Federal Ministry of Health
Ethiopia

National Implementation Plan

For

Community Case Management of Common Childhood Illnesses

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Acronyms

ACT	Artemisinin based combination therapy
AMREF	African Medical and Research Foundation
ANC	Antenatal care
ARI	Acute respiratory infections
BR	Birr, the Ethiopian currency
CCM	Community-base case management
CHW	Community health worker
CIDA	Canadian Development Agency
C-MNCH	Community-based maternal, newborn and child health
CSTWG	Child Survival Technical Working Group
DPT	Diphtheria, pertussis, tetanus vaccine
EDHS	Ethiopian demographic and health survey
EFY	Ethiopian fiscal year
EHA	Emergency and humanitarian action
ENA	Essential nutrition actions
EPHA	Ethiopian Public Health Association
EPS	Ethiopian Pediatric Society
EPI	Expanded program on immunization
FMOH	Federal Ministry of Health
FP	Family planning
HC	Health center
HEP	Health extension program
HEW	Health extension worker
HF	Health facility
Hib	Hemophilus influenzae type B (vaccine)
HIV/AIDS	Human immunodeficiency virus/ acquired immunodeficiency syndrome
HMIS	Health management information system
HP	Health post
HPDP	Health promotion and disease prevention
HSC	Health science college
IEC	Information, education, communication
IFHP	Integrated Family Health Program
IMCI	Integrated management of childhood illnesses
IMNCI	Integrated management of neonatal and childhood illnesses
IRC	International rescue committee
IRS	Indoor residual spraying
ITN	Insecticide treated nets
IYCF	Infant and young child feeding
JICA	Japan International Cooperation Agency

JRM	Joint review meeting
JSI	John Snow, Inc
KMC	Kangaroo mother care
L10K	Last Ten Kilometers
LLINs	Long lasting insecticide treated nets
LMIS	Logistics management information system
MDG	Millennium development goal
MOH	Ministry of Health
MPS	Make pregnancy safer
MTOT	Master training of trainers
MUAC	Mid-upper arm circumference
NGO	Non-governmental organization
ORS	Oral rehydration solution
ORT	Oral rehydration therapy
OTP	Outpatient therapeutic program (outpatient management of uncomplicated cases of SAM)
PFSA	Pharmaceutical fund and supply agency
PMTCT	Prevention of mother-to-child transmission (of HIV)
RDT	Rapid diagnostic test
RHB	Regional Health Bureau
RUTF	Ready-to-use therapeutic food
SAM	Severe acute malnutrition
SC	Save the Children
SCMS	Supply chain management system
SFP	Supplementary feeding programs
SNNPR	Southern Nations, Nationalities, and People's Region
TFP	Therapeutic feeding program (combination of inpatient (TFU) and outpatient (OTP) program)
TFU	Therapeutic feeding unit (inpatient management of complicated cases of SAM)
TOT	Training of trainers
TT	Tetanus toxoid vaccine
TTC	Tetracycline ointment (eye ointment)
TWG	Technical working group
U<1	Children under one year of age
U<5	Children under five years of age
UNICEF	United Nations Children Funds
USAID	United States Agency for International Development
VAS	Vitamin A supplementation
VCHW	Voluntary community health worker
WHO	World Health Organization
WorHO	Woreda Health Office
ZHD	Zonal Health Department

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NATIONAL IMPLEMENTATION PLAN FOR COMMUNITY-BASED CASE MANAGEMENT OF COMMON CHILDHOOD ILLNESSES

Executive summary

Over the past two decades, Ethiopia has witnessed a steady more than 40 percent reduction in child mortality across the country.[1] However, despite this remarkable achievement, it is estimated that 360,000 children under the age of five still die each year from preventable or treatable conditions such as acute respiratory infection primarily pneumonia, neonatal problems, malaria, diarrhea and malnutrition[2]. A large proportion of deaths and illnesses attributed to these diseases can be prevented at the community level by the Health Extension Workers (HEWs) through preventive interventions and early, appropriate and low-cost treatment of sick children in the home or community, with antibiotics, anti-malarias and oral rehydration therapy. The Federal Ministry of Health (FMOH) has given high priority to strengthen the community based health service delivery system through the Health Extension Program, implemented by HEWs.

Based on the growing demand of Ethiopian rural communities, local studies on the operational feasibility of pneumonia management by HEWs, the health sector development plan III (HSDP III) midterm review and the joint review meeting (JRM) recommendation, the FMOH has decided to introduce community based pneumonia treatment by HEWs[3]. The decision is bringing a huge opportunity for Ethiopia to quickly scale up this high impact child survival curative intervention within a very short period of time and achieve the Millennium Development Goal 4.

Similarly, the outpatient management of severe acute malnutrition by the HEWs at health post level was successfully piloted in 100 woredas in 2008[4] and now being integrated in the health extension package.

The overall goal of this implementation plan is through Community-based Case Management (CCM) of Common Childhood Illnesses, ensure the greatest possible reduction of mortality in children less than five years of age in order to achieve the Millennium Developed Goal 4 by 2015. To achieve this goal, the capacity of HEWs to properly assess, classify and manage common childhood illnesses (pneumonia, malaria, diarrhea and severe acute malnutrition) and assessment and referral of newborn conditions at a community level need to be strengthened. Also, the skills and capacity of HEW supervisors and woreda health extension program (HEP) focal persons to supervise and manage the CCM by HEWs need to be reinforced. Finally, regular and continuous supplies of equipments and consumables required for CCM should be ensured. All these activities will be regularly monitored and evaluated to ensure that accomplishment of the overall implementation goal move forward.

[1] UNICEF, Child survival, the state of the world children, 2008
[2] Ethiopia Demographic and Health Survey, 2005
[3] HSDP III Mid Term Review , Main Report, 2009
[4] Decentralization of out-patient management of severe malnutrition in Ethiopia, Sylvie Chamois, Field Exchange Emergency Nutrition Network, July 2009, Issue 36, page 11

Major activities

Using this new initiative, the plan is to strengthen the community based case management of the common childhood problems. The first activity will be to provide orientation to Ministry of Health (MOH) officials at all level. This will be followed by:

Training, which include updating of training materials, tools and job aids; and provide training of trainers (TOT) for national master and regional trainers; and CCM training at woreda level for HEWs, their supervisors and woreda HEP focal persons.

Supply and logistics, which take into account creating a list of the essential drugs, necessary equipment, job aids and tools needed during the training and roll-out of CCM in health post; and organizing a sustainable logistic system to ensure no stock outs of essential drugs in the health posts.

Coordination and management, under the central guidance of the Health Promotion and Disease Prevention (HPDP) General Directorate, the role and responsibilities of each management level of the regional health bureau (RHB), Zones and Woredas are well articulated in this document. Also, the national and regional child survival technical working group (CSTWG) will be reactivated to assist with coordination.

Monitoring and evaluation, the main activities include establish a baseline information for the project, develop indicators and set targets for CCM of common childhood illnesses; follow up after training and regular supportive supervision and routine collection of information using the registration book and reporting format. Lastly, regular review meetings and operational research will be undertaken.

Budget and funding, the above mentioned activities have all been costed and budgeted. The total amount of money required for the three year of implementation is **Birr 206,209,184 or US$ 16,496,735** for the four regions, which comes to an implementation cost per capita per year for the four regions of **Birr 1, or US$ 0.08**. Out of this cost, the estimated cost to only implement treatment of pneumonia at community level will be **Birr 30,421,420 or US$ 2,433,714** which is **Birr 0.15 or US$ 0.01** per capita per year for the four big regions for the three years. This estimation only captures the assumed direct costs of CCM of pneumonia without taking into account other common childhood illnesses. However, to improve child survival in Ethiopia and to reach MDG 4, all four major childhood killers need to be tackled in an integrated manner.

1. Introduction

Over the past two decades, Ethiopia has witnessed a steady more than 40 percent reduction in child mortality across the country.[5] However, despite this remarkable achievement, it is estimated that 360,000 Ethiopian children under the age of five still die each year from preventable or treatable conditions such as acute respiratory infection primarily pneumonia, neonatal problems, malaria, diarrhea and malnutrition[6]. A large proportion of deaths and illnesses attributed to these diseases can be prevented at the community level by the Health Extension Workers through preventive interventions and early, appropriate and low-cost treatment of sick children in the home or community, with antibiotics, anti-malarias or oral rehydration therapy. This Community-based Case Management of Common Childhood Illnesses approach is the most feasible way of scaling up the implementation of the high impact child survival curative intervention in the foreseeable future[7].

Table 1: Disease attribution to child mortality in Ethiopia

Condition	% Attributable mortality	Attributable deaths	% Preventable deaths	Preventable deaths
Pneumonia	28	100,800	65	65,520
Newborn problems	25	90,000	55	49,500
Malaria	20	72,000	91	65,520
Diarrhea	20	72,000	88	63,360
Measles	4	14,400	100	14,400
AIDS	1	3,600	48	1,728
Other	2	7,200	0	0
Total	**100**	**360,000**	**72**	**260,028**

This table show how each specific disease attributes to the child mortality in Ethiopia and how, with the preventive interventions and correct assessment, classification and treatment, many deaths can be prevented. Moreover, malnutrition is the underlying cause of 57% of the under five children death[7].

1.1 National coverage for Case Management of Common Childhood Illnesses

Since the start of the Health Extension Program (HEP) in 2004 and the deployment of Health Extension Workers (HEWs), the coverage of most of the high impact preventive intervention has shown significant improvement:

- The Penta3 and measles coverage from 73 % and 65.2% in 2007 to 82% and 77.3% in 2009 respectively[8]
- Children under five sleeping under insecticide-treated bed nets (ITN) from 1.5% in 2005 to 43% in 2008
- Vitamin A supplementation from 50% in 2005 to 94 % coverage in 2009[9]
- National sanitation coverage from 11.5 % in 2003 in 54.8 %in 2009[10]

[5] UNICEF, Child survival, the state of the world children, 2008
[6] Ethiopia Demographic and Health Survey, 2005
[7] National Strategy for Child Survival in Ethiopia, 2005
[8] FMOH/WHO/UNICEF joint reporting formats (JRF) officially communicated for 2007 and 2008 and 2009 FMOH progress report (projected using the 2009 nine months progress reports)
[9] National coverage of Expanded Program for Immunization administrative report, 2009
[10] Sanitation update: Ethiopian sanitation coverage in 2009

- The coverage of the management of severe acute malnutrition has gone from close to zero in 2003 to over 280 woredas and 5,000 health posts in 2009

Additionally, to tackle the common childhood illnesses, the HEW have been trained to systematically detect danger sign, assess the sick children for the major child killers, treat for malaria, diarrhea and malnutrition and refer if the child is severely ill or if he or she has a disease that the HEW can not treat, such as pneumonia or complicated severe acute malnutrition. The HEWs should also counsel the caregiver of the sick child on how to administer all of the treatments provided.

1.2 The high impact child survival intervention for the four major killers

For each of the major killers of children under five; pneumonia, newborn problems, diarrhea, malaria and severe acute malnutrition there are a number of high impact, low cost preventive and curative interventions that can undertaken to save the majority of lives of Ethiopian children. Of all the interventions listed in table 2 below, currently the HEWs have been trained to undertake almost all of them, except PMTCT with nevirapine, antibiotic treatment of pneumonia, dysentery and sepsis. As of 2010, part of the CCM by HEW initiative, HEWs will start to introduce antibiotic treatment of pneumonia at the community level.

Table 2: Preventive and curative intervention targeted to the four major under five killers

Target condition	Preventive intervention	Curative intervention
Pneumonia	• Exclusive breastfeeding • Adequate complementary feeding • HIB vaccination • Pneumococcal vaccine • Measles vaccination • PMTCT with nevirapine	• Antibiotic treatment
Newborn problems	• Focused antenatal care • TT immunization • Skilled delivery • Clean delivery • Prevention of hypothermia • Early and exclusive breastfeeding • Hygiene/sanitation/safe water	• Resuscitation of newborn • Management of hypothermia • Antibiotics for sepsis
Diarrhea	• Hand washing /sanitation/safe water • Household water treatment at point of use • Exclusive breastfeeding • Adequate complementary feeding • Vitamin A supplementation • Vaccination against measles	• ORT/ORS • Antibiotics for dysentery • Zinc treatment
Malaria	• Long-lasting insecticide treated bed nets • IRS	• Anti-malarial drugs
Severe acute malnutrition	• Essential nutrition actions (optimum breastfeeding, adequate complementary feeding, continued feeding when the child is sick, vitamin A supplementation, iron supplementation and universal salt iodization) • Supplementary feeding when the child is moderately malnourished	• Therapeutic feeding treatment with RUTF • Systematic antibiotic treatment and deworming • Measles vaccination

Regardless of all of the effort done by HEWs, little progress has been made to scale up the case management of major common childhood illnesses in Ethiopia. According to the 2009 all Africa progress report, only 5 percent of children under five with suspected pneumonia receiving antibiotics, 15 percent of children under five with diarrhea receiving ORT with continued feeding and the percentage of children under five with fever receiving anti-malarias were 10[11].

Improvements in care at health facilities through Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and other initiatives are necessary but not sufficient. Children from the rural community and from the poorest families are less likely to be brought to health facilities. Therefore, the most appropriate way of increasing access to treatment for the common child illnesses is through a community based approach, using the human potential available at the community level.

[11] Malaria Indicator Survey (MIS) in Ethiopia, 2007

1.3 Pneumonia the leading cause of death in under five children

Pneumonia kills more children under five years of age than any other illness across the world. The most important interventions recommended to control pneumonia in children include the following[12]:

- Protect children from acquiring pneumonia by providing them with an environment where children are at low risk of pneumonia;
- Prevent children from becoming ill with pneumonia;
- Treat children who become ill with pneumonia.

Ethiopia is doing relatively well in improving the coverage of the high impact preventive child survival interventions that addresses pneumonia, such as improved coverage of immunization for Hib and measles and there is also a plan to introduce pneumococcal vaccine starting January 2010.

Regardless of improved coverage of preventive interventions, approximately 4 million childhood pneumonia cases are occurring in Ethiopia annually and majority of these children have limited access to quality clinical care.

Early intervention studies conducted both locally and globally show that case management of pneumonia by community health workers has a significant impact on the overall and pneumonia specific under five mortality. A recent meta-analysis of community based pneumonia case management studies estimated a 20 percent reduction in all cause of under one mortality and a 24 percent reduction in all causes of under five mortality[13].

In addition, observations of the feasibility of introducing community based pneumonia management by HEWs were made during the field visits of both the Mid Term Review of HSDP III and the 2009 Joint Review Mission teams. Both group strongly recommended that pneumonia management by HEWs should be included in the HEP.

1.4 Community case management: the evolution in Ethiopia

Ethiopia has many years of experience in Community Case Management (CCM) of common childhood illnesses in different regions across the country. The first experience dates in the late1980's when community workers were trained to treat childhood pneumonia using oral antibiotics in Butajira, SNNP region.

In Tigray region, a study on community based malaria treatment was conducted in 2000. The study modified an ongoing community-based malaria control program in order to serve more women and young children. In this study, community health workers (CHWs) – known as 'mother coordinators' – educated other mothers to recognize malaria symptoms in their children, give appropriate doses of chloroquine and identify adverse reactions to chloroquine. The study demonstrated a forty percent all cause under five mortality reduction[14].

[12] UNICEF, Maternal, Newborn and Child Survival in Africa : Progress in Intervention coverage , all Africa representative meeting, 2009

[13] UNICEF, Global action plan for prevention and control of pneumonia, potential reduction in pneumonia morbidity and mortality with selected interventions, 2008

[14] Kidane, G., and R. H. Morrow, 'Teaching Mothers to Provide Home Treatment of Malaria in Tigray, Ethiopia: A randomized trial', The Lancet, vol. 356, no. 9229, 2000, pp. 550–555.

The other CCM research available in Ethiopia includes the Liben study, conducted by Save the Children USA (SC) in a remote district of Oromia region. In Liben, between 2001 and 2006, CHW were trained and supervised on how to assess, classify and treat children with diarrhea, pneumonia and malaria. The result was certainly encouraging since the CHW were able to properly assess, classify and treat the three major killers of the under five kids safely without any serious problem if they were appropriately trained and supervised[15].

A wider scale of CCM was introduced after the deployment of the HEWs for malaria and diarrhea in children at the national level. The operational feasibility of including pneumonia in the treatment package for HEWs was tested in Boloso Sore, in SNNP region from 2006 to 2008. In this study, the HEWs maintained high standard of compliance with a case management for the three major killers. The percentage of under five children correctly assessed, classified and managed for diarrhea, malaria and pneumonia ranged from 88% to 90%[16].

The outpatient management of severe acute malnutrition by the HEWs at health post level was successfully piloted in 100 woredas in 2008[17] and now being integrated in the health extension package. As of March 2010, over 5,000 health posts in 280 woredas are identifying severe acute malnutrition, referring the complicated cases to the nearest inpatient therapeutic feeding unit (at hospital or health centre level) and treating the uncomplicated cases of severe acute malnutrition on outpatient basis (home-based treatment).

1.5 Health Extension Program: an opportunity to scale up CCM in Ethiopia

Health Extension Program (HEP) has radically changed the landscape of the community health service delivery system in Ethiopia. Many families and communities are now, after the introduction of HEP, empowered to take care of their own health through the model family training approach, which can be seen in the improved health care seeking behavior and demand for quality care among the rural communities.

HEWs are trained to assess and classify the four major killers: Pneumonia, malaria, diarrhea and severe acute malnutrition in under five children. However, to date, the provision of treatment by HEWs is limited to the three killers: malaria, diarrhea and severe acute malnutrition. For the first killer pneumonia, HEWs only asses and classify children with cough or difficult breathing and if they are found having pneumonia, they refer them to health facilities for treatment. The HEWs could not treat these children themselves.

Effective community treatment of pneumonia requires knowledge of the community, adequate training of HEWs, support, supervision and close links with functional health centers that have skilled health professionals and adequate drug supplies. Supervision structures, health information system, referral mechanisms and drug supply chains require strong relationship between health systems and HEP. The program activities must include procedures for monitoring the coverage and quality of services provided by HEWs.

Based on the growing demand of the communities for curative interventions for the common childhood illnesses including pneumonia at the village level and improving coverage for some of

[15] Tedbabe Degefie, David Marsh: Community Case Management Improves Use of Treatment for Childhood Diarrhea, Malaria and Pneumonia in a Remote District of Ethiopia, Ethiop.J.Health Dev. 2009;23(2)
[16] Integrated Family health program report of implementing Integrated case management of Newborns and childhood illness within the Health Extension Program, Boloso Sore, 2009
[17] Decentralizations of out-patient management of severe malnutrition in Ethiopia, Sylvie Chamois, Field Exchange Emergency Nutrition Network, July 2009, Issue 36, page 11

the promotive and preventive interventions, evidences from the local studies on the operational feasibility of pneumonia management by HEWs, the HSDP III midterm review and the JRM recommendation, the FMOH has decided to introduce community based pneumonia treatment by HEWs[18]. Coincidentally, this decision came immediately after the week of global pneumonia day celebration and it will certainly bring a huge opportunity for Ethiopia to quickly scale up this high impact child survival curative intervention and achieve the Millennium Development Goal 4.

2. Goal

Through Community-based Case Management of Common Childhood Illnesses, ensure the greatest possible reduction of mortality in children less than five years of age in order to achieve the Millennium Developed Goal 4 by 2015.

2.1 General objective

Improving Community-based Case Management of Common Childhood Illnesses including pneumonia using the Health Extension Program as a major vehicle

2.2 Specific objectives

1. Strengthen the capacity of HEWs to properly assess, classify and manage common childhood illnesses at a community level;
2. Introduce CCM of pneumonia by HEWs;
3. Reinforce CCM of malaria, diarrhea, malnutrition and other common childhood illnesses by HEWs;
4. Strengthen the capacity of HEW supervisor's skills to properly supervise HEWs management of CCM;
5. Strengthen the capacity of the woreda health office to coordinate the CCM by HEW and HEW supervisors;
6. Ensure regular and continuous supply of equipments and consumables required for CCM;
7. Establish a mechanism of regular and continuous monitoring and evaluation of CCM.

2.3 Opportunities and challenges for CCM

FMOH has given high priority to strengthen the community based health service delivery system through the HEP.

To achieve the Millennium Development Goal 4 (MDG4) for child survival in Ethiopia, focused and coordinated action to strengthen the health system and to reduce inequities in access to effective preventive and curative interventions against the diseases which kill young children are needed. This implementation plan should take advantage of existing opportunities and address the challenges which may hinder implementation.

[18] HSDP III Mid Term Review , Main Report, 2009

2.4 Opportunities of rolling out CCM in Ethiopia

- Availability of 32,000 HEWS, two in each village across the country brings an enormous advantage to effectively deliver most of the high impact child survival interventions to the rural community at the grass root level;
- Availability of both local and international experience in successfully rolling out of CCM of common childhood illnesses;
- Existence of strong partnership for child survival including, solid support for HEP and of rolling out CCM by HEWs;
- Availability of in country experience in harmonization of community based MNCH interventions and conducting integrated refresher training for HEWs;
- Availability of more than 3,000 HEW supervisors throughout the country;
- An ongoing expansion of first level referral health facilities, health centers which can potentially be strengthened to establish a strong primary health care unit for the rural communities;
- Initiation of the new distance learning program with Open University to upgrade HEWs to level IV.

2.5 Challenges of rolling out CCM in Ethiopia

- Coverage and utilization of essential curative health intervention is very low with wide regional variations;
- Shortage of staff with program management skills at all levels;
- Lack of motivation of health workers at all levels;
- Weak supply and logistic system and with frequent stock-outs at heath posts;
- Weak health information and management system at the community level;
- HEWs are overburden and over-assigned with a huge number of tasks and meetings;
- Monitoring and evaluation are very week and more so at the community level;
- Supportive supervision at all levels need to be strengthened;
- Inclusion of practical skills and experience both during pre-service and in-service training of HEWs is insufficient.

3. Major activities

The major activities to be undertaken for the implementation of the CCM by HEWs in the implementing regions are:

- Conduct orientation meetings for all stakeholders from national, regional, zonal and woreda levels;
- Prepare and distribute all necessary training materials before the commencement of the trainings;
- Organize cascaded trainings that include master TOT at national level, TOT at regional level and actual training of HEWs, HEW supervisors and woreda HEP focal person at woreda level;
- Train HEW supervisors and woreda HEP focal persons on post training follow up skills which will be integrated to the actual case management trainings;
- Conduct post training follow up visits to all HEWs trained on CCM;
- Identify all essential drugs, supplies and equipments needed for the implementation of CCM and making them available in all the selected health posts ;
- Develop coordination and management framework for CCM;

- Cost the logistics and operations needed to roll out the CCM implementation plan;
- Develop a sound monitoring and evaluation framework for CCM.

3.1 National, regional and woreda cluster level orientation meetings of CCM

Orientation for key MOH program managers, partners, implementing regions and professional associations is crucial for the successful implementation of CCM by HEWs in the implementing regions.

The objective of orientation is to create common understanding among key stakeholders about the nature and extent of major child health problems, available solutions and how to reduce the unacceptably high mortality and morbidity among Ethiopian under-five children through the implementation of CCM by HEWs. In addition, this meeting will help to generate support from stakeholders and establish strong partnership and collaboration for successful implementation.

The orientation will start by giving a brief overview of HEP in general, why under-five children die, when they die and existing, proven high impact community based interventions to save the lives of many children who are dying in Ethiopia. This will be followed by presenting and discussing the rationale and implications of introducing CCM by HEW, an intervention that includes treatment of pneumonia with antibiotics by HEWs. The other issues to be discussed will be the revitalization of the Child Survival Technical Working Group (CSTWG) at national and regional level to support the implementation of CCM by HEWs in all implementing regions. At the end of the orientation meeting, participants will reach consensus on the implementation process of CCM by HEWs at community level and develop an agreed action plan that depict the steps of CCM by HEWs.

All orientation meetings at national, regional and woreda cluster levels will be conducted for one day.

3.1.1 National level orientation

During the national level orientation meeting a total of 55 participants will participate from FMOH, RHBs, development partners (UNICEF, WHO, L10K, IFHP, Save the Children USA, Save the Children UK, USAID, CIDA, AMREF, IRC, JSI etc), and professional associations (EPHA and EPS) and AAU (Pediatrics Department and School of Public Health). The national level meeting is expected to be conducted on the 23rd of February 2010 and it will be lead by the Health Promotion Disease Prevention General Directorate, with the technical support from the CSTWG.

3.1.2 Regional and woreda cluster level orientation

Orientation meetings at regional and woreda cluster level will be held with same preparations, objective and content as that of the national orientations. People who attended the regional level orientations will collaborate with the RHBs and regional CSTWG to organize cluster level orientation and planning meeting for all woreda health offices in the implementing regions. In Tigray, region, only one regional level orientation meeting will be conducted while Amhara, SNNPR and Oromia regions will conduct 3, 3, and 5 rounds respectively at regional and woreda cluster levels, at nearby zonal town.

The regional and cluster level orientation meetings are expected to be completed in the 3rd and 4th weeks of March, 2010. Expected number of participants of the regional and cluster level orientation meetings is 188; 305; 163; and 51 in Amhara, Oromia, SNNP, and Tigray regions respectively.

3.2 Training on CCM

3.2.1 Preparation of training materials

Preparation of training guides, tools, job aids, registration forms, and supplies for demonstration during trainings ahead of time will be a crucial step for starting the training of trainers, woreda HEP focal persons, supervisors, and HEWs on CCM. The training materials and job aids for the CCM by HEW training were prepared in 2006 and field tested in Boloso sore woreda. At this juncture, the national C-MNCH harmonization technical working group has started revising training materials and job aids. The revision of these materials is expected to be finalized in January 2010, the materials will be field tested in SNNPR and the printing and distribution will be completed by the end of March 2010. In addition to the training guides; drugs, supplies, and equipments needed for demonstration and practices during the training will be distributed and be available at the training facilities before commencing the trainings. Regions and zones/ woredas will collect the needed materials from each respective level and they will be responsible for making the material available at the training sites prior to the training starts.

Table 3: List of training materials, equipments, and supplies needed to implement CCM

Printed and audio visual	Equipments/ others	Drugs and supplies
Facilitator's guide	Self-inflating newborn ambu-bag and mask	Co-trimoxazole syrup and pediatric tablets
Chart booklet	Baby model mannequin and breast model	Amoxicillin capsule and syrup
Photo booklet	Cloth for positioning, drying and wrapping	Tetracycline eye ointment
Exercise booklet	Clinical thermometer	Vitamin A tablets
Video film	Watch showing seconds	Mebendazole/Albendazole tablets
Counseling card	Weighing scale	RUTF (Plumpy 'Nut® or BP100®)
Photo booklet	MUAC tape	Paracetamol tablets
Registration book for sick young infant below 2 months	ORT equipment	ORS sachets and zinc tablets
Registration book for sick child 2 months to 5 years		Artemether-Lumefentrine (Coartem)
Reporting format		Chloroquine syrup and RDT

3.2.2 Conduct training

To facilitate the training process from national to woreda levels, it will be essential to create a pool of trainers at national, regional and zonal levels. These trainers will support the rollout trainings for woreda HEP focal persons, HEW supervisors and HEWs at woreda levels. The potential training facilitators will be pediatricians, MDs, and health officers who will be drawn

from FMOH, RHBs, hospitals, health centers, universities, regional health science colleges, and partners who will attend TOT training on CCM by HEWs. The planned trainings are described below.

3.2.3 Master training of trainers (MTOT)

To establish national level pool of trainers who will facilitate subsequent trainings in the implementing regions, two rounds of MTOT will be conducted at federal level. These trainings will be led by the FMOH, HPDP- General Directorate with the technical assistance from the national CSTWG. Participants will be from FMOH, implementing regions (RHB, hospitals, and HSC), partners and universities in respective regions.

The duration of each training, including the training on post-training-follow-up for HEW supervisors, will be 7 days. A total of 60 participants will be trained in two rounds. Each of the training will be facilitated by a minimum of 6 experts who are well experienced in facilitating CCM.

3.2.4 Regional level TOT

The regional level TOT will create a pool of trainers who will facilitate the subsequent rollout trainings for woreda HEP focal persons, HEW supervisors and HEWs at woreda level. The duration of each TOT will be 7 days (including training on post training follow up skill for HEW supervisors) and will be facilitated by master trainers who attended national level TOT. The trainer to trainee ratio will be at a minimum 1 to 5, with 30 participants per round.

A total of 480 trainers will be trained in all implementing regions (Amhara: 90, Tigray: 60, SNNPR: 90, and Oromia: 180). This means a total of 14 rounds of training sessions are required.

3.2.5 Training of woreda HEP focal person, HEWs and HEW supervisors

Training of the woreda HEP focal persons, HEW supervisors and HEWs is a critically important and challenging step. This needs good preparation and organization in order to deal with the actual implementers of the initiative in a way that insures quality on one hand and adequate speed and volume of implementation on the other.

The training will be organized in woreda towns with busy health centers for trainees to practice case management of sick children. Necessary preparations will be made before the training sessions to maintain the quality of training and sick children will be mobilized as needed so that trainees will have enough number of sick children to practice case management.

Six hundred and three woreda HEP focal persons and 2,264 HEW supervisors will be trained. In 1,021 training sessions the implementing regions will train 22, 634 HEWs.

The duration of the actual CCM by HEWs training will be 6 days. The woreda HEP focal person and the HEW supervisors will get an additional one day training on post training follow-up skills. The trainer to trainee ratio will be maintained at 1:5, with 25 trainees per round.

Table 4: Number of woreda HEP focal persons, HEW supervisors and HEWs to be trained by region

Region	Woreda HEP focal person	HEW supervisors	HEWs	Total
Amhara	142	571	5 712	6 425
Tigray	35	108	1 076	1 219
SNNP	147	648	6 476	7 271
Oromia	279	937	9 370	10 586
Total	**603**	**2 264**	**22 634**	**25 501**

3.3 Post training follow-up

For a program to be successful, giving quality training alone will not be enough. Therefore conducting post training follow-up /start-up follow up/ after completion of the CCM training will be critically important to undertake. The objectives of the post-training follow up visits are to:

- Reinforce integrated case management skills and assist HEWs to transfer these skills to actual practice in the community;
- Identify problems faced by HEWs in managing sick children and help solve these problems;
- Gather information on the performance of HEWs and explore conditions that influence performance in order to improve the implementation of CCM of sick children under five in the future.

The follow up visit will be conducted 4 to 6 weeks after the training of the HEWs. This will also be an opportunity to distribute essential materials like registration books, drugs and other supplies. It helps to initiate or start-up of activities. The supervisors (HEW supervisor and woreda HEW focal person) will mentor HEWs on how to use;

- Registration book (make sure that it is completed properly);
- Chart booklet (utilization of job aids);
- Standard stock management;
- Reporting forms and regular report of performance.

Supervisors will also identify major problems encountered by HEW in doing CCM, agree on their solutions through discussion with the HEWs. Most of the problems will be solved at the health post (HP) level while a few issues will need involvement of the woreda, zonal health offices or RHB depending on its nature. Supervisors conducting follow-up supervision will produce complete report of the visit as per the standard format and indicators.

3.3.1 Training on follow-up supervision after training of HEW supervisors and woreda HEP focal persons

Supervisors need training on supervisory skills and this will be given to those who are involved in TOT as they will be trainers of supervisors and woreda HEP focal person and HEW supervisors. The training will take one day and it will be integrated in the TOT. At woreda level it will occur on the seventh day of the CCM by HEWs, where only woreda HEP focal person and HEW supervisors will attend.

3.3.2 Timeline for the post training follow-up visits

As mentioned earlier, all HPs will be visited by at least one trained supervisor, preferably by both the HEW supervisor and woreda HEP focal person within 4 to 6 weeks after the training. Taking the geographic variation in to account a supervisor or a team of supervisors/woreda HEP focal persons will visit 1-2 HPs per day.

All 22,634 HEWs trained on CCM should receive post training follow up at their HPs with the recommended time. The total number of HPs to be supervised in the implementing regions within the first 4 to 6 weeks will be 11,317 (Tigray, 538; Amhara, 2,856; Oromia, 4,685; and SNNP, 3,238).

The woreda HEP focal person and HEW supervisors with the support of master trainers (RHB, hospitals, RHSC, and partners) will be responsible for conducting the follow-up visits and ensure that case management is started at HPs. They will also ensure that registration book, chart booklet, and other job aids, drugs and supplies are available at the health posts as per the standard.

Post training follow up visits will be important but will not be enough and should therefore be followed by the regular integrated supportive supervision including integrated CCM, as regular integrated supportive supervision is the only guarantee for sustainable implementation of CCM. This should fit to the schedule of the HEW supervisors and woreda health supervisory visit to HP.

As follow-up visits and regular supportive supervisions are critical to ensure quality and coverage, the necessary logistics like transportation, follow up checklist, and other resources need to be planned before conducting the follow up visits.

3.4 Ensuring quality of trainings

The effectiveness and impact of the integrate CCM starts from the beginning, with ensuring quality at all levels of the cascade training. The following activities have been put in place to maintain quality throughout the training process:

- Selection of the right trainees for TOT and engage them in skill based training to facilitate cascade of trainings in the same manner;
- Preparation of all involved trainers to make sure that they are prepared for all session throughout the training and that they continuously review the progress of the trainees and adapt to the training to ensure all trainees leave with the required skills to implement CCM;
- Selection of appropriate venue and site for adequate practical sessions and with electric power supply to show a video;
- Preparation of the training site prior to conducting the training session, insuring that all the necessary materials, supplies and equipment is available and that sick children have been mobilized to visit the training site during the training;
- Adherence to the standard training guidelines during training and preparation (duration, facilitator to trainee ratio, method of training, type and number of training materials).

To ensure the quality of the trainings, the FMOH should organize a team of expert supervisors from national and regional levels who will observe and support trainings at each level using standard checklists. Ten percent of all trainings at woreda level should be observed and

supervised. At the same time, the woreda level trainers should take the responsibility of ensuring quality of each woreda level training using a standard checklist.

The supervision and quality assurance of the trainings should be started from the beginning in order to use the outcome of the training assessments for improving the subsequent trainings in a timely manner.

4. Supply and logistics

Continuous supply of drugs, job aids and equipment will be essential for a successful implementation of the CCM of common childhood illnesses.

4.1 Essential consumables

To roll out CCM by HEWs; Co-trimoxazole for pneumonia, ORS for diarrhea, Coartem, Chloroquine syrup and RDT for malaria and RUTF, Amoxicillin and deworming tablets for severe acute malnutrition will need to be made available from the start of the trainings and throughout the implementation process and beyond.

4.2 Equipments

Watches that clearly display seconds, ambu-bag and mask, thermometer, weighing scales, MUAC tapes and ORT utensils are among the key equipments for CCM.

4.3 Job aids and tools

Registration books for both sick young infants age 0 to 2 months and sick children 2 months to 5 years, chart booklets, and hand books are the main job aids and tools that should be made available to HEWs to properly implement CCM.

4.4 Supply and logistics strategy

To create a smooth implementation plan for CCM by HEWs, in line with the evolvement of the national logistic system for health commodities, the CCM supply and logistics strategy will be divided into three time periods: immediate, medium-term and long term.

Immediate

The MOH and partners will continue to provide the supplies to HEP through ongoing programs: malaria, HP kit distribution, Therapeutic Feeding Program, etc. Supplies which are not yet or not sufficiently available at community level will be procured centrally. UNICEF and other partners will assist in the procurement and distribution. Training materials and tools will be printed or procured centrally, and distributed to the regions, where it will collected. In addition, some training material and tools/ job aids are already available at regional level, ready for collection. To ensure immediate availability of pneumonia treatment at the onset of the program, each HEW will be given enough Co-trimoxazole for at least 6 months upon completions of the CCM training. At the same time, they will also be provided with registration books and other job

aids. It is therefore necessary that Co-trimoxazole pediatric tablets (100 mg sulphmethoxazole + 20 trimethoprim), sufficient for at least 6 months, registers and other job aids are made available before any training commence. To ensure availability of drugs and prompt startup of CCM pediatrics Cotrimoxazole will be procured from abroad. However, to have a sustainable in country supply, in country production will be explored.

Medium-term

CCM supplies will gradually be integrated in the harmonized logistics management information system (LMIS) which is being developed by SCMS/PFSA. Following the phased roll-out, supplies will be delivered directly from the PFSA hubs to the woredas. As the health post will be considered a remote dispensary of the health center, requests from the health post should be integrated in the health center logistics and supply system. From the HCs, the supplies will either be collected by the HEW's and/or dropped off at the health post during supervisory visits. A simple stock management system will be set up at each HP, enabling stock monitoring, expiry date controlling and requesting new stock when needed. Stock records and expiry dates should be checked during supervisory visits.

Long-term

All CCM commodities, including the supplies provided by partners or managed by regions or zones, are channeled through PFSA. PFSA will procure based on the information generated by the harmonized LMIS and deliver from the hubs directly to the HC's. From the HCs, the supplies will either be collected by the HEW's and/or dropped off at the health post during supervisory visits.

5. Coordination and management

Identifying the roles and responsibilities of major players in implementing CCM by HEWs is an important component of this implementation plan. A well established outline of tasks and functions at each level of the implementation plan will advance the efficient and effective human and financial resources utilization which will ensure achieving the desired goal of reducing under five mortality. The role and responsibilities of different stakeholders at all levels in the implementation of this plan is outlined and described below.

5.1 Role and responsibility of FMOH/ HPDP General Directorate

- Give guidance and implementation directions to regions and partners;
- Coordinate orientation workshops and trainings on CCM of under five children;
- Mobilize resources for CCM of under five children by HEWs;
- Ensure that CCM by HEWs activities and indicators are properly addressed in the Woreda based health sector plan;
- Ensure supply of drugs, job aids and equipments for CCM by HEWs to regions for both the trainings and the implementation of CCM by HEWs;
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the implementation of CCM by HEWs;
- When necessary, review policy on community based child survival interventions.

5.2 Role and responsibility of RHB/ZHD (HPDP Core Process)

- Gives guidance and implementation directions to zonal health department and woreda health offices;
- Coordinate orientation workshops and trainings on CCM;
- Mobilize resources for CCM by HEWs;
- Ensure that CCM by HEWs activities and indicators are properly addressed in the Woreda based health sector plan;
- Ensure supply of drugs, job aids and equipments for CCM of common childhood illnesses to ZHD/Woreda Health offices;
- Coordinate supportive supervisions, review meetings and other relevant M&E methods to continuously improve the implementation of CCM by HEWs;
- Develop human resource technical capacity of the region on CCM by pooling seconded staffs from partners for consultancies and short term TA mechanisms which can give technical assistance at regional level.

5.3 Role and responsibility of woreda health office

- Ensure that CCM by HEWs activities and indicators are well captured in the woreda based health sector plan;
- Coordinate trainings and follow up after training to HEWs, their supervisors and relevant Woreda health office staffs on CCM;
- Ensure continuous supply of drugs, job aids and equipments for CCM at health posts;
- Strengthen the referral linkage and communication systems between the health post and health centers by capacitating both referral points in implementing CCM i.e. health centers and health posts;
- Ensure that the HEW supervisors conduct regular supportive supervision to enhance capacity of the HEWs in assessing, classifying and managing common childhood illness;
- Conduct supportive supervision and regular review meetings to enhance the program management CCM by HEWs;
- Ensure complete and timely reporting of activities on CCM by HEWs and HEW supervisors and by the Woreda health office to the zonal and regional health bureaus.

5.4 Role and responsibility of the national child survival technical working group

As clearly stated in the National Strategy for Child Survival in Ethiopia, the following are the main roles and responsibilities of the National CSTWG:

- Advises the HPDP General Directorate on community based child survival issues;
- Support the planning, implementation, monitoring and evaluation of CCM by HEWs;
- Support the establishment/reactivation of CSTWGs in the regions;
- Assist in the development or revision of guidelines, job aids and other relevant documents on community based case management of common childhood illnesses;
- Assist the HPDP in resource mobilization, optimal utilization and efforts on sustainability of the services;
- Coordinate advocacy on key community based child survival interventions;
- Establish ad hoc working groups for specific tasks when necessary.

5.5 Role and responsibility of the regional child survival technical working group

The regional CSTWG will have the following roles and responsibilities:

- Advises and update the RHB (HPDP core process) on community based child survival issues;
- Assist in the preparation and coordination of the orientation and trainings on CCM at regional and woreda cluster level;
- Coordinate the planning, implementation, monitoring and evaluation of CCM by HEWs in the region;
- Assist the RHB in resource mobilization, optimal utilization and efforts on sustainability of the CCM by HEW services;
- Adopt/translate/customize CCM guidelines, job aids and other relevant documents to make them locally appropriate i.e. in the local language/s;
- Advance advocacy on key community based child survival interventions.

5.6 Role and responsibility of HEW supervisors

- Ensure CCM implementation is well coordinated, implemented and followed at the kebeles of their respective catchment areas;
- Provide supportive supervision to HEWs to reinforce their skill of assessing, classifying and managing common childhood illnesses;
- Facilitate smooth referral linkage between HCs and HPs;
- Ensure that essential supplies are in place at HP by strengthening HEWs capacity in keeping track of supplies;
- Conduct timely and regularly joint review by involving all HEWs supervised at HC level.

5.7 Role and responsibilities of HEWs

- Ensure the availability and proper utilization of necessary supplies (drugs, job aids and equipments) in the health post and request for timely supply to woreda health office;
- Assess, classify and manage sick children for common childhood illnesses properly;
- Properly register sick children managed in the kebele and report to the woreda health office timely;
- Build the capacity of voluntary community health workers (VCHWs) and model families to improve the health care seeking behavior in the community with the support of Woreda health office;
- Ensure that referred patients are actually reach to the health centers; by giving proper counseling on the reasons for referral to mothers/care givers, visit the houses following the referral, address reasons for potential hindrance for not going to HCs, inform the VCHWs to make close follow up and, in collaboration with community leaders and community social organizations;
- Ensure that patients referred back to the community adhere to the advise given by HCs and comply with the medication;
- Ensure that the CCM issues are discussed in community conversations in the kebele.

5.8 Role and responsibility of VCHWs and model families

- Have the appropriate skills and tools to increase the knowledge, attitude and health seeking behavior of mothers, caretakers and the community at large;
- Continuously undertake health promotion, counseling and social mobilization activities in the community to improve the knowledge, attitudes and health seeking behavior of caretakers;
- 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 children;
- Ensure that referred cases are actually go to HCs by proper counseling and creating enabling conditions for referral.

5.9 Role and responsibility of referral HC

One of the main objectives of CCM is to identify seriously sick children and urgently refer them to the next referral level. Hence, the following major activities will be conducted:

- HCs need to build their capacity of IMNCI and referral services;
- Feedback to referring HP/HEW after giving appropriate care to referred cases;
- Support HEWs in building their skills to assess, classify and manage common childhood illnesses;
- Ensuring continuous supply for IMNCI services.

5.10 Roles and responsibilities of kebele administration

The community is one of the major stakeholders in implementation of CCM. Through the kebele administration, communities can be engaged in undertaking this task. Hence, the kebele administration will have the following roles and responsibilities to ensure community participation in CCM.

- Conduct community conversation on CCM;
- Support HEWs in identifying and training of VCHWs;
- Facilitate the referral of seriously sick children;
- Mobilize local resources for implementation of CCM.

5.11 Roles and responsibilities of partners

The large scale implementation of CCM by HEWS can't be achieved without the involvement and participation of partners. They work with the MOH to develop and print training materials, job aids; orient and train service providers and supervisors; follow-up procurement and distribution of training material, essential drugs and supplies; and provide supportive supervision and Monitoring & Evaluation of the overall program.

There has been a very good momentum in the area of partnership on child survival. The Global Child Survival Partnership/ Partnership for Maternal Newborn and Child Health was formed in 2003 and the main purpose of the partnership was to enhance the scale-up of effective child survival interventions in 42 countries where there is high burden of childhood deaths. Ethiopia has been member of the Global Child Survival Partnership/ Partnership for Maternal Newborn

and Child Health. Ethiopia's Health Sector Development Plan indicates participation of the private sector and the NGO sector for accelerated implementation of the health sector development plan. In line with this, the country has created an enabling environment for participation, coordination and mobilization of funds.

Recently, the FMOH has initiated a national level harmonization of community based maternal, newborn, and child health and nutrition (C-MNCHN) interventions. To support this initiative, a central technical advisory working group has been established. The main object if the TWG is to ensure that community based maternal, newborn and child health interventions will be delivered in a harmonized approach as part of HEP.

One of the first activity of the C-MNCHN harmonization TWG is the development of a harmonized core package of essential community based health interventions for HEWs and VCHWs, applicable in the Ethiopian setting. Partners like UNICEF, WHO, IFHP, JSI/L10K, SC-UK, SC-US, and others are members of the harmonization group. The National C-MNCHN harmonization TWG will have major role in the roll-out of CCM of common childhood illnesses including pneumonia.

The role of partners in the scale-up of CCM of common childhood illnesses will be:

- Conducing mobilization of resource;
- Strengthening the health system (follow-up, supervision, sharing of information);
- Supporting community mobilization and behavior change communication (generate demand);
- Building up logistic systems;
- Training and following-up of HEWs on case management of common childhood illnesses including pneumonia;
- Monitoring and evaluating jointly of progress based on agreed indicators;
- Distributing materials and supplies to health posts;
- Ensuring quality.

Table 5: List of organizations and activities related to newborn and child health

Organization	Activity	Remark
CARE	Child health and nutrition	
IFHP	Reproductive, maternal, newborn, and child health	Amhara, Oromia, Tigray, SNNPR, Somali Regions (283 woredas)
Irish Aid	Water and sanitation, training of CHW	SNNPR and Tigray
JICA	Provision of vaccines and medicines for reproductive health and child, survival and cold chain	
JSI/L10K	Reproductive, maternal, newborn, and child health (community based)	Amhara, Oromia, Tigray, and SNNPR (115 woredas)
SC-UK	Child health	
SC-US	Child health, maternal and neonatal health and nutrition	
The World Bank	HSDP support, mainly facility construction and HIV/AIDS prevention	
UNDP	Expand and rehab PHC facilities, support HIS, improve quality of health services through human	

	resource development	
UNFPA	Reproductive health and FP, DHS, HIV prevention	
UNICEF	Maternal, newborn and child health and nutrition, EPI/plus, DPT, OTP, IMNCI, C-IMNCI, HIV/AIDS, water and sanitation	
USAID	EPI/plus, HIV/AIDS, IMCI, ENA, Community Mobilization, Reproductive Health, Logistics, HMIS, Health Care Financing	
WHO	Safe motherhood, IMCI,EPI/plus, MPS , HIV/AIDS, EHA, Support to strengthening local institutions, macroeconomics and health	

6. Monitoring and evaluation

As this implementation plan is the first of its kind, a comprehensive M&E system is crucial so that lessons learnt from the implementation are captured and feed back given timely to improve the availability, coverage and quality of services and to increase the demand of the community. Cognizant of the fact that both the utility and the cost of a monitoring and evaluations plan has to be considered; illustrative process indicators that are feasible to collect with in the existing health system are selected. Impact and outcome indicators that will be tracked by DHS, MICS and other sub national and regional levels are included. The following methods will be used:

6.1 Regular and continuous supportive supervision

Program focused supportive supervision will be conducted aiming at improving program management of CCM of common childhood illnesses at all levels. This supportive supervision will be carried out on regular basis by all levels to the next lower level using standard supervision checklist focusing on program management issues.

FMOH and RHB/ZHD conducts joint supervision to selected HPs, woreda health offices and ZHDs twice a year. The team will be composed of 4 people; representatives from FMOH, RHB, ZHD and TWGs at one go. It is estimated that 15 days will be spent by a team on the field. The number of teams to cover regions varies based on the geographic coverage and depicted in the table below.

The woreda health office staffs conducts such supportive supervision with or with out the involvement of HEW supervisors twice a year. Considering the current trend of a woreda health officer assigned to supervise 5 kebeles, 5 staffs are required to cover all kebeles in the woreda (assuming 25 kebeles exist in a Woreda and 5 kebeles will be supervised by a woreda staff in 5 days).

Skill reinforcing supportive supervision to the HEWs through the existing HEP supervision using the HEW supervisors on monthly basis. Support will be provided to the HEWs to properly assess, classify and manage common childhood illnesses. The supervision will also assess how the HEWs are counseling the caretakers to ensure treatment compliance, how the HEWs are enhancing the skills of VCHWs and model families on CCM related behavior and how the HEWs

are managing supply and equipment. The supervision will be carried out using the adopted checklist for follow up after training.
Note: Supervisions made by HEW supervisors are not costed in this document. It remains a point of further discussion with FMOH.

Feedback will be provided on the spot and written feedback will be kept at both the visited sites and in the supervisors' offices.

The purposed frequency of visits, number of teams and days required for supervision by regions are shown in table below.

Table 6: Frequencies, required number of teams and days for supportive supervision at all levels

National/regional/zonal*				
Region	**Frequency/year**	**Number of teams/region**		**No of supervision days**
Amhara	2	2		15
Oromia	2	3		15
SNNPR	2	2		15
Tigray	2	1		15
Woreda level**				
Region	**Frequency/year**	**Number of teams/kebeles**	**No of woredas**	**No of supervision days/team**
Amhara	2	5	142	5
Oromia	2	5	254	5
SNNPR	2	5	135	5
Tigray	2	5	35	5

*4 people per team
** The actual supervision can be done using five woreda officers in a team covering all kebeles or each woreda officer may supervise 5 kebeles

6.2 Recording and reporting

The CCM of childhood illnesses activities will be recorded, reported, analyzed and the information will be used for action at all levels. The following materials should be available for recording and reporting purposes:

- Case management registration books; 0 to 2 months and 2 months-5 years;
- Monthly/ quarterly reporting formats;
- Family folder;
- Supply logbook;
- Supervision report notebook;
- Referral forms;
- Supervision checklist.

These materials should help in monitoring and evaluation of the implementation of CCM by providing the necessary information to track progress status of the selected indictors on coverage, availability and quality of service. When possible, specific indicators will be included in the HMIS. See table 9 detailed lists of indicators that will be traced as part of the CCM M&E.

6.3 Review meetings

Regularly conducting review meetings is one of the key monitoring activities that help to review the progress of CCM implementation in larger group by identifying opportunities, challenges and looking for solutions. Experience sharing and dissemination of success stories, good practices and lessons learnt are addressed in such meetings.

Review meetings will be held at national and regional level at least once a year and at woreda level at least twice in a year involving relevant stakeholders. FMOH, RHBs and woreda health offices are responsible to organize review meetings at their respective level. In order to make the review meetings effective and feasible, CCM review meetings will be conducted by integrating with other health review meetings. Panel discussions and special sessions will be held on key issues identified during implementation of the CCM. Proceedings of the reviews are expected to be disseminated to all levels timely.

Table 7: Frequencies and number of participants at different levels in one year

Review meeting	Frequency/year	No of days	No of participants	No of sites
National level	1	2	60	1
Regional level				
Amhara	1	1	85	2
Oromia	1	1	150	2
SNNPR	1	1	145	1
Tigray	1	1	45	1
Woreda level				
Amhara	2	2	60	142
Oromia	2	2	60	254
SNNPR	2	2	60	135
Tigray	2	2	60	35

6.4 Operational researches

6.4.1 Baseline information

In the implementation of CCM, having a baseline with information on coverage of access, availability, quality and services utilization is critical to effectively monitor the progress, to evaluate outcomes and for further scale up at national level.

There are three proposed options to obtain the required baseline information:

6.4.2 Review available documents

A number of surveys have been done on coverage of interventions of interest for this implementation plan at different times covering different geographic areas in the country. Some of the available surveys are: ESHE end line household surveys of 2008, the L10K baseline household survey of 2009, the malaria indicator survey of 2007, EDHS 2005 and global estimates. If needed, data from one or a combination of many can be used as a baseline for CCM.

6.4.3 Using the upcoming surveys

The 2010 HEP evaluation that will be undertaken in January-February 2010 can be considered as an opportunity to include some key indicators addressing the required baseline information on CCM.

The Ethiopian DHS 2010, which will be undertaken in September 2010, when most of the CCM training has been completed at woreda level and the HEWs are ready to commence CCM implementation. Although the timing is not optimal, EDHS could be considered as important opportunity of obtaining the baseline information on CCM.

6.4.4 CCM specific household survey

Household survey is a standard approach to obtain information on such type of important community based interventions. However, to establish a baseline by creating a specific CCM household survey demands huge resources in terms of finance, human and time.

Considering the advantages and disadvantages of the above options, the document review method and 2010 HEP evaluation are recommended considering timeliness, cost and availability of documents.

6.4.5 Continuous monitoring

The progress of the CCM of under five children implementation will be monitored using routine reports, supportive supervision and review meetings reports at all levels. Findings which require timely intervention will be dealt in subsequent supportive supervisions and other ways of mitigation mechanism. Key issues will also be presented and discussed during review meetings and other child survival forums. The frequencies of these activities are mentioned in Table 8.

6.5 Evaluation

The outcome of the CCM interventions can be evaluated using different methods at one point in time. HH survey (specific or integrated with other surveys) can be conducted at the end of this CCM implementation plan to compare with the baseline data established in 2010.

Table 8: Summary of schedules for M&E at levels

Activity	National and RHB /ZHD	Woredas, with or with out HEW supervisors	HEW supervisors
Program focused supportive supervision	Twice a year	Twice a year	
Skill enhancing supportive supervision		Quarterly	Monthly
Review meetings	Once	Twice	Monthly

6.6 Indicators

Table 9 lists the selected indicators for monitoring and evaluation of the CCM implementation. In addition to the below mentioned monitoring indicators from the routine report/activity report/supervision reports, the following indicators will be used to evaluate the implementation of the CCM.

1. Impact indicators from DHS, which includes mortality rate indicators (neonatal, infant, child and under 5 mortality rates)
2. Outcome indicators from DHS and other house hold surveys (HHS), which includes morbidity rate and treatment seeking behavior, from DHS and standard indicators from the HHS

Table 9: CCM monitoring and evaluation activities

Activity	NO	Indicators	Numerator (N) /Denominator (D)	Source	Level	Frequency	Responsibility
Orientation	1	Proportion of woredas participated in the regional orientation	**N=** Total number of Woredas participated in the regional orientation **D=** Total number of selected (for CCM implementation) rural Woredas	Orientation Report	Region National	Once before June 2002	RHB FMOH
Coordination	2	No of meetings held by the national TWGs	Total number of national TWG meetings conducted , compared to total number of planned meetings based on the TOR of the TWG	Meeting Minutes	National	Annually	FMOH
	3	No of meetings held by the regional TWGs of the respective regions	Total number of regional TWG meetings conducted , compared to total number of planned meetings based on the TOR of the TWG	Meeting Minutes	Regional	Annually	RHB
Training	4	No of master trainers trained	Total number of trainees participated the national level TOT, compared to total number of planned trainees	Activity (training) report	National	Once before June 2002	FMOH
	5	No of TOT trainers trained	Total number of trainees participated the regional level TOT, compared to total number of planned trainees	Activity report	Regional National	Quarterly	RHBs FMOH
	6	Proportion of HEWs trained on CCM	**N=** Total number of HEWs trained on CCM **D=** Total number of HEWs planned for CCM training	Activity report	Woreda, RHB, National	Quarterly	WorHO, RHB, FMOH
	7	Proportion of HEW supervisors trained on CCM (including CCM supervision)	**N=** Total number of trained HEW supervisors **D=** Total number of HEWs supervisors planned for CCM training	Activity report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH
	8	Proportion of Woredas with at least one officer who is trained on CCM & CCM	**N=** Total number of Woredas with at least one CCM+S trained officer working in the WorHO	Activity report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH

		supervision (CCM+S)and working in the WorHO	**D=** Total number of selected Woredas (for CCM implementation)				
Activity	**NO**	**Indicators**	**Numerator (N) /Denominator (D)**	**Source**	**Level**	**Frequen-cy**	**Respon sibility**
Training	9	Proportion of CCM trainings supervised for quality assurance by Master trainers[19]	**N=** Number of CCM trainings supervised by master trainer **D=** Total number of CCM trainings conducted	Activity report	Region, National	Quarterly	RHB, FMOH
Supplies	10	Proportion of HPs with no stock out[20] of any of the essential drugs[21] for CCM on day of supervision	**N=** Number of HP with no stock outs of essential drugs **D=** Total number of HPs supervised	Supervision report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH
	11	Proportion of HPs with all functional essential equipments[22] for CCM on day of supervision	**N=** Number of HP with all functional essential equipments **D=** Total number of HPs supervised	Supervision report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH
	12	Proportion of HPs with all essential job aids[23] for CCM on day of supervision	**N=** Number of HP with all essential job aids **D=** Total number of HPs supervised	Supervision report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH
Supportive supervision	13	Proportion of HPs supervised on CCM[24]	**N=** Number of HP supervised on CCM **D=** Total number of HPs	Supervision report	Woreda, Region, National	Quarterly	WorHO, RHB, FMOH
	14	Proportion of sick children with classifications of **cough**[25] who are assessed correctly	**N=** Number of sick children with classifications of cough who are correctly assessed **D=** Total number of sick children with classifications of cough	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	15	Proportion of sick children with classifications of **cough** who are correctly treated/managed	**N=** Number of sick children with classifications of cough who are correctly treated & managed **D=** Total number of children with classifications of cough	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH

[19] For assurance of quality while cascading the trainings suggested target is10%, at least 1 training out of 10 should be supervised by master trainer.
[20] Stock out is defined operationally as essential drug not available at the time of visit.
[21] Essential drugs are six; Co-trimoxazole, Amoxicillin, ORS, Coartem, Chloroquine and RUTF.
22 Essential equipments are Watch, ORS mixing jag/bottle or equivalent, cup, thermometer, RDT, RDT reagent, MUAC tape and weighing scale.
[23] Essential job aids are chart booklet, printed standard under 5 registration book, counseling card/Family health card
[24] Supervision by HEW supervisor is considered to be CCM supervision if the checklist prepared for CCM is used during the visit.
[25] Classifications of cough are Severe Pneumonia, Pneumonia and No Pneumonia.

Activity	NO	Indicators	Numerator (N) /Denominator (D)	Source	Level	Frequency	Responsibility
Supportive Supervision	16	Proportion of sick children with classifications of **pneumonia** who had follow up	**N=** Number of sick children with classifications of pneumonia and have follow up **D=** Total number of sick children with classifications of pneumonia	Supervision report	Woreda	Quarterly Biannually	WorHO, RHB, FMOH
	17	Proportion of sick children with classifications of **diarrhea**[26] who are assessed correctly	**N=** Number of sick children with classifications of diarrhea who are correctly assessed **D=** Total number of sick children with classifications of diarrhea	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	18	Proportion of sick children with classifications of **diarrhea** who are correctly treated/managed	**N=** Number of sick children with classifications of diarrhea who are correctly treated & managed **D=** Total number of sick children with classifications of diarrhea	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	19	Proportion of sick children with classifications of **persistent diarrhea & dysentery** who had follow-up	**N=** Number of sick children with classifications of persistent diarrhea & dysentery who had follow-up **D=** Total number of sick children with classifications of persistent diarrhea & dysentery	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	20	Proportion of sick children with classifications of **fever**[27] who are assessed correctly	**N=** Number of sick children with classifications of **fever** who are correctly assessed **D=** Total number of sick children with classifications of fever	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	21	Proportion of sick children with classifications of **fever** who are treated and managed correctly	**N=** Number of sick children with classifications of fever who are treated and managed correctly **D=** Total number of sick children with classifications of fever	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	22	Proportion of sick children with classifications of **malaria & measles with**	**N=** Number of sick children with classifications of malaria & measles with eye/mouth complication who had follow-	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH

[26] Classifications of diarrhea are “severe dehydration”, “some dehydration”, “no dehydration”, “severe persistent diarrhea”, “persistent diarrhea” and “dysentery”.
[27] Classifications of fever are “very severe febrile disease”, “malaria”, “fever malaria unlikely”, “no malaria”, “severe complicated measles”, “measles with eye/ mouth complication” and “measles”.

		eye/mouth complication who had follow-up	up **D=** Total number of sick children with classifications of malaria & measles with eye/mouth complication				
	23	Proportion of sick children with classifications of **uncomplicated severe acute malnutrition** who are correctly treated/ managed	**N=** Number of sick children with classifications of uncomplicated severe acute malnutrition correctly treated/ managed **D=** Total number of sick children with classifications of uncomplicated severe acute malnutrition	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH
	24	Proportion of sick children with classifications of **complicated severe acute malnutrition** correctly referred to next level	**N=** Number of sick children with classifications of complicated severe acute malnutrition correctly referred **D=** Total number of sick children with classifications of complicated severe acute malnutrition	Supervision report	Woreda, Region, National	Quarterly Biannually	WorHO, RHB, FMOH

7. Budget and funding

This section will explain how the financial and budget requirements needed to roll out CCM by HEWs have been calculated. The total overall budget of implementing CCM by HEWs in the four selected regions over a three year period is **US$ 16,496,735 (Birr 206,209,184)**, which is US$ 0.08 (ETB 1) per capita per year for the four big regions for the three years.

Table 10: Three years budget requirement to scale up CCM in four regions*

Items	Amount in ETB	Amount in USD
Orientation and training	46,254,655	3,700,372
Supplies	17,778,380	1,422,270
Drugs	135,611,214	10,848,897
Supervision	1,911,286	152,903
Post training follow-up and supervision	4,653,649	372,292
Total	**206,209,184**	**16,496,735**
Cost per capita per year for the four implementing regions	**1**	**0.08**

Taking only into account the implementation of pneumonia treatment at community level in the four selected regions, the estimated budget for three years will be **US$ 2,433,714 (ETB 30,421,420)**, which is US$ 0.01 (ETB 0.15) per capita per year for the four big regions for the three years.

The estimated cost for the management of severe acute malnutrition as per the National Nutrition Program is **US$ 15,600,000 (ETB 195,000,000)** for the four regions, which comes to an implementation cost per capita per year for the four regions of **US$ 0.07 (ETB 0.94).**

This estimation only captures the assumed direct costs of community case management of pneumonia and severe acute malnutrition out of the other common childhood illnesses. However, to improve newborn and child survival in Ethiopia and to reach MDG four, the four major newborn and childhood killers need to be tackled in an integrated manner. See tables below.

Table 11: Three years budget requirement to initiate pneumonia CCM only, with assumption of incurring direct costs of pneumonia

Items	Amount in ETB	Amount in USD
Orientation	90,750	47,260
Training (1/5 of total training)	9,132,781	730,623
Supplies (1/5 of total supplies cost)	3,555,676	284,454
Drugs (only Co-trimoxazole & Paracetamol)	15,829,226	1,266,338
Supervision (1/5 of total)	382,257	30,581
Post training follow up (1/5 of total)	930,730	74,458
Total	**30,421,420**	**2,433,714**
Cost per capita per year for the four implementing regions	**0.15**	**0.01**

The budget and funding has been calculated based on estimation of under five population from the 2007 census: Tigray: 14.6%; Amhara 13.5%; Oromia 16.4% and SNNP 15.6%. For the projected population for EFY 2003 and 2004, an annual population growth rate of 2.5 was used.

7.1 Cost estimates for orientation meetings

Fifty five participants will attend and per diem is budgeted for twenty of them as the rest will be from partners who will cover their own cost. Air transportation cost for five participants coming from Jima, Bahrdar and Mekelle. See the detail list of a unit orientation workshop cost in Annex 4.

Table 12: Orientation meeting cost, at national & regional level

Activities	Unit cost (ETB)	No of meetings	Total in ETB	Total in USD
National TOT	34,850	1	34,850	2,788
Amhara	46,325	3	138,975	11,118
Oromia	46,325	5	231,625	18,530
SNNPR	46,325	3	138,975	11,118
Tigray	46,325	1	46,325	3,706
	Subtotal	**13**	**590,750**	**47,260**

7.2 Cost estimates for CCM trainings

Master TOT and HEW trainings budget includes per diem for participants, facilitators, temporary help, drivers and support staff per diem, cost of conference hall, refreshment, stationery supplies, drugs for demonstration during the trainings as well as transport cost. For the HEW training at woreda level it was assumed that 25 participants and five facilitators will attend each training and that the training will be conducted in 1160 rounds for the four regions. See the detail list of a unit master's level training cost in Annex 5.

Table 13: Master's level trainings cost, at national and regional level

	Unit cost (ETB)	No of trainings	Total in ETB	Total in USD
National TOT	132,497	2	264,994	21,200
Amhara	98,464	3	295,392	23,631
Oromia	98,464	6	590,784	47,263
SNNPR	98,464	3	295,392	23,631
Tigray	98,464	2	196,928	15,754
	Subtotal	**16**	**1,643,490**	**131,479**

Below is the table of the total cost of CCM training of HEWs at woreda level. For a complete table of how the cost of the training was calculated, please see Annex 6.

Table 14: Actual HEWs trainings at woreda

	Unit cost (ETB)	No of Trainings	Total in ETB	Total in USD
Amhara	43,115	257	11,080,555	886,444
Oromia	43,115	424	18,280,760	1,462,461
SNNPR	43,115	291	12,546,465	1,003,717
Tigray	43,115	49	2,112,635	169,011
	Subtotal	**1,021**	**44,020,415**	**3,521,633**

7.3 Cost estimates for training materials

All materials that are needed to conduct training will be printed and procured centrally. This will reduce printing cost and time. The materials needed to conduct the trainings are listed in table 15. Also note that MUAC tape and a weigh scale should also be made available, however, it has not been costed here since it is already accessible in HCs.

The chart booklet, exercise booklet and counseling cards will be printed one per HEW. The rest of the materials are calculated for each zones and will be used for training at the districts. For the registration books we have included reserve supply of 50% of the total requirement.

Table 15: Materials to be printed/purchased centrally, for 4 regions

No	Items	Unit cost (ETB)	Number	Total cost in ETB	Total cost in USD
1	Chart booklet	30.00	46,960	1,408,800	112,704.0
2	Exercise booklet	20.00	32,460	649,200	51,936.0
3	Facilitator guide	20.00	2,996	59,920	4,793.6
4	Photo booklet	40.00	1800	72,000	5,760.0
5	Video films (VHS)	100.00	180	18,000	1,440.0
6	Wall chart/ Quick reference guide	60.00	140	8,400	672.0
7	Reg. book young infant	100.00	12100	1,210,000	96,800.0
8	Reg. book sick child	100.00	18100	1,810,000	144,800.0
9	Baby mannequin	1,200.00	240	288,000	23,040.0
10	Breast model	40.00	240	9,600	768.0
11	Ambu-bag	500.00	11740	5,870,000	469,600.0
12	Counseling card	6.00	63610	381,660	30,532.8
13	Thermometer	15.00	16,000	240,000	19,200.0
14	Watch	150.00	29,000	4,350,000	348,000.0
15	TV	2,760.00	180	496,800	39,744.0
17	Video Player	1,200.00	180	216,000	17,280.0
18	Water jug	10.00	46,000	460,000	36,800.0
19	Cups	5	46,000	230,000	18,400.0
	Total			**17,778,380**	**1,422,270.40**

7.4 Estimated cost for consumables and logistics

7.4.1 Cost estimates for HP consumables and equipment

Health post supplies for each HP is calculated as follows:

For each health posts, two ambu-bags and four thermometers will be given. In addition, four water jug and cups will be provided per health post to allow care for more than one child at a time. Three TVs and IMNCI video films dubbed in local language are budgeted per zone giving total of 180. Four baby model mannequin and breast model per zones comes to a total of 240.

To calculate drug requirements, we took the expected cases of pneumonia, diarrhea, malaria and severe acute malnutrition as well as utilization of services. For the under five population, the expected cases of pneumonia are assumed to be 30%; diarrhea and malaria 25%. For severe acute malnutrition we used the regional severe wasting prevalence as reported in EDHS 2005: Tigray 1.9%; Amhara 3%; Oromia 2.4% and SNNP 0.9%. For de-worming and vitamin dosed we used the whole under five population.

During the first year of implementing CCM by HEWs (For EFY 2002) we assumed a 5% coverage in the fourth quarter as orientation, training and setting up will take most of the year. We calculated on average per child: 20 pediatric Co-trimoxazole tablets, five ORS sachets and Chloroquine syrup. We used wholesale price of the drugs as per EFY 2001 with a 10% price inflation.

The costs of Amoxicillin, Coartem, ITN, RUTF, Vitamin A and Folic acid are not included in this implementation plan. The costs of these drugs are assumed to be covered by other programs (specifically Global Fund). We have used different feasible level of coverage for the three years. The needs for the subsequent years can be calculated using actual consumption.

Table 16: Annual budget requirement for EFY 2002

EFY 2002						
	Tigray	**Amhara**	**Oromia**	**SNNP**	**Yearly total in ETB**	**Yearly total in USD**
Co-trimoxazole tablets	122,101	450,465	873,510	460,219	1,906,295	152,504
ORS	1,356,689	5,005,167	9,705,665	5,113,540	21,181,061	1,694,485
Folic acid					-	-
TTC eye ointment	63,560	246,922	404,797	230,109	945,388	75,631
Paracetamole	48,541	125,267	325,018	211,796	710,622	56,850
Chloroquine syrup	190,276	701,975	1,361,219	717,174	2,970,644	237,652
				Total	**27,714,010**	**$2,217,121**

Table 17: Annual budget requirement for EFY 2003

EFY 2003						
	Tigray	**Amhara**	**Oromia**	**SNNP**	**Yearly total ETB**	**Yearly total USD**
Co-trimox tablets	751,660	2,773,063	5,377,326	2,833,106	11,735,155	938,812
ORS	1,391,963	5,135,301	9,958,012	5,246,492	21,731,768	1,738,541
Folic acid					-	-
TTC eye ointment	291,740	1,266,708	2,076,610	1,180,461	4,815,519	385,242
Paracetamol	49,803	128,524	333,469	217,303	729,099	58,328
Chloroquine syrup	229,674	847,325	1,643,072	865,671	3,585,742	286,859
Co-trimox tablets	751,660	2,773,063	5,377,326	2,833,106	11,735,155	938,812
				Total	**42,597,283**	**3,407,783**

Table 18: Annual budget requirement for EFY 2004

EFY 2004						
	Tigray	**Amhara**	**Oromia**	**SNNP**	**Yearly total ETB**	**Yearly total USD**
Co-trimox tablets	2,056,542	7,587,100	14,712,365	7,751,377	32,107,384	2,568,591
ORS	1,428,154	5,268,819	10,216,920	5,382,901	22,296,794	1,783,744
Folic acid					-	-
TTC eye ointment	434,902	1,689,535	2,769,782	1,574,498	6,468,717	517,497
Vitamin A capsule					-	-
Paracetamol	51,098	131,865	342,139	222,953	748,055	59,844
Chloroquine syrup	235,645	869,355	1,685,792	888,179	3,678,971	294,318
				Total	**65,299,921**	**5,223,994**
				Grand Total	**135,611,214**	**10,848,897**

7.5 Estimated cost for technical assistance

7.5.1 Supervision and review meetings

One vehicle is assumed to travel 300 km per day for national and regional supervision and 200 km for zonal supervision. For vehicle it is estimated that one liter of fuel will last for 5 km while one motor bike is assumed to travel 70 km per day and uses one liter for 8 km for woreda supervision. For the review meetings, we have included cost of per diem, hall rent, refreshment and travel. National and woreda level review meetings are calculated for two days while regional level one day. It is assumed that the CCM review meeting will be conducted jointly with the overall program review meetings to minimize

cost, ensure integration, review the overall HEP programs and to avoid a piecemeal approach to CCM.

Table 19: Post training follow up for CCM performance

Activities	Unit cost (Br)	No of supervisions	Total (ETB)	Total (USD)
Amhara	608,328	1	608,328	48,666
Oromia	1,014,905	1	1,014,905	81,192
SNNPR	689,694	1	689,694	55,176
Tigray	114,994	1	114,994	9,200
		Subtotal	**2,427,921**	**194,234**

Table 20: Nation/regional integrated supportive supervision of CCM performance

Activities	Unit cost (ETB)	No of super-visions	Total (ETB) EFY 02	Total (ETB) EFY 03	Total (ETB) EFY 04	Total (ETB)	Total (USD)
Amhara	18,270	2	36,540	36,540	36,540	109,620	8,770
Oromia	29,205	2	58,410	58,410	58,410	175,230	14,018
SNNPR	18,270	2	36,540	36,540	36,540	109,620	8,770
Tigray	17,070	2	34,140	34,140	34,140	102,420	8,194
		Subtotal	**165,630**	**165,630**	**165,630**	**496,890**	**39,751**

Table 21: Woreda health office integrated supportive supervision of CCM performance

Region	Unit cost (ETB)	No of train-ings	Total (ETB) EFY 02	Total (ETB) EFY 03	Total (ETB) EFY 04	Total (ETB)	Total (USD)
Amhara	186,508	2	373,016	373,016	373,016	1,119,048	1,119,048
Oromia	333,613	2	667,226	667,226	667,226	2,001,678	2,001,678
SNNPR	177,314	2	354,628	354,628	354,628	3,120,726	1,063,884
Tigray	24,073	2	48,146	48,146	48,146	144,438	144,438
		Sub-total	**1,443,016**	**1,443,016**	**1,443,016**	**4,329,048**	**4,329,048**

Table 22: CCM review meeting

Activities	Unit Cost (ETB)	No of Supervisions	Total (ETB)	Total USD
National	63,558	1	63,558	5,085
Regional	236,490	1	236,490	18,919
Woreda	637,705	2	1,275,410	102,033
	Subtotal	**4**	**1,575,458**	**126,037**

8. Annex

Annex 1: Activity Plan

No	Activity	Participants	Responsible	Timeline	Remark
1	**National and regional orientation for of CCM of common newborn and childhood illnesses**				
1.1	National level	[40] FMOH (6), RHBs (8), partners (UNICEF, WHO, L10K, IFHP, SC USA, SC UK, USAID, CIDA, AMREF, IRC, JSI [15]), prof. assoc, (EPHA and EPS [2]); AAU (pediatrics and Public Health [2])	FMOH, HPDP General Directorate and CSTWG	23rd February 2010	1 round of orientations
1.2	Amhara region	Region level: [40] [RHB (5), ZHD (11), partners (IFHP, L1OK, UNICEF, WHO, SC UK) [10], Gondar university (2)] Cluster level: 148 (1/woreda)	Amhara RHB with the support of partners	3rd and 4th Weeks of March, 2010.	3 rounds of orientations
1.3	SNNP region	Regional level: [35] RHB (5), ZHD and Special Woreda (20), (IFHP, L1OK, UNICEF, WHO, SC USA [10]), Hawassa university (2) Cluster level: 128 (1/Woreda)	SNNPR RHB with the support of partners	3rd and 4th weeks of March, 2010.	3 rounds of orientations
1.4	Tigray region	Regional level: [51] RHB (5), woredas (34), partners (IFHP, L10K, UNICEF, WHO) (8), Mekelle university (2),	Tigray RHB with the support of partners	3rd week of March, 2009	1 round of orientations
1.5	Oromia region	Regional level: [50] RHB (5), ZHD and Special woreda (18), (IFHP, L1OK, UNICEF, WHO, SC USA [15]), Haromaya and Jimma universities (4), Cluster level: 255	Oromia RHB with the support of partners	3rd and 4th week of March, 2010	4 rounds of orientations
2	**Training materials revision and printing**				
2.1	All implementing regions: Revision and printing of training guides and tools		FMOH with the support of CSTWG	End of March, 2010	
2.2	All implementing regions: Procurement of supplies		FMOH	**A detailed timeline will be finalized when all procurement has been completed.**	
2.3	All implementing regions: Distribution of training materials and supplies		FMOH		
3	**Training**				
3.1	Master level TOTs				
3.1.1	Master training of trainers	[60] FMOH, in the implementing regions: (RHB, Hospitals, and HC), partners, and universities	FMOH, HPDP General Directorate and Child Survival TWG		2 rounds of trainings
3.1.2	Regional level TOT s				

3.1.3	Amhara	[90][11 ZHD (11X 6 = 66), 8 Hosp.l (1 X8 = 8): 8 Regional HSC (1X8=8), partners [IFHP, L10K, UNICEF, WHO, SC UK (5X2=10)]		Amhara RHB utilizing facilitators who attended master TOT		3 rounds of TOTs
3.1.4	SNNPR	[90][14 Hospital (22): 5 Regional HSC (3X5=15), partners [IFHP (4), L10K (2), UNICEF (1), WHO (1) (8), ZHD and Special Woredas (40)]		SNNPR RHB utilizing facilitators who attended master TOT		3 rounds of TOTs
3.1.5	Tigray	[60][10 Hospital (2 X 10 = 20): 2 regional HSC (2X2=4), Partners [IFHP (3), L10K, UNICEF, WHO (5), woreda /HC (1 from each woreda: 34)]		Tigray RHB utilizing facilitators who attended master TOT		2 rounds of TOTs
3.1.6	Oromia	[180][23 Hospital (2 X 23 = 46): 10 regional HSC (2X10=20), partners [IFHP (4), L10K (2), UNICEF (2), WHO (1) (9), ZHD (18x6=108)]		Oromia RHB with the support of partners		6 rounds of TOTs
3.2						
3.2.1	Amhara Region	(6425) (142 woreda focal persons and 571 HEW supervisors =713) The 713 will be HEW supervisors and 5712 are HEWs		ZHD and WorHO with the support of RHB		257 rounds of training
3.2.2	Tigray Region	(1219)[1 from each of the 35 Woreda, 108 HEW supervisors, 1076 HEWS]		RHB		49 rounds of trainings
3.2.3	SNNPR Region	(7271)[1 from each of the 147 Woredas, 648 HEW supervisors, 6476 HEWS]		ZHD and WorHO with the support of RHB		291 rounds of trainings
3.2.4	Oromia Region	(10586)[1 from each of the 279 Woredas, 937 HEW supervisors, 9370 HEWS]		ZHD and WorHO with the support of RHB		424
4						
4.1	Region	Number of Health Post to be followed up	Number HEW to be followed up	Responsible person		Remark
4.2	Amhara	2856	6425	Mater Trainers, Trainers, and Supervisors		
4.3	Tigray	538	1219	Mater Trainers, Trainers, and Supervisors		
4.4	SNNPR	3238	7271	Mater Trainers, Trainers, and Supervisors		

4.5	Oromia	4680	10586	Mater Trainers, Trainers, and Supervisors		

Annex 2: Schedule for CCM planning workshop
Place: Bishoftu
Venue: Kuriftu
Dates : 15 – 17 December, 2009

Date	Time	Activity	Responsible
15 Dec, 2009	8 :00 – 8 :20	Opening remark	Dr. Kessete
	8:20 – 8:40	Outline of the implementation plan	Dr. Assaye
	8:40 – 10:00	Discussion on the outline of the Implementation plan	Group members
	10:00 – 10:30	Tea break	Organizers
	10:30 – 12:30	Group work	Group members
	12:30 – 2:00	Lunch break	Organizers
	2:00 - 4:00	Group work	Group members
	4:00 – 4:20	Tea break	Organizers
	4:20 – 6:00	Group Work	Group members
16 Dec, 2009	8:00 – 9:00	Progress report	Group members
	9:00 - 10:00	Group work	Group members
	10:00 – 10:30	Tea break	Organizers
	10:30 – 12:30	Group work	Group members
	12:30 – 2:00	Lunch Break	Organizers
	2:00 – 4:00	Group work	Group members
	4:00 – 4:20	Tea break	Organizers
	4:20 – 6:00	Group work	Group members
17 Dec, 2009	8:00 – 10:00	Group presentation	Group members
	10:00 - 10:30	Tea break	Organizers
	10:30 – 12:30	Group work - Revise the document as per the comments	Group members
	12:30 – 2:00	Lunch break	Organizers
	2:00 – 4:00	Compile and finalize the draft document	Group members
	4:00 – 4:20	Tea break	Organizers
	4:20 – 5:00	Way forward and closing	Group members
	Follow up meeting at UNICEF 3PM		
21 Dec 2009	3:00 – 5:30PM	Discussion of 0 draft of the CCM implementation plan	Group members

Annex 3: Group members who composed the implementation plan

List of participants			
First Name	**Last Name**	**Title**	**Organization**
Hibret	Alemu	RMNCH Manager	JSI/L10K
Sentayehu	Tsegaye	Public Health Specialist	USAID
Ayenew	Messele	Child Survival Officer	FMOH/UNICEF
Mebrahtom	Belay	Health officer	FMOH/UNICEF
Tedbabe	Degefie	Health Unit Head	SC US
Abbaynesh	Ahmed	DPHP officer	FMOH
Hailemariam	Legesse	Health Specialist for CMNCH	EPS
Ida	Neuman	Health Specialist	UNICEF
Assaye	Kassie	Health Specialist	UNICEF
Solomon	Emuy	NPO/CAH	FMOH/WHO

Annex 4: Detail estimated unit cost for national, regional and zonal level orientations

National level orientation workshop unit cost estimate					
No	**Training Cost**	**Unit Cost (Br)**	**Partici-pants**	**No. of days**	**Amount in Br**
1	Per diem (per person/day)	150	20	3	9,000
2	Refreshment (2/person/day)	70	55	2	7,700
3	Transport air (2/person/training)	1,500	5	1	7,500
4	Transport ground (2/person/training)	250	15	1	3,750
5	Facilitators Fee (per trainer/day)	-	4	1	-
6	Conference Room (per day)	1,000	1	6	6,000
7	Supportive staffs per diem	100	2	1	200
Sub total					**34,150**
Stationeries					
8	Notebook	15.00	40	1	600
9	Pen	2.50	40	1	100
				Sub total	**700**
				Grand Total	**34,850**

Regional/zonal level orientation workshop unit cost estimate					
No	**Training Cost**	**Unit Cost (ETB)**	**Partici-pants**	**No. of days**	**Amount in ETB**
1	Per diem (per person/day)	150	70	3	31,500
2	Refreshment (2/person/day)	35	80	1	2,800
3	Transport air (2/person/training)	0	0	0	-
4	Transport ground (2/person/training)	50	70	2	7,000

5	Facilitators fee (per trainer/day)	0	0	0	-
6	Conference room (per day)	500	1	6	3,000
7	Supportive staffs per diem	100	1	8	800
				Sub total	**45,100**
Stationeries					
8	Notebook	15	70	1	1,050
9	Pen	3	70	1	175
				Sub total	**1,225**
				Grand total	**46,325**

Annex 5: Detail estimated unit cost for national level master TOT (1 round) and regional/ zonal level TOT

National level master TOT cost estimates (1 round)				
Training Cost	**Unit Cost**	**Participants**	**No. of days**	**Amount in ETB**
Line Item				
Per diem (per person/day)	150.00	30	15	67,500
Refreshment (2/person/day)	70.00	40	6	16,800
Transport air (2/person/training)	1,500.00	10	1	15,000
Transport ground (2/person/training)	250.00	20	1	5,000
Facilitators fee (per trainer/day)	300.00	6	10	18,000
Conference room (per day)	750.00	1	6	4,500
Temporary help (per person/day)	100.00	2	4	800
Fuel for transport during training (6 liter/day)	90.00	1	8	720
Driver per diem during training	100.00	1	8	800
Supportive staffs per diem	100.00	1	8	800
			Sub total	**129,920**
Training Material	**Unit Cost**	**Participants**	**No. of days**	**Amount in ETB**
Stationeries				
Notebook	15.00	40	1	600
Pen	2.50	40	1	100
Pencil	2.00	40	1	80
Eraser	3.00	40	1	120
Sharpener	1.50	40	1	60
Plastic bag	30.00	40	1	1,200
Flip chart	70.00	2	1	140
Marker	100.00	1	1	100
Scotch tape	10.00	2	1	20
			Sub total	**2,420**
Drugs for demonstration				
ORS	2.00	5	1	10
Paracetamol	2.00	1	1	2
Co-trimoxazole-syrup	25.00	1	1	25
Co-trimoxazole-tablet (strip)	4.00	1	1	4
Amoxacillin capsul (strip)	3.00	1	1	3

Amoxacillin syrup	35.00	1	1	35
Vitamin A	0.00	0	1	-
Zinc	0.00	0	1	-
Mebendazole	2.00	1	1	2
Coartem	0.00	0	1	-
RDT	0.00	1	1	-
Chloroquine syrup	0.00	0	1	-
Tetracycline eye ointment	3.00	1	1	3
			Sub total	**84**
Materials/supplies				
Cloth for drying and wrapping	25.00	1	1	25
Cloth for KMC positioning	25.00	1	1	25
RUTF	4.50	5	1	23
			Sub total	**73**
			Grand total	**132,497**

Regional level TOT cost estimates (1 round)				
Line item	**Unit cost**	**Participants**	**No. of days**	**Amount in ETB**
Per diem (per person/day)	150.00	30	12	54,000
Refreshment (2/person/day)	55.00	40	6	13,200
Transport air (2/person/training)	1,000.00	4	1	4,000
Transport ground (2/person/training)	150.00	26	1	3,900
Facilitators fee (per trainer/day)	250.00	6	10	15,000
Conference room (per day)	500.00	1	6	3,000
Temporary help (per person/day)	100.00	2	4	800
Fuel for transport during training (4 liter/day)	60.00	1	8	480
Transport during training driver per diem	100.00	1	8	800
Supportive staffs per diem	100.00	1	8	800
			Sub total	**95,980**
Stationeries	**Unit cost**	**Participants**	**No. of days**	**Amount in ETB**
Notebook	15.00	40	1	600
Pen	2.50	40	1	100
Pencil	2.00	40	1	80
Eraser	3.00	40	1	120
Sharpener	1.50	40	1	60
Plastic bag	30.00	40	1	1,200
Flip chart	70.00	1	1	70
Marker	100.00	1	1	100
Scotch tape	10.00	2	1	20
			Sub total	**2,350**
Drugs for demonstration				
ORS	2.00	5	1	10
Paracetamol	2.00	1	1	2
Co-trimoxazole-syrup	25.00	1	1	25

Co-trimoxazole-tablet (strip)	4.00	1	1	4
Amoxicillin capsul (strip)	3.00	1	1	3
Amoxicillin syrup	35.00	1	1	35
Vitamin A	0.00	0	1	-
Zinc	0.00	0	1	-
Mebendazole	2.00	1	1	2
Coartem	0.00	0	1	-
RDT	0.00	1	1	-
Chloroquine syrup	0.00	0	1	-
Tetracycline eye ointment	3.00	1	1	3
			Sub total	**84**
Materials/ supplies				
Cloth for drying and wrapping	25.00	1	1	25
Cloth for KMC positioning	25.00	1	1	25
			Sub total	**50**
			Grand total	**98,464**

Annex 6: Detail estimated unit cost for woreda level HEWs, HEW supervisors and woreda HEP focal persons training (1 round)

HEWs, HEW supervisors and woreda HEP focal person's training estimated unit cost					
A. Human and transportation cost	**Unit cost**	**Partici-pants**	**No. of Days**	**Total cost in ETB**	**Total cost in USD**
Per diem (per person/day)	100.00	25	8	20,000	1,600
Refreshment (2/person/day)	30.00	35	6	6,300	504
Transportation two trips per trainee	35.00	25	2	1,750	140
Transportation two trips/facilitator	50.00	5	2	500	40
Facilitators fee, per diem and loading	150.00	5	10	7,500	600
Conference room (per day)	300.00	1	6	1,800	144
Temporary help (per person/day)	100.00	2	4	800	64
Transport during training fuel (6 liter/day)	90.00	1	8	720	58
Driver per diem	100.00	1	10	1,000	80
Supportive staffs per diem	100.00	1	4	400	32
Fuel cost (3 liters per day)	45.00	1	6	270	22
			Sub total	**41,040**	**3,283**
B. Stationeries	**Unit cost**	**Partici-pants**	**No. of days**	**Total cost in ETB**	**Total cost in USD**
Notebook	15.00	32	1	480	38
Pen	2.50	32	1	80	6
Pencil	2.00	32	1	64	5
Eraser	3.00	32	1	96	8
Sharpener	1.50	32	1	48	4
Plastic bag	30.00	32	1	960	77
Flip chart	70.00	1	1	70	6
Marker	100.00	1	1	100	8
Scotch tape	10.00	2	1	20	2
			Sub total	**1,918**	**153**

C. Drugs for demonstration	Unit cost	Number	No. of days	Total cost in ETB	Total cost in USD
ORS	2.00	5	1	10	1
Paracetamol	2.00	1	1	2	0
Co-trimoxazole-syrup	25.00	1	1	25	2
Co-trimoxazole-tablet (strip)	4.00	1	1	4	0
Amoxicillin capsul (strip)	3.00	1	1	3	0
Amoxicillin syrup	35.00	1	1	35	3
Vitamin A	0.00	0	1	0	0
Zinc	0.00	0	1	0	0
Mebendazole	2.00	1	1	2	0
Coartem	0.00	0	1	0	0
RDT	0.00	1	1	0	0
Chloroquine syrup	0.00	0	1	0	0
Tetracycline eye ointment	3.00	1	1	3	0
			Sub total	**84**	**7**
D. Materials/supplies	**Unit cost**	**Number**	**No. of days**	**Total cost in ETB**	**Total cost in USD**
Cloth for drying and wrapping	25.00	1	1	25	2
Cloth for KMC positioning	25.00	1	1	25	2
RUTF	4.50	5	1	23	2
			Sub total	**73**	**6**
			Grand Total	**43,115**	**3,449**