Experiences from Scaling up iCCM in Uganda: 2010 - 2016

Presentation at the Regional Meeting on iCCM for GFATM MOU
16-18 February 2016, Nairobi
Overview of iCCM Implementation

- Uganda introduced iCCM strategy in 2010
  - Early implementation phase (22/112 districts)
  - Review after early implementation (2012)
  - Scale up phase (48 districts; PSM mainstreaming)
- Funding by GOU and partners
Definition of iCCM

- Community treatment of Pneumonia, Malaria, Diarrhoea and Newborn Danger signs identification and referral
- CHW – volunteer, selected by community members, able to read and write
- CHW Kit - pre-packaged and colour coded medicines (Amoxicillin, ACTs, Rectal Artesunate, ORS+Zinc), medicine boxes, job aid, ARI timers, RDTs, Waste mgmt kits
- Technical leadership by MOH to implement iCCM including IMNCI, national iCCM TWG, task force
Programme Implementation

Key Intervention activities:

- Sensitization of leaders
- Training for VHTs – basic package 5 days; iCCM + NB care – 6 days
- Quarterly Supportive supervision for VHTs
- Demand creation through BCC and mobilization
- Supply chain management
- Monitoring & reporting system through HMIS
GF iCCM Scale up

- Concept note submitted in June 2014
- Grant signature was effected in February 2015
- Implementation commenced in May 2015

Table 1: Partners involved in GF iCCM programme:

<table>
<thead>
<tr>
<th>MOH Coordinating departments:</th>
<th>MOH (Child Health dept, National Malaria Control Program, Pharmacy Division)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>GOU, Global Fund, UNICEF, RMNCH Trust Fund, DFID, KOICA, USAID/PMI</td>
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<tr>
<td>Principal recipient:</td>
<td>TASO, MOF/MOH</td>
</tr>
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<td>Technical advisors:</td>
<td>CHAI, Malaria Consortium, UHSCP</td>
</tr>
<tr>
<td>Implementing partners:</td>
<td>PACE/PSI, UHMG, PILGRIM</td>
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<tr>
<td>Total Budget:</td>
<td>10 million USD over 2 years</td>
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<td>Duration of program:</td>
<td>2015-2016 (15 districts in 2015 and additional 18 in 2016)</td>
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</tbody>
</table>
## iCCM Financing

### Uganda iCCM Funding Gaps (2016-2017)

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Source of Funding</th>
<th>Funding available</th>
<th>Gap</th>
<th>Total</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 UNICEF districts (public)</td>
<td>UNICEF</td>
<td>2,367,233</td>
<td>1,578,155</td>
<td>3,945,388</td>
<td>Funds available can only procure stock of commodities required for up to April, 201, gap to procure adequate stocks for the May-December 2017.</td>
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<tr>
<td>20 UNICEF /CHAI (private)</td>
<td>UNICEF</td>
<td>1,000,000</td>
<td>0</td>
<td>1,000,000</td>
<td></td>
</tr>
<tr>
<td>33 GF districts (UNICEF procuring non-malaria commodities) public</td>
<td>UNICEF</td>
<td>2,000,000.0</td>
<td>3,200,000</td>
<td>5,200,000</td>
<td>33 GF districts, to procure the non-malaria commodities (ORS/Zinc and Amoxicillin) requires USD 2,600,000 annually. UNICEF planned to commit not more than USD 1,000,000 annually.</td>
</tr>
<tr>
<td>33 GF districts (GF procuring ACTs and mRDTs and delivering the iCCM package)</td>
<td>Global Fund</td>
<td>2,344,000</td>
<td>4,189,000</td>
<td>6,533,000</td>
<td>Funding gap is based on budget estimates in the GF iCCM implementation plan 2015-2016</td>
</tr>
<tr>
<td>14 Midwestern districts</td>
<td>UNICEF for procuring iCCM commodities for Malaria Consortium</td>
<td>3,703,000</td>
<td>1,930,096</td>
<td>5,633,096</td>
<td>DFID channeled GBP 4,300,000 for procuring iCCM commodities through UNICEF for 14 districts. DFID grant expires in April 2017, gap for procuring commodities for May-December 2017.</td>
</tr>
<tr>
<td><strong>TOTAL (USD)</strong></td>
<td></td>
<td><strong>9,070,233</strong></td>
<td><strong>6,708,251</strong></td>
<td><strong>15,778,484</strong></td>
<td></td>
</tr>
</tbody>
</table>
Progress To-date
Malaria treatment based on RDT result – MOH Policy

Presumptive treatment of Malaria (no RDTs)
Surveys results: Treatment within 24 hours

Seeking treatment within 24 hours improved
Surveys Results: Source of treatment

Mid-west: 1\textsuperscript{st} place for seeking treatment

1\textsuperscript{st} choice in seeking treatment shifted from both public and private to VHT
Challenges

• Procurement of VHT training and reporting tools, and materials: a number of internal system approvals and processes related to the tendering process
• Stock out of commodities: related to end of projects
• Voluntary spirit of VHTs: potential for VHT attrition
• Fund disbursement: delays in the actual disbursement of funds
• Contractual arrangements/processes: Longer than anticipated between PR and SRs; UNICEF and NMS for delivery of commodities to the central warehouse
Lessons Learned

• Access to **timely** and **appropriate** treatment of sick children has increased with the introduction of iCCM

• Coordination among iCCM stakeholders is key to scale up of programme including political leadership

• Linking iCCM with health facilities is critical for sustainability and improves quality of services

• Capacity building for facility staff in managing referred cases, VHT supplies, training/supervising VHTs a critical element of ICCM

• Continued community participation and mobilization is required to enhance demand and accountability

• Adequate planning and lead time required for procurement logistics especially during scale up ….
Recommendations

• **Coordination**: Strong coordination at all levels to ensure stakeholder alignment

• **Procurement**: early procurement planning, colour coded medicines or coloured envelopes

• **Leveraging supplies**: redistribution of commodities

• **Integration within existing health delivery structures**: sustainability

• **M&E**: tools, reporting, operational research, reviews and learning and adaptation
Thank You