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Integration of vitamin A supplementation Program in to Health System, Ethiopia

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Presentation Outline

- Background
- The Integration Process
- Delivery strategies
- UNICEF Preliminary Study
- HEP Achievements
- Results Achieved (MI Support)
- Constraints
- Future Direction
- Conclusion

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BACKGROUND

- Ethiopian has been implementing HSDP since 1997 decentralization and standardizes the health care at all levels
- Program focused on accelerated expansion of PHC services of which a key component is HEP
- It is designed to provide 16 different packages
  - focusing on primitive & preventive
- VAS implementation started in 1996 by integrating with Polio NIDs, SNIDs and measles campaign which is house to house strategy delivered by volunteers
- Then through EOS, CHD, and routine (HEP)

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EOS

- Ethiopia has been implementing bi-annual VAS through the campaign-based, vertical Enhanced Outreach Strategy (EOS) since 2004
- De-worming for children 24 -59m & nutritional screening for children 6-59ms, and PLW were also included in the EOS
- The EOS was scaled up at a rapid pace to reach all children in the country

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CHD Delivery of VAS

- The CHDs are quarterly events that are organized locally at kebele level by health extension workers. In CHDs vitamin A supplementation and de-worming are conducted every six months while nutritional screening of children 6-59 months and pregnant and lactating women is conducted every three months

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HEP Delivery of VAS

- **Routine Health Service (HEP):** The routine HEP modality is a daily service delivery of VAS which is mainly a mix of facility based, outreach and house to house delivery.
- Routine service delivery of VAS is complete integration of VAS delivery into the existing routine health system (HEP)
  - Currently delivered in **387** woredas of the country
    - in three Urban regions (Addis Ababa, Diredawa & Harare
    - In four Agrarian regions (Tigray, Amhara, Oromia and SNNP)

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SERVICE DELIVERY : COMPONENTS

- **Vitamin A supplementation**

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SERVICE DELIVERY

- Deworming

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SERVICE DELIVERY

- **Screening** and referral to **Targeted Supplementary Feeding**

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The integration Process

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The transition Process (EOS to CHD & HEP)

- Consensus among partners that VAS coverage through EOS is impressive & should be sustained through transferring of responsibility to the Government health system
- In the fourth health sector development plan (HSDP IV) and in 2008 National Nutrition Plan (NNP), the FMoH clearly indicated the need to integrate vertical EOS program into the routine Health Extension Program (HEP)
- Existence of well-established health system at grass route (kebele)
- Subsequently, FMoH has requested MI to support the transition process

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PHASE OF TRANSITION

1. Transition from EOS to CHD Criteria:
   - Woreda has been conducting EOS/EEOS over three years,
   - Reported consistent high coverage for VAS of greater than 80%,
   - Reported consistent high coverage of screening of more than 80%
   - Presence of HEWs in every health post.

2. Transition from CHD to HEP (routine) Criteria:
   - Commitment of the woreda officials to transit CHD into the HEP,
   - HEWs who implemented/actively participated in CHDs are operational and have a proof record of high performance,
   - Substantial number of graduated model families,
   - High EPI coverage
   - Woredas with active HDA,
   - Functional health center cluster system
   - Effective and functioning supportive supervision that inform decision making.

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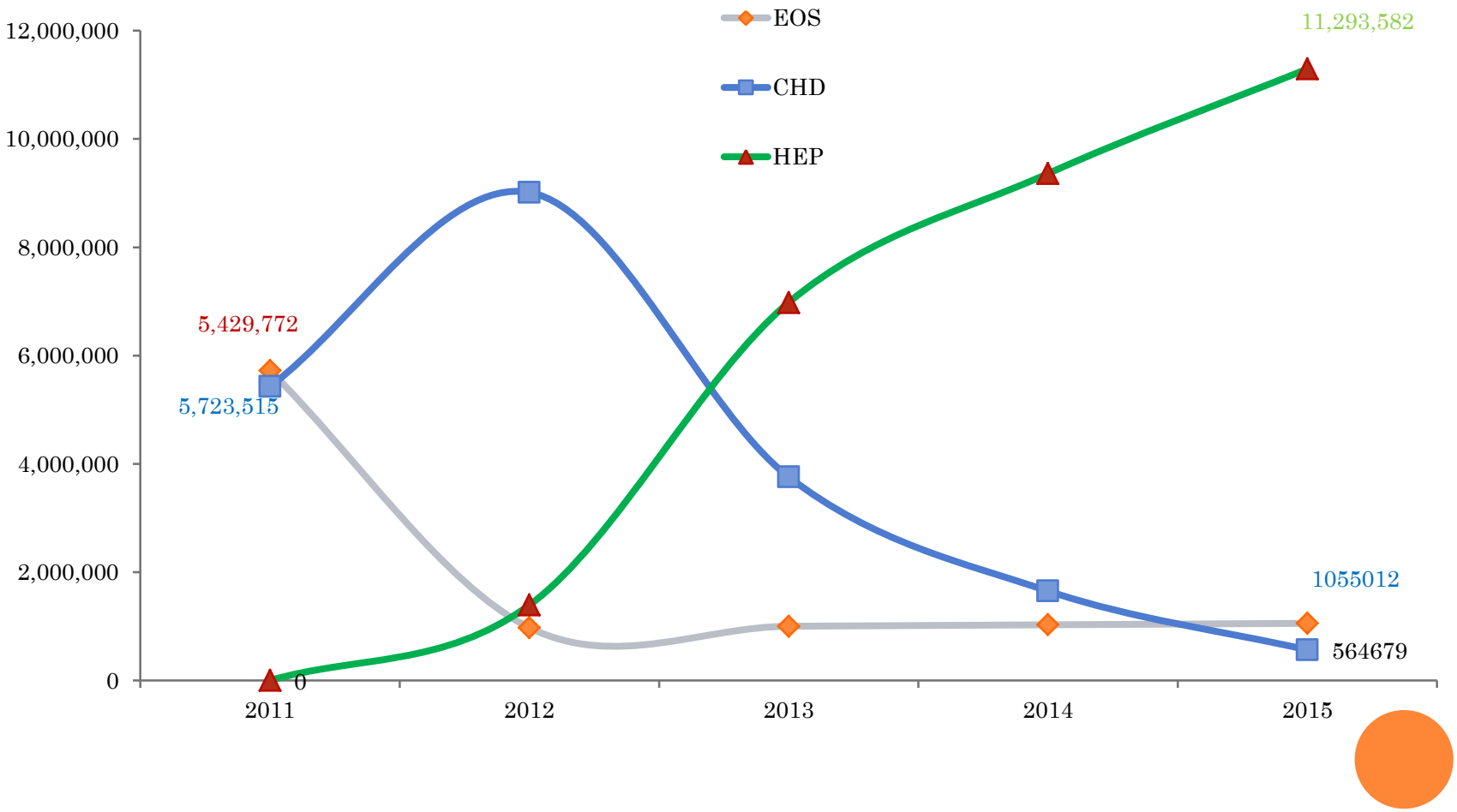
VAS INTEGRATION PLAN: EOS, CHD,HEP



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Delivery Strategies

- Catalyzing and supporting Integration of VAS in to the HEP
- Assist capacity building activities in the regions, conducing refresher training for HEWs,
- Support regions in supportive supervision and review meetings in the implementation of VAS through HEP
- Assist the development and dissemination of SBCC messages
- Ensure availability of VAC throughout the year
- Support the monitoring and evaluation of HEP delivery of VAS to ensure coverage is maintained above 80%

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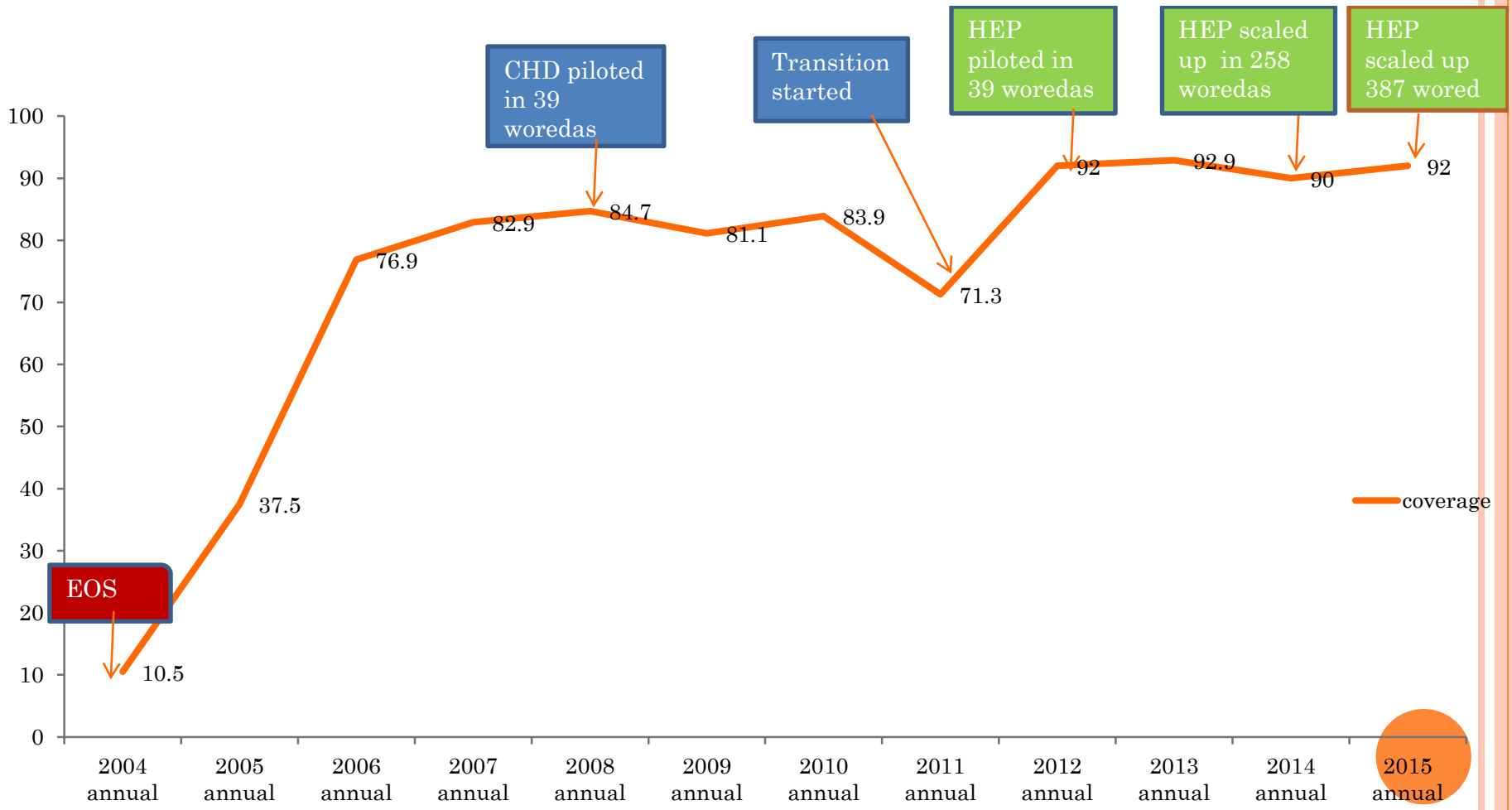
VAS INTEGRATION TIMELINE



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Preliminary findings of baseline study (UNICEF)

- Majority of stakeholders in all four regions are **optimistic** about the transition from CHD to routine service delivery (HEP)
- HEWs believe that RSD is **more accessible to mothers** due to the schedule flexibility
- Two thirds of HEWs believe that the **quality of services will improve** with the transition to RSD
- The majority of HEWs reported feeling **confident in their ability** to provide all three services
- Regular structured training was suggested as a mean to improve HEW's skills and ability and to **keep them motivated**

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Preliminary findings of baseline study (UNICEF)

- Some HEWs reported concerns with an **increasing workload**
- While house-to-house visits are ideal for clients, this approach may not be feasible or sustainable over time due to **limited staff and time constraints** for HEWs
- Another key concern: low awareness and **low health seeking behaviours** of the community
- **Supply management gaps** were noted, especially regarding stock outs

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HEP (ROUTINE) VAS ACHIEVEMENT

- MI support created ownership of the program
- Parallel monitoring tools developed and distributed
- Demand was created in Urban regions by developing VAS message and disseminate through radio
- All players, FMoH, RHBs, UNICEF and MI have come to an understanding that integration of VAS in routine health system is possible and they agreed to work towards this common goal
- VAS service is integrated into the routine service delivery (HEWs are providing VAS as part of their regular health services)
- VAS is part and parcel of the IRT skills upgrading program
- VAS is integrated into other health services using the integrated supportive supervision checklist
- VAS indicator are incorporated to the HMIS
- The routine HEP reported coverage by woreda health office was maintained above 80%

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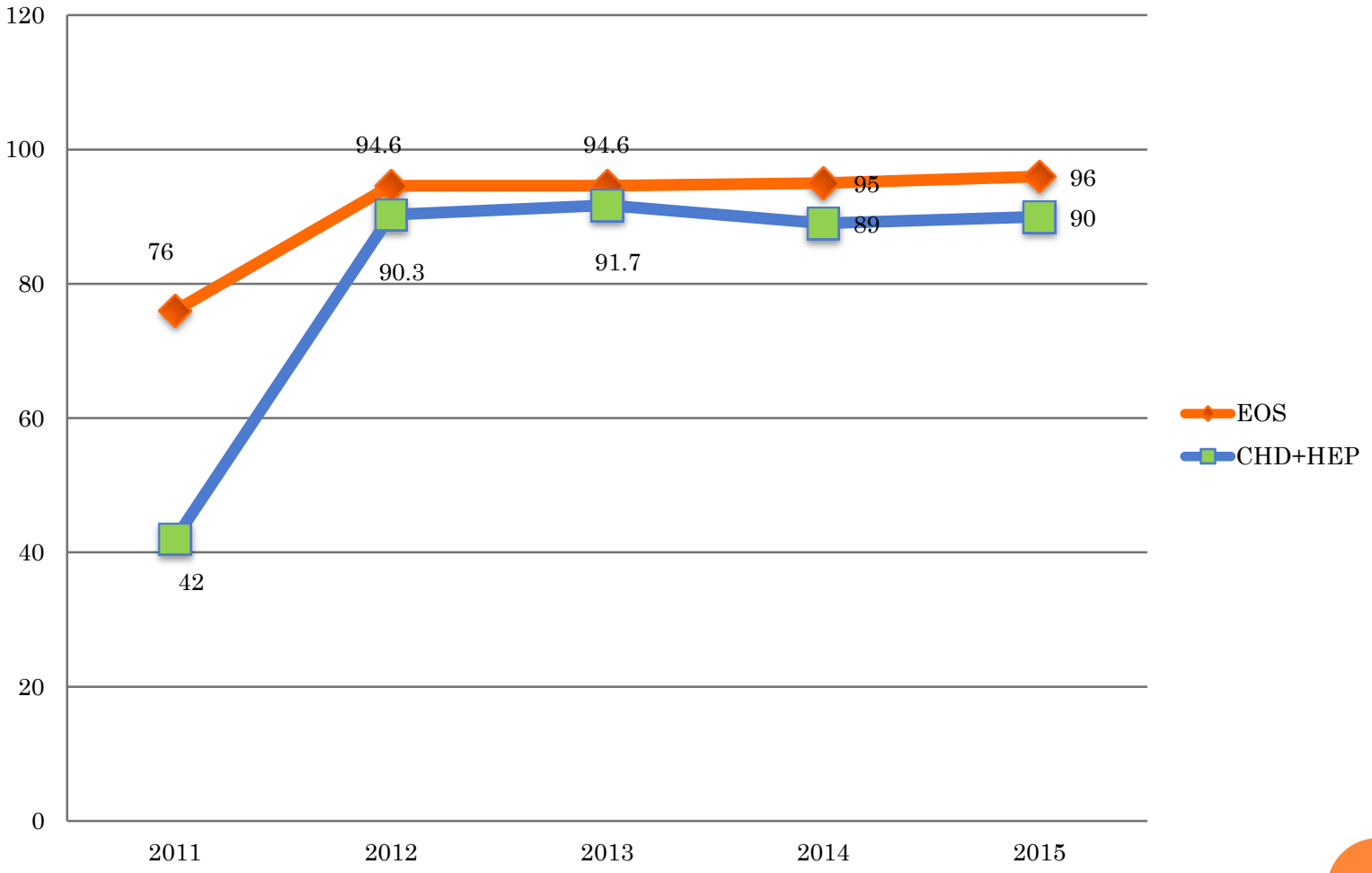
RESULTS ACHIEVED THROUGH MI SUPPORT (2012 – 2015)

- 673 woredas of Amhara, Tigray, Oromia and SNNP transitioned the VAS delivery from EOS to CHD.
- In 2013, a total of 143 woredas are transitioned to HEP - all 27 woredas of Addis Ababa, Diredawa, and Harare urban regions, all 46 in Tigray, 27 in Amhara, 23 in Oromia, and 20 in SNNP regions
- In 2014, a total of 115 new woredas in Amhara (67) and SNNPR (48) have transited from CHD to HEP through Muskoka Grant
- In 2015, a total of 258 woredas i.e. in Amhara (94), Tigray (all 46), Oromia (23) and SNNPR (68), Addis Ababa (10), Dire Dawa (9), and Harare (8) woredas are implementing HEP delivery of VAS through Muskoka Grant
- Through DFATD Bilateral Grant 129 woredas in Oromia region are also implementing HEP delivery of VAS (29 additional woredas from the plan through Bilateral)
- In total 378 woredas are implementing HEP delivery of VAS in 2015 (54% of the woredas in Agrarian and urban regions)
- In addition, five woredas in Ben/Gumuz region, and six woredas in Afar region have transited from EOS to CHD

2011 to 2015 VAS coverage trend by delivery strategy: integrated vs Campaign (in %)



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Progress toward Integration into the health system (MI's framework for integration)

- The baseline score quantifying the extent of VAS integration into the health system in 2011 was 17 points
- Total score in 2015 is 25 points, two points less than the 2015 target
- Successes have been achieved in the areas of planning and reporting, service provision, and monitoring reporting and evaluation.
- Integration of VAS into local systems of procurement and distribution, and financing is not fully integrated into the routine health system

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CONSTRAINTS/ONGOING ISSUES

- VACs not fully integrated within PFSA's Logistics Management Information System (LMIS)
- Reporting of the HEP VAS coverage is integrated to the HMIS, however, the HMIS doesn't allow to track two dose VAS coverage
- Tracking mechanism to supplement children at exactly six months is not properly practiced
- There is no planning on analysis of data every six months and taking action both at the HC and HP level

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MITIGATION STRATEGIES

- Planning for VAS has to be made for six months and HEWs are required to reach all target children every six months with VAS & DW,
- HEWs need to trace children at six months interval and be able to provide the second dose in a year, they should track new born children and provide VAS at six months,
- Registration of children by their sub-village (Gott, Kushet, Gare) could be easy way of tracing children for second dose provision,
- Individual children should be followed-up and supplemented for the second time within the year,
- There is a need to coach and mentor HEWs on the use of VAS, DW monitoring chart &woreda Health offices also need to use monitoring charts to monitor their performance,
- Periodic focused assessment of the routine VAS implementations by all concerned,
- Support operational research on the routine using a checklist of bottle neck analysis,

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FUTURE DIRECTIONS

- Building the technical capacities of FMoH, RHBs and woredas health management teams
- Technical assistance for the revision and distribution of routine (HEP) VAS planning, tracking, performance review, supportive supervision and VAC stock management tools and guides
- Monitor and evaluate the programme through supportive supervision and review meetings (through woredas VAS mentors)
- Technical support for the transition of EOS to CHD in Pastoralist regions
- Integration of VAS supply into the national essential medicine supply chain system (PFSA)
- Conduct cost effectiveness of VAS transition for further policy advocacy and furnish knowledge base for global programming

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Conclusion

Encouraging results were achieved in the integration of VAS in to the routine HEP through:

- Availability of HEWs at grass root level, strong commitment from zonal health department to community (health post) level
- strong health system support at all levels
- Strong/functional health center-health post cluster system
- Involvement of health development army (one to five networking) in awareness creation activity and community mobilization

Invest in nutrition for national development