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ICCM in Uganda: Background and Process

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Ministry of Health

Why ICCM matters

Currently 144,000 children die before their fifth birthday in Uganda each year.

40% of these deaths are caused by pneumonia, malaria and diarrhoea.

These three diseases cause 56,400 deaths in children under five.

ICCM Uganda

Aim:

Improve correct use of life-saving treatments by making them available, assuring their delivery, good quality, and mobilising demand for them

Target:

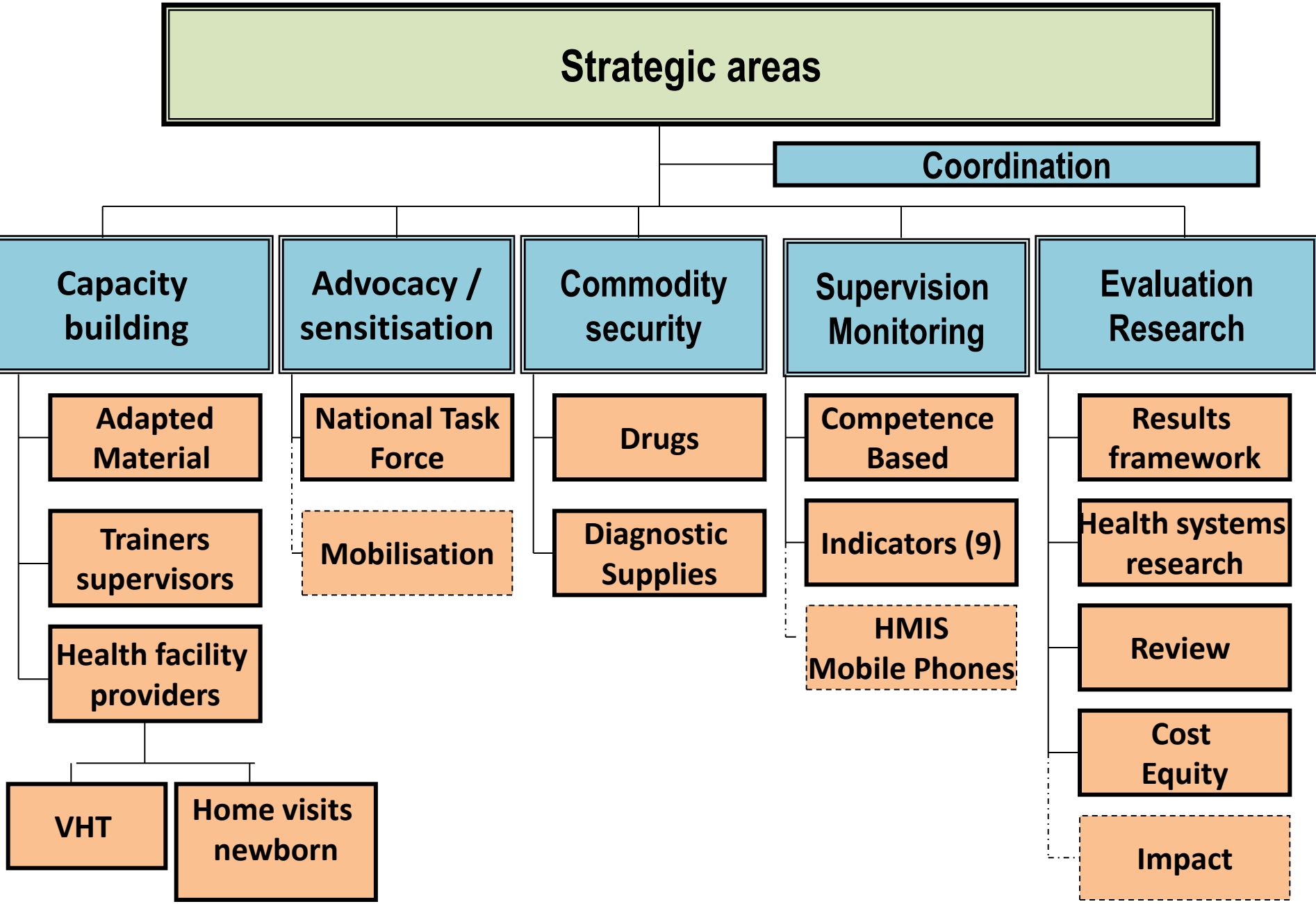
0-28 days: identify danger signs and refer immediately

2-59 months: diagnose and treat malaria, pneumonia, diarrhea (Malnutrition)

ICCM Objectives

Program plans to increase to at least:

- 80% the U5s non severe disease receiving appropriate treatment within 24 hours of onset of illness
- 80% severe disease promptly referred to formal providers including newborn with danger signs
- 80% VHTs who correctly manage simple cases of Mal, Pneum + DDs
- 60% VHT with zero stock outs rates for 1st line medicines.
- Suspected malaria cases tested with RDTs from 5% to 80%
- Confirmed cases treated with ACTs from 10% to 80%
- Acute Malnutrition identified and referred for therapeutic feeding


Strategic areas
Coordination
Capacity building
Advocacy / sensitisation
Commodity security
Supervision Monitoring
Evaluation Research
Adapted Material
Trainers supervisors
Health facility providers
VHT
Home visits newborn
National Task Force
Mobilisation
Drugs
Diagnostic Supplies
Competence Based
Indicators (9)
HMIS Mobile Phones
Results framework
Health systems research
Review
Cost Equity
Impact

Who are village health teams (VHTs)

- Chosen by community, considerations: ability to read & write, gender
- 4-5 VHT volunteers per village (2 for ICCM)
- Roles (a) Identify danger signs, refer newborns
  (b) Treat malaria pneumonia and diarrhea
- Training (a) Basic Health Promotion for 5 days
  (b) ICCM hands on training
  - » Based on Sick Child job aid and Register.
  - » Use of respiratory timers and RDTs.
- Non monetary incentives e.g. bicycles, T-shirts, badges

The VHT ICCM package

Medicine: Prepackaged color coded A/L, Amox, ORS+Zn, rectal AS

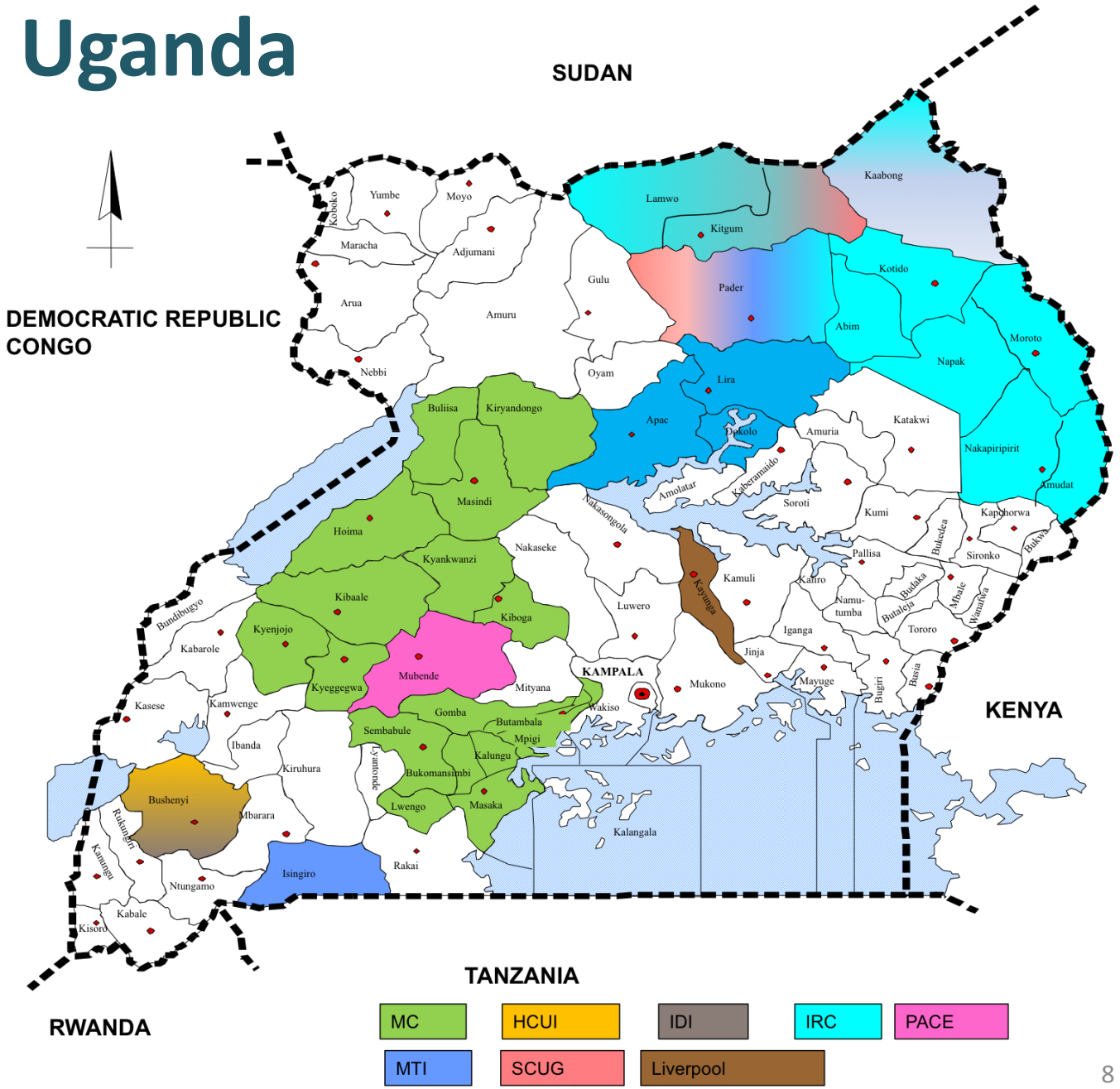
Diagnostics: Respiratory timer, MUAC, +/- malaria RDTs

Sick child laminated pictorial **job aid** (also for postnatal care)

Patient **register** – cases managed and referred – and **referral notes**

In some areas, mobile phone (**mTrac**) weekly reporting system on cases, drug stock, symptom

ICCM in Uganda



National Implementation phases

- Introduction and adaptation: 15 months
- Early implementation: 12-18 months
  20/80 districts
- Pre-Expansion: 19-24 months
  34/112 districts
- Scale Up/improve: review started in Jan 2013

How we introduced and implemented ICCM

- Applied Home Based Management of Fever lessons in Uganda 2002-2008
- “Piloted” use of antibiotics with Internally Displaced Populations (IDP) in 2004
- Drug policy review – pneumonia, diarrhea and PPT 2009
- Adapted generic WHO training materials – literacy, other existing courses for VHT 2010
- Involved UNICEF – working in community health, IDP and newborn health
- Defined roles for the different levels – developed Implementation Guidelines

Lessons learnt from early implementation of ICCM

- Districts are at different stages of establishing VHT system
- The two VHT trainings (basic and ICCM) are a continuation of each other
- ICCM is hands-on differential diagnostic training – differs from Home Based Management of Fever training
- Principals of good planning required: bottom-up
- Coordination important: multiple players, new districts and villages, new partners

Lessons learnt (cont)

- Commodity and medicines security crucial
- Motivation of VHTs and availability of drugs is critical for proper implementation
- Sustainability: Use of Government of Uganda systems & steady supply of drugs
- Partners who work with health facilities right from the start – better integration in the health systems, mobilisation of resources

What next?

Strengthen and scale up countrywide

- Developed comprehensive costed proposal – R10 GF
- National Medical Store preparation to supply medicine
  - Drug quantification study in four districts
  - Co-packaged ORS and Zinc
  - Drug stock tracking using mTrac (phone) to report weekly - 8 districts
  - Explored new partnerships such as private manufacturers
- ICCM early implementation program review + advocacy
- Early work ICCM in private informal sector – PACE
- Stronger link with health facility - QI Model, Pages for VHT in the mother child health passport

Key constraints & challenges

- Mainstreaming medicine distribution in the national system
- Weak linkages with the health facilities
- Integration of iCCM in the district structure including into the health information system
- Health facility staffing and continuous improvement in VHT skills
- Newborn component lagged behind; little information on this. More demand from districts
- Coordination of partners and program inputs

Opportunities

- The round 10 GF grant has taken into consideration the VHT component using the ICCM approach.
- Global focus on diarrhoea and pneumonia- opportunities such as the UN commission for life saving commodities
- ICCM programme review being carried out by MoH
- Opportunities for learning from early implementation to feed the next phase of scale up/improvement

Acknowledgements

- UNICEF – piloting iCCM
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- CHAI – commodity
- National DPCC, ICCM and Newborn Steering committees