



InSCALE Inception Meeting Report  
February 4-5<sup>th</sup> 2010

Kabira Country Club, Kampala, Uganda



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## Abbreviations

ACT – Artemisin Based Combination Therapy  
ACSD – Accelerated Child Survival and Development  
ALRI – Acute Lower Respiratory Infection  
AMFM – Affordable Medicines Facility – Malaria  
APE - Agentes Polivalentes Elementar  
BMGF – Bill & Melinda Gates Foundation  
BCC – Behaviour Change Communication  
CAO – Chief Administrative Officer  
CCM – Community Case Management  
CDD – Community Drug Distributor  
CIDA – Canadian International Development Agency  
CHDC – Child Health and Development Centre  
CHW – Community Health Worker  
CMD – Community Medicine Distributor  
DFID – Department for International Development  
DHO – District Health Officer  
HBMF – Home Based Management of Fever  
HC – Health Centre  
HCU – Healthy Child Uganda  
HF – Health facility  
HMIS – Health Management Information System  
HSA – Health Surveillance Assistant  
iCCM – integrated Community Case Management  
ICT – Information & Communication Technology  
IMC – International Medical Corps  
IMNCI – Integrated Management of Neonatal and Childhood Illness  
IRC – International Rescue Committee  
ITN – Insecticide Treated Net  
JMS – Joint Medical Stores  
JSI - John Snow Inc.  
MACIS – Malaria and Childhood Illness NGO Secretariat  
MC – Malaria Consortium

MDG – Millennium Development Goal  
MMV – Medicines for Malaria Venture  
MOH – Ministry of Health  
MSH – Management Sciences for Health  
MUK – Makerere University  
MUST - Mbarara University of Science and Technology  
NMS – National Medical Stores  
OPD – Out Patient Department  
ORS – Oral Rehydration Salts  
RDT – Rapid Diagnostic Test  
SC – Save the Children  
SPH – School of Public Health  
ToS – Trainer of Supervisor  
ToT – Trainer of Trainer  
UNICEF – United Nations Children’s Fund  
USAID – United States Agency for International Development  
VHT – Village Health Team  
WB – World Bank  
WHO – World Health Organization

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## Preamble to the meeting

Malaria Consortium organized a two-day meeting with different stakeholders to discuss the inception of the iNSCALE Programme. As a prelude to the meeting, the invited stakeholders were given copies of a concept note with details and background information.

## Background

During the last decade child mortality has reduced significantly in a number of African countries. Scale up of appropriate management of diarrhea, pneumonia and malaria was partly the reason behind the success. As a way of increasing access to treatment for sick children where health services are geographically and financially inaccessible, several African countries are currently investing in community based agents (CBAs) to deliver treatment. Uganda was one of the first to take this policy to scale through the Home Based Management of Fever (HBMF) strategy, which aimed to improve prompt and appropriate treatment of presumptive malaria using volunteering community medicine distributors (CMDs). Recently, the HBMF strategy was integrated into the more holistic Village Health Team (VHT) strategy. As part of the this new strategy, VHTs do not only provide health promotion / health education and treatment for malaria, but also treatment of diarrhea and pneumonia – so called “integrated community case management” (iCCM). However, experiences from HBMF indicate that VHT supervision and motivation are critical constraints that limit coverage of community-based delivery of health care. It was also observed that proper collection, flow and use of data between VHTs and the health system is another major challenge that hinders optimal implementation. Recently, Malaria Consortium was awarded a grant from Bill & Melinda Gates Foundation to better understand work motivation, attrition and better use of data, and to find feasible and acceptable solutions to VHT retention and performance which are vital for successful implementation of iCCM at scale. This programme will complement a project funded by CIDA which Malaria Consortium is implementing in Uganda and Mozambique.

### iNSCALE Programme Goal

The overall goal of the iNSCALE is to demonstrate that government-led iCCM programmes in 2 African countries (Uganda and Mozambique) can be scaled up to 50% of the districts, primarily resulting in greater access to standard case management for children with diarrhea, pneumonia and malaria.

## Meeting overview

To achieve the project goal of increasing coverage of integrated community case management (iCCM) in the two countries with VHTs that perform optimally and who remain functional over longer periods of time, there is need to address the following questions:

- What the main challenges are that currently limit coverage of iCCM in terms of its geographical distribution and quality and how they can be overcome?
- How to improve supervision of VHTs to ensure regular and effective feedback which result in high performance of VHTs?

## Objectives of the meeting

1. To share iCCM implementation experiences.
2. To discuss the role of various stakeholders in iCCM implementation in Uganda.
3. To share views on the requirements for successful scale up of iCCM in Uganda.
4. To consult with stakeholders about the ways in which supervision and motivation of VHTs can be improved as well as the information flow and use of data collected by VHTs.

## Expected outcomes

1. Stakeholders' awareness of the INSCALE programme and its objectives.
2. Stakeholders' agreement on how the INSCALE programme can address the country needs through testing and documentation of the effect of new and improved strategies.
3. Stakeholder recommendations and

- How to increase motivation of VHTs to ensure high satisfaction and retention of VHTs?
- How to improve the information flow and make better use of the data collected by VHTs?

It is anticipated that governmental and non-governmental organisations will play a major role throughout the life of the project. In particular, we foresee a fruitful collaboration whereby partners will provide input into intervention design, participating in dissemination activities, involvement in development of guidelines for introduction of iCCM at district level, supporting districts to mobilise resources for iCCM, supporting districts to have regular supply of medicines for iCCM and sustaining the programme at national scale. The continuous MoH support of health facilities to provide referral care and equip VHTs with medicines, tools, supervision and training is also a necessity for the success of the project.

## Structure of the report

This report is sequentially organized along the meeting agenda. Each section contains highlights of the presentations, questions and other feedback from the audience, and any outstanding issues

## DAY 1: 4<sup>th</sup> February 2010

Chair: Dr. James Tibenderana

The chair of the morning session welcomed participants to the meeting. He briefly explained that Malaria Consortium received two grants to support the implementation of iCCM. This particular meeting was focused on the INSCALE component. The aim was to generate input into this project from the different stakeholders.

The session chair then facilitated the process of individual introductions. Thereafter he invited the Uganda Country Director of Malaria Consortium to give the objectives of the meeting and introduce the agenda.



## Introductions, objectives of the meeting, overview of the agenda

*By Dr. Godfrey Magumba – Uganda Country Director of Malaria Consortium*

After welcoming participants to the workshop, Dr. Magumba reiterated the objectives of the meeting. He emphasized the importance of partnership between Malaria Consortium, the Ministry of Health and other stakeholders, if they were to effectively intervene in the area of



health and communicable diseases. Malaria Consortium works in Africa and Asia with a regional office in Kampala. They have many projects including the iNSCALE Programme.

Malaria Consortium targets iCCM in a specific population, i.e. Bunyoro region in six districts namely Hoima, Kiboga, Kibaale, Kyenjojo, Bulisa and Masindi. After concentrated efforts through diverse projects

(including STOP Malaria funded by USAID, Pioneer Project, CIDA iCCM project which is Malaria Consortium's implementation project for iCCM, a project strengthening the health system in the districts, etc.) the aim was to measure the impacts on childhood mortality. Implementing colleagues from the Districts are important to the success of this work.

The main purpose of this meeting was to put in motion one of the projects, namely the iNSCALE Programme. Dr. Magumba described the iNSCALE programme as:

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*'... the inspector general of all our projects. It will watch and see the outcome after putting all these resources together on all these illnesses. iNSCALE will test and work out solutions to the scale up of iCCM'.*

Funded by the Bill & Melinda Gates Foundation, this two-country project in Uganda and Mozambique is going to follow fairly standardized tools and comparable methodologies, in order to advise governments about scale up of iCCM. The Malaria Consortium has two projects on iCCM, namely: the implementation arm funded by CIDA, and the research/evaluation arm funded by BMGF.

In conclusion, Dr. Magumba emphasized to the participants that after learning about the structure of the iNSCALE programme, it is important for them to input into the process by giving good guidance on how to implement the project, and advising on essential interventions that can facilitate scale up of iCCM.

Thereafter he introduced the Ministry of Health representative, Mr. Paul Kaggwa.

## Opening remarks

*By Mr. Paul Kaggwa – Ministry of Health Representative*

Mr. Kaggwa relayed apologies from the Minister. In his opening remarks, he emphasized the important role of iCCM in reducing child mortality from controllable diseases. Although some gains have been made in Uganda to combat malaria, pneumonia and diarrhea in children, they are not enough. Challenges include the lack of interventions, and inadequate human resources. These challenges can be addressed by using community-based agents to cover the gap in availability of health workers particularly in rural areas. For example the recent HBMF strategy led to a significant reduction of malaria. Therefore Ministry of Health strongly supports the strategy of Village Health Teams because it caters for people who cannot be reached at the health facilities.

He also highlighted the importance of coordinated

We have had confusion in this country with everybody trying to reach the poor in a confused manner, with single interventions, limited coverage, and overlap in services delivered. We need to get the stakeholders on board, so that we move together in an organized manner. Partners will play an important role, but they need to work in collaboration with the MoH. We have developed the training modules, guidelines for rolling out the VHT strategy and we need to come together to review the materials and

### Outstanding issues:

1. Disjuncture in terminology for community based agents: While MoH uses Village Health Teams, the INSCALE programme seemed to prefer Community Medicine Distributors.
2. A reminder that while it is important to deal with treatment of illnesses through case management, it is also critical to think of innovative ways to eliminate the mosquito. Otherwise we shall treat a child, and send him home to get bitten by another mosquito.
3. The need to develop indicators on partnership, and continuous monitoring in order to measure deviations and good partnership strategies.
4. Let us deal with case management, treating, but also think about how to deal with the

collaboration and working under the guidance of the Ministry of health.

There has been some progress in implementing VHT strategy in Uganda. While some areas have gone as far as 50% coverage, other areas are still in the starting phase.

## Overview of the INSCALE programme

*Dr. Karin Källander – Regional Project Coordinator*

This presentation briefly outlined the project goal, objectives, timeline and indicators to be measured.



In addition to formative research, the project will also undertake studies in feasibility, evaluation, and costing, as well as do dissemination and scale-up.

Key points made by Karin were:

- The project team are aware that there is a need for a project name. This will be identified over the coming weeks. The plenary were asked to nominate a project name if they had some good ideas.
- There is a renewed interest in scaling up iCCM but very few countries have moved beyond district level and haven't achieved national scale up. This has often been due to lack of drugs, poor use of data, high drop out of CMDs and their equivalents and poor performance.
- BMGF grant has been provided to document and record the conditions which lead towards better motivation, satisfaction and performance of CMDs towards scale up of iCCM and ultimately lead to decrease in child mortality and morbidity from the key childhood killers.
- Formative research through the five year project life



partnership

### Chairman

At the end of this morning session, the Chair reiterated that Malaria Consortium was ready to work in partnership with the MoH.

### Comments from the floor:

- It is critical that we collaborate with partners following from Paul Kaggwa's comments. In order to achieve 33% coverage of districts we need to work together as partners under the coordination of the MoH. We can work together under the good stewardship of the government and MoH to show that the targets are possible and we can achieve our aims through collaboration.
- There needs to be an indicator for

He also promised to get people to suggest the indicators to measure partnership and continuously feedback the findings to the Ministry of Health.

## Current implementation status of iCCM in Uganda

*Dr. Jesca Nsungwa-Sabiiti*

This presentation by a MoH member focused on the progress of implementing the iCCM strategy in Uganda. It described the iCCM strategy, discussed its process of development, and the plans for further implementation.

In Uganda, iCCM was implemented as an add-on to the VHT strategy of health promotion and disease prevention. A historical background to the iCCM strategy described the successful scale-up of HBMF from 11 districts in 2002, to 23 districts in 2004, to all districts in Uganda except Karamoja and Kampala in 2005, and ultimately to all the districts in 2006.

Thereafter iCCM was first piloted in Acholi and Lango regions in 2004. In 2008 the MoH developed plans to initiate scaling-up iCCM to the whole country, as well as initiated dialogue about the pneumonia drug policy change. The task force held several consultative meetings to design the implementation framework, review related drug policies, plan for roll out of training and finalize on the materials developed through adaptation of general iCCM materials from WHO. Technical support was obtained from partners including SC, UNICEF, and WHO. It was important to obtain clearance from the MoH hierarchies because moving from HBMF to iCCM has implications for policy.

The aim of iCCM in Uganda is to increase the correct use of life-saving treatments by making them available, ensuring that their delivery is good quality, and mobilizing demand for them. The target groups include:

1. Infants aged 0-28 days, for identifying danger signs and immediate referral, and
2. Infants aged 1-59 months, for treatment of malaria, pneumonia and diarrhea.

The components of the iCCM strategy in Uganda include:

- Pre-packaged medicines and supplies
- Mobilizing communities
- Giving pre-referral rectal Artesunate
- Collecting iCCM data and timely reporting
- Facility staff managing referred cases and supervising VHTs

Major stakeholders and players in this process included WHO, UNICEF, SC, MC, IRC, HCU, MSH, MMV, WB, DFID, USAID, and NGOs such as IRC, IMC, MACIS, Consumer org, as well as academic institutions especially MUST/HCU, MUK (CHDC, SPH).

District implementation involves:

- ❖ Introduction and capacity building during pre-visits for sensitization, and training of trainers.
- ❖ Planning and health systems which considered the district coverage plan, strengthening of referral systems, drug procurement, timers, and other attributes of readiness.
- ❖ Training of facility staff specifically in case management, trainers and supervisors, mapping villagers, integration, VHT follow-up by HF supervisors, refreshing available staff and replacement of drop-outs.
- ❖ VHT including selection, training, certifications, supply of drugs, timers,



Thereafter, Dr. Nsungwa-Sabiiti presented the four phases of national

implementation, highlighting that the introduction and adaptation phase was almost complete. Early implementation in 20/80 districts would then commence for twelve months, followed by the expansion phase for 24 months, and finally the accelerated expansion for the last 12 months.

Materials necessary for implementing iCCM include the VHT handbook, facilitator and trainee manuals, VHT register, supervision checklists and summary sheets, iCCM TOS and TOT materials, iCCM job aid for the VHT, iCCM implementation framework, the pneumonia treatment revised policy, plan for rolling out the two VHT trainings, iCCM research agenda, and commodity security plan.

### **The key challenges emphasised were:**

- ❖ Most of the districts that Malaria Consortium is considering fall into the early implementation phase. An outstanding issue was about when to phase out HBMF and introduce iCCM. Were the health facilities ready to support the whole system of iCCM and VHT? It is hence key that districts are on board with the challenges of iCCM before scale up
- ❖ VHTs are responsible for postnatal newborn visits. However there were differences between who can do these home visits, informed by culture, gender and social norms. The insertion of newborn component into the VHT strategy is ongoing
- ❖ The drug commodity issues of approval, packaging, policy, procurement, etc. Is it possible to fast track the process particularly for those drugs not yet approved or in the country?
- ❖ Private shops sell antibiotics over the counter. However while there are subsidies for antimalarials from WHO, there are no subsidies for antibiotics as yet.
- ❖ There is a need to balance funding for implementation vis a vis funding for research. While the money for research is way beyond that for implementation, the research relies on implementation of iCCM in order to examine any measures. Therefore there might

In conclusion, Dr. Nsungwa-Sabiiti highlighted the way forward for implementation, focusing on forthcoming harmonization and stakeholder meetings, finalization of materials, baseline studies for mortality and other measures, commencement of training, and exploring the possibilities for new partnerships such as AMFM.

### **Comments from the audience:**

- Districts representatives will be key in implementation particularly in light of the ongoing emphasis on partnership. Called for the development of concrete indicators in terms

### **The key lessons emphasised were:**

- The importance of implementing the two stages of VHT training
- Planning both bottom up and top down and recognising the decentralised districts roles
- Coordination of all the key players to promote synergy and efficiency
- Need to ensure drug availability
- Costing all activities
- Integrating program inputs at facility as opposed to community or partner level (HSS component)
- Districts and HFs to monitor quality of implementation and provide support
- Support existing drug supply system – need to ‘avoid ‘push’ system for drugs’
- Coverage plans for iCCM should be tailored at district level

of quantity and quality off partnership to be developed during the two day meeting.

- iNSCALE is not just a research project, it is not a pilot so we will be learning by doing as well as researching and documenting.



**Plenary discussion on presentations:**

Q1: What is the donors interest in the VT strategy – is there a plan to reach out to the donor community? More and more seem to be pulling out?

A1: Interest from donors still exists. They are not pulling out but being organised to harmonise their activities. Issue is to harmonise the planning cycle. Will start planning from July to June. PMs office developing strict guidelines for aid management and have asked the department to

streamline their guidelines. Increased focus on reporting

Q2: From floor: On sustainability. Would be good to have the drugs in place but what is the plan for sustaining it?

A2 We are not creating a new drugs system. The biggest problem is that there are only small budgets for drugs. Learnt that Kenya and Tanzania paying for their own drugs and there is a focus on this. There is a still a problem with drugs though.

Q3: Each village has five VHTs but two with drugs but they are all assigned households. Why can't all have drugs?

A3: It will be too expensive to develop 2,000 x 5 kits too expensive. Also skills will decay if not used and 2 are enough for the caseload. Everyone will be trained though so if there is a change of roles it is possible to reassign.

Q4: Who will do the HH follow up on newborn care. All VHTs or the two assigned drugs? Any plans for strengthening HF support?

A4: Have developed guidelines for strengthening health facilities – focus on training for newborn skills (resuscitation etc). There is a big BCC strategy we are developing with the help of UNICEF. When selecting the VHTs we need to make sure we select people who can make home visits to mothers of newborns.

## Results of stakeholder analysis and mapping

*Dr. Karin Källander*

This presentation was a summary of the preliminary results of a stakeholder analysis and mapping exercise conducted for Malaria Consortium by an external consultant. The exercise involved systematic gathering and analysis of qualitative information to determine whose interests were to be taken into account when developing the program. Individual interviews were held



with key informants representing important stakeholders including WHO, MoH, UNICEF, SC, NMS, DHOs, CAOs, Secretaries of Health in the districts, Malaria focal persons, and VHTs. These were combined with focus group discussions with VHT members in the implementation districts.

The discussion of results from the stakeholders' mapping and analysis focused on their different roles, as perceived both by themselves and the other interviewees. Furthermore, the presentation focused on reported challenges and opportunities for VHT scale-up in Uganda specifically in the areas of 1) constant drug supply, 2) training, 3) incentives, 4) supervision, and 5) use of data.

### Key points to emerge from the analysis emphasised by Karin were:

- Common findings were that this project represents a collaborative opportunity in the health interests of Uganda's children.
- There is a need to clarify the roles of key stakeholders – MoH, WHO, UNICEF, Save the Children, plus many other players.
- There was a universally acknowledged belief in the validity and relevance of the strategy
- Streamlining and harmonizing activities among stakeholders is necessary
- There is a need to focus on health system strengthening so that children are not referred to a dead end
- Drug stock outs are a big problem. When drugs are available there needs to be transport and / or fuel available to deliver the drugs to the health facilities.
- A key point that emerged with regard to VHT motivation was to focus on putting VHTs forward for other income generating activities. The key once again is to harmonise the

## WHO experiences and lessons learned from iCCM implementation

*Dr. Geoffrey Bisoborwa*



The WHO representative presented an extensive review of evidence for and against iCCM in the developing world. Because only a few studies documented the processes of implementation, or even conducted evaluation, most of the examples were drawn from outside Africa. However because CCM can make a difference in the lives of children, and also because CHWs with appropriate training and supervision can provide care to children; there is need for more information regarding scaled up programmes. Malaria Consortium's iCCM interventions will

contribute towards addressing this gap.

Three successful examples of CCM interventions against pneumonia, diarrhea and malaria were examined. In Bangladesh, a trial evaluating the impact of ORS and zinc when implemented in the community found significant reductions in duration of diarrhea episodes, hospitalizations, for diarrhea, the prevalence of diarrhea and non-injury deaths. ORS use increased by 50% and antibiotic use decreased by 60%. A meta-analysis of 9 studies found that CCM of pneumonia reduced overall mortality in children under five years by 24% and

pneumonia specific mortality by 36%. In Tigray in Ethiopia, treatment of malaria by mothers in the home reduced overall and malaria related mortality among children under five by 40%.

Thereafter, the presenter reviewed diverse experiences of implementing CCM by several partners including WHO, UNICEF, John Hopkins University, USAID, CORE Group drawing from both published and unpublished data as well as interviews with program managers.

There are varied modes of implementing CCM in the world, including:

- ❖ CHW limited treatment and verbal referral,
- ❖ CHW limited treatment and facilitated referral,
- ❖ CHW fever treatment,
- ❖ Family fever treatment
- ❖ CHW malaria treatment and surveillance,

Several observations from this review were then highlighted. There is no standardization in the terms used; 'home treatment' and 'community treatment' have a wide range of meanings which make comparison difficult. The quality of documentation is very uneven. Most programs focus primarily on one disease. Thus the level of evidence is best for multiple-case management, while there is minimal evidence for other approaches. Diarrhea tends to have a low profile and thus there is limited training of CHWs on severe dehydration. It is difficult to measure the quality of care given by CHWs,

hence very little is known about their quality of care. There was the added challenge of low utilization of CHWs observed by other programs.

The rest of this presentation was devoted to in-depth examination of CCM interventions in Malawi implemented by health surveillance assistants (HSAs), and the Accelerated Child Survival and Development programme (ACSD) in West African countries namely Benin, Ghana, Mali and Senegal.

In conclusion, this review highlighted that CCM and its constituent interventions can be efficacious. However there is need for more information about factors for success and failures in the effectiveness of large-scale interventions. Interventions must go beyond training CHWs and giving them drugs, to also address critical health system gaps such as planning, management and supply chain management.

#### **Questions / Comments arising from the audience**

C1. We may not demonstrate impact but we can map the reasons why this was not achieved

Q1. What was involved in the VHT mapping exercise?

A1. UNICEF mapped the VHTs in the country and will present the results tomorrow. Line of enquiry was to learn whether the VHTs were functional and whether they had been trained.

They also did some interviews about incentives and motivation using qualitative questions. Q2. Is the lesson from ACSD that we should not be packing too many interventions in one go?

A2. For ACSD to succeed all interventions are required at the same time. The question is whether they must all be delivered by the same people? Perhaps not.

Q3. Malawi seems to be the model iCCM country for scaling up. What can we learn in terms of scale up in Uganda? What are they doing differently apart from paying people?



A3. There is intensive training, they are part of the health system and they are paid. In addition they receive 6 days training of CCM apart from basic training in health. They are strongly attached to health facilities but in

addition to these factors the context is that Malawi generally have a stronger health system. The Malawian model is also closer to the Ethiopian model.

Q4. I have more fears than hopes. There have been more stock outs of Coartem than “stock ins”. Health Facilities have no drugs and vaccines and they ‘run away’ as a result. I do not wish to be a ‘prophet of doom’ but what are we going to do differently? What is needed is to get Coartem where it is needed.

### **Chairman**

At the end of this session, the Chair reiterated that new models for iCCM implementation are emerging from Africa. He summarized that it is not very easy to implement these interventions, let alone measure them. Furthermore, there were challenges with assessing impact measures particularly when there is lack of recorded impact.

## **Malaria Consortium experiences and lessons learned from iCCM implementation**

*Mr. James Ssekitooleko – CIDA iCCM Project Coordinator Uganda*

Different African countries are at different stages of implementing iCCM, ranging from planning, to introduction and scale-up. This presentation focused on differences and similarities in iCCM implementation in four sub-Saharan African countries with varying epidemiological and health system settings – namely Uganda, Southern Sudan, Mozambique and Zambia.



Names differ ranging from village health teams (VHT), community drug distributors (CDD), Agentes Polivalentes Elementares (APEs), or community health workers (CHWs). While the CHWs are volunteers in Uganda and Sudan, they are paid a monthly salary and even sign contracts of employment in other contexts. There are also differences in duration of training. While the Ugandan scenario offers VHT training for five days and then six more days for iCCM, APEs in Mozambique are trained for four months, and CDDs for five days. There are different training needs for literate, low literate and non-literate individuals. Contexts of low literacy require skills for adult learning and more practical teaching methods. Furthermore slow learners may require additional days for training.

Diverse reporting systems are used including the bottle system, paper system, buddy system with registers, and a recently piloted electronic-based system. A challenge arose when reporting co-morbidity using the bottle system, which for example could not capture multiple illness episodes in one child. Furthermore, simpler forms are better to use than complicated ones.

The presenter also stressed the need for establishing sustainable drug and commodity supply mechanisms. The initial push after the training was sustained by weaknesses in the general medical stores that necessitated restocking from health facilities. Irregular drug supplies make implementation difficult. Perhaps giving each VHT a medicine kit or drug box would solve short-term drug storage shortages.

It was important to strengthen the links to the health facilities where patients were referred for medical interventions. Furthermore, supervision was discussed in terms of mode, seasonal variations, quantity and quality. Coordination of supervision is critical to the success of the project because it can also be a motivator for the VHTs.

## Save the Children experiences and lessons learned from iCCM implementation

*Dr. Stephen Ataro Ayella – Technical Manager Health and Nutrition*



Save the Children has global leadership in rolling out CCM. In Africa, different countries are at varying levels ranging from testing, introduction and scale-up phases. This presentation focused on experiences from Ethiopia, Malawi and Mozambique.

ICCM in Ethiopia has taken off well. The uniqueness of this country is that new players are coming on board, such as USAID, SC/Italy and partnering with the MoH. The technical package is similar namely that the target diseases are malaria, pneumonia

### Key points made by James were:

- Key approach to ensure accountability of VHTs is to get a signed contract for the delivery of services by VHTs – even if, and perhaps especially, if they are volunteers
- Training has varied in duration but as often in conditions of low literacy there should be a focus on adult learning approaches and more practical elements
- With regard to reporting – one method used is the bottle system where different colour stones for different disease incidence are put in a glass bottle to be counted later. Key challenge is recording co-morbidity incidence. The lesson is that there needs to be more training on reporting and the forms should be as simple as possible with minimal ...

and diarrhea. The interventions are also similar, namely ORS and zinc, RDT/ACT or chloroquine if *Plasmodium vivax* is suspected, and referral for fast breathing. The scale-up will focus on current interventions and perhaps test a new strategy for pneumonia. There are also considerations of changing the drug policy from Cotrimoxazole to Amoxicillin.

The impact area comprises two main areas: Shebedino and Lanfero districts and Derashie and Konso districts. They are targeting 370,000 people and 75,000 under-fives. They have paid MOH extension workers who are supported by CHWs. Training is cascaded and given by SC, MoH, and JSI. It is often delivered in Amharic language for the CHWs, trainers and supervisors. Certification is based on overall impression during training. So far, only 2/109 failed.

Initially there were different registers, but these have now been harmonized. CHWs are provided with a range of materials including a 7—page IMNCI chart book and counseling cards, register, supervisory checklist, etc. Supervision is done monthly by the MoH which goes

to the Zonal level. There are no supervisors or supervisor-of-supervisors other than MoH staff. The biggest lesson learnt is that there was low use of curative care for under 28 months, more female CHWs and prenatal care visits at home.

Due to limitations of time, the Malawi and Mozambique case material was barely discussed although the presenter gave the details in his power-point slides.

### Questions arising from the audience

Q1. Do all those countries with ICCM should have it at national scale? Implementing the donut approach in met with a lot of resistance. How did determine where to start and where

Q3. Why did people choose to do way they did them? What thinking behind this? In Ethiopia there are



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extension

### Key points made by Stephen were:

- Save the Children make are an important player in the global leadership on CCM
- CCM has been taken up well in Ethiopia.
- Supervision of supervisors has not been part of CCM previously and is an ongoing

workers and CHWs. In Malawi they are working with health facilities.

### Use of data

*Ms. Racheal Seruyange*

This presentation focused on the Health Information System (HIS) and how it related to the data collected and utilized by the VHTs. After describing the multiple sources of information categorized as 1) Population based statistics, 2) Health services based statistics, and 3) Research data, the presenter discussed the critical roles of the national Health Management Information System (HMIS) for the successful planning, delivery and implementation of the minimum health services as outlined in the Health Sector Strategic Plan.

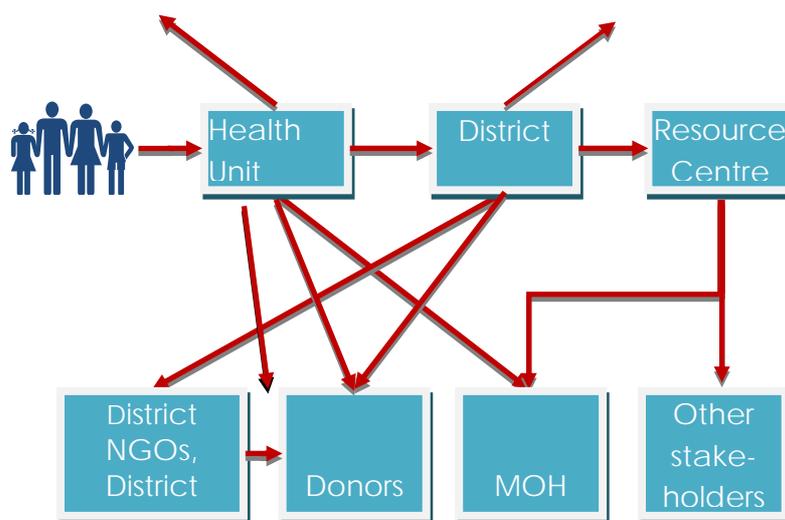
The National Health Information Resource Center (NHIRC) was established in 1999 with the mandate to "develop an enabling environment for, and undertake activities to support effective and efficient management of information of the entire health sector", in collaboration with local government and other stakeholders. Its objectives are to gather health data, analyze and



use it for evidence-based decisions, resource allocation, planning, and policy formulation for the success in all efforts to improve health care.

In order to meet these objectives, the HMIS must ensure that data are compiled, analyzed, used and reported within the system in an accurate, timely and cost-effective manner. Furthermore, relevant and timely feedback to frontline health workers, policy makers, health managers and other stakeholders must be provided in a context that enables them to improve their decision-making and respond to contemporary health problems.

### Current Data Flow

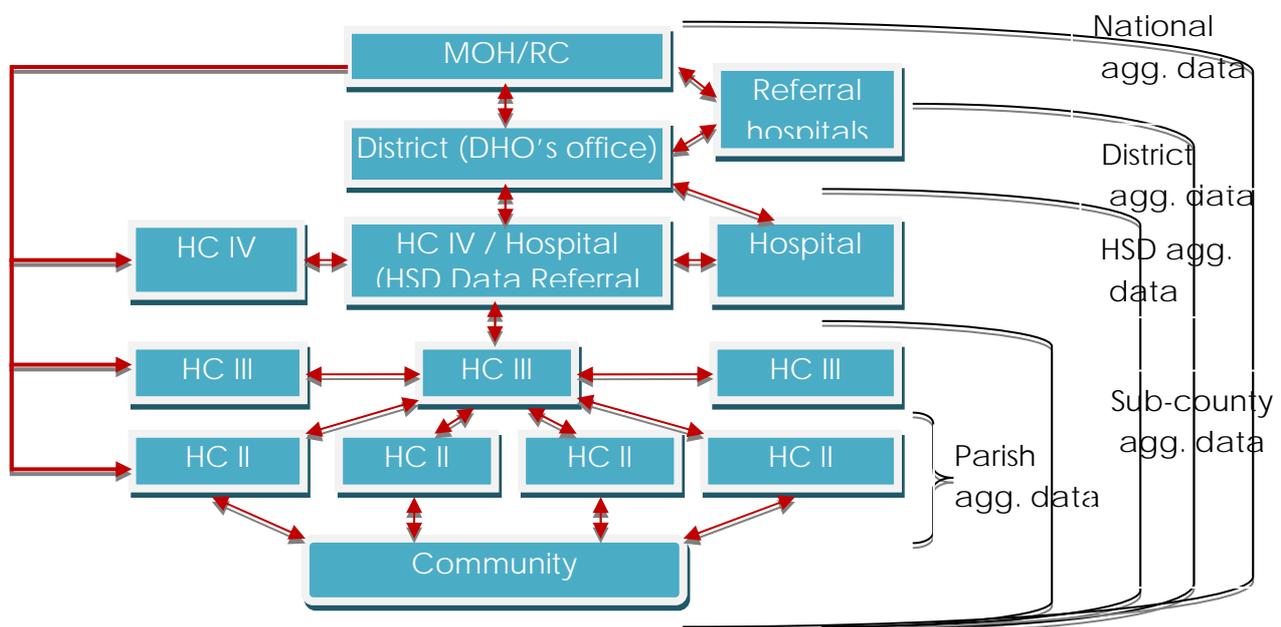


Data collected from the CMDs and VHTs was to be collated and compiled on a monthly basis by the nearest health facility. Examples of the simple information collected at the community level include total number of children under 5 years treated, total number of children treated within 24 hours, total number of children sleeping under ITN in the previous 24 hours. However challenges to obtaining these community based data were apparent. Information was obtained from only about 30% of the CMDs. Their activities were not supported; such that they often lacked stationery, transport, and supervision. If these challenges were addressed, the desired multi-directional flow of information illustrated below would be attainable in Uganda.

Several challenges contribute to the current data flow presented, including:

- ❖ poor recruitment and capacity building lead to understaffing at facilities, districts, and central level
- ❖ poor coordination of health information activities within the MoH and other key partners involved in generation of data
- ❖ pervasiveness of information systems that do not communicate with each other
- ❖ lack of a national identity card and unique client identifier system to facilitate integration of data
- ❖ private health facilities and non-compliance to national HMIS reporting requirements
- ❖ lack of ICT standards for health data management (hardware and software)
- ❖ poor ICT infrastructure at most of the lower level facilities
- ❖ poor coverage and use of vital registration systems
- ❖ poor information utilization culture at different levels of the health system

### Flow of information



### Questions / comments arising from the audience

Q1: Do you have or are you aware of any experience of people using ICT to collect / disseminate data? Do you see any other opportunities or innovations that would be worth implementing? Are there any two way flows of information so that there is also feedback supplied to the people that generate it?

Q2. Does any of the data collected relate to BCC? How rich is the data and how much do you get to use?



C2. Mine is an observation from which we need to plan a way forward. We are getting about 30% of the data and mainly from the public sector. Even then on average only about 70% of the public services are reporting every month. There is very little capacity at the public facilities. Maybe the rest of patients go to private practitioners or traditional and contemporary providers of health services. The public media carries many announcements of self-styled providers and traditionalists. We do not have a form that captures these data. How do we capture this type of healthcare

services?

Q3. The official HMIS form filled by MoH has only three slots for indicators from the community. Only three were included and it was difficult to append them. Can we add more indicators for the community data to the HMIS form?

Q4. Some communities in some countries keep track of their own data against indicators? Is there anything being done in this regard?

A4. The diagram of the data flow that was displayed is haphazard. The system is not working so well and is still being worked on. It is often an issue of staffing.

Q5. Regarding the information flow, the ideal would be from communities to HC2, 3, 4 up to community. But our experience is that the system handicaps fail this. Staff members go on leave. How can information flow in that form? Another example is that information often goes straight to the district and then from the district to the centre. Is it possible to waive the staff ceiling in order to provide more staff?

Q6. The Uganda Newborn Study (UNEST) is working hand-in-hand with the district to work with CHWs. My observation on the HMIS form is that there is no space for information on neonates. Therefore their issues are not captured on the forms such as how many died or survived after intervention? Is there any plan to improve on that form for the system?

Q7. The official HMIS form filled by MoH has only three slots for indicators from the community. Only three were included and it was difficult to append them. Can we add more indicators for the community data to the HMIS form?

Q8. Where can new technologies be used in this information flow? Might



these have a knock off effect on the challenges to motivation? Many organizations are discussing this innovation in Uganda. What is your input on this?

Q9. Regular and good technical supervision can be good motivators. However most of the vehicles that were given to districts are down. 80% of these vehicles are damaged. The costs of repairs are high. If they worked for long, they are in bad state. Donors deal with procurement for big officers but not the junior ones on the grounds. Mid-level people are very good but do not have motorcycles, yet these are people who can supervise the VHTs. Districts cannot procure these vehicles and motorcycles. And projects that offer their services do not give them for VHTs to work. And yet it would be a good motivator that would facilitate better implementation of iCCM. This is a comment not a question.

Q10. It is simpler to supervise the VHTs who are trained in iCCM but not the VHT who are trained in the basic package and may be up to five people. Visiting each VHT once every month is unrealistic. It is possible to visit them all initially and immediately after training, but

then the frequency will be reduced later.

Q11. Another big challenge is for the VHTs to travel to a HF for review meetings on a monthly basis. However, that too is supervision. Unless there is a big incentive to pull people from their home to the village, it is a big challenge. Are there incentives for submitting these forms?



Q12. A challenge that I see is when the parish chairperson is asked to supervise other VHTs. There is a problem of flow of language. How do you deal with these intermediary supervisors who are not health related?

## Medicines and supplies management

*Dr. Martin Oteba – Assistant Commissioner Health Services (Pharmacy)*



The supply chain management was simply conceptualized as a sequence of activities and related firms or organizations involved in the movement of materials or supplies from the source to the ultimate user.

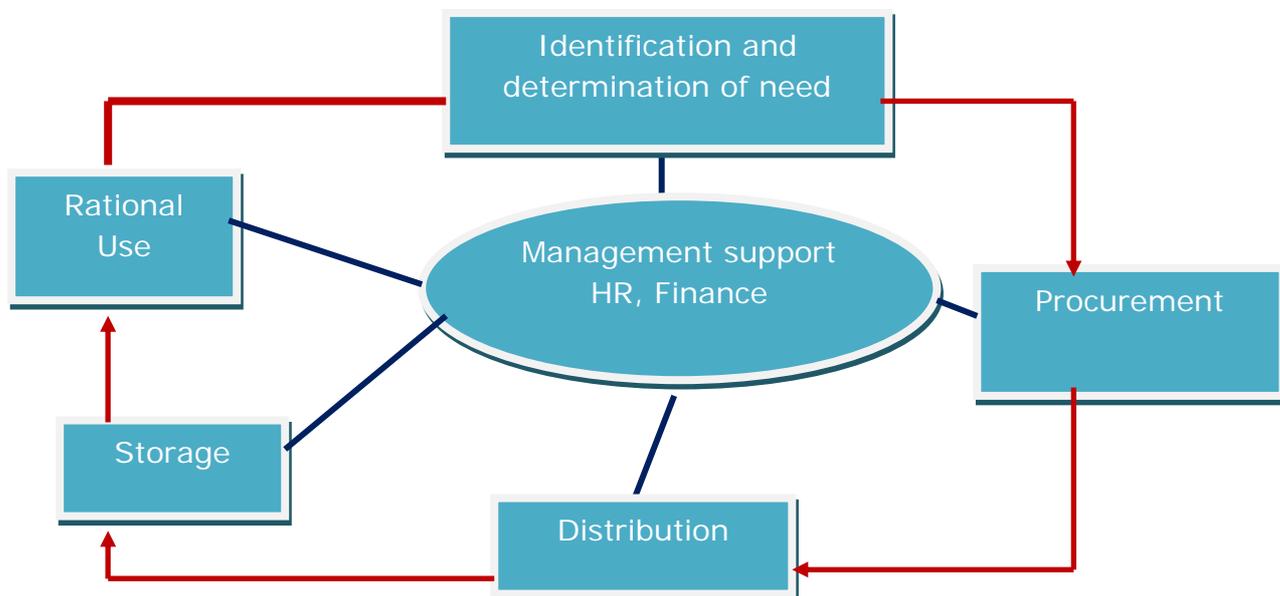
Given the relatedness of each component of the supply chain management, financial resources required for any part of the chain are important. Even the identification process becomes a priority component of procurement. The processes of identification and determination of need involve all health units in districts, and all departments in the hospitals. Thus it is a collaborative process that requires the input of DHOs, HFs, hospitals, their varied

departments and units. Identification and determination of need must feed into institutional priorities in order for the chain to flow smoothly.

### Key points made by Rachel in response to questions:

- The MoH is in the process of developing the information flow strategy.
- Regarding indicators: Currently there are the ones that are proposed by the different divisions. The next step is to go on and establish how it can be collected. Not all the information will come through the HMIS.
- BCC is not there – it is not the type of information that can be collected routinely.
- For monthly reporting from health centres we use paper based information. For integrated disease surveillance response (diseases that are epidemic prone) there is a system for weekly reporting on the phone.
- When we review the HMIS we have to consider the fact that the staffing at HFs is not sufficient, yet we have not reached our staff ceilings. The ceiling issue is beyond the MoH. It is a challenge to know whether to raise the ceiling when it hasn't been reached.
- The programme should stimulate the data collection and it should be our role to send the information back to those who collect it. Unfortunately this is not often happening.
- We need to look at what needs to be collected on the VHT forms. The challenge is how to get VHTs to collect data efficiently.
- Through a project by Makerere University palm technology has been used in eastern Uganda for the collection of data. These methods have also been used in the Millennium Villages project. The resource centre is open to suggestions which can help informatino

Procurement is a complex process that includes the intimate link between identified needs, available inventory and finance, placement of orders, pipeline monitoring, receipt of supplies, reconciliation of identified items with receivables and finally making good the financial implication of the process.



There are different actors and power centers in the procurement chain management including the user units such as OPD, Surgery, Obstetrics, Paediatrics, etc. which define the need, the pharmacy, MTC who assess justification of the needs and priorities such that budgets are then adjusted to meet the need.

Pharmacy must support each stage of the above process through quantification, technical specifications and guidance in the building up of orders. It is the role of the pharmacy to follow up with the NMS or other institutions to ensure that the EMHS are packaged, delivered and appropriately handled at the facility to ensure the quality of the items is maintained along the supply chain. The pharmacy must continuously coordinate all the user units, monitor usage and advise the management regularly in senior management meetings on the patterns and actions that need to be taken. Furthermore, the pharmacy continues to supervise, advise and monitor stores with respect to EMHS, and should provide necessary information on medications as may be required by the various health professionals and the patients in the hospital. Finally, the pharmacy receives from stores, processes and supplies individual units' requirements and keeps track of uptake, rational use and maintains a record of individual unit utilization patterns, feeds back to the AO, MTC, Senior Management and advises on overall resource needs for EMHS at this level.

A recent policy change in financing of medicines altered the existing medicine supply chain management. During the 2009/2010 financial year, 100% budget for medicines was transferred to Vote 116 at NMS to enable NMS appropriately procure and distribute adequate levels of EMHS to the hospitals and other health facilities. Furthermore 33% of the budget will continue being appropriated directly from MoFPED to the hospitals this financial year, while this will reduce to 30% effective in the 2010/2011 financial year.

The presenter discussed both the order flow from hospitals and HCs to NMS and back with full and timely supplies, as well as the substitute in case of drug stock-outs at the NMS which then necessitated alternative stocking through the JMS for top-up supplies.

### Questions arising from the audience

1. Is not doing anything an option? You have rightly said that we need to rethink our strategy. I would like to hear more on the way forward in terms of rethinking. What do you suggest for people who are trying to operate at that level of the community, which is very challenging?
2. What do the people at the districts feel about relocating the budget for drugs to them?
3. Community interventions are not new, we have distributed ORS, pills, etc. We have registered success in some areas and not so much in other areas. What are the reasons behind the different performances?
4. What is the new procurement process of drugs with regard to the current policy? Is it 100% covered by the districts? Or 32.3%?
5. Recently NMS said that the certificate of non-availability was suspended. Has it been



### Key points made by Martin:

- When the HF is planning for medicines, they refer to their catchment area and plan for under-fives who will come for services. Depending on age, one estimates that there may be six or five episodes of malaria. The CMD also puts in orders for medicines for the village population he caters for. All come to the store for their supplies. But both orders are planned for the same population. Therefore there will be a jam.
- Community based medical supply chain management between the CMDs and health facilities is heavily resource consuming and requires careful monitoring. The interactions between the levels must be very close. Returns and referrals have to be maintained at the community level as they are at the HF level, otherwise the quality of healthcare provided by CMDs risks being below optimal.
- It is important to understand the global politics of funding and how they impact availability of drugs in Uganda. For example the impacts of the withdrawal of Global Fund support upon the availability of Coartem. Without full control of the resources needed, we cannot attain full supply chain. Thus it is important to keep planning while we are implementing; redesigning while implementing.
- We need to seriously engage with the politicians and the political situation so that it works for us. Planning must take this into consideration

restored? If we get a certificate of non-availability from NMS, do we then go to other suppliers? Is it only to JMS or are other private suppliers allowed?

6. We have PNFP health centers in my district. However UPDF, army HFs get drug supplies from Bombo Barracks. But then because of drug stock outs in Bombo, they also request us for drugs. This raises accountability problems. Do these private army health facilities also qualify for the public health system of procuring drugs?



7. There is some problem of understanding the role of the new national monitoring units in the State House. According to the local FM radio stations, the budget for drugs in the country with money from donors, the country has enough drugs. And yet you say that the resources for drugs are insufficient. How do you explain this?

8. How do you explain the ghost health centers? Where did they come from and who is going to

be held responsible for creating them? In the districts some of us got much more Coartem than we needed because of these ghost centers. So we got drugs due to the push system not the pull system.

9. What is the relationship between State House and MoH? There were unknown health centers created because of spelling errors. And yet all those listed got medicines. Yet other health centers that really needed the drugs did not get any or they did not get enough. When the Monitoring Unit came, they arrested some of us and charged us for conniving with MoH to create ghost centers. So I want to know the relationship between State House, which sent this Monitoring Unit, and the MoH.
10. When do we get community Coartem?
11. What happens? We send our orders for drugs early. Some of us do not get any drugs, some get a quarter of their order, and others get all. How are you going to assure us that after taking up all the procurement, we shall not face the same problems as before?
12. Why are we disturbing the community if we cannot ensure that there are drugs?

## **DAY 2: 5<sup>th</sup> February 2010**

### **Chair: Dr. James Tibenderana**

The chair invited new participants who missed yesterday's deliberations to introduce themselves. Thereafter he invited the ICCM Regional Coordinator to briefly present the previous day's discussion points.

## VHT survey in Uganda

*Dr Flavia Mpanga*



Districts in Uganda are at different levels of implementing the VHT strategy. The country is yet to attain full coverage of VHT. This survey conducted on behalf of UNICEF sought to examine successes and challenges of VHT implementation in the districts, and scale-up issues. Of the areas visited during the survey, 25 have VHT, 60 have some VHT, and importantly 16 do not have VHT – such as Masaka district.

Currently there are many VHT training and promotion materials. Some of these were designed in the early years of introducing primary health care delivery in developing

countries. Others were developed by different NGOs working with the concept of CHWs, although not specific to iCCM. UNICEF is currently spearheading the review, adaptation and revision of all existing materials, in order to standardize them into a pack that will be used for the VHTs and iCCM.

Training is important for the effectiveness of VHTs. Those who are slower than others can get more time with the trainers. However, there were disparities in quality, quantity and duration of training. While some CHWs had received multiple training sessions, others had only attended once and time had elapsed since their refresher courses were due. On average, training was for five days, instead of the two weeks that are recommended. It is important to keep the training simple.

VHTs faced diverse challenges. There are some who could not refer patients that clearly needed referral. A large majority could not measure MUAC. It is critical to take the training sessions slowly and to design them simply so as to enhance comprehension.

A major challenge was the lack of incentive for work done. Bare foot doctors in China were paid. What motivates our CHWs who are not paid? Among factors boosting their motivation was the supervisory meetings attended monthly. It is important to unpack the relationship between the meetings and per diems. Could the motivation be the monies received as reimbursement for transport?

The survey found that there was no budget for supervision. The districts would rather use the money for outreaches. Thus generally supervision was not done. Although it is expensive, supervision is also important to successful implementation.

Intersectoral linkages must be strengthened because various sectors go to the VHTs for their activities, e.g. Ministry of Justice, Department of Water, Ministry of Gender, etc. However there is no communication across the sectors, which means that resources are wasted on parallel training.

There were challenges with the registers. In most villages, there were no VHT registers. Thus there was no monitoring, or feedback to the group. Discussions are ongoing about whether to have one register per VHT or else one Master register which is kept centrally. Of the limited data that are collected, there is data loss, which implies wasted effort on the part of whoever took the trouble to collect the data. Thus a large component of the data collected by VHTs does not get recorded in the HMIS.

### Outstanding issues

1. There was a recommendation for the creation of a portfolio for a technical assistant to be established at the MoH specifically working on only VHT and iCCM issues.
2. VHT training and promotion materials are in the final stages of development and will be available when scale-up of the iCCM strategy starts.
3. Discussions about the type of VHT register and whether or not to centralize it are ongoing. The debate is still ongoing whether there should be one VHT register per each

### Key points made by Flavia:

- VHTs save lives and training is the first step. Need to keep it simple from both the health system and community perspective. There needs to be:
  - Strong district leadership for success (one district plan and pooling of funding)
  - Documentation and measurement of implementation and impact
  - Strong links across sectors
  - Strong links between VHT and and HFs
  - Motivated VHTs. The VHT logo should be used so people know that the official VHT is being used
  - Supervision needs to be reflected on and improved
  - Knowledge, practices and skills need to reach high standards to impact on

member or one per whole VHT?

4. The average training was 5 days and not many had gone for the desired 14 days.

### Questions arising from the audience

Q1: Can the generation of such VHT data be maintained and can we have annual updates?

A1. Every district should be given a spreadsheet so they can collate their data and it can be collated at ministry level. Districts were given information and briefed on what it was necessary to provide. The ball is now with the MOH to follow up on this information.

Q2. Data collection and flow – what is the problem?

A2. With the current paper system there is often great loss of data and late or no submission, and as a result the data that eventually gets to the central level is less than desired. FIND has

started a project using rapid SMS to check on health units in completion of HMIS form. Drilled down to see how many malaria cases, use of drugs etc which feeds into a database and is shared with the district. VHTs also need feedback so let us ensure that we can provide this feedback to the people that collect the data.

Q3. Is there an easier way of doing this mapping so that we can do this annually? Is it possible to maintain a system of constantly generating such survey data?

Q4. Was there another VHT training manual that was used? Was this manual different to what is being developed?

Q5. Regarding the graph results showing that lives were saved by VHTs, was this in villages with drugs, with supervision, or did it make no difference?

Q6. Who has the responsibility of training supervisors, providing checklists or materials, and also monitoring the supervision?

Q7. What factors are responsible for lowering the data that goes up to the district levels? Is it analysis, compiling or collecting? Why don't the districts have access to this information?

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## Group work and feedback sessions

Dr. James Tibenderana introduced the participatory group exercises. He explained that Malaria Consortium was supporting an iCCM programme in Uganda through the grants received from CIDA and BMGF. The main components of the BMGF programme are: 1) To document and evaluate experiences from routine implementation as highlighted by the national guidelines, 2) to conduct research on improvements that can be made to routine implementation, and 3) to promote introduction of iCCM in other districts and facilitate national scale up.

Objectives of the group work:

- I) To identify new and feasible ideas / solutions that have potential to improve implementation but need to be tested to find out their effects.
- II) To identify the critical challenges to routine implementation of iCCM and their solutions which we can already use now without testing them to find out their effect.

The ideal scenario was to ultimately have:

- VHTs who are keen to stay in their job.
- VHTs who are engaged, happy and enthusiastic to carry out their duties.
- VHTs who provide care at high standards over time.

This goal of having iCCM in more than 33% of districts in Uganda was to be achieved within five years.

Groups were encouraged to suggest ideas, initiatives and innovations that may work, and could be tested within the iNSCALE programme. It was important that their suggestions could be promoted in other parts of the country. The question was posed of what other innovations

can be tested that will ultimately lead to a more motivated cadre of VHTs and a better operating health system.

Three groups were given topic guides, and tasked to appoint a rapporteur, facilitator, and chair. One member of the Malaria Consortium team was in each group.

## Group I: Supervision

### Increasing the Frequency of Supervision

Standard	Innovation
<b>Home visits</b> <ul style="list-style-type: none"> <li>Monthly by health workers for the first 3 months</li> </ul>	<b>Home visits</b> <ul style="list-style-type: none"> <li>Monthly by peer coordinators</li> </ul>
<b>Meetings</b> <ul style="list-style-type: none"> <li>Quarterly by health workers</li> </ul>	<b>Meetings</b> <ul style="list-style-type: none"> <li>Quarterly by health workers</li> </ul>

### Setting Supervisory Targets

Standard	Innovation
<b>Monetary incentives</b> <ul style="list-style-type: none"> <li>Peer supervisors and health workers when they go for home visits</li> <li>VHTs when they come for meetings</li> </ul>	<b>Number and proportion of ICCM VHTs visited</b> <ul style="list-style-type: none"> <li>&gt;80% per month for peer coordinators</li> <li>&gt;80% per quarter by health workers</li> <li>Evidence/verification that the supervision took place and it was of good quality</li> <li>Pre-determined schedule of supervision</li> </ul>
<b>Using Trained Supervisors</b> <ul style="list-style-type: none"> <li>Central supervisors of district supervisors</li> <li>District supervisors of health facility supervisors</li> <li>Health facility supervisors of ICCM VHTs</li> </ul>	<b>Using Trained Supervisors</b> <ul style="list-style-type: none"> <li>Training the health unit management committee as supervisors of VHTs</li> </ul>

### Questions / Comments from the audience:

C1. If the funds are available there will be supervision – funding is the main thing. The example of Kiboga shows that supervision runs like clockwork when the funding is available.

Q1.How can VHT training be increased?

A1: The Minister has some funding for training of VHTs but it is not enough. Maybe we need to draft an MOU as to what will come from ministry and what will come from partners.

C2. VHTs have other roles as well besides giving drugs. There is a need to give the training the benefit of the doubt and give it a chance to work as prevention is better than a cure.

C3. An annual training calendar is a worthwhile tool to develop and make available so everyone knows where things are at.

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## Group II: Motivation

The group defined 'motivation' for VHTs as "an inward drive for an individual to do a job with satisfaction. A willingness, contented with the achievement, a drive to do something and linked to performance."

<b>"Must have" interventions</b>	<b>"Nice to have but not essential" interventions</b>	<b>Innovative interventions</b>
<ul style="list-style-type: none"> <li>• Availability of medicines at all times</li> </ul>	<ul style="list-style-type: none"> <li>• Boots, bicycle, umbrella, Christmas package, sign post, stickers, phone</li> </ul>	<ul style="list-style-type: none"> <li>• Exchange visits between different districts / Sub-counties</li> </ul>
<ul style="list-style-type: none"> <li>• Job facilitation (Job aide kit-bag, reference material, registers and report formats)</li> </ul>	<ul style="list-style-type: none"> <li>• A package once in a while containing e.g house supplies, T-shirt etc.</li> </ul>	<ul style="list-style-type: none"> <li>• VHT participation in meetings at all levels</li> </ul>
<ul style="list-style-type: none"> <li>• Review meetings (Monthly among VHTs, Quarterly at subcounty level, provision of lunch allowance and transport refund)</li> </ul>	<ul style="list-style-type: none"> <li>• Recognition at public functions to increase accountability of VHTs to their community</li> </ul>	<ul style="list-style-type: none"> <li>• Quizzes and awards for best performers</li> </ul>
<ul style="list-style-type: none"> <li>• Reporting forms to keep track of No. people treated, drugs used etc.</li> </ul>		<ul style="list-style-type: none"> <li>• Radio talk shows including VHTs or talking about VHTs</li> </ul>
<ul style="list-style-type: none"> <li>• Way of recognition such as uniforms, certificates, IDs</li> </ul>		<ul style="list-style-type: none"> <li>• Integrate VHT in other programmes e.g distribution of ITNs, immunisation, NAADS, IGA government/NGO programmes at sub county and village level</li> </ul>

• Sub-county supervisor regularly visiting		
• Refresher trainings (Annually)		

**Questions / Comments from the audience:**

C1. I like the innovations – particularly the exchange visits.

C2. The “must haves” must be there before the start. You can get to ‘nice to have’ elements if you get stuck. Are there any indicators for motivation? Perhaps by measuring how many are still in post after some time. We should also measure demand from VHTs, such as how many report regularly and demand for tools to do their job. That can be seen as a continuum of motivation.

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**Group III: Data flow and use**

Key points:

- Ensure numeracy and literacy of person tasked with data collection
- Generate user-friendly tools but better to update existing tools rather than create new ones. Just ensure that it can capture malaria, pneumonia and diarrhoea data.
- Data should be analysed by a team – VHTs and their supervisors at sub county headquarters. Feedback to be provided by HFs. Info collected should be fed back.
- Data displayed in user-friendly way – displayed at sub county headquarters so that all VHTs can see their counterparts’ results. Bar graphs for visual display.
- Cell phones are more cost effective than transport for relaying data. Can facilitate data transfer.

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**Closing remarks**

*Dr. Ruyonga Joseph - DHO of Hoima*

On behalf of the different meeting participants, and the Ministry of Health, the District Health Officer of Hoima, Dr. Ruyonga, made some closing remarks. He appreciated the Malaria Consortium for a job well done seeking funding partners and researchers to support the diverse efforts for iCCM interventions in Uganda. The biggest problem he identified in the districts is the handling of data. However, the DHO promised that the health officials in the different districts will work hard as implementing partners to facilitate the scale up of iCCM activities, and thereby improve their indicators.



## Annex 1 – Draft agenda

**INSCALE PROGRAMME INCEPTION MEETING, FEBRUARY 4-5, 2010, KABIRA COUNTRY CLUB, KAMPALA, UGANDA**

### Objectives of the meeting

1. To share iCCM implementation experiences
2. To discuss the role of various stakeholders in iCCM implementation in Uganda
3. To share views on the requirements for successful scale up of iCCM in Uganda
4. To consult with stakeholders the ways which supervision and motivation of VHTs can be improved as well as the information flow and use of data collected by VHTs

### Expected outcomes

1. Stakeholder awareness of the iNSCALE programme and its objectives
2. Stakeholder agreement on how the iNSCALE programme can address the country needs through testing and documentation of the effect of new and improved strategies
3. Stakeholder recommendations and advice on essential interventions that can facilitate scale up of iCCM

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### Day 1

**Thursday, February 4, 2010**

**Chair Jesca Nsungwa Sabiiti**

8.30-9.00 Registration

9.00-9.20 Introductions, objectives of the meeting, overview of the agenda Godfrey Magumba

Overview of the iNSCALE programme Karin Källander

9.20-9.30 Opening remarks MoH rep. Paul Kaggwa

9.30-10.00 Current implementation status of iCCM in Uganda Jesca Nsungwa Sabiiti

10.00-10.20 Results of stakeholder analysis and mapping Karin Källander

10.20-10.45 Discussion

10.45-11.15 Coffee/Tea break

11.15-11.35	experiences and lessons learned from iCCM implementation in selected African countries	Malaria Consortium James Ssekitooleko
11.35-11.55	experiences and lessons learned from iCCM implementation in selected African countries	Save the Children Stephen Ayella
11.55-12.15	and lessons learned from iCCM implementation in selected African countries	WHO experiences Geoffrey Bisoborwa
12.15-13.00		Discussion All
13.00-14.00		Lunch

### Chair Godfrey Magumba

14.00-14.20	Rachel Seruyange	Use of data
14.20-14.40	Motivation of VHTs	Supervision and TBD
14.40-15.00		Discussion
15.00-15.20	supply management	Procurement and Martin Oteba
15.20-15.40		Discussion
15.40-16.00		Coffee / Tea break
16.00-17.00	James Tibenderana	Plenary discussion
17.00-17.15	Consortium	Wrap-up Malaria

### Day 2 Friday, 5<sup>th</sup> February 2010

#### Chair Dr James Tibenderana

9.00-9.15	Re-cap of day one	Karin Källander
9.15-9.25	Introduction to group discussions	Zelee Hill
9.25-10.30	Group discussions	
	Group a) supervision of VHTs	
	Group b) motivation of VHTs	
	Group c) data flow and use of data	
10.30-11.00		Coffee/Tea break

11.00-11.20		Group discussions
11.20-11.30	group a) supervision	Presentation from group a rapporteur
11.30-11.45	All	Discussion supervision
11.45-11.55	group b) motivation	Presentation from group b rapporteur
11.55-12.10	All	Discussion motivation
12.10-12.20	group c) data flow and use of data	Presentation from group c rapporteur
12.20-12.35	All	Discussion use of data
12.35-12.50		VHT survey in Uganda Flavia Mpanga
12.50-13.00		Discussion
13.00-13.15	and recommendations	Summary, conclusions Karin Källander
13.15	Closing of meeting	
13.20	Lunch	

## Annex 2 - Attendance list inception meeting to discuss the iNSCALE programme

	Name	Institution	Email Address
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