



a decade in communicable disease control and child health

Three Years of ICCM in Uganda

Highlights of Results from Monitoring & Evaluation Data from 17 Districts

September 2013



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Outline

- **Project briefs**
- **Routine data:**
 - Data transmission processes
 - Results & highlights
- **Evaluation data:**
 - Methods, results & highlights
- **Way forward?**

Projects Briefs

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Programme Implementation Approach

- Embedded project within Ministry structures and systems
- From start-up engage with existing processes to instil strong Ministry involvement and ownership
- Provide additional technical knowledge to strengthen national policies, guidelines and implementation
- Participation in relevant national technical working groups

Programme Implementation

Key Intervention activities

- Community-based case management of malaria, pneumonia and diarrhoea
- Diagnosis at community level
- Drug formulations, unit dosed pre-packaged for community level
- Refresher training of health facility staff
- Training for CHWs including job aids
- Supportive supervision for CHWs
- ICCM data management
- Demand creation through Behaviour Change Communication
- Programme evaluation

Strategy & Commodities

Malaria:

Diagnosis: RDTs – not Central

Treatment: Artemether / lumefantrine

Pneumonia:

Diagnosis: Respiratory timers

Treatment: amoxicillin dispersible tablets

Diarrhoea:

Treatment: Low osmolarity ORS and zinc supplement

Danger signs of severe illness:

Refer to health facility

Project Area – Mid-West



- Funded by CIDA
- Project started April 2009
- Est total pop. 1.8 Million
- Est. 360,000 children <5 yrs
- Approx. 3,500 villages
- Malaria treatment based on RDT result

- MoH target of 2/5 VHTs per village trained in ICCM achieved
- Training target 6,800 VHTs
- 7,098 trained (100%)
- Attrition rate 2%, as at Mar 2013

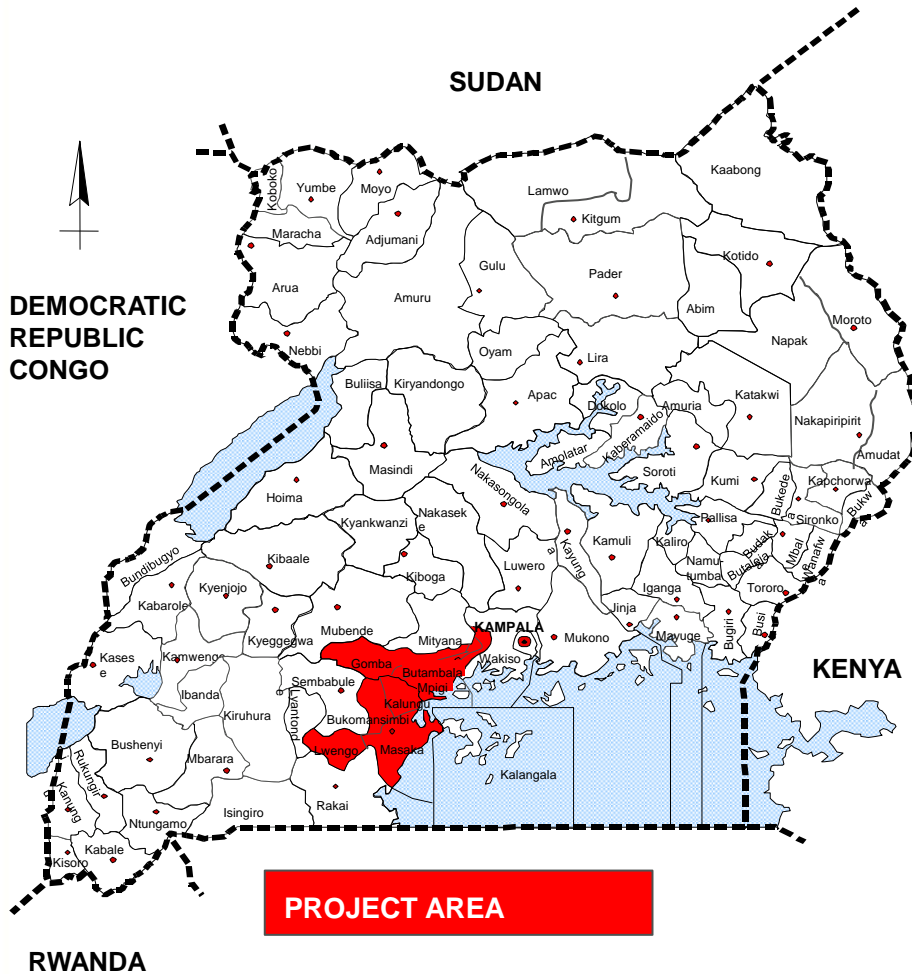
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Project Area – Central



- **Funded by UNICEF**
- **Project started July 2010**
- **Est. total pop. 2.45 Million**
- **Est. 530,000 children <5 yrs**
- **Approx. 2,980 villages**
- **Presumptive treatment of Malaria (no RDTs)**

- **MoH target of 2/5 VHTs per village trained in ICCM achieved**
- **Training target 5,600 VHTs**
- **5,586 trained (100%)**
- **Attrition rate 3.8%, as at Dec 2012**

Routine Data

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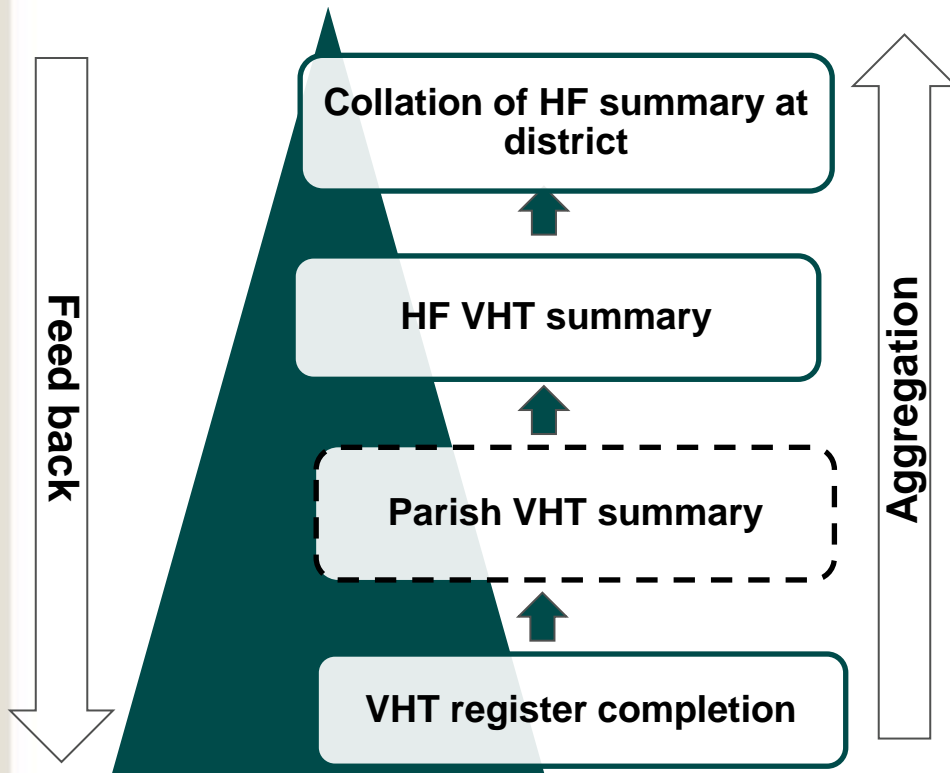
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Routine Project Monitoring

➔ **Monitoring & reporting system structured to align with routine HMIS structures and adapted based on needs**



- No incentives for reporting
- Routine data collected
 - VHT patient data
 - Stock monitoring data
- Entry and processing at Malaria Consortium office
- Feedback to districts at a quarterly basis

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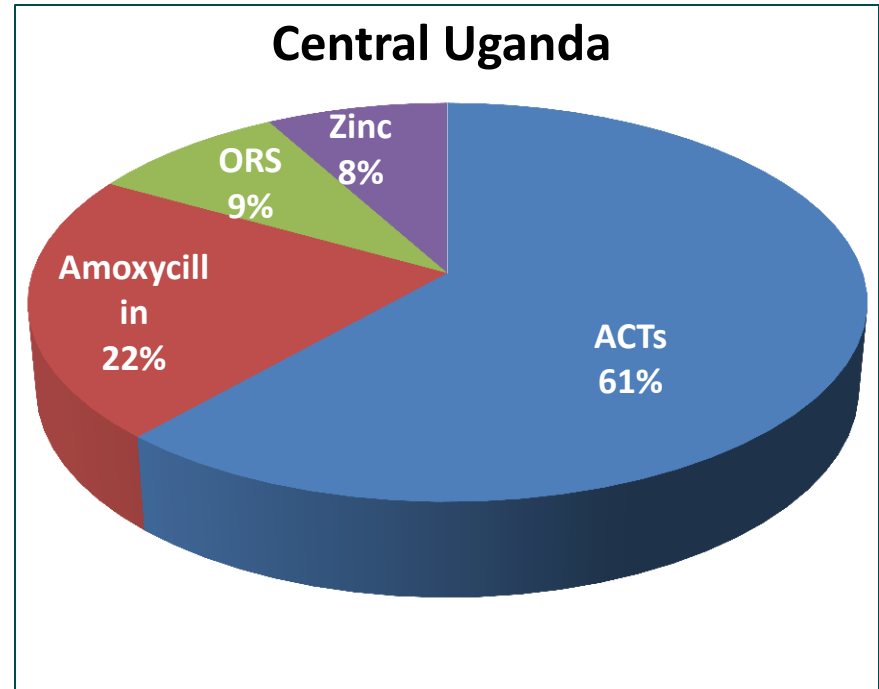
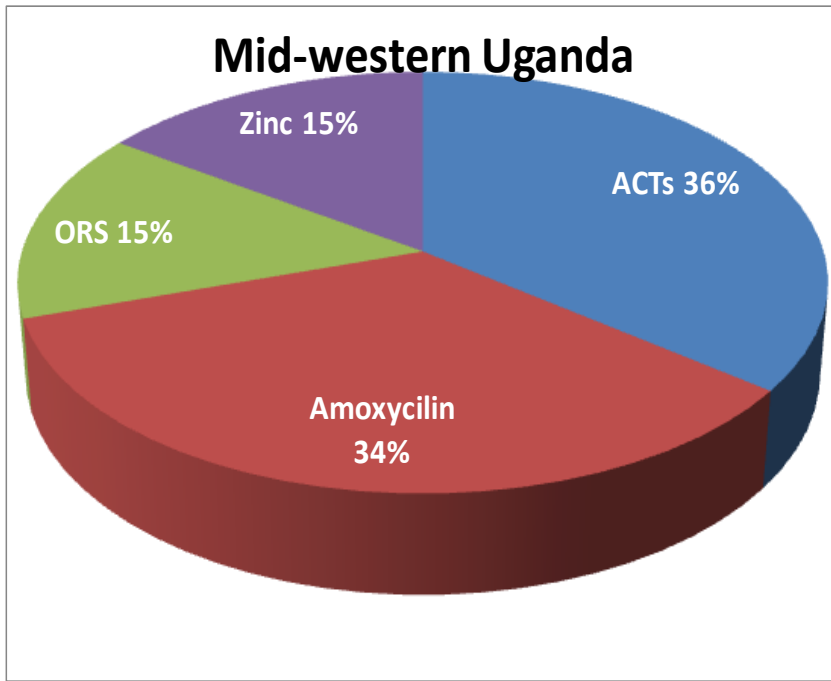
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Treatments Provided

Treatments (doses)	Midwest	Central
ACTs	610,048	971,418
Amoxicillin	590,667	340,616
ORS	252,401	138,782
Zinc	263,156	127,230
Total Treatments	1,716,272	1,450,816
Total cases seen	1,406,342	1,437,030

- Midwest: Average cases seen per VHT per month: Median (IQR) 12.5 (9.9-15.6)
- Central: Average cases seen per VHT per month: Median (IQR) 15 (9-23)

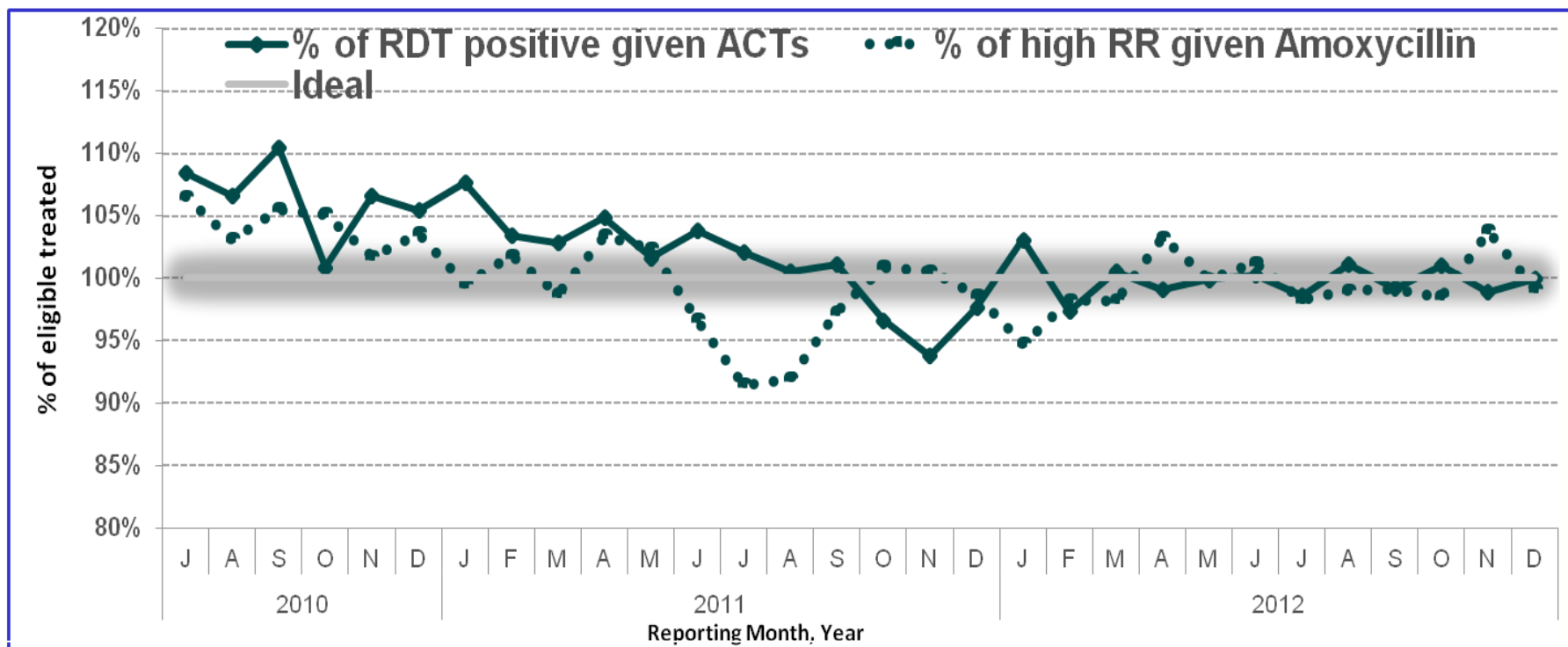
Treatments Provided



- ➔ Mid-west: Malaria treatment based on RDT result
- ➔ Central: Presumptive treatment of Malaria (no RDTs)

Midwest: Compliance to diagnosis for malaria and pneumonia

- ➔ ACTs should be dispensed based on positive RDT results
- ➔ Amoxicillin should be dispensed based on high RR



Treatment according to diagnosis improved over time and is now as expected

Project evaluation

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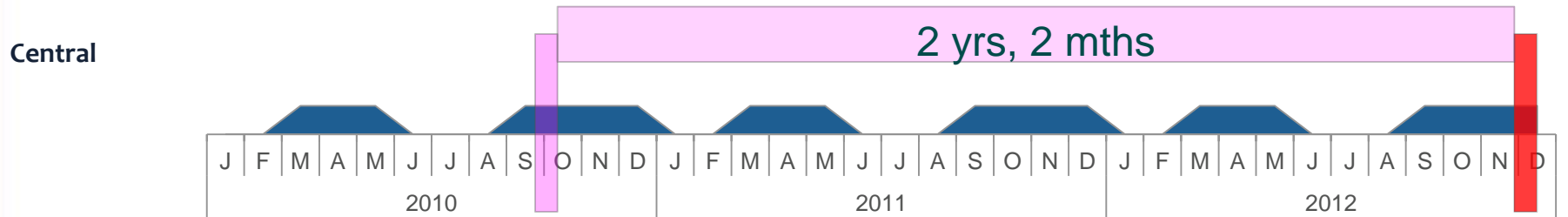
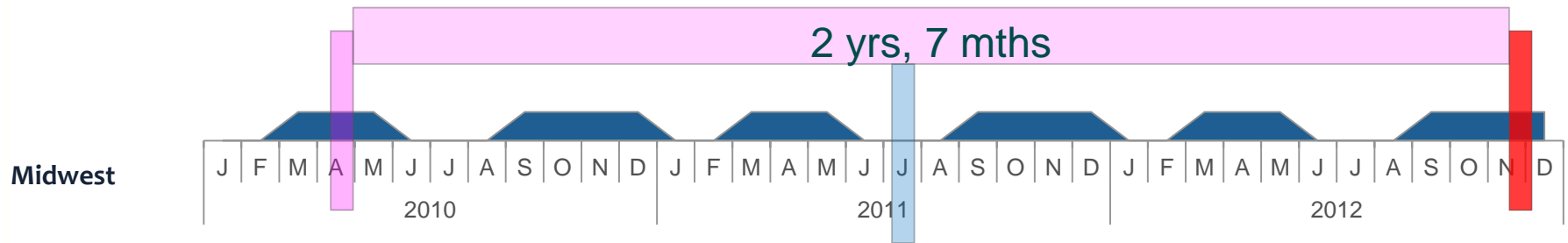
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Surveys - Design & Methods

- Cross sectional household survey at each round (baseline & endline)
- Mortality sample required 4000 households (100 clusters)
 - Mortality survey only conducted at endline (using birth history)
- Child health sample required 1600 households (40 clusters)
 - Same clusters at baseline with random households surveyed at endline
- Used 2-stage cluster sampling technique
 - Sample clusters using probability proportionate to size of village, then households
- Data collection, processing & analysis followed standard Demographic & Health Surveys procedures

Surveys - Timelines



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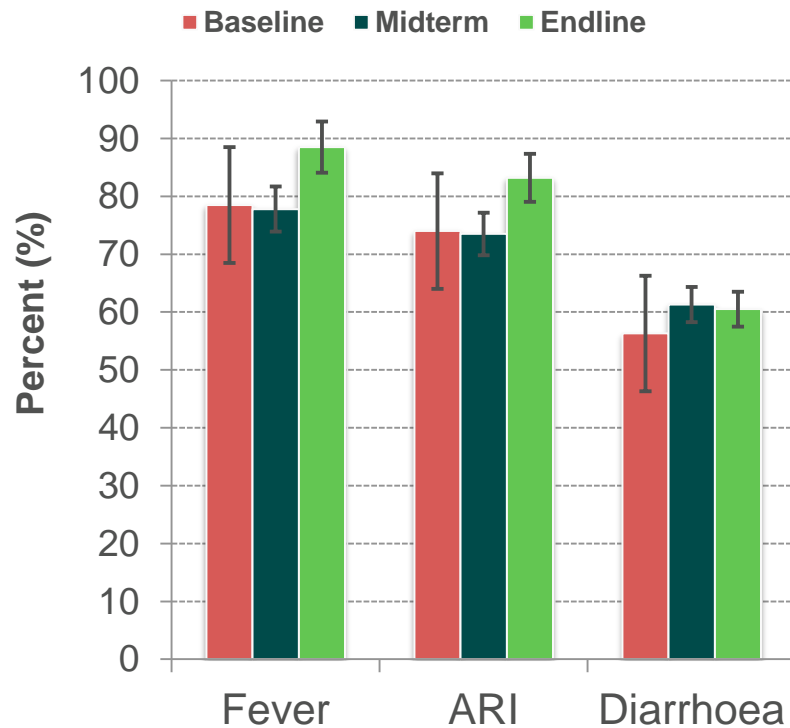
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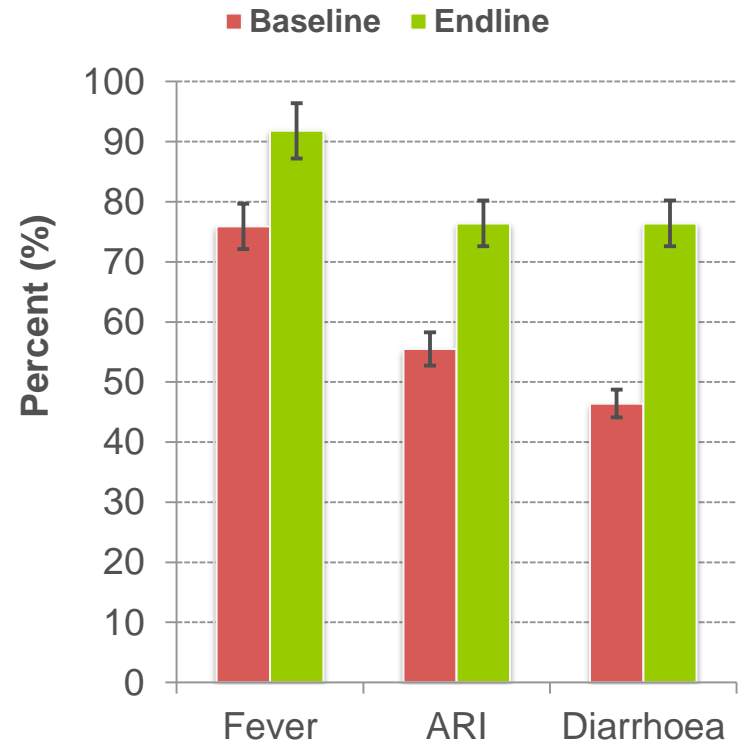
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Surveys results: Treatment Seeking

Mid-western

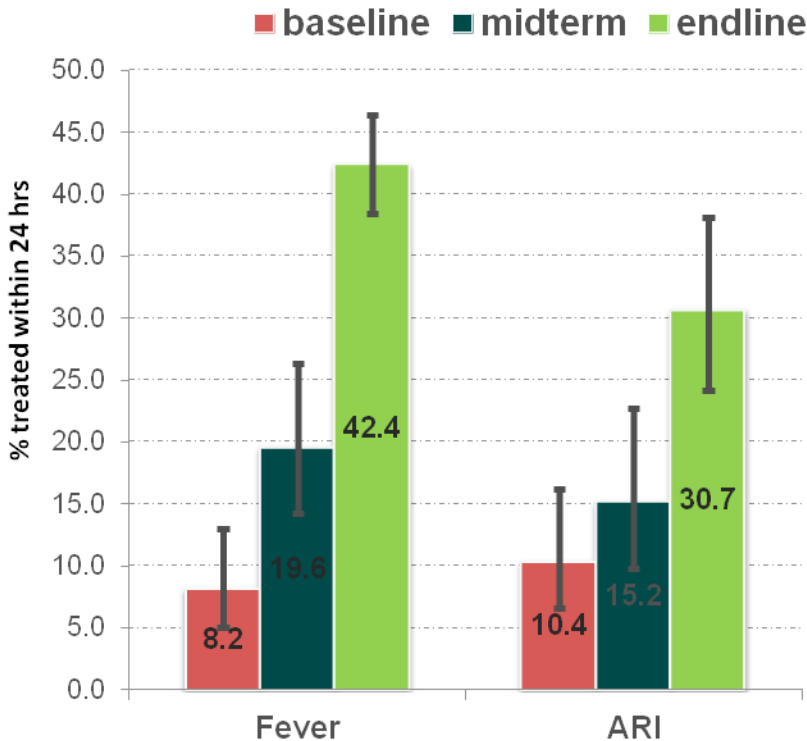


Central

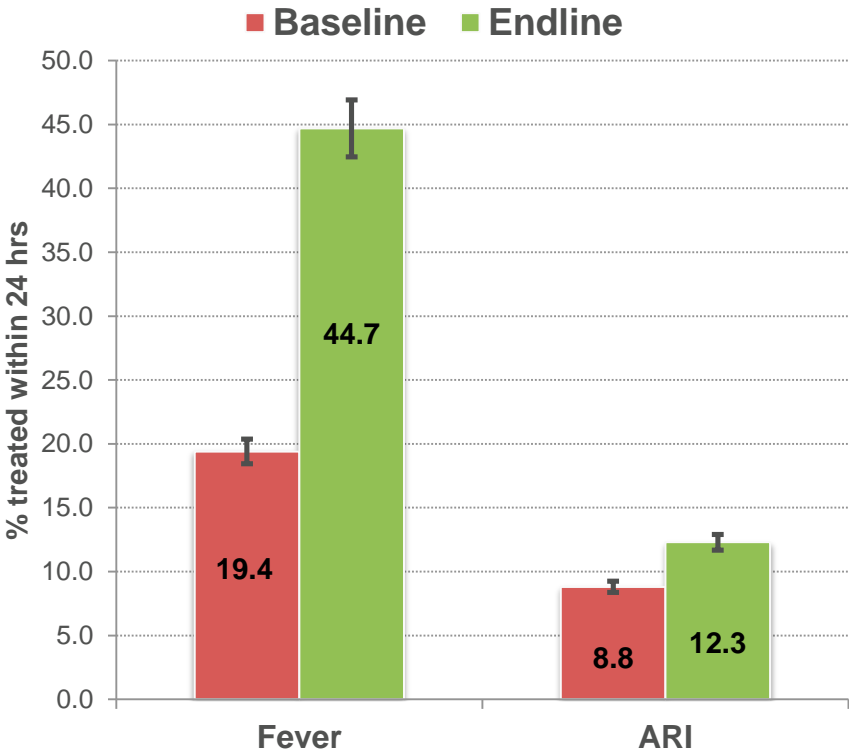


Surveys results: Treatment within 24 hours

Mid-western



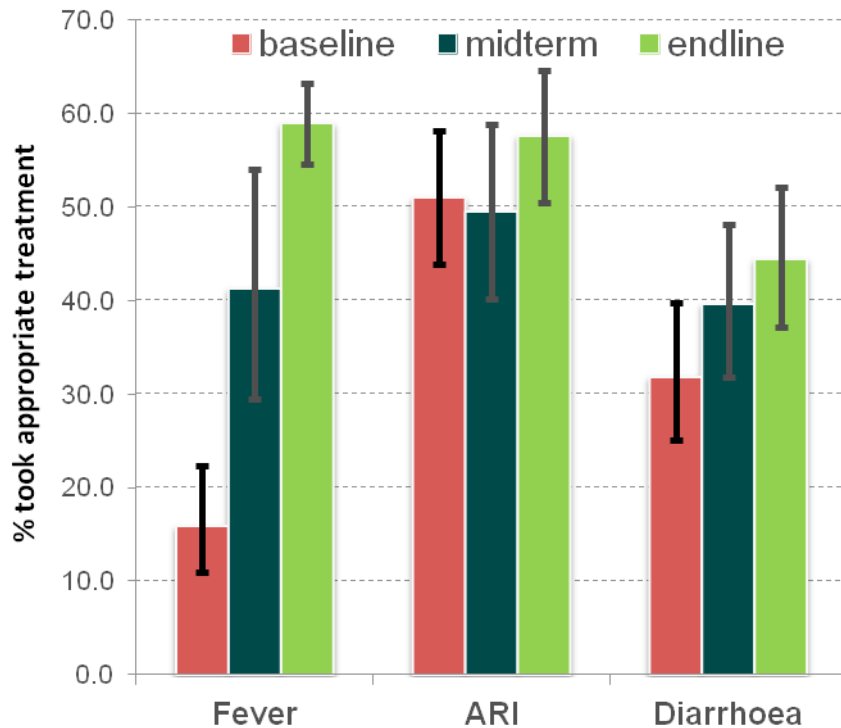
Central



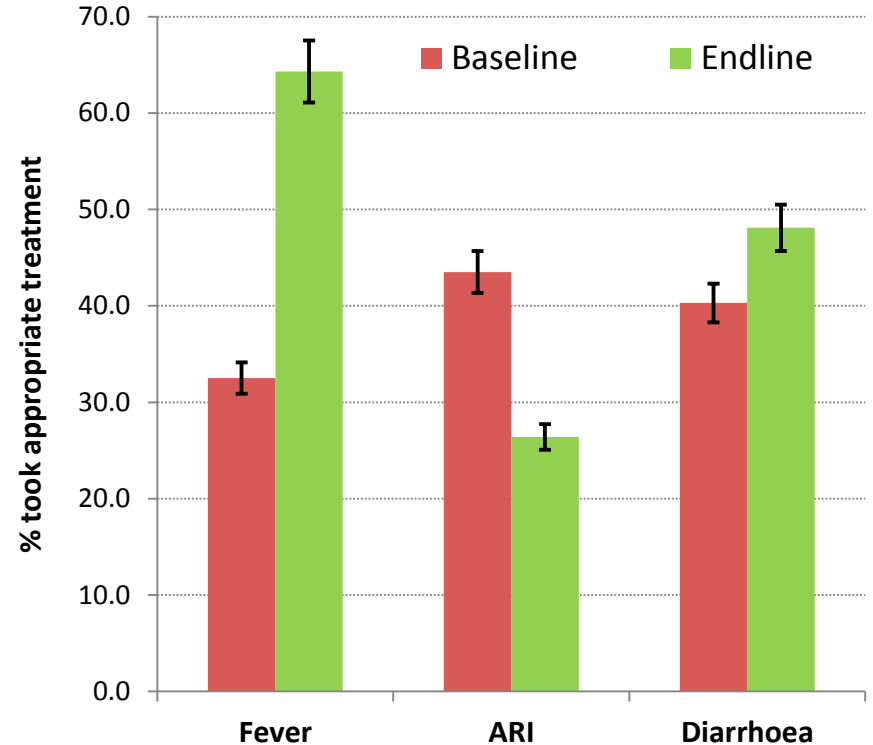
Seeking treatment within 24 hours improved

Surveys Results: Appropriate treatment

Mid-western



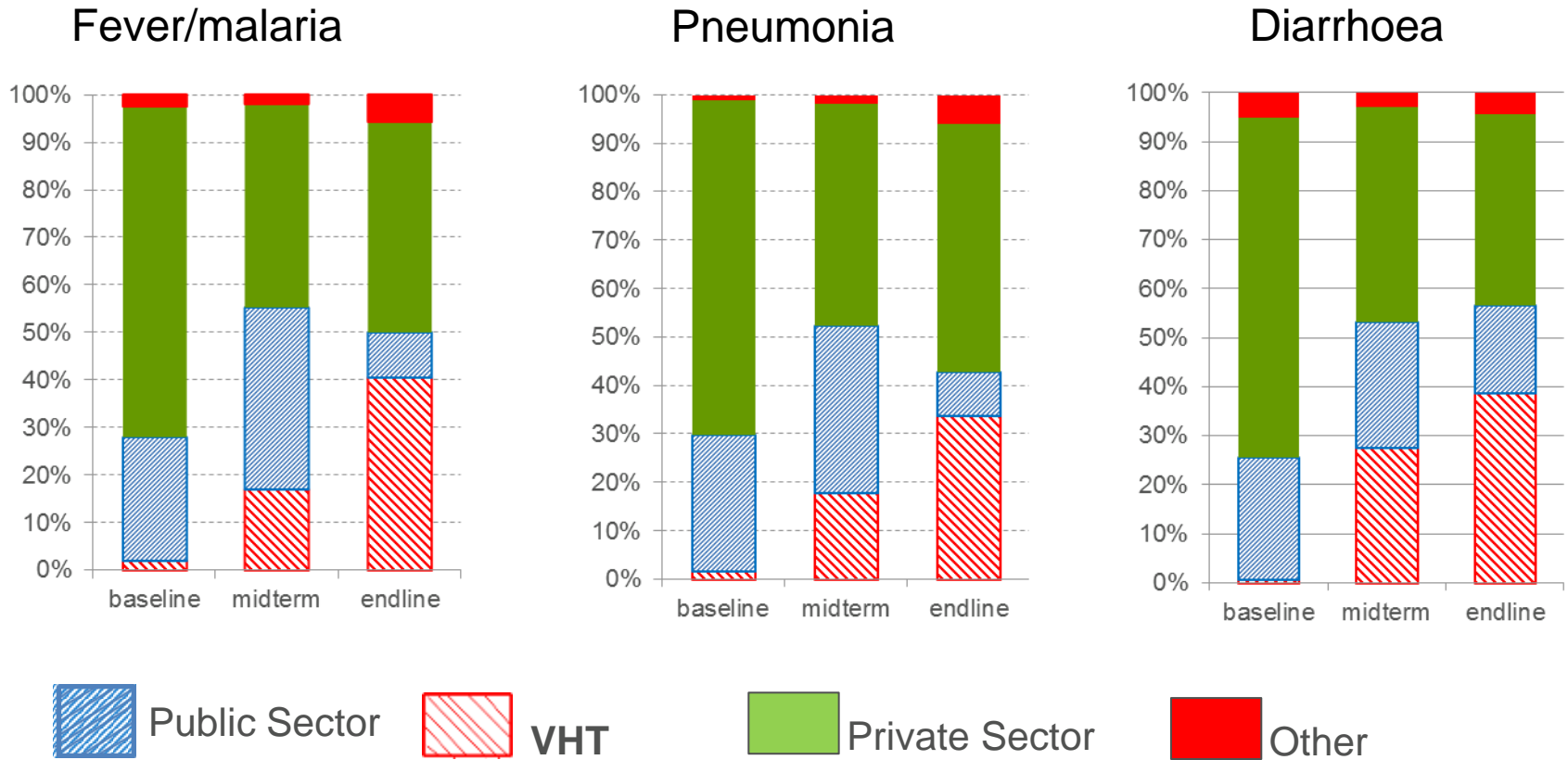
Central



Appropriate treatment for all three diseases improved, except for ARI in the Central Region; which may be due to stock outs of Amoxicillin

Surveys Results: Source of treatment

→ Mid-west: 1st place for seeking treatment

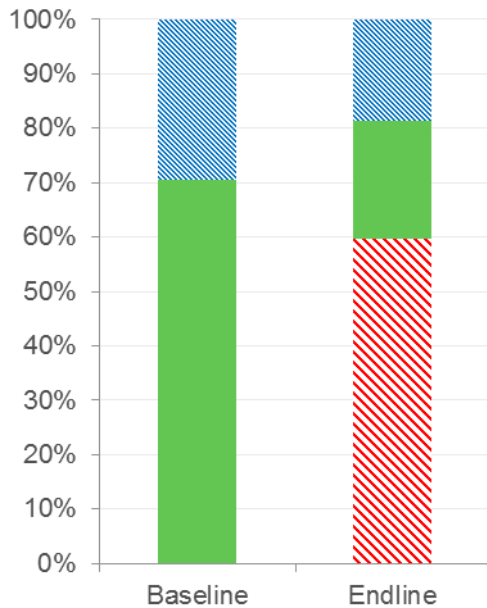


1st choice in seeking treatment shifted from both public and private to VHT

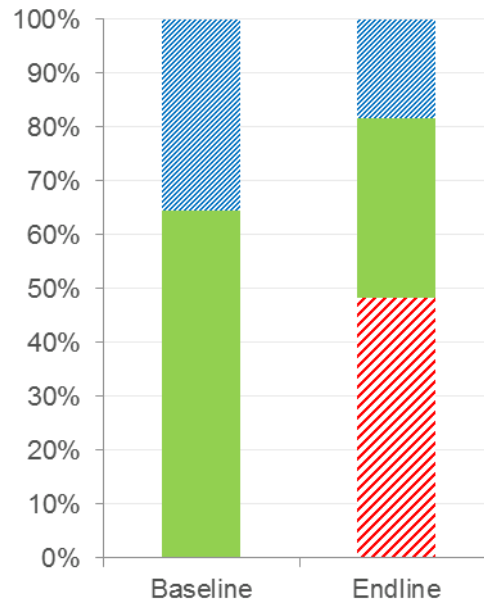
Surveys Results: Source of Treatment

→ Central: 1st place in seeking treatment

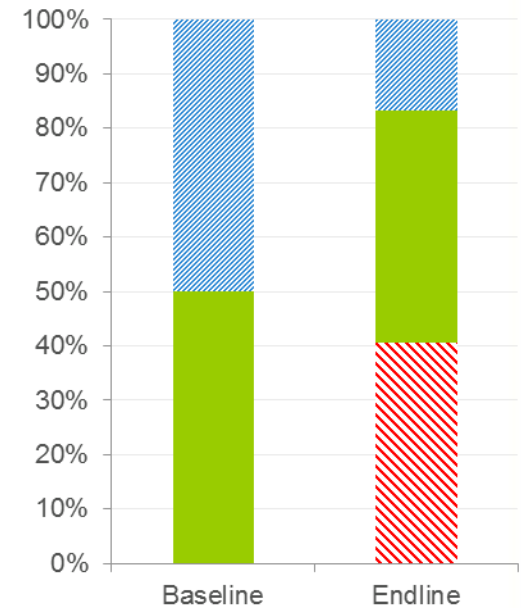
Fever/malaria



Pneumonia



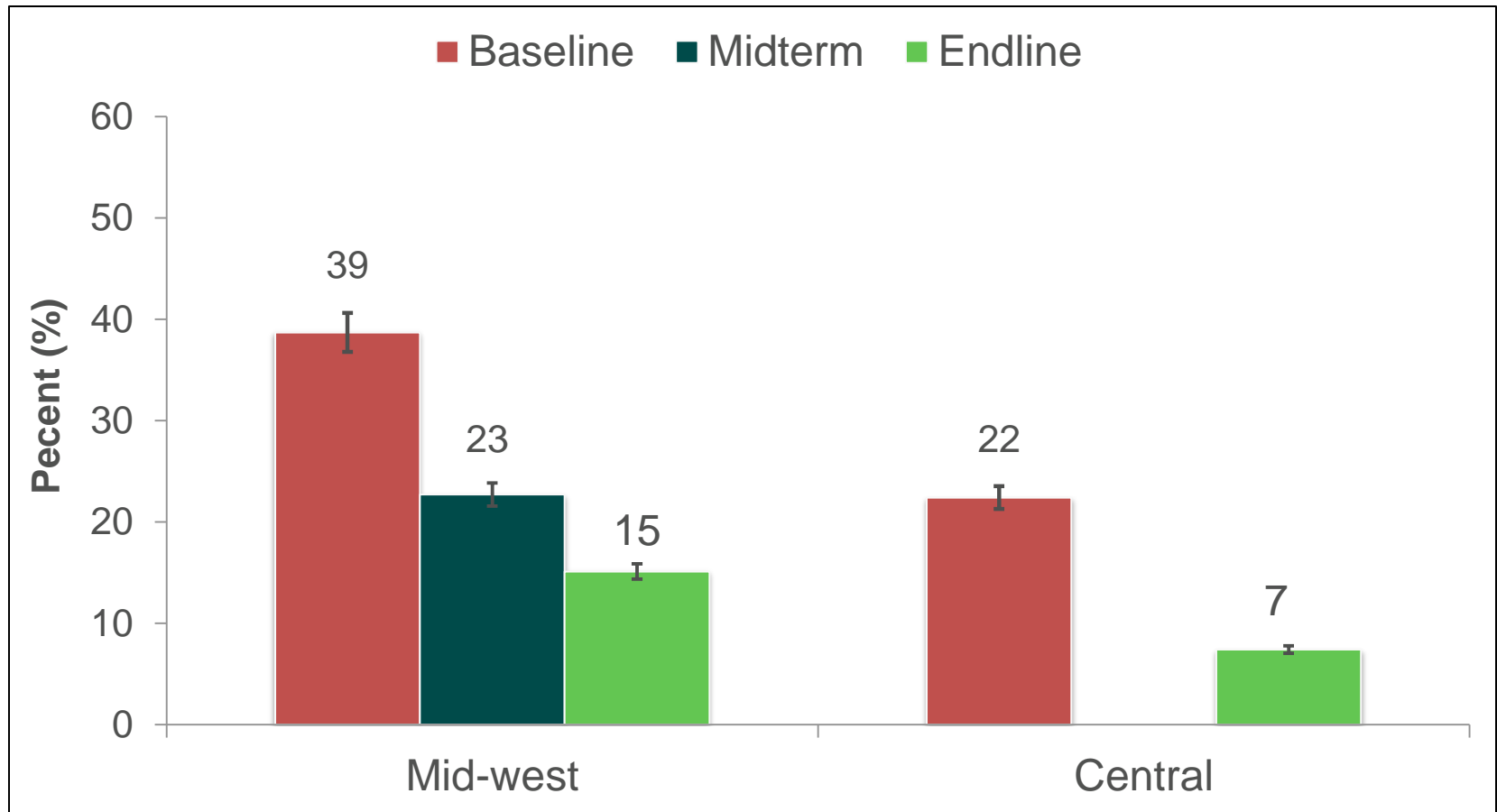
Diarrhoea



Public Sector VHT Private Sector

1st choice in seeking treatment shifted from both public and private to VHT

Surveys results: Malaria Parasite Prevalence



Malaria parasite prevalence has reduced; may also be due to the distribution of LLIN in 2010 in half of the project area

LiST: Modelling Impact of ICCM

■ **LiST (Lives Saved Tool)**

- Part of a compendium of modelling modules (SPECTRUM) that aid projection of impact of existing interventions
- Software focusing on child survival - projects changes in child survival based on changes of coverage of child health interventions

■ **Model Inputs**

- Population covered by age category, population growth rate
- Child health indicators before & after ICCM implementation
- Expected trend in non implementation areas

■ **Model outputs**

- Changes in mortality estimates during the period
- Lives saved (deaths averted)
- Projected changes over a longer period (5 years)

LiST: Modelling Impact of ICCM in Mid-west

Indicator	Implementation Period				Projections		
	2009	2010	2011	2012	2013	2014	2015
Mid west							
U5 Mortality rate	100	96	90	86	79	75	72
Lives saved (0-59 months)	0	151	297	439	574	614	629
% deaths averted	4%				7%		

Learning

- ICCM can be a mechanism for health systems strengthening
 - The 1st source of treatment has shifted to VHTs
- Access to **timely** treatment and **appropriate** of sick children has increased with the introduction of ICCM
- The implementation model has essential elements as well as contextual variations that ensure feasibility of implementation
- Model projections illustrate a potential for mortality reductions with sustained ICCM

Way forward?

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The scale up vision

Establish

Evaluate

Sustain and Expand

Sustainability



What?

- Sustain current coverage and use
- Scale up to high coverage

Why?

- Beneficial effects on child health
- Optimise the use of limited resources

How?

- Political & financial commitment from:
 - Central Government
 - Donors
 - Local Governments



www.malariaconsortium.org

Thank You

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