utilization at PHCU level	Avoid service interruption (HPs is closed most of the time)	Write circular letter to RHBs to strictly follow the revised HEP guideline which states HP shall be opened every day to provide HP based services	x												FMOH
		ICCM and CBNC implementation is not a part of HEWs/HPs/PHCU performance monitoring evaluation	The PHCU director/HC has to establish a monitoring mechanism with a kebele command post to create accountability at lower level when the HP is closed	x	x	x	x	x	x	x	x	x	x	x	x	WHO & PHCU
			Share standardized conversion factors for newborn and children to RHBs	x				x				x				FMOH & RHB
			Properly plan management of newborn & childhood illnesses at HP and HCs in the woreda based health sector plan	x				x				x				WHO & PHCU

5. Roles and responsibilities

5.0.1. Roles and Responsibilities of FMoH

- Lead the implementation of the quality improvement and transition plan
- Coordinate regional level sensitization meeting with the regional health bureau heads and program focal person (one to one planning & consensus reaching)
- Mobilize resources for the ICCM/CBNC quality and transition plan
- Ensure that ICCM/CBNC 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/ CBNC implementation.
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the implementation of the QIP
- Organize annual review meetings.

5.0.2. Roles and Responsibilities of PFSA

- Delivery of pharmaceuticals for the management of ICCM/CBNC to health centres that are responsible to supply HPs involved in CBNC;
- Provide supply information for RHB,ZHD & woreda Health office
- Build the capacity of all PHCU that will be involved in ICCM/CBNC 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;

5.0.3. 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/ CBNC;
- Ensure that ICCM/CBNC 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 CBNC to ZHD/Woreda Health Offices; and
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the implementation of CBNC by HEWs.

5.0.4. Roles and Responsibilities of Woreda Health Office

- Ensure that ICCM/CBNC 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 on CBNC;
- Ensure continuous supply of drugs, job aids and equipment for CBNC 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 neonatal sepsis cases respectively ;
- Conduct supportive supervision and regular review meetings to enhance the Program management CBNC by HEWs;
- Ensure complete and timely reporting of activities on CBNC by HEWs and PHCU Director; and

5.0.5. Roles and Responsibilities of the National Technical Working Group

- Assist in the development or revision of guidelines, job aids and other relevant documents on CBNC;
- Assist the FMoH and RHBs in resource mobilization, optimal utilization and efforts on sustainability of the services;
- Establish ad hoc working groups for specific tasks, when necessary.

5.0.6. Roles and Responsibilities of the Regional Technical Working Group

- Coordinate the planning, implementation, monitoring and evaluation of ICCM/ CBNC by HEWs in the region;
- Assist the RHB in resource mobilization, optimal utilization and efforts on sustainability of the CBNC, by HEW services;
- Adopt/translate/customize CBNC 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 neonatal health interventions.

5.0.7. Roles and Responsibilities of PHCU/ Referral HC

- Train and support HEWs in building their skills to assess and manage common newborn illnesses;
- Ensure the continuous supply for IMNCI, CNBC and other MNH services;
- Ensure that CBNC implementation is well coordinated, implemented and followed at the kebeles of their respective catchment areas;
- Conduct PRRT/PRCMM quarterly in their catchment
- Conduct timely and regularly program based supportive supervision and integrated supportive supervision on a monthly basis
- Give appropriate and constructive feedback to referring HP/HEW after giving appropriate care to referred cases;

5.0.8. 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 at least 8 hrs/ day and 5 days per week 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/ CBNC services, including complete registration and regular update of pregnant women, as well as follow-up, essential newborn care, manage newborn with intrapartum asphyxia in case of home delivery scheduled postnatal 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 CBNC issues are discussed in community conversations in 1 to 5 networks.

5.0.9. 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 CBNC through HDA ;
- Facilitate the referral of seriously sick newborns;
- Mobilize local resources for implementation of CBNC

6. Budget and funding

This section will explain how the financial and budget requirements needed to roll out CBNC quality improvement have been calculated. The total overall budget of implementing the quality improvement plan in the four agrarian regions over a three years period is USD 7,083,073 (ETB155,827,606).

Budget Break Down

1. Budget for 1st year

S.N	Planned activities	Estimated cost in US \$ for 1 st year by level						Year one total
		National	Regional			Tigray		
			Amahara	Oromia	SNNP			
1	ICCM/CBNC TOT training for collage teachers	0	10768	8614	8614	4307	32303	
2	Pre-deployment training for HEWs	0	144068	200421	212211	32775	589475	
3	Gap filling training on ICCM/CBNC/IMNCI	0	27818	47013	25036	6955	106822	
4	Training and Other materials revision	5015					5015	
4	Supportive supervision	31304	11237	22475	17980	6743	89739	
5	PRCMM/PRRT regional /zonal and worda cascade	0	140052	241124	128121	34933	544230	
6	National ,Regional and Zonal TA (Salary, PD and cost of vehicle rent)	27272	581890.9	1108800	792654	371127.3	2881744	
7	Orientation Training for Regional and Zonal TA	50000					50000	
8	Local Media utilization	12120	12120	12120	12120	12120	60600	
9	Regional Advocacy	0	12517	24561	20152	8309	65539	
10	ICCM/CBNC Demand generation & service utilization (for zonal and worda level HAD sensitization)	0	109114	223956	114985	22354	470409	

11	IPLS training and child health commodity regular quantification and forecasting	10204	20000	40000	25000	7000	102204
Total		135915	1069585	1929084	1356873	506623.3	4998080

2. budget for 2nd year

S.N	Planned activities	Estimated cost in US \$ for 2 nd year by level						Year 2 total
		National	Regional			Tigray		
			Amahara	Oromia	SNNP			
1	ICCM/CBNC TOT training for collage teachers	0	10768	8614	8614	4307	32303	
2	Pre-deployment training for HEWs	0	129660	180379	190990	29497	530526	
3	Gap filling training on ICCM/CBNC/IMNCI	0	30600	51715	27540	7650	117505	
4	Training and Other materials revision						0	
4	Supportive supervision	32870	8429	16856	13485	5057	76697	
5	PRCMM/PRRT regional /zonal and worda cascade	0	0	0	0	0	0	
6	National ,Regional and Zonal TA (Salary, PD and cost of vehicle rent)	30000	610985.4	1164240	832287.2	389683.6	3027196	
7	Orientation Training for Regional and Zonal TA						0	
8	Local Media utilization	12120					12120	
9	Regional Advocacy	0	0	0	0	0	0	
10	ICCM/CBNC Demand generation & service utilization (for zonal and worda level HAD sensitization)						0	
11	IPLS training and child health commodity regular quantification and forecasting	10000					10000	
Total		84990	790442.4	1421804	1072916	436194.6	3806347	

3. Budget for 3rd year

S.N	Planned activities	Estimated cost in US \$ for year 3 by level							Year 3 total
		National	Regional			SNNP	Tigray		
			Amahara	Oromia					
1	ICCM/CBNC TOT training for collage teachers	0	0	0	0	0	0	0	0
2	Pre-deployment training for HEWs	0	116694	162341	171891	26548	477474		
3	Gap filling training on ICCM/CBNC/IMNCI	0	33660	56886	30294	8415	129255		
4	Training and Other materials revision						0		
4	Supportive supervision	34513	6321	12642	5056	3793	62325		
5	PRCMM/PRRT regional /zonal and worda cascade	0	0	0	0	0	0		
6	National ,Regional and Zonal TA (Salary, PD and cost of vehicle rent)	31500	672084	1280664	915516	428652	3328416		
7	Orientation Training for Regional and Zonal TA								
8	Local Media utilization	1200					1200		
9	Regional Advocacy	0	0	0	0	0	0		
10	ICCM/CBNC Demand generation & service utilization (for zonal and worda level HAD sensitization)						0		
11	IPLS training and child health commodity regular quantification and forecasting	12000							
Total		79213	828759	1512533	1122757	467408	4010670		

4. Total cost for 3 years

S.N	Planned activities	Estimated cost in US \$ for 3years by level	
		Total cost in US \$	Proposed source of funding
1	ICCM/CBNC TOT training for collage teachers	64606	USAID
2	Pre-deployment training for HEWs	1597475	USAID
3	Gap filling training on ICCM/CBNC/IMNCI	353582	UNICEF
4	Training and Other materials revision	5015	MOH
4	Supportive supervisiona	228761	USAID
5	PRCMM/PRRT regional /zonal and worda cascade	544230	UNICEF
6	National ,Regional and Zonal TA (Salary, PD and cost of vehicle rent)	9237357	UNICEF/USAID
7	Orientation Training for Regional and Zonal TA	50000	IHI
8	Local Media utilization	73920	UNICEF
9	Regional Advocacy	65539	USAID
10	ICCM/CBNC Demand generation & service utilization (for zonal and worda level HAD sensitization)	470409	UNICEF
11	IPLS training and child health commodity regular quantification and forecasting	124204	CHAI
Total		12,815,098	

7. Monitoring and Evaluation Plan

7.1. Monitoring and Evaluation Description

Principles (Integration, Focus, and Data use): The implementation of this accelerated quality and coverage plan for iCCM/CBNC will be monitored through established monitoring mechanisms of the health system, i.e routine HMIS. In cases where existing HMIS reporting tools and system does not provide the required data for management decision, alternative data sources and review mechanisms will be instituted in consultation with FMOH (PPD), RHBs, ZHDs and WoHOs. Key priority indicators that measure implementation progress (input and process level) and, outputs and outcomes of planned interventions, will be measured periodically and routinely against each of the four objectives (Please refer to the indicators matrix below). Special focus will also be given to improve feedback mechanisms and use of data for decision-making and program improvement. Some outcome indicators will also be collected through the end line assessment of the IDEAS project as well as other operational researches

Review of program: Monthly and quarterly review meetings will be conducted at PHCU, WoHO, ZHD, and RHB will be utilized to review implementation progress and address key challenges. These meetings will be designed in a way that ensures review of key indicators collected through HMIS (and non-HMIS models) by the respective health facilities and offices so that improvement actions are generated and followed up. Such reviews will happen bi-annually at the national level. Moreover, efforts will be exerted to include the key CBNC/iCCM indicators as part of the MNCH scorecards and using them at lower levels of the health system to ensure periodic ranking of PHCUs and Woredas by their performance for accountability purposes.

Evaluation Plan: On top of the routine monitoring of progress, it is necessary to understand the impact of implementation measuring how far we have achieved the intended objectives. To enable measurement of outcomes and impact, key baseline indicators that necessitated intervention are identified from the CBNC Implementation Mid-term Survey/IDEAS/, DHS 2016, other partner evaluations/surveys as needed. These will be used as a baseline for quantitative and qualitative comparison with the end line evaluation that is planned to be conducted by IDEAS. The end line will be a mixed methods cross-sectional survey of households and health facilities.

Priority indicators and monitoring plan: The following matrix shows key selected indicators, their definition, data source, unit of analysis and responsible body to generate, compile and analyze data at various levels.

7.2. iCCM/CBNC Program quality improvement performance monitoring plan

indicator	Matrix	baseline	Target	source of data	means of data collection	frequency of reporting	critical assumptions	responsible party
1	proportion of health science colleges with at least 10 of the tutors have received ToT on Pre-deployment CBNC-iCCM training for HEWs	0	20	Training report	Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.	Quarterly	There would be national training data base and Zonal, regional and national TA's will have a system to collect training data	Zonal, regional and national TA
2	proportion health posts staffed with at least 1 HEW trained on iCCM and CBNC	98%	100		Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.	Quarterly		Zonal, regional and national TA

3	proportion of PHCUs with at least 2 staffs are trained/oriented on IMNCI+iCCM-CB-NC and supervisory skill	Numerator: number of PHCUs staffed with at least 2HWs trained/oriented on IMNCI+iCCM-CBNC and supervisory skill Denominator: total PHCUs in the country	72%	100	Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.	Quarterly	Zonal, regional and national TA
4	proportion of Woredas with at least 2 staffs are trained/oriented on IMNCI+iCCM-CB-NC and supervisory skill	Numerator: number of woredas staffed with at least 2HWs trained/oriented on IMNCI+iCCM-CBNC and supervisory skill Denominator: total woredas in the country	---	100	Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.	Quarterly	Zonal, regional and national TA
5	proportion of zones with at least 2 staffs are trained/oriented on IMNCI+iCCM-CB-NC and supervisory skill	Numerator: number of zones staffed with at least 2HWs trained/oriented on IMNCI+iCCM-CBNC and supervisory skill Denominator: total zones in the country	---	100	Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.		Zonal, regional and national TA

6	proportion of regions with at least 2 staffs are trained/oriented on IMNCI+iCCM-CB-NC and supervisory skill	Numerator: number of regions staffed with at least 2HWs trained/oriented on IMNCI+iCCM-CBNC and supervisory skill Denominator: total regions in the country	-----	100	Training coordinators compile training data after completion of each training session and submit to zonal/regional TA. Regional TA then submit to national TA that the data is aggregated centrally.		Zonal, regional and national TA
Objective 2: To improve sick newborn and children service utilization at PHCU level							
7	Proportion of PHCUs which has a report on HPs functionality during working days and hours from kebele command post(KCPI) to create accountability at lower level	Numerator: number of PHCUs which received information from KCPs and reported to woreda Denominator: total number of PHCUs in the country		100%	KCP chair person will compile monthly data and report to PHCU director with signed off time sheet of HEWs. PHCU director will compile all HPs data under the catchment and submit to district focal person.	Monthly	PHCU director, woreda focal person and Zonal TA
					FMOH would have standard guideline to PHCUs in establishing monitoring mechanism. And KCPs would regularly and honestly report HPs functionality during working days and hours to PHCUs		

10	Proportion of health centers with written action plans to support HEWs, KCPs and HDAs in creating demand for service utilization	Numerator: number of health centers with written action plans to support HEWs, KCPs and HDAs in creating demand for service utilization Denominator: total number of Surveyed HCs		survey		periodically	
11	Proportion of Level 1 HDAs who have knowledge on maternal danger signs	Numerator: number of Level 1 HDAs who have knowledge on maternal danger signs Denominator: total number of Surveyed HDAs		survey data		periodically	
12	Proportion of Level 1 HDAs who have knowledge on newborn danger signs	Numerator: number of Level 1 HDAs who have knowledge on newborn danger signs Denominator: total number of Surveyed HDAs		survey data		periodically	

13	Proportion of Level 1 HDAs who have knowledge on family guide use	Numerator: number of Level 1 HDAs who have knowledge on family guide use Denominator: total number of Surveyed HDAs		survey data		periodically	
14	Proportion of HPs that Integrated/ included Newborn and Child Health issue in School health platforms	Numerator: number of primary schools in a kebele that reported integration of newborn and child health issues in health education sessions Denominator: total number of Surveyed schools		survey data		periodically	A kebele has one HP and one elementary school
Objective 3: To ensure continuous availability of supplies and commodities and improve the efficiency and effectiveness of the supply chain management system for child and newborn health commodities							

15	Proportion of HPs which had gentamicin stock out for one week or more in the reporting quarter	Numerator: number of HPs which had gentamicin stock out for one week or more in the reporting quarter Denominator: total number of HPs	5%	Supervision checklist	PHCU director will compile data from supervision reports and submits to woreda focal person. Woreda focal person compiles the woreda data and submits to zonal TA. Zonal TA to regional TA and regional TA to National TA	Quarterly	comprehensive supervision to health post checklist will have stock status data on essential drugs	PHCU director, woreda focal person and Zonal TA
16	Proportion of HPs which had Amoxicillin stock out for one week or more in the reporting quarter	Numerator: number of HPs which had Amoxicillin stock out for one week or more in the reporting quarter Denominator: total number of HPs	5%	Supervision checklist	PHCU director will compile data from supervision reports and submits to woreda focal person. Woreda focal person compiles the woreda data and submits to zonal TA. Zonal TA to regional TA and regional TA to National TA	quarterly		

17	Proportion of HPs which had ORS+ Zinc stock out for one week or more in the reporting quarter	Numerator: number of HPs which had ORS+ Zinc stock out for one week or more in the reporting quarter Denominator: total number of HPs	5%	Supervision checklist	PHCU director will compile data from supervision reports and submits to woreda focal person. Woreda focal person compiles the woreda data and submits to zonal TA. Zonal TA to regional TA and regional TA to National TA	Quarterly		
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7.3. Milestones for implementation

Number	MILESTONE	Expected date of completion							
		Y1				Y2			
		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Objective 1: Improve HEWs, HWs, and supervisors competency in management of sick Newborn and common childhood illnesses at PHCU level									
Milestone 1.1	CBNC and iCCM training modules, facilitator's guide and chart booklet are merged in line with the new revised national guideline, and printed	x							
Milestone 1.2	Action plan developed to provide cascaded training to HEWs as per the standard guide during the ToT trainings		x				x		
Milestone 1.3	IMNCI program specific SS checklist for Primary Hospital and WorHOs to visit HCs revised					x			
Milestone 1.4	ISS checklist at all levels (National-Regional-Zonal-woreda-PHCU) - is revised and includes iCCM/CBNC/IMNCI key indicators					x			

Milestone 1.5	The woreda based annual work-plan includes supportive supervision plan linked with costed budget (month for program specific SS and Quarterly for ISS)	x	x						
Milestone 1.6	Performance review and refresher training (PRRT) facilitator guide is revised from PRCCM guide to be held at HC level and focuses on quality and service utilization improvement	x							
Milestone 1.7	Zones regions and FMOH staffed with 1, 2 and 1 TA's respectively to provide technical support to the system	x	x	x	x	x	x	x	x
Objective 2: To improve sick newborn and children service utilization at PHCU level									
2.1	Circular letter is written to RHBS to strictly follow the revised HEP guideline which states HP shall be opened every day to provide HP based services	x							
Milestone 2.2	Very severe diseases /neonatal sepsis, pneumonia, diarrhea early PNC and management of LBW newborn & Severe acute malnutrition treatment indicators are included as part of performance evaluation indicators for HP, HCs and WorHOs	x							
Milestone 2.3	Key messages for transmission using local media on danger signs and service availability developed		x	x	x	x	x	x	x
Objective 3: To ensure continuous availability of supplies and commodities and improve the efficiency and effectiveness of the supply chain management system for child and newborn health commodities									
Milestone 3.1	Orientation on IPLS integrated with other trainings			x	x				
Objective 4: To strengthen performance monitoring and accountability on Child and Newborn Health									
Milestone 4.1	Adequate number/critical iCCM/CBNC indicators are included on HMIS	x	x						
Milestone 4.2	iCCM/CBNC/IMNCI targets are included on Annual woreda base plan-	x	x						
Milestone 4.3	iCCM/CBNC/IMNCI program Focal persons assigned at Zonal/Woreda levels to ensure accountability	x	x						



Photo credit: Bizuhan Gelaw Birhanu/UNICEF Ethiopia