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

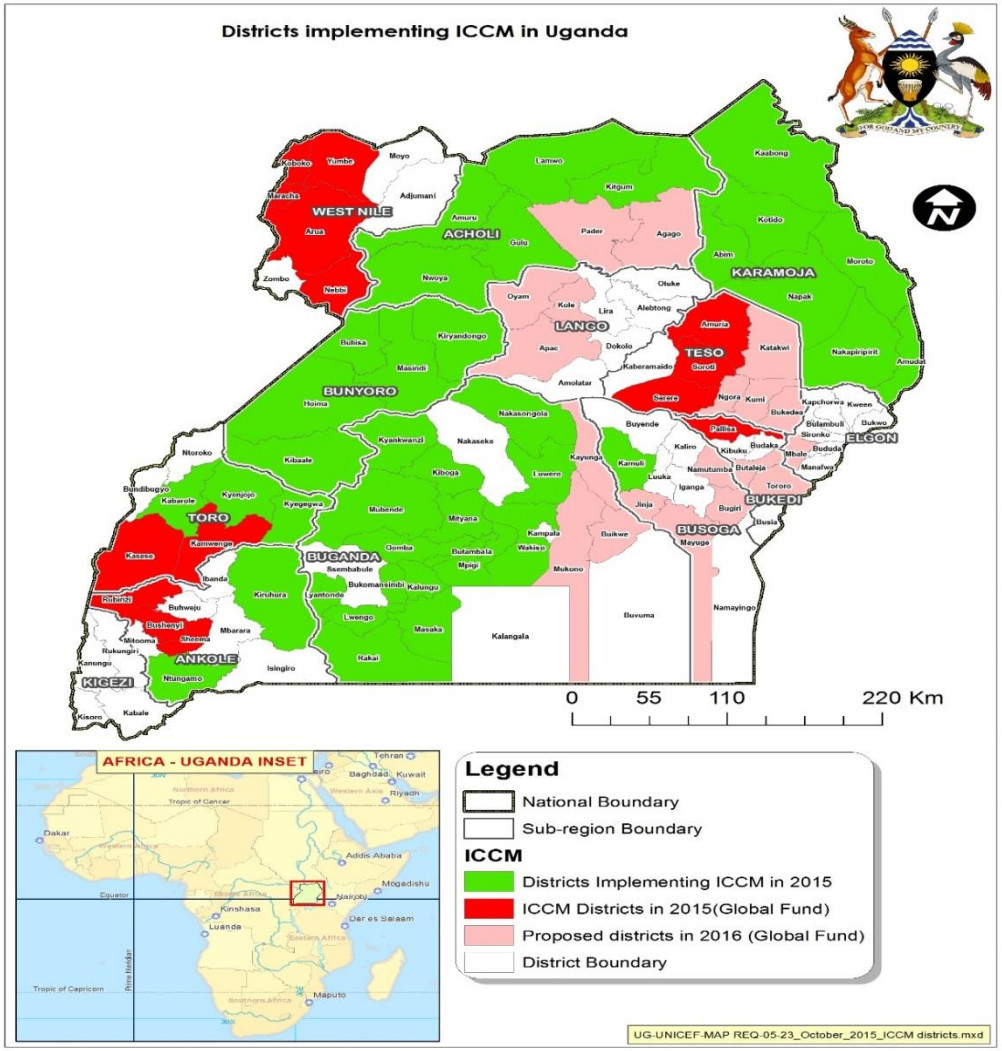
- Community treatment of Pneumonia, Malaria, Diarrhoea and Newborn Danger signs identification and referral
- CHW – volunteer, selected by community members, able to read and write
- CHW Kit - pre-packaged and colour coded medicines (Amoxicillin, ACTs, Rectal Artesunate, ORS+Zinc), medicine boxes, job aid, ARI timers, RDTs, Waste mgt 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

Geographical Coverage



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:

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

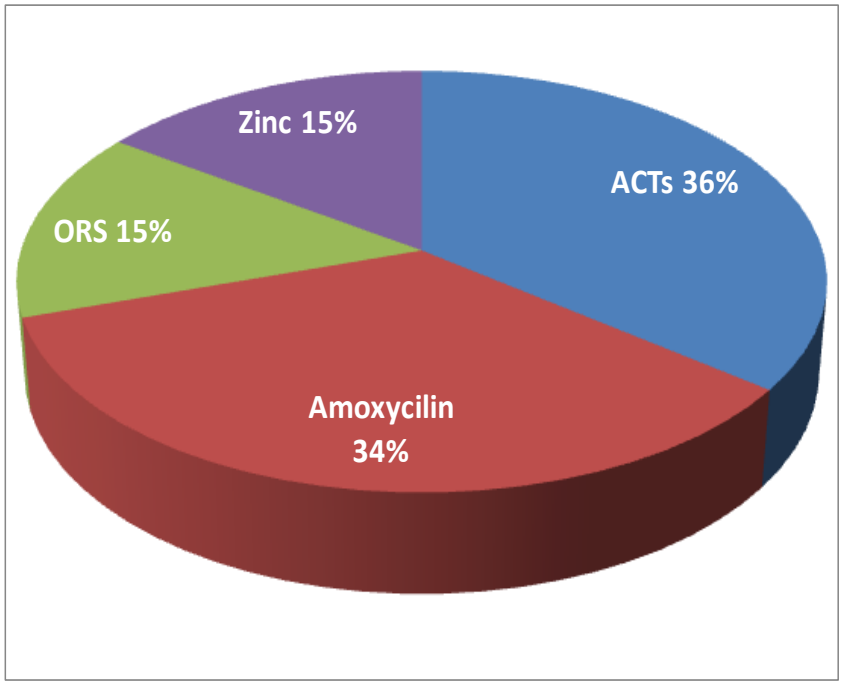
iCCM Financing

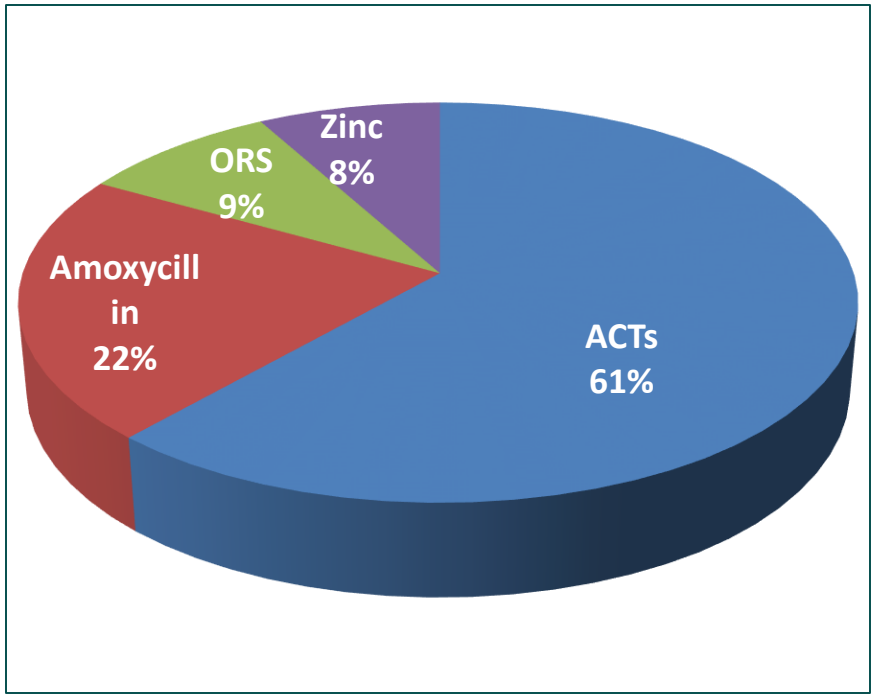
Uganda iCCM Funding Gaps (2016-2017)

Coverage	Source of Funding	Funding available	Gap	Total	Comments
19 UNICEF districts (public)	UNICEF	2,367,233	1,578,155	3,945,388	Funds available can only procure stock of commodities required for up to April, 201, gap to procure adequate stocks for the May-December 2017.
20 UNICEF /CHAI (private)	UNICEF	1,000,000	0	1,000,000	
33 GF districts (UNICEF procuring non-malaria commodities) public	UNICEF	2,000,000.0	3,200,000	5,200,000	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.
33 GF districts (GF procuring ACTs and mRDTs and delivering the iCCM package)	Global Fund	2,344,000	4,189,000	6,533,000	Funding gap is based on budget estimates in the GF iCCM implementation plan 2015-2016
14 Midwestern districts	UNICEF for procuring iCCM commodities for Malaria Consortium	3,703,000	1,930,096	5,633,096	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.
TOTAL (USD)		**9,070,233**	**6,708,251**	**15,778,484**	

Progress To-date

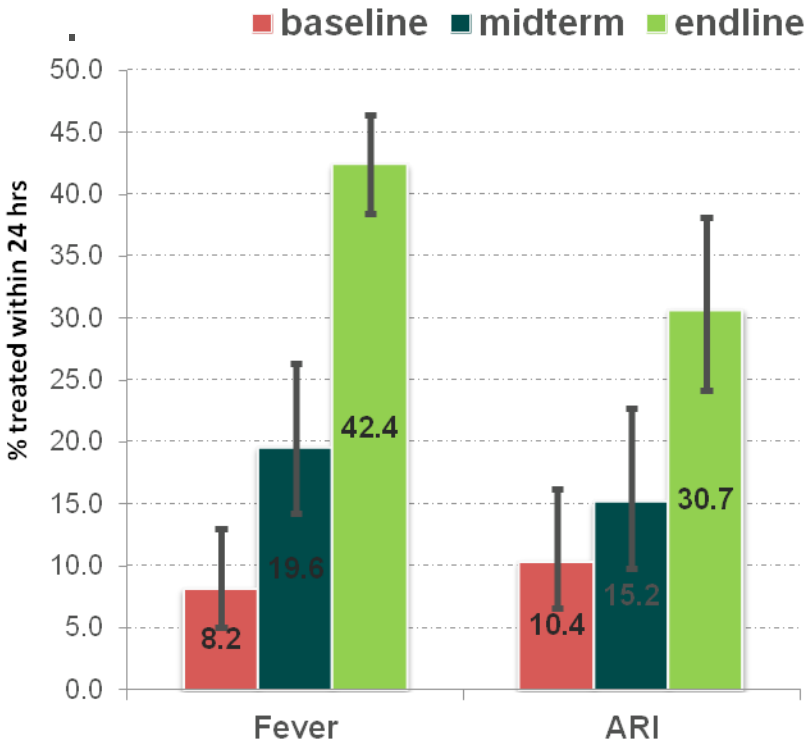
Treatments Provided

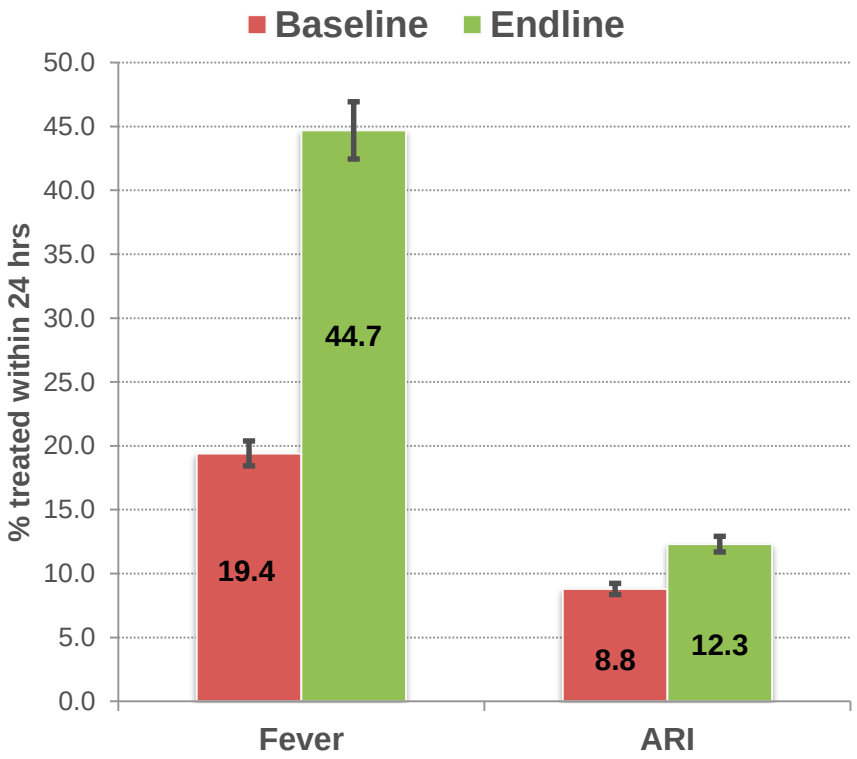




- Malaria treatment based on RDT result – MOH Policy
- Presumptive treatment of Malaria (no RDTs)

Surveys results: Treatment within 24 hours



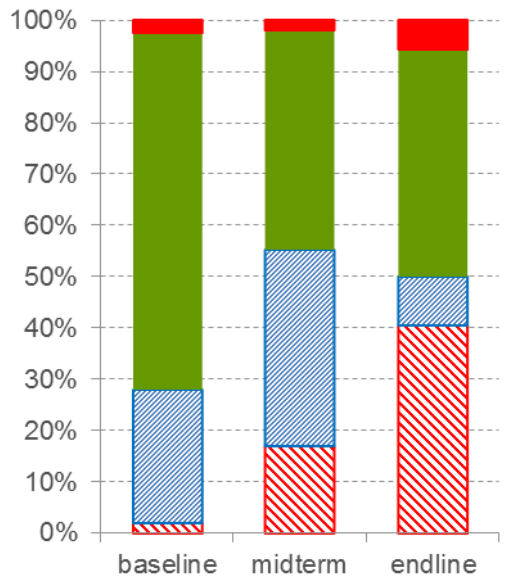


Seeking treatment within 24 hours improved

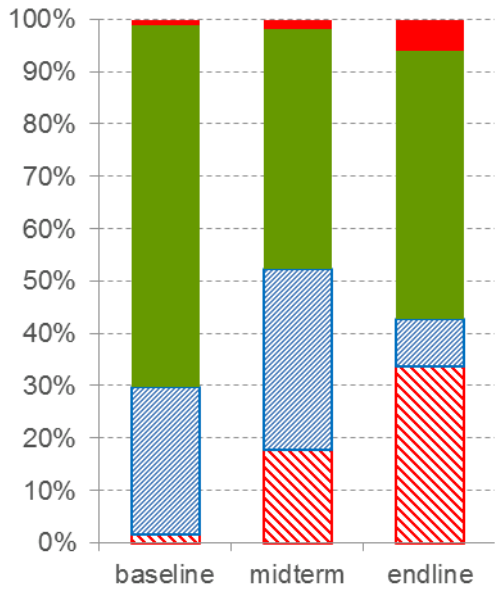
Surveys Results: Source of treatment

➔ Mid-west:1st place for seeking treatment

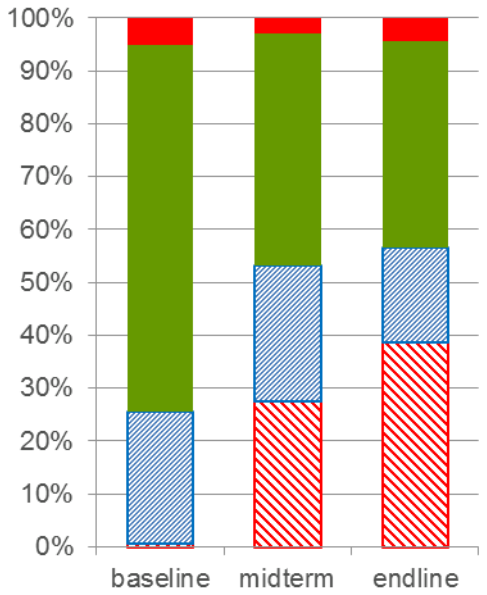
Fever/malaria



Pneumonia



Diarrhoea



Public Sector VHT Private Sector Other

1st 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 …..

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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

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