ICCM in Uganda: Background and Process

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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 1\textsuperscript{st} 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
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
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