MINISTRY OF HEALTH

Integrated Community Case Management Of childhood illnesses

IMPLEMENTATION GUIDELINES.

unicef World Health Organization

November, 2020.

Suggested citation. Strategic Plan of the Integrated case Management: Equity At The Heart Of Child Survival In Uganda, Ministry of Health 2001

CONTENTS

Table of Contents

FOREWORD

Integrated community case management (iCCM) of childhood infection saves lives in hard-to-reach communities in Uganda. The objective of this strategy is to strengthen iCCM implementation and and set the path to institutionalizing rapid reduction in under five mortality in the national and district health during 2020 to 2060. The Village health teams in remote poor urban and rural communities provide the needed lifesaving treatments to sick children within 24 hours with efficacious treatment without which most die or are left with lifelong debilities. Treatment provided by the VHTs in the community target the common childhood killers in Uganda cover malaria, pneumonia and diarrheoa for children between 1 month and 5 years and active referral for sick newborn, expose TB and HIV cases as well as children with moderate to severe malnutrition.

In addition to increasinguse of curative interventions, made accessible and available at the community level, VHTs also carry out the preventative and health promotion home visits and link the community with health facilities through facility based technical supervisors and the health facility governance committees. They are thus critical for the revitalized low-cost primary health care and indispensable in ensuring universal health coverage, including strengthening the health resilience in times of crisis

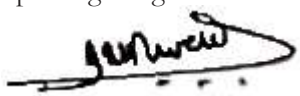
In pursuit of the Ministry of Health mission, bringing services closer to the people in the community is a key component of the strategies to reduce inequities to health services, among others. Malaria, pneumonia, diarrheoa, TB, HIV, malnutrition, and newborn illnesses are significant causes of illness of children below the age of five, leading to suffering, death, and economic loss. Two or more of these diseases commonly occur together in the same patient, and their clinical presentations overlap.

It should be appreciated that iCCM is part of the effort to operationalize the Village Health Team (VHT) concept, which has been evidenced to provide appropriate safe, and effective medicines to treat sick children as soon as symptoms develop.

The update of these guidelines builds on best practices, challenges faced during implementation of the program since 2013 in over 70 districts of the country, and other related community health programs. In addition, the guidelines include updates on the expanded package to include TB and HIV assessment.

This document is to guide policymakers, managers, districts, health workers, communities, NGOs, and all other stakeholders on how to implement integrated community case management (iCCM) of childhood malaria, pneumonia, and diarrheoa to reduce under mortality and take actions to introduce, implement, monitor and evaluate iCCM at all levels of health services delivery chain. It describes activities for sensitization and advocacy, capacity building through training, medicines and commodity chain management, supervision, monitoring, evaluation, and research.

I wish, therefore, to commend these implementation guidelines to all, and it is my conviction that if they are implemented faithfully, the performance of the health sector will be transformed. I finally want to appreciate the iCCM TWG and all different levels of health care, development, and implementing partners who have contributed to updating the guidelines.



Dr Henry G. Mwebesa

Director-General of Health Services Ministry of Health

ACKNOWLEDGEMENTS

The Ministry of Health acknowledges the efforts of many stakeholders and partners who supported the development and update of different components of this guideline for integrated community case management. iCCM is a key strategy to reducing child mortality, and the iCCM TWG is commended for the successful update of the new guidelines that build on past experiences in implementing the program in the country.

I acknowledge the following people for their contribution in the entire process of writing the iCCM guidelines: Dr. Fred Kagwire, Dr. Flavia Mpanga, Dr. Bodo Bongomin, Dr. Andrew Balyeku, Dr. Christine Mugasha, Dr. Allen Nabanoba Semambo, Dr. Maureen Amutuhaire, Dr. Jimmy Opigo, Dr. Dennis Rubanika, Ruth Nabwire, Tosca Terra, Elisha Nangosha, Kemigisa Divine Mercy, Grace Nakanwagi, Phillip Nyeko, Dr. Richard Oketch, Agnes Namagembe, Nakabugo Stella, Mukwano Fred, Sheila Karungi, Mary Achen, Dr. Lorna Muhirwe, Sam Ibanda, Kakaire Godfrey, Mataka Juliet, Dr. Mary Tabaro, Richard Arogai, Lorraine Kabunga, TB/HIV community resource person, Moorine Ssekadde, Jude Asiimwe, Dr. Paul Onzubo, Musungu Toppy, Maracha, Kenneth Arinda, Wonyima Isaac, Steven Bwoye, Dr. Sarah Naikoba, Rebecca Babirye,

The Ministry also applauds the collaborative support and technical input of UNICEF, World Health Organization, USAID through its MNCH Activity, Living goods, Brac Uganda, Save the Children, Healthy Entrepreneurs, and World Vision for the development and reviewing of this implementation plan, printing, and dissemination of this guidelines.

Dr Jesca Nsungwa Sabiiti
Commissioner Reproductive and Child Health

Acronyms

VHT	Community Health Worker
IMNCI	Integrated Management of Newborn and Child Illnesses
PHC	Primary Health care
TWG	Technical Working Group
MOH	Ministry of Health
M&E	Monitoring and Evaluation
VHT	Village Health Team
DHMT	District Health Management Team
HW	Health Worker
MOU	Memorandum of Understanding
MRDT	Malaria Rapid Diagnostic Test
CSO	Civil Society Organisation

1 INTRODUCTION

1.1 CONTEXT

Children compose 17.2% of Uganda's population but account for 40% of the disease burden in the country. Uganda has steadily reduced child mortality rates between 1995 and 2016 from 156 to 64 per 1000 live births. On average, about 350 children under five years of age lose their lives per day, of which a quarter die of malaria, pneumonia, and diarrhoea. Annually, these three diseases account for half of all the under 5 OPD attendances[1]. and together contribute over 17 million disease episodes[2].

These diseases are preventable, and measures to prevent them include using LLINs, good WASH practices, improved housing, and ventilation, among others. The deaths attributed to these diseases can be averted through the use of prompt diagnosis and treatment with lifesaving curative interventions. Sick children are detected, treated, or referred by trained VHTs within the renewed Primary Health Care (PHC) approach at the community level. The integrated Community Case Management (iCCM) approach provides the framework for delivering these treatments, especially to families with poor access to facility care.

The National integrated Community Case Management (iCCM) guidelines were first introduced in 2010 promoted from the national level by the Ministry of Health. iCCM is a key strategy to deliver lifesaving interventions for malaria, pneumonia, and diarrhoea to populations with poor access to health services. It enables community health workers (VHT) to provide basic lifesaving treatment for sick children living in remote communities for these diseases using a standardized assessment and treatment algorithm, "Sick Child Job Aid."

1.2 WHY ICCM

In Uganda, facility-based services are inadequate to provide access to treatment, and most importantly, not within the crucial window of 24 hours after onset of symptoms. If child mortality is to be sufficiently reduced, there is a need to address the challenge of access to care for sick children. In addition, most sick children present with more than one disease condition and will need an integrated approach to care. With adequate training, an uninterrupted supply of medicine and equipment, support supervision, community health workers can retain the skills and knowledge necessary to provide the appropriate care.

The RMNCAH sharpened plan 2020-2025 have prioritized strengthening service package at the community level with iCCM as one of the core packages targeting the health of mothers, newborn, and children. It's an extension of the facility-based IMNCI strategy to improve access to prompt lifesaving treatments for sick children in hard-to-reach communities.

The approach is consistent with practices recommended by WHO, UNICEF, and other international health agencies. WHO, UNICEF, and other international agencies have jointly called on countries to adopt and promote policies and programs with strong community-based components to deliver interventions for diarrhoea, malaria, pneumonia, newborn care, and acute severe malnutrition while improving services at first-level health facilities?

1.3 PURPOSE OF THESE IMPLEMENTATION GUIDELINES

This implementation guide aims to facilitate the institutionalization of the iCCM services into the district health system. It seeks to accomplish this through the following mechanisms:

1. Offering guiding principles by which implementing partners, districts, and other organizations can lead the process of adapting or scaling up iCCM service packages
2. Delineating mechanisms for iCCM guidance to be disseminated for use in front-line healthcare settings
3. Helping districts and partners assess and monitor their process of full iCCM implementation and sustainability
4. Offer practical information on iCCM on (i) Implementation process and (ii) attendant support tools to guide each step

[1] *Annual Health Sector Performance Report 2019/20*
[2] *Disease episodes per child per year; Malaria 3.5%, pneumonia 0.3%, and diarrheoa 1.4%.*

These guidelines tackle barriers to iCCM scale-up such as workload for VHTs who still remain volunteers in Uganda, difficulties in maintaining the quality of care, more logistics of additional training, shortage of commodities, and lack of ownership by stakeholders at all levels. These changes are critical to the movement towards universal access where the VHT providing iCCM functions as part of a larger VHT that includes volunteers focusing on home visits, health education, key family practices, and prevention.

1.4 ORGANIZATION OF THE GUIDELINES

In implementing this framework, common tools shall be used at all levels and all VHTs attached to VHT linked facility and referral system connected to nearest IMNCI facility. The guidelines are arranged in three sections, with the first section providing the background, presenting the current core package for iCCM, and laying out the strategic framework for 2020-2025 within which the implementation guide works, the implementation. The second section, shows the implementation steps at the national, district, facility, and community level needed to scale up iCCM services, and the third section provides the tools to support implementation.

1.5 WHO SHOULD USE THIS GUIDE

Ministry of health, national program managers, health development partners, district health teams and health workers, nongovernmental organizations (NGOs) providing iCCM services, implementing partners, and the private sector can all use this guide as an aid to incorporate iCCM at the national and local levels.

2 iCCM STRATEGIC FRAMEWORK

2.1 GOAL

To contribute to the rapid reduction of mortality among children under five years of age from the top causes of child illnesses by increasing the use of curative and preventive interventions at household and community levels, particularly in the poorest and hard to reach populations[3].

2.2 OBJECTIVES

1. To increase to at least 90% the proportion of children under-five years with malaria, pneumonia, and diarrhoea receiving appropriate treatment within 24 hours of the onset of illness by 2025.
2. To increase to at least 90% the proportion of sick children under-five years with fever and danger signs, suspected TB, HIV, and those with severe acute malnutrition who are identified in the community referred to health facilities.
3. Increase to at least 90% the proportion of caregivers in hard-to-reach communities who recognize childhood disease early, promptly seek iCCM services, and follow treatment recommendations properly by 2025.
4. To increase to at least 90%, the proportion of VHTs trained to manage malaria, pneumonia, and diarrhoea and refer sick children with danger signs.

2.3 TARGET AND BENEFICIARIES

iCCM targets children under five years (0-28 days; identification of danger signs and immediate referral to the health facility, 2-59 months; management of iCCM package)

2.4 GUIDING PRINCIPLES

- **Community Ownership:** The community is responsible for the selection, supervision, and support of the VHT. The VHTs are fully accountable to the communities they operate in, and their services/ responsibilities are community-driven.
- **Equity and Access:** iCCM VHT services are meant to provide family-centered integrated care and increase access within 24 hours for all sick children under five years of the community, especially those in rural peripheral areas or marginalized communities

[3] *Rural sub-counties without HC III and parishes without HC II, High population density, poor urban settlements, Mobile populations, Hard to reach areas and areas where child health outreaches are carried out, including islands, Refugee and host communities, including refugees in urban areas and outside the settlements, Mass disasters and situations where routine facility services are disrupted*

- **Community Support:** While performing their roles and responsibilities, the VHTs shall be supported by local health facilities and their communities.

3 THE CORE iCCM PACKAGE

iCCM is part of the Village Health Team strategy for promoting health and preventing deaths. The VHT strategy aims to deploy about five volunteer health workers called VHT members in each village. The community care strategy is implemented by VHTs who are trained and supported to deliver or promote the use of preventive interventions, including home visiting (see VHT Strategy and Community Health extension worker Strategy).

The core iCCM package is delivered passively by two VHT members selected from the team of 5 VHTs per village operating from their homes most of the time. However, the private sector who are in one way or another remunerated from their sales or paid could adopt a proactive "iCCM" where VHT members move to homes seeking sick children.

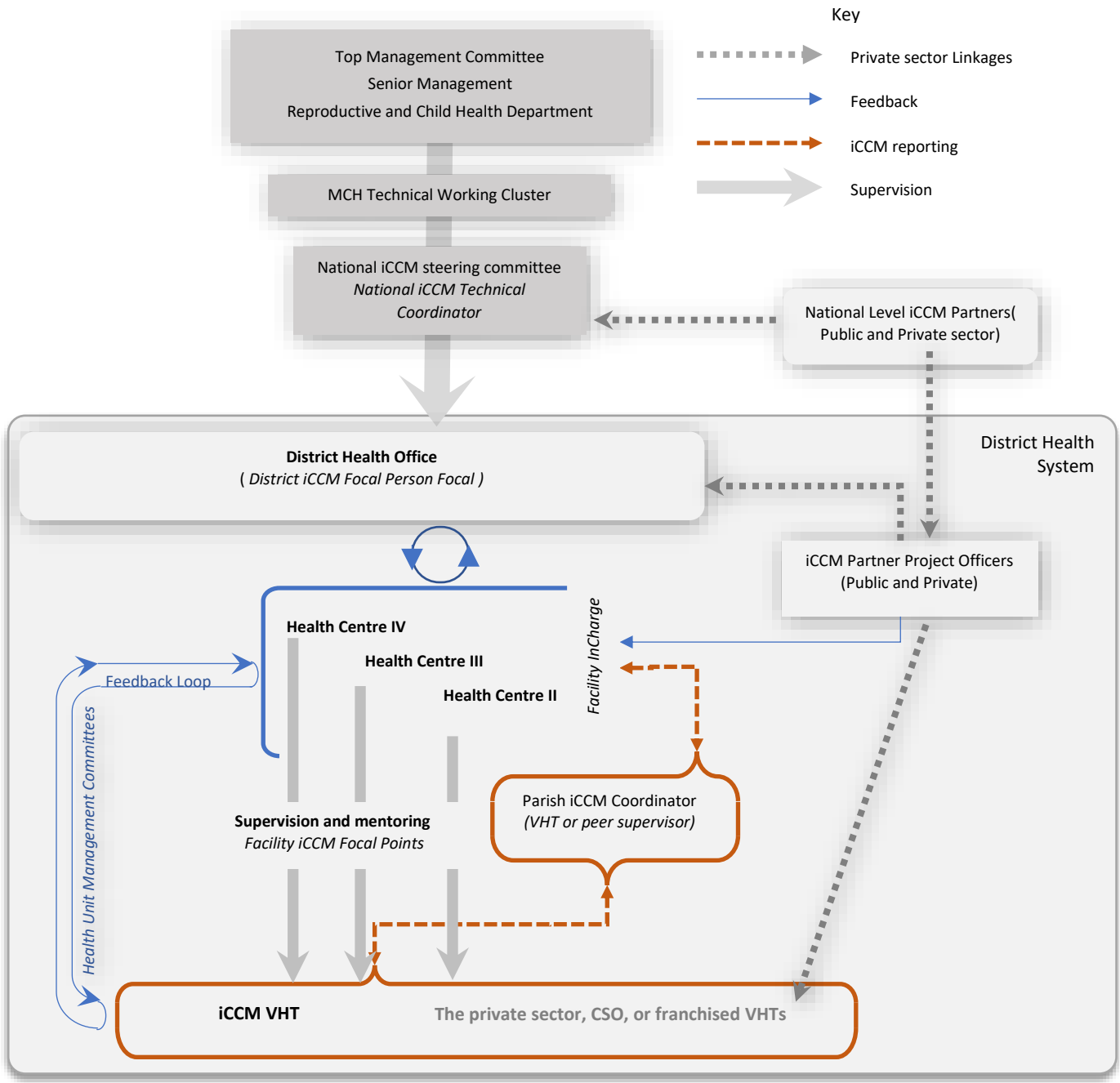
PACKAGE DELIVERED BY iCCM VHTS	PACKAGES DELIVERED BY ALL VHTS
i. Malaria diagnosis with mRDT; treatment with ACTs; pre-referral treatment of complicated malaria with Rectal Artesunate	i. Home visiting
ii. Pneumonia diagnosis for fast breathing and treatment with Amoxicillin Dispersible Tablets	ii. Mobilization of communities for utilization of health services
iii. Diarrhoea with Zinc and ORS co-pack	iii. Health Promotion and Education
iv. Emergency referrals of sick children and newborn with danger signs to the health facilities	iv. Community-based case management of common ill-health conditions
v. Identification and referral of children suspected to have HIV and TB	v. Follow up of the mothers during pregnancy and after birth and the newborn for provision of advice, recognition of danger signs, and referral
vi. Follow up of sick children managed at home after three days and sick newborn on days 1-7 to ensure referral compliance and care.	vi. Follow up of people who have been discharged from health facility and those on long term treatment
vii. Screening and referral of severe acute malnutrition (SAM)	vii. Distribution of health commodities
	viii. Community information management
	ix. Disease surveillance
	x. Key family care practices

3.1 IMPLEMENTATION TARGET

- All districts implement iCCM as part of the district health system
- Every hard-to-reach community within a sub-county has iCCM services.
- iCCM provides quality assured services
- iCCM delivered as an integral part of the linked Health facility services
- Community participation, engagement, and ownership of iCCM

4 IMPLEMENTATION STRUCTURE FOR iCCM

This provides the overall common national iCCM implementation framework to be followed by the public and private sector, led by the government with partners in a supporting role. The national level will provide the general policy framework, guidance, and technical assistance, whereas planning and implementation in communities will be overseen by the



5 OVERVIEW OF CORE iCCM ACTIVITIES

5.1 NATIONAL LEVEL ACTIVITIES

Form the national iCCM Technical Working Group that will:

a) Advocate and mobilize resources
b) Sensitize and orient districts and other stakeholders
c) Develop and monitor implementation TORs for the iCCM focal persons
d) Design and oversee national iCCM rollout plans
e) Building initial capacity for district training and supervision
f) Monitor, supervise, and evaluate national iCCM program
g) Utilize iCCM data for decision making at all levels
h) Research to guide implementation of the strategy
i) Ensure medicines and commodity security at all levels

5.2 COMPOSITION OF iCCM TECHNICAL WORKING GROUP

a) Ministry of Health departments/programs (i.e., Reproductive and Child Health, Malaria, HIV and TB, Community Health, Health Information, Human Resource, Nutrition, Pharmacy)
b) MoH Agencies (i.e., National Drug Authority, National Medical Stores)
c) Other sector (Local government, Education and, Gender and Social Services)
d) Partners and Donor agencies
e) Private Sector actors
f) The iCCM TWG will establish working committees and co-opt members

5.3 DISTRICT/HSD LEVEL ACTIVITIES

The DHT will lead district iCCM planning and implementation through:

a) Leadership and ownership of District/HSD iCCM programming
b) Sensitize and guide communities in selecting VHTs for iCCM
c) Train of health workers who in turn train VHTs
d) Train public and private health facilities to manage referred cases
e) Manage iCCM medicine and commodity quantification and supply chain
f) Supervise and monitor public and private sector iCCM provision
g) Use community health data in planning and decision making

5.4 HEALTH FACILITY LEVEL ACTIVITIES

The health facility is the main level ensuring successful implementation of iCCM by VHTs.

a) Support communities to select VHTs for iCCM
b) Train, mentor, and supervise VHTs
c) Manage referred patients referred
d) Manage medicine supply chain
e) Summarise VHT records and report to the HSD and district
f) Use iCCM data to improve effectiveness of VHT.
g) Maintaining good linkage with communities

5.5 COMMUNITY-LEVEL ACTIVITIES

a) Advocate and mobilize communities to demand and utilize iCCM
b) Select VHTs for iCCM.
c) Encourage data sharing and use in VHT meetings
d) Strategies and innovations to motivate and incentivize VHTs distributing medicines
e) Monitoring distribution of medicine

5.6 VHT LEVEL ACTIVITIES

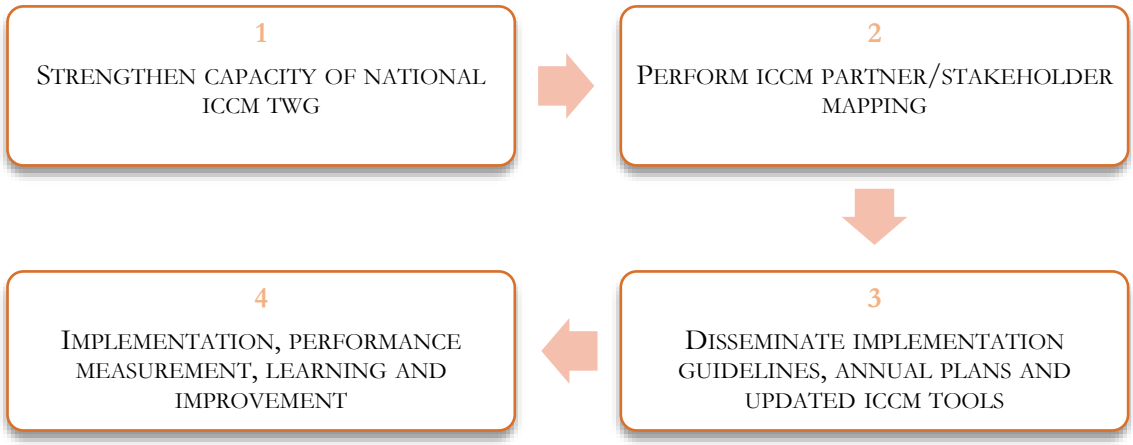
a) Home visiting
b) Mobilization of communities for utilization of health services
c) Health Promotion and Education
d) Community-based case management of common ill-health conditions
e) Follow up of the mothers during pregnancy and after birth and the newborn's for provision of advice, recognition of danger signs, and refer
f) Follow up of people who have been discharged from health facility and those on long term treatment
g) Distribution of health commodities
h) Community information management
i) Disease surveillance

6 IMPLEMENTATION STEPS

6.1 IMPLEMENTATION AT THE NATIONAL LEVEL

A strong national iCCM leadership is essential to ensure the effectiveness, efficiency, equity, quality, and timeliness of implementing the guidelines. The national technical home for iCCM is in the Ministry of Health Reproductive and Child Health Department. The Technical coordination of iCCM will continue to be under the designated iCCM Technical Officer, who will coordinate the disease components in the iCCM package (Malaria, TB, HIV, Nutrition) and the Community health department to support the delivery of iCCM within districts health systems. National-level planning, implementation, monitoring, and assessment of iCCM activities will be facilitated using the set of iCCM benchmarks organized according to eight system components, each containing vital activities and milestones.

Figure 1: Components of National Level Implementation



6.1.1 ADVOCACY AND SENSITIZATION

Step 1: Regular meetings of the National iCCM TWG

At the national level, the mandate is to ensure continuous advocacy for increased resources, partners, and buy-in for iCCM. The national level will spearhead coordination, harmonize advocacy activities, and disseminate policy guidelines within and outside the sector. This step is aimed at facilitating the integration of iCCM services with multiple national strategies, including Child Survival, IMNCI, Malaria Reduction, and Elimination strategy, Diarrhoea and Pneumonia Prevention, Promotion and Treatment framework, community health, Public-Private-Partnership for Health, development partners, and implementing partners, etc. which will form the iCCM advisory TWG. The TWG is mandated to harmonize and coordinate joint efforts for nationwide iCCM scale-up; there will be a need to review needed capacity and attendant gaps in the iCCM TWG to enable successful implementation. The TWG should be able to guide the different programs, implementers, districts, and stakeholders and provide leadership and coordination to use shared iCCM framework, standards, and protocols in both public and private sector, and pool resources to strengthen health systems, institutions, infrastructures, and capacity building including research and innovation on iCCM. The TWG will meet every month and share updates with the Child Health TWG and later the MCH cluster. ✍ *Supportive Tool: iCCM Benchmark tool*

Step 2: Perform iCCM partner/stakeholder mapping

Mapping key stakeholders in iCCM programming should be done based on strategic areas supported by donor partners and implementation scope. The stakeholder Mapping will facilitate the iCCM TWG to formally learn the different perspectives of stakeholders, their affiliation and the area they represent, what interests or views they bring to iCCM scale up and sustainability in the country. For each iCCM benchmark component, identify specific national-level partners, agencies, and individuals responsible;

agree on a timeframe and objectives/outcomes to monitor and report on while implementing the scale-up plan. *Supportive Tool: Stakeholder Mapping Guide*

STEP 3: Disseminate Implementation Guidelines, Annual Plans, And Updated iCCM Tools

The TWG will support the dissemination and distribution of information and materials to iCCM program stakeholders. The intent is to spread the agreed-upon revised tools at policy, district/facility management, and VHT levels. For dissemination to work, there should be a "who, what, and how" at each level. The "who" is the stakeholder that benefits. The "what" is the outcome or the reason that dissemination is occurring. The "how" is the indicator or the way the dissemination is measured.

Supportive Tool: Dissemination/communication Tool

STEP 4: District pre-visit for sensitization

Before introducing iCCM in a district, the national task force will pre-visit districts to sensitize them on the iCCM policy, reach a consensus on the plan to roll out iCCM in the districts, including funding sources. The target group will be the extended district health team, including partners involved in community mobilization activities. The following materials developed by the Ministry of Health will be used for the sensitization activities: handouts on iCCM guidelines, iCCM brochure, VHT situation analysis reports, drug policies for pneumonia, malaria, and diarrhoea,

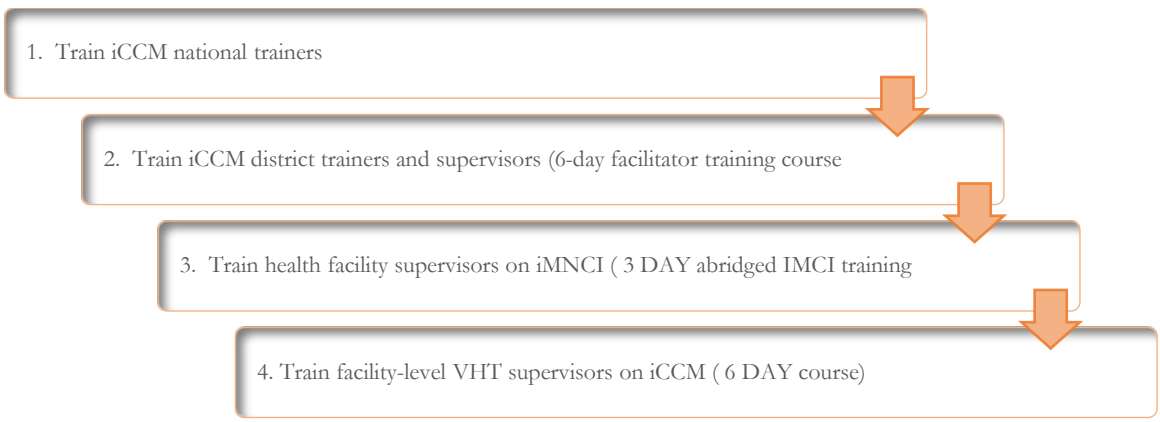
Step 5: Implementation, Performance Measurement, Learning, And Improvement

Implementation of iCCM requires coordinated and continuous action of many partners, units, and individuals over an extended period. The activities and outputs defined in the implementation plan will be regularly monitored using the Key performance indicators (KPIs) so that challenges and delays in implementation are recognized, analysed, and addressed immediately on a continuous improvement process. *Supportive Tool: PDSA Tool*

6.1.2 Capacity Building

The national-level mandate is to develop training guidelines and build district capacity for their implementation. Therefore, the national level will support the districts to initiate training, monitor and evaluate the process of rolling out the training. Capacity building will involve building technical and managerial competencies at all level's health service delivery. The main aim is to effectively impart knowledge and skills for treating malaria, diarrhoea, and pneumonia, including patient referrals for sick children at risk of TB, HIV, Malnutrition, and PSBI and records and drug supply management. The training will be conducted using a cascade approach from the National, district, health facility, and VHTs at the community level. Figure 2 below. Details of the specific activities at national, district, health facility, and community.

Figure 2: Cascaded Training Approach



a) Development and pretesting training materials

The national-level team will adapt and pretest WHO generic materials by reviewing national policies, clinical guidelines, and drug supply systems to determine the relevant recommendations to include in the course materials for iCCM (the case management charts, modules, and other materials including community supply chain management. They will also be required to develop refresher training materials to reinforce knowledge on gaps identified during program implementation. The following materials to support iCCM training in Uganda have been developed:

a) Facilitators Guide
b) iCCM video script
c) Sick Child Job Aid
d) VHT/iCCM Register
e) Reporting tools (HMIS tools)
f) Job aid for community medicines management
g) Community supply chain tools (Consumption log, summary form for consumption and requisition, magic calculator, product issue log
h) Refresher IMNCI course for facility staff
i) Sample medicines for iCCM
j) Key family care practices

b) Training of national-level master trainers

Recognized international and national experts will train a team of national-level master trainers and supervisors in a 6-day training course. These will be drawn from technical programs at the MoH, regional, and district levels, based on their experience in adult learning skills and availability to support scaling of the training. The training will cover the content of the two iCCM training packages: VHT, facilitation, and supervision skills course (see annex for sample training agenda). The training will be conducted immediately before a course in which trainees will serve as facilitators.

c) Sensitization and planning for district training:

Before conducting district training, a one-day meeting to sensitize district health teams will be organized by the master trainers. The aim is to reach a consensus on whom to train, where, when, and the resources for training. Managers of the clinical training site will also be targeted so that they can provide the necessary support. The following materials will be used for the orientations: (i) Handouts on iCCM strategy, (ii) Brief on the training strategy for iCCM and (iii) Status on VHT implementation in the district (establishment and training)

d) Train district trainers and supervisors for iCCM:

Master trainers at the national level will train district trainers in a 6-day course organized at the regional level. A total of 30 participants will be trained in each course by four facilitators (ratio of 1: 6). One of the facilitators will act as the course director and the clinical instructor (see facilitator guide for instructions). The target is to train at least six trainers and supervisors per district constituting DHT and HSD level members based on their previous experience in training and deployment. The same training content and materials for master trainers will be used. Training supervisors of supervisors is competency-based and uses adult learning methods. The main competencies are to track a VHT supervisor's competencies through role-playing and correct analysis, interpretation, and response. The district supervisor will also learn how to problem-solve with VHT supervisors who have too few contacts with their VHTs and monitor the content and quality of supervision.

6.1.3 MEDICINE AND COMMODITY SUPPLY MANAGEMENT FOR ICCM

Improving the supply chain for iCCM drugs and commodities constitutes one of the most critical aspects for the performance and sustainability of the program. The medicines for iCCM include: Artemether/Lumefantrine(20mg/120mg tablet strength), Amoxicillin 125mg dispersible tablet, Low osmolarity ORS, Zinc 20mg tablet and rectal artesunate (50mg). Other commodities include respiratory timers, rapid diagnostic tests, registers, medicine storage boxes, and job aids. The main aim is to institutionalize supply chain management practices that improve the availability and use of these essential health products for iCCM. The previous programs for community case management have identified supply constraints for the availability of the right medicine, in the right quantity and condition, in the right place for the right patient, at the right time, and for the right costs, which need to be addressed as we roll out iCCM. As described below, these constraints will be addressed through various mechanisms at different levels, supported by training, communication, and advocacy.

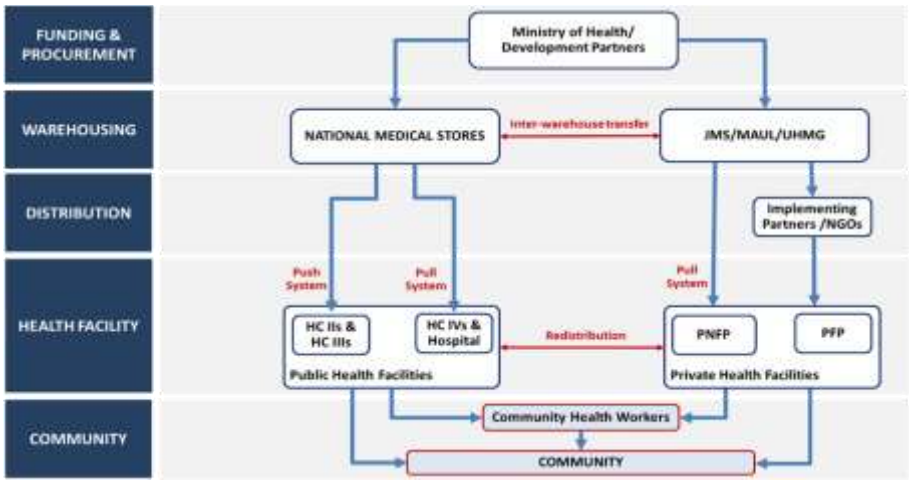
It is the responsibility of the national level to mobilize resources, procure, stock, and supply districts with iCCM medicines and commodities through the National Medical Stores. iCCM medicines and commodities will be procured alongside essential medicines and health supplies for use at the health facility and community. The routine medicine supply chain from the central to the community will be used. For the private sector, implementing entities will follow guidance from the MOH and National Drug authority guidelines while procuring and distributing the required medicines for the VHTs. Medicines management will follow:

a) **Reclassification, branding, pre-packaging, and color-coding iCCM medicines:** The MOH national-level team will work closely with the National Drug Authority to reclassify iCCM medicines, including ACTs and Amoxicillin, from prescription-only (Class B) to over-the-counter medication. Except for ACTs which are already pre-packaged, medicines for iCCM will be pre-packaged locally according to the age bands and dosing regimens (no. of days for full course): Amoxicillin 2-11 months one tablet twice a day for 5 days (RED); 12-59 months two tablets twice a day for five days (GREEN). The pre-packaged iCCM medicines will bear the MOH logo and the NOT FOR SALE label to differentiate them from those in the private sector. Pre-packaged color-coded products facilitate compliance with dosage regimens.

b) **Financing, procurement, and storage of medicines and commodities:** Essential medicines and health supplies procurement is strictly a pull process through the application of the credit line extended by GOU to national medical stores under vote 116. When donors/partners decide to contribute to the drug requirements, efforts will be made to streamline the procurement with the national system. Through this system, districts are expected to pull the medicines. The national level will establish the quantities of drugs and commodities needed to be based on population, the number of episodes, utilization rates, and VHT coverage. iCCM commodities quantified will be procured alongside the essential medicines and health supplies for use at the health facility. The drugs will be shared in the percentage of 40:60 for health facility and community. Subsequently, following implementation in the district over time, medicine needs will be calculated based on their actual consumption rates and included in the district procurement plans (to be collected through good record-keeping practices (Stock cards and stock books) at the district level. The national iCCM coordination team will guide the national medical stores on buffer stocks in case of epidemics or other unanticipated situations. All iCCM commodities will be monitored to meet the quality standards as per the NDA resolutions.

c) **Sustainability of commodity supply:** Before implementing the iCCM guidelines, there is a need to plan for the institutionalization and sustainability of iCCM. iCCM medicines will be incorporated into the credit line so that districts access them together with other medicines. The current medicine budget is inadequate, and the long-term plan should be developed, including reducing inefficiencies in the drug supply and the pilferages, overuse for treatment through scaling up the newly developed community supply chain tools, supervision, and monitoring. Private sector iCCM implementing providers will implement iCCM in accordance with the above guidelines and will be required to provide medicines agreed upon in the iCCM medicines kit. Other medications like family planning, nutrition, NTD will also be guided and implemented according to the respective MOH guidelines.

Figure 3: Supply chain system for ICCM medicines and supplies



6.1.4 SUPERVISION FOR ICCM

Supervision is an integral part of the implementation phase of iCCM. Supervision aims to provide ongoing support, identify best practices, challenges, and coping mechanisms, and generate information for the monitoring and evaluation process. For supervision to be effective and sustainable, it must be an integral component of ongoing national supervision activities, and it should be competence-based. Details of the specific activities at national, district, health facility, and community are described below.

The national-level mandate is to develop supervision guidelines and build district capacity to implement the guidelines and support district supervision to the lower levels.

a) **Update the national supervision guidelines to include iCCM:** The national task force will update the quality assurance and area team supervision guidelines to include the iCCM component.

b) **Review national supervision plans and integrate iCCM:** The plan will incorporate key activities, frequency of supervision, responsible persons, reporting mechanism, modes of supervision, and logistical requirements.

c) **Conduct iCCM technical supervision:** The iCCM national team will carry out technical supervision bi-annually to establish iCCM coverage in the districts and if iCCM activities are integrated into district plans and the progress made. The supervision will last two days and will be spent field visiting a sample of at least two health facilities and 2 VHTs in the HF catchment area.

d) **Private sector:** The national team will ensure that private sector implementation is supervised at least once a year. Supervision will involve the engagement of the district team to assess the implementation of the private sector. A sample of VHTs will be assessed and followed through to see linkages with their health facilities.

6.2 IMPLEMENTING ICCM AT DISTRICT LEVEL

The district represents an important level for planning and implementing the iCCM program within the overall district health plan. The DHO, the head of the district health team (DHT), oversees and monitors iCCM program implementation. Together with his team develops action plans, mobilizes resources, trains district trainers who cascade training to health facility and VHT level, and provides technical support to the lower levels. The DHO may assign one of the DHT members as the iCCM focal person. Implementation at the district level should use these guidelines to adopt and integrate the delivery of the iCCM package within district health work plans. The implementing team at the district will include District Health Teams (ADHO MCH and ADHO environmental health, District health educator, District health inspector, Biostatistician, District Medicine Management supervisors, Implementing Partners, and Private Health Provider Associations.

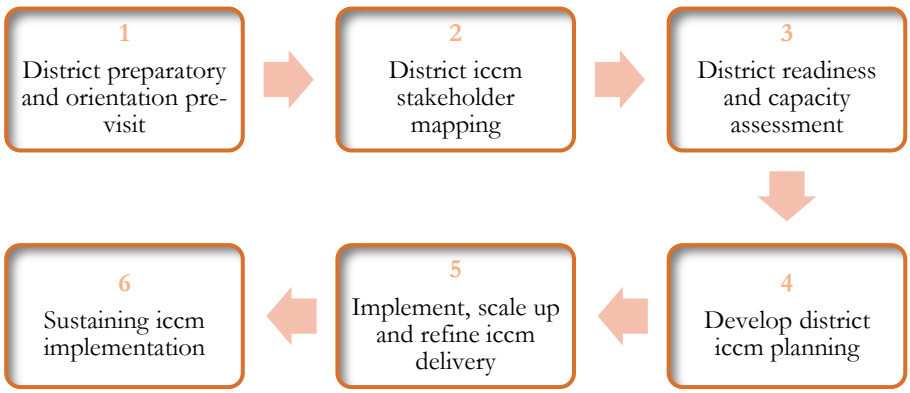


Figure 4: Components of the district level implementation

6.2.1 ADVOCACY AND SENSITIZATION

STEP 1: Carry Out District Preparatory And Orientation Pre-Visit.

The district will receive an iCCM preparatory visit from the national level. The district will mobilize the extended DHT, CAO, ACAO Health, RDC, LCV5, Secretary for health and have them oriented on vital components of iCCM implementation by the national task force.

- Introduce the iCCM guidelines and present a summary of the steps taken for their development.
- Brief the stakeholders about the basis of iCCM is a key government strategy vital for improving child survival and thriving.
- Ensure a clear understanding of the district roles, scope of iCCM, and the implementation process.
- Reach a consensus on the plan to roll out iCCM in the health facilities.
- Emphasize the need to include iCCM activities in the district health work plan.
- Orient the health facility in-charges from the targeted health facilities on the iCCM implementation program Advocacy and sensitization of Health Unit management committees

  Organize advocacy and sensitization meetings to prioritize iCCM activities, respond to issues or problems raised by the community, e.g., through the suggestion box and mobilize community resources.
- Advocacy and sensitization of sub-counties Organize sensitization meetings for sub-county leaders and technical planning committees to identify and mobilize existing resources to support iCCM, including resources for supervision, procurement of VHT supplies, and support the referral of patients from the community.
- Provide a platform to have a structured dialogue with the private sector

  Representatives of umbrella associations for private sector entities involved in community health be represented on the district platform. Special efforts should be made to identify and include those who can introduce evidence-based innovations in iCCM products, technologies, service delivery models, etc., to help leapfrog health system bottlenecks to iCCM implementation.

Tools
- iCCM policy brief
- iCCM implementation guidelines, plan, and ME framework
- Sick child job aid

STEP 2: Perform A District iCCM Stakeholder Mapping

Stakeholder mapping is a way for the district to learn stakeholders' perspectives, their affiliation, the area they represent, and their interests and/or perspectives to the iCCM program. Potential stakeholders are interested in or can influence the process of integration and implementation of the iCCM program. Establish and assess partners working locally using the district iCCM stakeholder mapping tool to avoid duplication of activities within the same facilities or geographical area and wastage of resources.

Tools
- District iCCM Stakeholder Mapping Matrix

The roles of stakeholders to support successful stakeholder engagement should be defined at this stage.

STEP 3: Conduct district readiness and capacity assessment

The objective is to determine the district's preparedness to implement iCCM activities. This step provides baseline measures on the availability of current iCCM tools and other resources required to support the implementation of the iCCM program. Inconsistencies and gaps should be identified and filled before implementation. The district will be required to compile a list of health facilities IMNCI health facilities and verify the availability of an IMNCI trained personnel at the health facilities and plan for this training in case of a gap. Map service delivery areas to establish possible referral points for managing severe illnesses and HIV, TB, severely malnourished children. This information should be made available during the training to support compliance with VHTs referrals. Selected iCCM referral facilities should attain basic minimum standards of having: (i) IMNCI-trained and competent staff present (ii) Overnight duty and inpatient care, (iii) Competence to treat severe pneumonia and malaria using IV and IM medicines, (iv) Competence to treat severe and complicated malnutrition and (v) Neonatal(zero to four weeks) care facilities.

Tools
- District iCCM Readiness Assessment Checklist

STEP 4: DEVELOP DISTRICT IMPLEMENTATION PLAN

Develop the district implementation plan that identifies how to put iCCM implementation into action. Include activities from the implementation plan in the annual operating plans and budgets at all levels; mobilize resources for unfunded or under-funded activities. Carefully plan what needs to be done, when and where it needs to happen, how it will happen, and who is responsible. Determine the procedures and resources (including financial resources) that need to be in place to implement revised guidance. During this phase, carry out iCCM Caseload projection to estimate workload and VHT need and quantify iCCM commodities for the district per year.

Tools
- *District iCCM Planning matrix*
- *Caseload projection tool*
- *iCCM commodity quantification tool*

STEP 5: Train district trainers and supervisors for iCCM:

It is a district-level mandate to prepare VHT trainers and supervisors drawn from the health facilities. It is important that these supervisors and trainers are prepared to manage referred patients and support VHTs in their catchment. Two types of training are required for health facility staff; case management (IMNCI) and iCCM trainer/supervisors training course.

+ Health Facility supervisor IMNCI training

A 3-day refresher training for health workers who last received IMNCI training in the last five years. Training will consist of classroom sessions, clinical training, and interactive sessions, including individual reading and feedback, video, photos, demonstrations, role-plays, and observation/participation in activities in the clinics.

Courses will be organized in batches to ensure that the trainee numbers are small enough (20) to allow hands-on experience during the clinical sessions. End of training assessment is critical to ascertain the level of competence in iCCM gained out of the training.

Training materials
- Facilitators and clinical (inpatient and outpatient) instruction guides
- Patient recording forms and course monitoring forms
- Video
- Sick Child Job Aid
- VHT tools (VHT/iCCM register, Referral form)
- Reports Quarterly Household summary report, Health Facility quarterly household summary, 097b report,
- Supply chain tools: Consumption log, Summary form for consumption and requisition, consumption and requisition, magic calculator, product issue log,
- Sample medicines of iCCM

+ Training trainers/district supervisors

Master trainers at the national level will train district trainers in a 6-day course. The target is to train at least six trainers/district supervisors per district constituted from DHT and HSD levels. The same training content and materials for master trainers will be used. In consultation with the DHO, the course director will select 3-5 health units with high outpatient and inpatient load, which shall be designated as training sites. Transport should be organized for participants to move to the training sites. Courses will be organized in batches to ensure that the trainee numbers are small enough to allow hands-on experience during the clinical sessions. End of training assessment is critical to ascertain the level of competence in iCCM gained out of the training.

+ Training facilitators and supervisors:

A follow-on training will involve district trainers training facility staff as trainers and supervisors for VHTs in a 6-day course using the same training materials and course content for district trainers will be used. Two trainees will be selected from each health facility based on their ability to train and supervise VHTs. Follow on CMEs should be conducted to engage all the health facility staff.

STEP 6: Sustaining iCCM implementation in district health system

Sustaining iCCM requires effort by the district towards improving and retaining VHTs and the competency levels and embedding iCCM within the routine planning, budgeting, implementation, and reporting processes of the facility and district. The system needs to ensure continued high-quality performance; -Optimize the supply chain for the full range of iCCM commodities and tools, Continuous training and support supervision of VHTs, motivation of VHTs through (i) ensure management procedures continue to support and facilitate the use of iCCM guidelines and (ii) integration of iCCM into the routine government systems

6.2.2 MEDICINES AND SUPPLY CHAIN MANAGEMENT

a) **Districts retain the mandate and responsibility to prepare medicines and supplies plans,** originate orders, follow up with national medical stores, and monitor utilization (health systems). District procurement plans (for HCIV and above) and essential medicines kits (HC3 and HC2) for drugs and supplies will be prepared through the aggregation of health facility plans which should be annexed to the district operational plans. It is important that store management is explicitly planned for in the

operational plans. It continues to be a weakness in many local governments and districts verifying medical supplies from the national medical stores before bi-monthly distribution to the health facilities. Inventory management, procurement lead time, and delivery schedules are central measures to ensure successful district engagement with NMS. In addition, districts are responsible for pharmaco-vigilance (keeping alert and reporting adverse drug reactions) and drug inspection in the private sector.

b) **Districts will train and integrate iCCM commodities into existing district quantification, procurement, supply chain** to the "last mile," inventory control, resupply, and logistics management information system (LMIS). Medicine needs will be calculated based on consumption rates using the existing supply chain tools for health facilities and the community.

c) **Ordering and Distribution of iCCM commodity needs:** Orders of iCCM commodities will be made alongside the other HF credit line order for EMHS and incorporated in the district procurement plan submitted to national medical stores. It is this plan or order that will be honored by National Medical Stores. Medicine needs will be calculated based on their consumption rates (to be collected through good record-keeping practices) at the health facility level. Districts will be responsible for forecasting and keeping buffer stocks for epidemics or increases in cases. Once mechanisms for drug subsidies have been made for private facilities, the district will oversee the quantification and supply of drugs to these facilities. Once NMS delivers commodities to the districts, they will be distributed to the HF alongside the EMHS using existing systems. Districts will supervise facilities to ensure adherence to using community supply chain tools to ensure proper accountability of medicines and supplies given to the VHTs.

d) **Pharmaco-vigilance and medicine inspection:** Standard adverse drug forms will be used to track adverse reactions reported by VHTs. The VHT follows up sick children per protocol, including identifying possible adverse medicine reactions, and requests HF staff for investigation. The HF staff investigates possible adverse medicine reactions and documents on standard Adverse Drug Reaction Forms, reported to the DHO office and NDA Pharmaco-vigilance center in regional referral hospitals.

6.2.3 MONITORING, MENTORSHIP, AND SUPPORT SUPERVISION

The district mandate will be to monitor, mentor, and supervise iCCM supervisors (Health facility in-charge and Health assistant) based at the Health Facility. This will be integrated into the routine support supervision activities. Both public and private health facilities have the responsibility to oversee VHT implementation in their catchment areas. All iCCM supervisors will be monitored at least quarterly using the iCCM health facility supervisor's checklist. The district will strengthen mechanisms to supervise the iCCM private sector through extended DHT meetings and private sector associations.

Review patient care

A member of the DHT visiting a health facility shall hold a meeting with the VHT supervisor to share reports, including referral records, management of referred cases, the attrition rate of VHTs, medicine and commodities records, and HMIS tools.

Frequency of supervision

Review iCCM supervisor Supervision Coverage Chart to verify the frequency of supervision and if it has occurred often enough, either at the health facility or in the community.

Strengthen Supervisor's competencies

The DHTs will occasionally (once or twice a year) monitor the content and quality of supervision. Through directly observing the supervisor supervise a VHT, the supervisor will use the checklist entitled Supervising Supervisor of VHTs providing iCCM

Conduct iCCM supervision

The DHT will carry out technical supervision quarterly. This supervision will be integrated into the existing supervision arrangements. The supervision will cover all health facilities, and at least 2 sampled VHTs in the HF catchment.

Develop a costed plan for monitoring

The district will develop a plan and cost it to monitor all iCCM activities. The plan will entail frequency of monitoring visits, funds allocated, and responsible persons.

Monitor iCCM HF activities

The DHT, every quarter, will monitor iCCM HF activities. The activities to monitor will include the VHT training on iCCM, supply and distribution of iCCM commodities, management of referred cases, and record keeping.

Update the VHT situation analysis mapping

Strengthen Supervisor's competencies

The DHTs will occasionally (once or twice a year) monitor the content and quality of supervision. Through directly observing the supervisor supervise a VHT, the supervisor will use the checklist entitled Supervising Supervisor of VHTs providing iCCM.

The districts will update the VHT coverage map every quarter. The updates will include new sub-counties with new VHTs trained to implement iCCM. The updates will also aid in tracking the attrition of iCCM VHTs.

6.2.4 MONITORING AND EVALUATION AT DISTRICT LEVEL

Problems are expected to emerge, and the team must develop and engage in strategies to promote continuous improvement and rapid-cycle problem-solving. The district mandate will be to monitor activities at the HF, including the support given to VHTs. Both public and private clinics will be monitored at least quarterly using the supervisor of supervisor's checklist. Monitoring at the district level will mainly focus on training and supervision of VHTs, supply and distribution of commodities to VHTs, and management of referred cases. The district monitoring team will summarize reports in duplicates (one copy to be left at HF) and provide immediate feedback for corrective action.

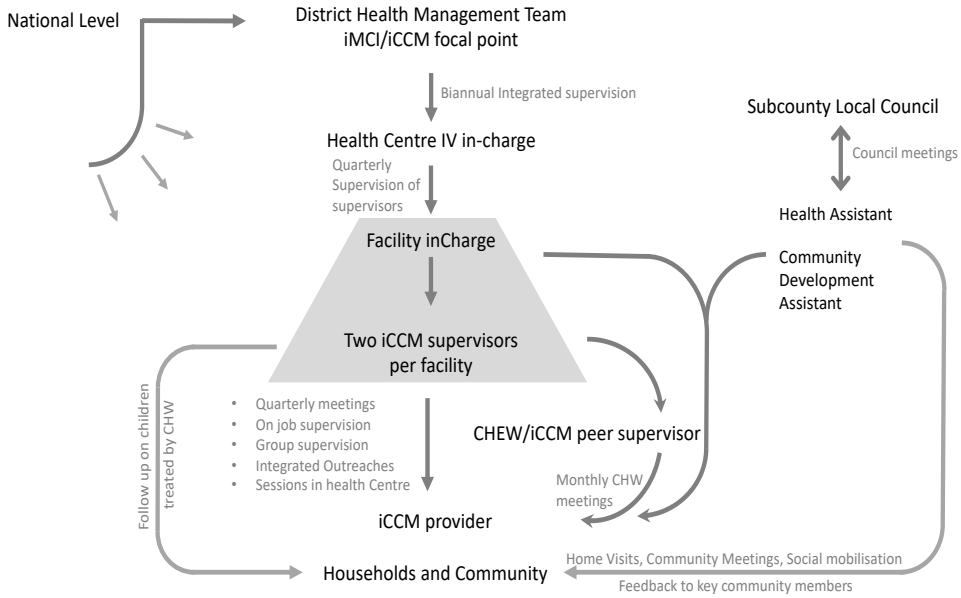


Figure 5:iCCM supervision structure

Activities at district level will involve (i) evelop a costed plan for monitoring: The district will develop a plan and cost it to monitor all iCCM activities. The plan will entail the frequency of monitoring visits, funds allocated, and responsible persons and integrate this within the district plan, (ii) Monitor iCCM HF activities: The DHT, every quarter, will monitor iCCM HF activities. The activities to monitor will include the VHT training on iCCM, supply chain management of iCCM commodities, management of referred cases, and record-keeping, emphasizing community reporting (097b) and, (iii) Update the VHT situation analysis mapping: The districts will update the VHT coverage map every quarter and ensure the database is updated. The updates will include new sub-counties with new VHTs trained to implement iCCM. The updates will also aid in tracking the attrition of iCCM VHTs.

6.2.5 IMPLEMENTATION STEPS AT HEALTH FACILITY LEVEL

All targeted health facilities should have joint annual planning with iCCM as part of facility plans. iCCM must be implemented as the community arm of facility-based IMNCI with clear referral and counter referral linkages for severely sick children. Each facility will be required to support communities in selecting their iCCM VHTs and, after that, utilize micro-plans drawn up with the VHTs to cover their

catchment populations. The maps should be the basis for prioritizing villages that need the iCCM approach for impact. The HSD/in-charge of the Health Centre IV takes on the leadership role for iCCM institutionalization and works with HC III and II in-charges and Health Inspector/Assistants for advocacy at sub-county local governments and planning implementation M&E of iCCM activities.

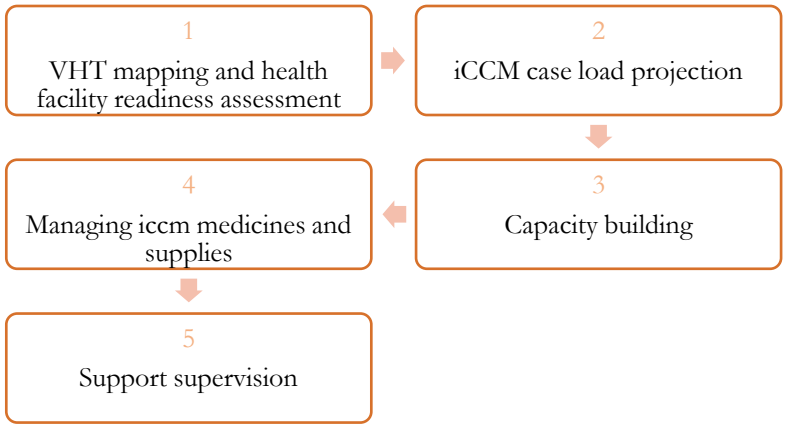


Figure 6: Components of facility level implementation

It is envisioned that General hospitals, HC IV, III, and II, will all have attached VHTs and thus will have designated iCCM supervisors/mentors. Only IMNCI ready Health Centres will provide referral care, and these should be functional before implementing the community level iCCM activities. The health facilities will be responsible for training, supervision, management of medicines and supplies, and reporting.

6.2.6 ADVOCACY AND SENSITIZATION

STEP 1: VHT Mapping And Health Facility Readiness Assessment

The purpose is to prepare and sensitize health facility staff and HMU on implementing the iCCM program. Highlighting the resources required, including commodities, the use of VHTs from their catchment, their roles and responsibilities in ensuring successful implementation, reporting, and use of data to be collected from the community. Sensitization will be done through individual contacts with patients at the HF as well as through outreaches.

Emphasis on engagement with the private sector and focus of catchment area population planning for action to service delivery based on data from the VHT register. During this stage, health facility staff who will require additional training in IMNCI will be identified, and training plans developed. The health facility will establish a linkage and supervision strategy for private VHTs if available.

The health facility will utilize the OPD attendance registers to demarcate and assign communities to the VHTs. Mapping should ensure that no duplication of iCCM activities occurs within the same villages. Using the VHT selection criteria, two VHTs already implementing a basic VHT program will be selected from each village to support iCCM activities. These VHTs will be attached to the nearest health facility. All iCCM VHTs in the private sector or by partners should directly report with the local health facilities aside from their project staff.

A VHT implementing iCCM in the public sector will not be eligible to support implementation in the private sector since the public sector requires dispensing of medicines for free, whereas the private sector requires payment for the medication.

Tool: Health Services Assessment Tool

1	Sensitize and mobilize communities for iCCM: Liaising with VHTs, opinion leaders, and other influential community members Health facilities will conduct health talks on the importance of iCCM and location of VHTs in the communities during outreach visits. Communities will be guided on the selection criteria for VHTs to provide iCCM services.	2	Health Education in the clinics: Patients accessing health services will receive group health education on available iCCM services. MOH will supply HF and communities with appropriate education/counseling charts for iCCM, including preventing these diseases. Health facilities will prioritize all VHT referrals received at the health facility.

STEP 2: Caseload Projection

The purpose is to use HMIS treatment ratios to advocate for the iCCM medicines and supplies in the facility and support the prioritization of health facilities for iCCM. Caseloads, especially of voluntary

VHTs delivering iCCM services, should neither be so low as to risk skill loss nor so high as to risk demotivation. The VHTs see an average caseload of 5 to 15 cases per month. The eligible target population for iCCM then could be calculated by each health facility and targets drawn for monitoring performance.

Tool: Facility Case Load Projection Tool

6.2.7 CAPACITY BUILDING BY TRAINING

STEP 1: VHT training on iCCM

VHTs will be trained on iCCM is a 6-day course. Each training course will cover 30-35 participants with a trainer trainee ratio of 1:10. Training two VHTs in iCCM should suffice for most communities unless they are very dispersed or large, including private providers. The district drug inspector will map all private drug shops and clinics in the district. The training materials will be translated into a local language where appropriate and iCCM trainers should translate to appropriate language understandable by the VHTs. Interactive and active learning methods must permeate VHT training to stimulate energy, enjoyment, and learning. Interactive methods will include ice-breakers, brainstorming, plenary discussion, small group discussion. Active methods will consist of practice, role-play, and games. The trained VHT members will be given certificates in a series of ceremonies overseen by the district leaders, equipped with the required medicines and supplies, and immediately deployed in sensitized communities.

Materials for Training

a) Facilitators Guide
b) Sick Child Job Aid
c) VHT/iCCM Register
d) HMIS Tools (Referral form, VHT Quarterly Household summary form,09b, consumption log, product issue log)
e) Evaluation forms(Pre and Post, daily activity assessment form, etc.)
f) Sample medicines of iCCM
g) Respiratory timers, medicine box,
h) Dolls

STEP 2: Certification of trainee VHTs for iCCM

Working closely with communities, trained health facility staff will certify VHTs who will distribute medicines under iCCM. The goal is for all trainees to "pass" and be certified at the end of training. Trainees are generally certified outright or provisionally certified. Certified VHTs should be able to perform the following functions:

- Able to use iCCM sick child job aid to manage sick children
- Complete VHT registers and report at the health facility
- Liaise and mobilize communities for iCCM

STEP 3: Medicines and supplies and supply chain management at the facility and community

The mandate of the Health Facility is to quantify medicine needs for their catchment population, include the needs in the medicines supply plan, receive, store and distribute iCCM medicines to the VHTs. It is crucial that drug quantification and forecasting are done appropriately to avoid medicine stockouts or expiry. Health facilities will also be responsible for ensuring that VHTs account for the drugs used and over-prescription avoided.

a) **Quantification, Ordering, and Storage for iCCM commodities:** Orders for iCCM commodities will be made by the supervising HF and will be based on the consumption records of the VHTs reporting to them. They will then be incorporated in the HF medicine order forwarded to the HSD/district. These needs should be incorporated during the procurement planning cycle for respective health units. Health Facilities will receive the iCCM commodities alongside their EMHS from the district/HSD. Health Facilities will store these commodities alongside their facility stock on behalf of the VHTs, following proper storage procedures.

b) **Management of iCCM commodities:** VHTs will be provided with a daily consumption log to record their daily consumption and stock balance for each of the medicines and supplies given to them at the health facility. Using this data, the health facility supervisor will compute the total amount consumed by each VHT over a period of 2 months. In addition, the supervisor registers the stock balance of each item used by the VHT as per the consumption log. At the end of every two months, data will be aggregated from all VHTs attached to the health facility into the summary form for consumption and requisition. Using this aggregated data, the In-charge/iCCM FP will determine the total quantity to replenish the VHTs using the magic calculator and send the requisition to the health facility store using the requisition issue voucher.

The lump of commodities will be issued to the facility in charge or iCCM focal person on the stock card and issue voucher and thereafter, issues the stock to individual VHTs based on the individual computation from the magic calculator. The In-charge/ iCCM FP will record details of the VHT, quantities of medicines issued, and the VHT receiving the supplies appends the signature in the product

issue log. This approach allows the traceability of the commodities issued from the National Medical Stores to the health facility up to the community system. It also provides the most efficient use of stock cards and ensures health facility oversight of the resupply process.

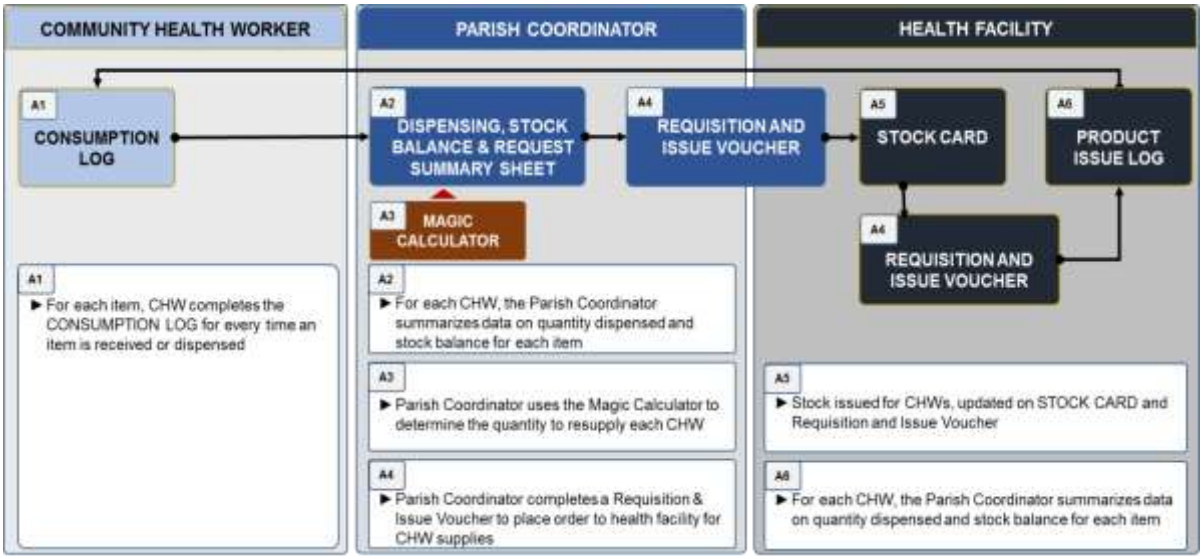


Figure 7: Management of iCCM commodities

c) **Distribution and replenishing of iCCM Medicines and supplies:** Initial distribution of iCCM commodities to the VHTs will be done immediately after the training on iCCM. Subsequently, VHTs will be supplied with commodities based on their consumption rate. The health facilities will follow proper inventory management procedures to replenish medicine stocks to VHTs, including cross-checking VHT registers and consumption logs to ensure appropriate accountability of the medicines. Health Facilities will also ensure the availability of drugs and supplies to handle referred cases. Medicines and supplies to provide include: Malaria RDT; ACTs (Artemether Lumefantrine and Rectal Artesunate); Amoxicillin Dispersible Tablets 250mg; ORS/Zinc co-pack; Respiratory timer; Safety box and; Examination gloves

d) **Support Supervision:** The HF mandate is to reinforce competencies, especially case management, drug storage, record-keeping, and reporting; problem-solving; identify and control possible malpractice or misdirection of drugs; provide technical updates and mentorships, as relevant; plan together and promote community participation in the iCCM strategy. For iCCM, there will be two methods of supervision, namely health facility supervision, and home visit supervision.

STEP 4: Conduct quarterly Health Facility VHT meetings

Health workers should organize quarterly meetings at the nearest health facility (or other agreed place, e.g., at parish headquarters) for all VHTs in the catchment area and with support from DHT/HSD. It is highly recommended that an LC representative be invited to these meetings. Long distances will discourage attendance. VHTs should receive transport refunds and safari allowances. During the quarterly group meeting, the following minimum standard will be followed:

- Report on progress by individual VHTs
- Review individual VHT registers for completeness, accuracy, and aggregate VHT health facility report.
- Identify key constraints, challenges faced and solutions applied by VHTs
- Ascertain knowledge gap and reinforce one or two competencies, e.g., knowledge of danger signs, how to complete register
- Introduce additional or new information, e.g., mobilizing communities to use insecticide-treated nets, enhance skills on assessing exposure to TB, HIV, Malnutrition, etc.
- Agree upon key action points for follow up at the next meeting and a date for the next meeting
- Replenish medicine and supplies if needed based on consumption and stock balance
- The health facility supervisor to sign the VHT Register during the meeting
- Refer to the integrated agenda for health facility support supervision

Expected Outcomes:

- Regular tracking of VHT performance
- Completed Health facility VHT register
- VHT deployment tracked
- Reports and monitoring information disseminated

STEP 6: Supervising VHTs in their communities (Home Visit

Health workers should supplement group meetings at health facilities with monthly community visits to VHTs for at least the first three months after training to identify problems quickly and coach those with difficulties. During these visits, the supervisors should:

- Observe the actual environment where the VHT operates, e.g., how they store medicines.

  The VHT provides iCCM or uses a case scenario, but remember that this can be stressful to the VHT especially if others are watching and give direct verbal feedback to the VHT throughout the supervision process and acknowledge what was done well. In a friendly way, point out any errors and agree on areas of improvement.
- Sign the VHT Register during the visit
- Complete the supervisor's Check-list by indicating the problems/ constraints identified, actions taken, and recommendations
- Liaise with the caretakers and local council leaders as needed.
- Complete the supervisor's summary form and checklist for submission to the district/HSD.
- Replenish medicine and commodity stocks if needed.

In addition to the above, the health workers will be assisted by their parish coordinators to ensure routine home visits are conducted to all VHTs in the catchment and share a summary to the health workers for VHTs requiring extra skills enhancement. The health iCCM supervisor will later use this to conduct routine visits during program implementation.

6.2.8 MONITORING AT HEALTH FACILITY LEVEL

Monitoring at the Health Facility for iCCM constitutes one of the most important activities. The Health Facility will monitor referred patients and all iCCM activities in the village to improve access and quality of iCCM services. During monitoring, aggregate, analyse, interpret and use the community health information. The Health Facility supervisors will be expected to display relevant indicators concerning VHT iCCM activities to track performance. The health facility will ensure regular and timely submission of iCCM data from the VHTs to the health facility for reporting. The health facilities will ensure that VHTs have sufficient HMIS reporting tools and conduct regular data quality assessments on the submitted data. Health facilities are expected to submit the VHT/iCCM report by the 7th day of the month/ quarter alongside the other facility HMIS reports submitted to the district.

STEP 1: Charting and posting the performance of VHT activities

During one-on-one supervision of a VHT, a supervisor will use a checklist to tally and indicate if a locally-defined "pass" has been achieved, i.e., the availability of drugs and the availability of supplies and equipment. Five rows are completed, one for each of the last five episodes seen, to record the classification-treatment consistency as recorded in the Register. A single row is completed for the directly observed skill of counting the respiratory rate.

STEP 2: Transfer and summarise data from the VHT Registers

To bring together data on episode treated, the supervisors complete one row for each VHT, transcribes totals from the Register on to a, and results from the supervisory checklist.

STEP 3: Chart and post the deployment of VHTs

All names of VHTs providing iCCM in each village will be captured to indicate whether the VHT is actively providing iCCM during the given quarter. This chart should be analyzed annually, informs the availability of iCCM and VHT annual attrition.

STEP 4: Report and disseminate monitoring information

After the monitoring visits, the supervisor will give feedback immediately to the VHT and during the quarterly review meetings.

6.3 IMPLEMENTATION AT THE COMMUNITY LEVEL

Each VHT will be assigned to a health facility with an IMNCI trained staff to provide personal mentorship and support supervision. The community, including the beneficiaries, should be involved in the iCCM planning, feedback, review, and incentives for the VHT/VHT. Community leaders or existing health committees should be supported to have continuous dialogue with VHTs regarding health issues in the village using data gathered.

Figure 8 Components of Community-Level Implementation

6.3.1 ADVOCACY AND SENSITIZATION AT THE COMMUNITY

STEP 1: Hold community engagement meetings and advocacy for iCCM ownership

The purpose of the engagement meeting is to introduce the concept of iCCM and start developing the governance and leadership support needed for the iCCM service delivery from the community. The facility staff should support community leaders and health unit management committee members to engage in continued dialogue with VHT regarding health issues in the village using data gathered from HMIS. Cultural, religious, and other gatekeepers in the community and the TCMPs and the private providers (e.g., drug shops) should be engaged in iCCM and the promotion of service uptake and demand. Carry out iCCM VHTs selection (or Community Health Extension Workers -VHTs where they exist) and initiate partnerships with other community-level providers.

Tools
- VHT strategy

a) **Mobilize communities for iCCM sensitization meetings**: Community leaders will mobilize the communities for iCCM village meetings. Meetings will include;- selecting VHTs to distribute medicines, planning, and review of iCCM, advocate for the benefits of iCCM. Drafted talking points about iCCM will be used to encourage uniformity.

b) **Mobilize communities to select VHTs for iCCM:** Community leaders will mobilize communities to identify two people among the 4 - 5 VHTs to be trained to provide iCCM drugs to treat malaria, diarrhoea, and pneumonia (eventually, all 5 VHTs will be trained in iCCM).

c) **Mobilize communities for participatory village planning and review of iCCM:** On a biannual basis, communities will be expected to plan with the VHTs for activities to support iCCM based on information on the progress and performance of this program. VHTs will be trained to use participatory methods to ensure that communities participate fully.

STEP 2: onduct community mapping and training on iCCM

It is important that communities own the iCCM program and support VHTs who are to undergo training. Communities will decide on which two VHTs to lead the implementation of the iCCM program in their villages. The two selected VHTs will undergo initial iCCM training, and a refresher training will be carried out every 18 months based on the iCCM training guidelines. The VHT will conduct a village mapping to profile households and demographics within their catchment areas. This needs to be performed routinely to update the village database. The VHTs will be facilitated with job

aids, HMIS tools, and medicines and supplies to support the implementation of their duties. Communities should have close linkages with facilities and should notify them on problems in implementing iCCM, e.g., attrition, adverse reactions on use of medicines, non-performing VHTs,

a) **Selection of VHT for iCCM** Villages will apply the following selection criteria to propose VHT candidates for iCCM training and implementation. The VHT for iCCM must be:

1 exemplary, honest, trustworthy, and respected
2 willing, able, and dedicated to serving the community
3 a permanent resident of the community
4 able to perform the specified iCCM-related tasks as outlined in the TOR
5 a good mobilizer and communicator
6 a village health worker, a community drug distributor, or licensed private health provider
7 at least 18 years old
8 at least Primary Seven level); read and write (at least in their local language)
9 acceptable to the community

b) **It is important that communities own the iCCM program and support VHTs** who are to undergo training. Communities will decide on which two VHTs to lead the implementation of the iCCM program in their villages. The two selected VHTs will undergo initial iCCM training, and a refresher training will be carried out every 18 months based on the iCCM training guidelines. The VHT will conduct a village mapping to profile households and demographics within their catchment areas. This needs to be performed routinely to update the village database. The VHTs will be facilitated with job aids, HMIS tools, and medicines and supplies to support the implementation of their duties. Communities should have close linkages with facilities and should notify them on problems in implementing iCCM, e.g., attrition, adverse reactions on use of medicines, non-performing VHTs.

Tools
- VHT strategy
- VHTs Strategy
- VHT Participant Manual
- iCCM training guide
- CAPA tool

c) **Incentives for VHTs:** iCCM VHTs must maintain a certain level of skills. However, they need to be motivated to achieve this. These VHTs will be volunteers (i.e., are not paid salaries); however, regular availability of medicines and supplies and broadly spreading knowledge about managing childhood illness is generally motivating. In addition, communities are expected to motivate the VHTs to deliver this program, and different incentive approaches will be adapted according to the national community health worker strategy.

STEP 2: Community-based communication and sensitization

As a hub of community-based health services, VHTs should be facilitated to transfer health literacy and skills between individuals and families to make informed choices and decisions for behavioural change. They should also create demand for better health services, mutual understanding, and trust among key actors within the community. Communities should Support the VHTs to:

a) **Deliver the community sensitization to improve care-seeking behaviour:** This should target reaching households that are most vulnerable or at risk of child mortality, such as isolated households, newborn's, or adolescent mothers, families affected by HIV, TB, Malnutrition, children with disabilities or chronic conditions, large families, or those living in conditions of extreme poverty, and families in which there have been recent cases of child death.

b) **Conduct Community Dialogues:** The meetings will provide a forum in which community dialogues will be held. These will be community lead and in attendance will be the public and service providers. The fora will be used to give feedback and accountability and develop action plans on how to bridge gaps within the iCCM program in those respective communities. The communities will decide who will be responsible for following up the action plans, including the timelines to do so. On an annual basis, recurring gaps will be picked to inform iCCM planning.

c) **Carry out Focus Group Discussion:** The aim is to generate information on caregivers' knowledge of illness signs and care-seeking practices, social-cultural issues affecting access to case management, perceptions of quality of care, and referral practices. The purpose is to understand community beliefs and practices to enhance care-seeking behaviours in the community.

STEP 3: ICCM commodity and supply chain management

a) **Rational use of commodities:** Irrational use of medicines by the VHTs can result in incomplete recovery, development of resistance, adverse medicine reactions, and overall failure of the program. VHTs will be provided with training on the rational use of iCCM medicines. This will include case definition/diagnosis, dispensing, record keeping, patient counseling, referral, patient follow-up, adverse drug reaction monitoring (Pharmaco-vigilance), inventory management to avoid expiries and stockouts. This will be reinforced by the use of appropriate guidelines, job aids, and support supervision. A record of medicines dispensed to the community will be kept in the VHT register and the consumption log.

b) **Collection and Storage of medicines:** VHTs will collect medicines bimonthly or whenever they are stocked out from their supervising health facility within their vicinity. VHTs will be provided with medicine boxes for proper Storage of their medicines to ensure that quality medicines are dispensed to the community.

c) **Private sector:** Private sector iCCM implementing providers will implement iCCM in accordance with the above guidelines and will be required to provide medicines agreed upon in the iCCM medicines kit. Other services components like family planning, nutrition, immunization, NTD, social mobilization, surveillance, etc. will also be guided and implemented in alignment with the respective MOH guidelines.

STEP 4: Continuous supervision and mentoring for iCCM service delivery

Each iCCM VHT is linked to a specific Health facility and will be required to keep a list of all VHTs on a VHT record that shows their training status and whether or not they are active or inactive. The iCCM supervisors/mentors at the facility have been trained and know the roles and responsibilities of VHTs, and their role towards the VHTs is familiar with the content of iCCM health promotion and other training. They should have copies of Standard Supervisory tools used to inform the writing of VHTs Supervision Reports. The information in the supervision reports is collated every quarter to find solutions to recurrent problems by refresher training etc.

Facility-based supervision of iCCM VHTs needs to be done, and VHTs should be availed opportunity to work at the Health Facility or child health outreach once every two months, preferably in small groups of 2 or 4. The available supervisor checks the registers, gives feedback, and collates data. They then provide the VHT with new knowledge or an update and how to refer urgently and fill in the register appropriately. The VHT, if available, stay and assist in the clinic giving health talk, organizing queues, registering patients, or checking MUAC. This is another opportunity to supervise and reinforce skills and knowledge. The iCCM VHTS collect any supplies and incentive before leaving. The very hard-to-reach and trained private sector VHTs may routinely use SMS messages for informing, reporting, and quantifying needs.

STEP 5: Monitoring at the community level

a) **VHTs keeping records of patients:** The VHT/iCCM register will be used to record important details for each episode of illness treated. The VHT starts a new row for every new illness – even if the child has been seen before. Each row has columns for, Date, Patient Name, Age, Sex, Respiratory rate, Classification (Within 24 hours of illness, after 24 hours of illness), Treatment, Referral, Outcome (recovered, died, adverse drug reaction). Most columns require only tick marks. The VHT supervisor aggregates important columns in the bottom row of the Register to summarize the experience over the time interval. This information is transferred to a summary form. (Quarterly Household summary form) at the health facility, and the information is linked to HMIS data sent to the district.

b) **Documenting home visits for newborn:** The VHT will visit a mother during pregnancy and at least three times (at birth, 3rd day, and 7th day) within the first week of delivery, which is recorded in the VHT register.

c) **Reporting to the nearest health facility:** The VHT will refer any newborn or sick child with danger signs to the nearest health facility.

d) **Reporting drug reactions:** The VHT will follow up any sick child with an adverse reaction and document it in the

7 ICCM MONITORING AND EVALUATION FRAMEWORK

According to the principles of iCCM outlined in the objectives of this document, the implementation of the iCCM M&E Framework will align with relevant existing HMIS and sector M&E systems to reduce the multiple reporting mechanisms that burden health workers. The ME framework also aims to increase data utilization at different levels of health care through routine monitoring of performance indicators.Building and maintaining systems to effectively monitor iCCM implementation at scale is inherently complex, involving data collection from thousands of volunteer community health workers (VHTs) with minimal formal education.

Table 1: Status of M&E for iCCM according to components of health information systems

Component	Current Status of iCCM M&E	Targeted iCCM M&E Status
Health information system resources	• Lack of M&E and data management staff within MOH with clear roles, responsibilities, and accountability for iCCM/VHT specified within job descriptions. • Inadequate HR capacity for timely and quality data collection, reporting, management, analysis, and use at the health facility • Largely paper-based	• Trained staff within MOH M&E staff explicitly responsible for iCCM/VHT data • Support mechanisms in place to provide ongoing mentoring and refresher training of health workers • Costed M&E plan for HMIS includes community HIS • Introduce digital health for iCCM data
Indicators	• iCCM/VHT Indicators are prioritized at national and district.	• To have iCCM/VHT indicators included in the district league table especially Testing in the community and Treatment in the community as per national malaria treatment guidelines. • Inclusion of iCCM/VHT indicator data analyzed in the quarterly district reviews and routine dissemination of community level data at the national level.
Data sources	• Inadequate HMIS tools for community data collection and reporting • Deficient use of ICT and mHealth solutions among VHT • Use of old/non-standardized HMIS tools	• Provision of adequate quantities of standardized community HMIS tools alongside the other routine health facility HMIS tools • Embrace appropriate ICT technology in the collection and reporting of community data

Component	Current Status of iCCM M&E	Targeted iCCM M&E Status
Data management	• Community treatment data not disaggregated by point of service • Implementing partners maintaining parallel reporting systems for short–term project requirements • Data from the private sector is not streamlined in the national reporting system • Gaps in VHT data collection and recording from the different levels of compilation	• Develop innovative ICT system to capture data from the point of service • Integration and centralization of community data • Align private sector players to report in DHIS2 • Strengthen supervision and continuous mentorship of VHTs at the community level to improve data recording • Routine assessment of iCCM data quality during the VHT meetings
Information products	• Limited visibility of community-level data in the national information products (MOH website) • The limited capacity of staff, especially at all levels, to analyze data, transform it into user–friendly information products, and disseminate it to decision-makers • Indicator manual for calculation of information products not disseminated.	• User–friendly information products (dashboards, reports) analyzing monitoring data for priority indicators produced regularly (at least quarterly) • District-level staff with the capacity to analyze data and produce information products • Disseminate indicator manual to enhance data utilization at different levels.
Dissemination and use	• Very low utilization of iCCM data • Limited dissemination of data collected and analyzed to the respective communities and health facilities	• iCCM data use integrated into existing data review and use mechanisms (e.g., community dialogues, quarterly review meetings at district level) • Training to facilitate data use across levels • Develop a community data dashboard to enhance data utilization and trigger actions. • iCCM data analysis and visualization aligned with prioritized indicators

7.1 GOALS AND OBJECTIVES OF THE ICCM M&E

To ensure that iCCM achieves its potential, the implementation of the national iCCM program should be guided by robust monitoring and evaluation (M&E). Valid and timely measures of iCCM performance enable program managers to identify problems, improve implementation and report progress to international, national, and sub-national stakeholders.

7.1.1 GOAL

To provide a joint framework for a systematic, coordinated, and harmonized tracking of iCCM service delivery to inform decision-making at all levels.

7.1.2 OBJECTIVES

This M&E plan is intended to guide how to track the implementation of the iCCM program in Uganda by monitoring the performance of the national iCCM strategy. The specific objectives are:

1. To describe the types, sources, and flow of data from the household to the national level.
2. To provide standard indicators, targets, and frequency of reporting for all iCCM implementers and stakeholders.
3. To guide documentation, enhance community data quality reporting, and use of iCCM data against the set targets.
4. To identify and cost key actions for effective monitoring and evaluation of iCCM implementation.

7.1.3 PRINCIPLES

1. iCCM Data is collected based on needs within the general management processes.
2. Work along the iCCM logframe measured by the corresponding indicators
3. Build iCCM M&E into the national HMIS framework so as not to overwhelm providers or make monitoring an additional activity by utilizing existing touchpoints
4. Minimal tolerance for insufficient data by building quality assurance processes to test the data for quality and giving constant feedback on acceptable standards
5. Ensuring iCCM M&E reports are engaging, clean, simple, and short

7.2 KEY PERFORMANCE INDICATORS

Through the iCCM Task Force (TF), the global partners proposed a list of iCCM indicators that national programs adopt to monitor implementation and evaluate progress. These provide a menu of iCCM indicators across program components and phases, standardized definitions, and metrics for iCCM indicators. The country adopts these indicators and rearranges them based on the national iCCM strategy results chain.

Over view of key performance indicators

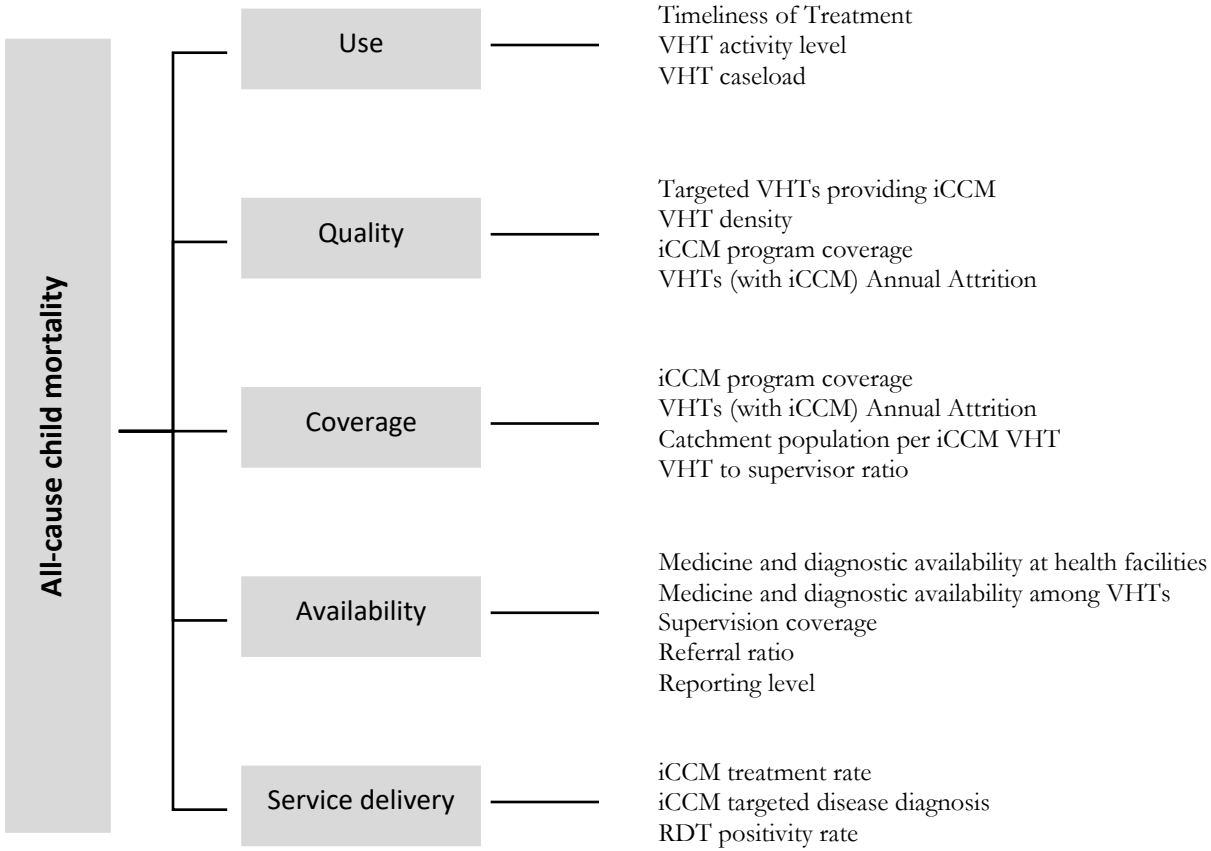


Figure 9: Overview of Key perfomance indicators

7.3 KEY NATIONAL PERFORMANCE INDICATORS

Indicator	Operational Definition	Measurement Method		Application		Baseline	Targets				
		Source	Frequency	Level	Use		20/21	21/22	22/23	23/24	24/25
GOAL											
All causes of under Five mortality	**Numerator**: number of children <5 who died from all causes in a given period in a defined area. **Denominator**: Total number of children <5 in the same period in the same defined area	097B report UDHS	Annually Five years	Health facility District Program	Tracks progress or impact						
Proportion of children treated within 24 hours for malaria	**Numerator**: Number of children treated within 24 hours for malaria of onset of symptoms in a given period. **Denominator**: Total number of sick children treated by VHTs with fever in the same period.	097B report	Quarterly Annually	Program District Sub-County Health Facility	**If low** ⇒ Explore why						
Proportion of children treated within 24 hours for diarrhoea	**Numerator**: Number of children treated within 24 hours for diarrheoa of onset of symptoms in a given period. **Denominator**: Total number of sick children treated by VHTs with diarrheoa in the same period.	097B report	Quarterly Annually	Program District Sub-County Health Facility	**If low** ⇒ Explore why						
Proportion of children treated within 24 hours for pneumonia	**Numerator**: Number of children treated within 24 hours for pneumonia of onset of symptoms in a given period. **Denominator**: Total number of sick children treated by VHTs in the same period.	097B report	Quarterly, Annually	Program District Sub-County Health Facility	**If low** ⇒ Explore why						
USE											
Proportion of sick children under five who seek care from the iCCM VHT	**Numerator**: Number of sick children under five that sought care from the iCCM VHT **Denominator**: Total under of sick children who sought care from the community and health facility	HMIS 097B HMIS 097B and HMIS 105	Quarterly, Anually	Program District Sub-County Health Facility	**If high**⇒ assess utilization of iCCM services **If low** ⇒assess availability of medicines and Knowledge						
VHT case load	**Numerator:** Number of cases seen by the iCCM VHT in a defined period. **Denominator**: Number of iCCM VHT providers in those areas that reported	097B Report	Quarterly Annually	Program District Sub-County Health Facility	**If high** ⇒ deploy more VHTs **If low** ⇒ access cause to inform action						
QUALITY											

Indicator	Operational Definition	Measurement Method		Application		Baseline	Targets				
		Source	Frequency	Level	Use		20/21	21/22	22/23	23/24	24/25
Targeted VHTs providing iCCM	**Numerator**: Number of VHTs providing iCCM services **Denominator**: Number of VHTs trained to provide iCCM services	097B reports Program report (VHT training database)	Quarterly	Program District Sub-County Health Facility	**If high** ⇒ continue supporting **If Low** ⇒ assess the cause and intensify support supervision						
VHT density (VHTs per 1,000 children under five in target areas)	**Numerator**: Number of VHTs who are trained and deployed (to serve in a specific target area) **Denominator**: Number of children under five in target communities / 1,000	iCCM Deployment Chart at HF	Annual	Program District Sub-County Health Facility	Guide on VHT mapping and deployment						
COVERAGE											
iCCM program coverage for the target population (Availability) (%)	**Numerator**: LC 1 (village or 1,000 people) in a defined area with two or more VHTs proving iCCM services. **Denominator**: Total number of targeted LC1 (village) in the defined area.	iCCM Deployment Chart at HF	Quarterly	Program District Sub-County Health Facility	Compared to plan; **If low** ⇒ explore						
VHTs (with iCCM) Annual Attrition (%)	**Numerator:** number of VHTs lost (stopped working) during the year. **Denominator:** Total number of VHTs who were trained and deployed	Program reports District	Annually	Program District Sub-County Health Facility	**If high** ⇒ Investigate						
Catchment population per iCCM VHT	Total population and estimated number of children under five per iCCM site	Program reports District	Annually	Program District Sub-County Health Facility							
VHT to supervisor ratio	**Numerator** Number of VHTs deployed **Denominator** Number of Trained iCCM supervisors			Program District Health Facility							
Supervision coverage (%)	**Numerator**: number of VHTs in the defined area who were supervised in the last three months **Denominator**: Total number of VHTs in the defined area in the same period	-Supervision Coverage Chart at HF	Quarterly	Program District Health Facility	**If low** ⇒ explore						

Indicator	Operational Definition	Measurement Method		Application		Baseline	Targets				
		Source	Frequency	Level	Use		20/21	21/22	22/23	23/24	24/25
Referral ratio	**Numerator**: number of under 5 (children referred by VHTs in the defined area in last three months. **Denominator**: total number of sick children under 5 with fever and danger signs, TB and HIV exposure, malnutrition seen by the VHT in the defined area in the same period.	VHT Register -VHT referral forms	Quarterly	Program Health facility	Compare with case mix and if inappropriate investigate						
District / HF Reporting level	**Numerator**: Number of Districts/HF submitting complete iCCM/VHT quarterly reports in DHIS2 **Denominator**: Total number of Districts/HF implementing iCCM program in a district in the same quarter	DHIS2	Quarterly	District Program	**If low** ⇒ probe to find the cause of low reporting for improvement	40%					
SERVICE DELIVERY											
iCCM treatment rate	**Numerator**: Number of treatments for children under five provided by iCCM conditions in twelve months in a target area by point of treatment (Community or health facility) **Denominator:** Number of children under 5 in target areas at a given time divided by 1,000.	HMIS UBOS	Annually	Program District Health Facility	**If high** ⇒ Encourage VHTs to continue If low ⇒ Evaluate cause and take action						
Malaria cases are treated appropriately.	**Numerator**: Number children under five assessed with confirmed malaria treated with ACT by the VHT **Denominator:** Number of children under five seen by the VHTs with malaria	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If high**⇒ assess utilization of iCCM services **If low** ⇒assess availability of medicines and Knowledge						
Pneumonia cases are treated appropriately.	**Numerator**: Number children under five assessed with pneumonia/fast breathing treated with Amoxicillin by the VHT **Denominator:** Number of children under five seen by the VHTs with pneumonia/fast breathing	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If high**⇒ assess utilization of iCCM services **If low** ⇒assess availability of medicines and Knowledge						

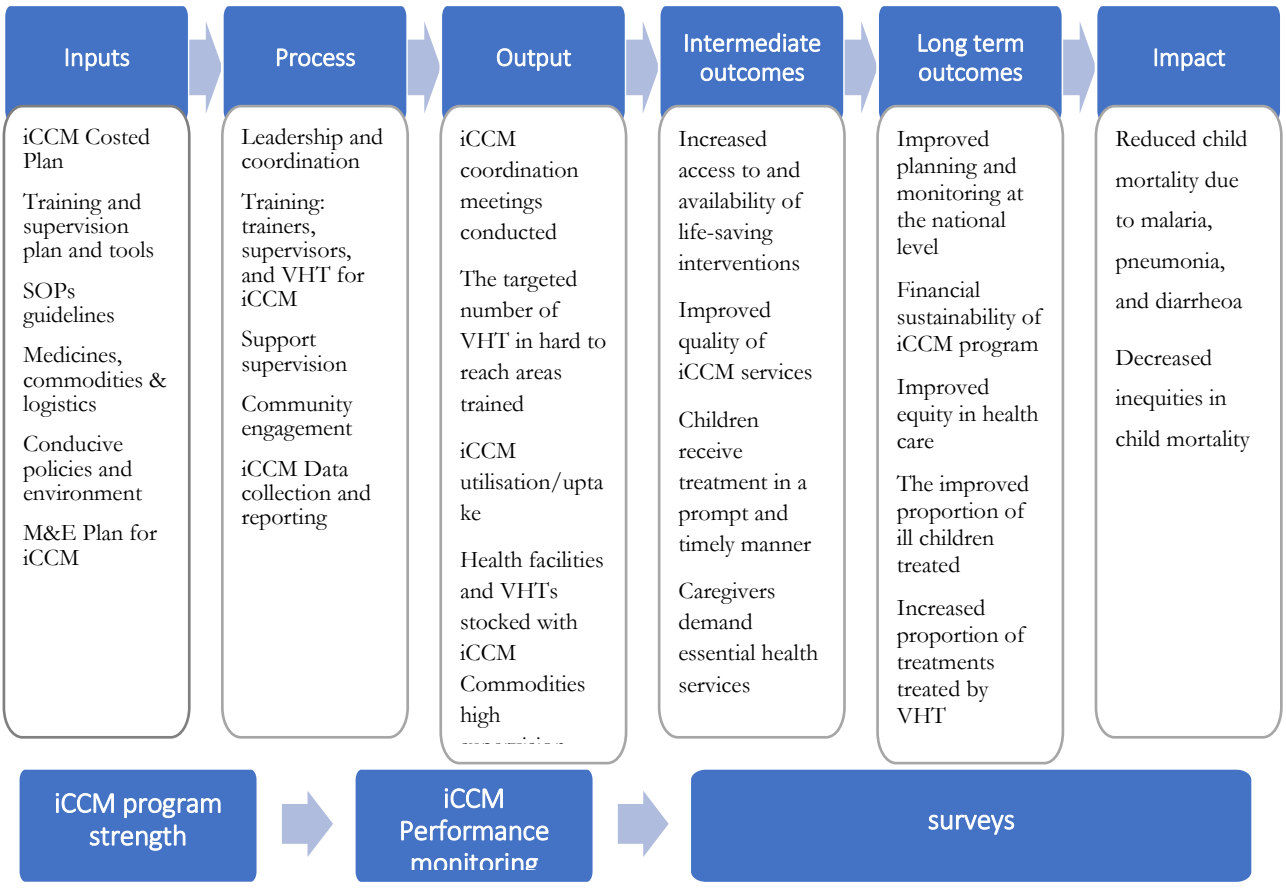
Indicator	Operational Definition	Measurement Method		Application		Baseline	Targets				
		Source	Frequency	Level	Use		20/21	21/22	22/23	23/24	24/25
Diarrhea cases are treated appropriately.	**Numerator**: Number children under five assessed with diarrheoa treated with ORS/Zinc by the VHT **Denominator:** Number of children under five seen by the VHTs with diarrheoa	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If high⇒** assess utilization of iCCM services **If low ⇒**assess availability of medicines and Knowledge						
TB Services	**Numerator**: Number children under five assessed with possible exposure to TB BY the VHT **Denominator:** Number of children under five seen by the VHTs in the review period	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If low ⇒** assess utilization of iCCM services **If high⇒** follow up on referrals at the health facility						
HIV services	**Numerator**: Number children under five assessed with possible exposure to HIV by the VHT **Denominator:** Number of children under five seen by the VHTs in the review period	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If low ⇒** assess utilization of iCCM services **If high⇒** follow up on referrals at the health facility						
Nutrition services	**Numerator**: Number children under five assessed with Red MUAC by the VHT **Denominator:** Number of children under five seen by the VHTs in the review period	HMIS 097B	Quarterly, Anually	Program District Sub-County Health Facility	**If low ⇒** assess utilization of iCCM services						
RDT testing	**Numerator**: Number of fever cases under five years of age presenting to VHT who were tested with RDT **Denominator**: Number of fever cases under five years of age presenting to VHT	HMIS 097B	Quarterly	Program District Health Facility	**If low ⇒** Assess for availability of RDTS						
RDT positivity rate	**Numerator**: Number of fever cases under five years of age presenting to VHT who were tested with RDT and received a positive result **Denominator**: Number of fever cases under five years of age presenting to VHT	HMIS 097B	Quarterly	Program District Health Facility	**If high TPR⇒** Encourage prevention measures at different levels If low ⇒ Maintain						
Medicines Availability											
Availability of ACT	**Numerator**: Number of villages reported with stock out of ACT in the review period **Denominator:** Total number of villages reporting	HMIS 097B	Quarterly	Program District Health Facility	**If high ⇒** maintain also access utilisation of ICCM services If low ⇒ Assess availability at the health facility						
Availability of RDT	**Numerator**: Number of villages reported with stock out of RDT in the review period	HMIS 097B	Quarterly	Program District Health Facility	**If high ⇒** maintain also access utilisation of ICCM services						

Indicator	Operational Definition	Measurement Method		Application		Baseline	Targets				
		Source	Frequency	Level	Use		20/21	21/22	22/23	23/24	24/25
	Denominator: Total number of villages reporting				If low ⇒ Assess availability at the health facility						
Availability of Amoxicillin. Dispersible tablets	**Numerator**: Number of villages reported with stock out of Amoxicillin in the review period **Denominator:** Total number of villages reporting	HMIS 097B	Quarterly	Program District Health Facility	**If high** ⇒ maintain also access utilisation of ICCM services If low ⇒ Assess availability at the health facility						
Availability of ORS/Zinc	**Numerator**: Number of villages reported with stock out of ORS/Zinc in the review period **Denominator:** Total number of villages reporting	HMIS 097B	Quarterly	Program District Health Facility	**If high** ⇒ maintain also access utilisation of ICCM services If low ⇒ Assess availability at the health facility						
Availability of Rectal artesunate	**Numerator**: Number of villages reported with stock out of rectal artesunate in the review period **Denominator:** Total number of villages reporting	HMIS 097B	Quarterly	Program District Health Facility	**If high** ⇒ maintain also access utilisation of ICCM services If low ⇒ Assess availability at the health facility						

7.4 THE M&E FRAMEWORK

Monitoring of the iCCM program will be within the national HMIS and coordinated by the Division of Health Information of the Ministry of Health. This iCCM monitoring framework is thus embedded in the health sector monitoring framework and informed by the needs of the iCCM linked programs and departments within the health sector. The iCCM focal point will support it. The iCCM TWG may form an M&E sub-group (that may have key implementing partners) that links with other programs (Malaria, TB, HIV, and nutrition) at least meet quarterly. The framework uses a logical framework to show the pathways inputs should lead to impact as outlined in the iCCM implementation plan.

Figure 10: Pathway to impact



7.4.1 DATA COLLECTION METHODS AND TIMELINE

The Data sources for iCCM M&E activities will come from several levels: client, program, service environment, population, and geographic levels. The primary iCCM routine data collection tools are shown below. These provide data that are collected continuously, such as information that VHTs collect from the patients utilizing their services. Indicators from these tools are primarily for use by program managers and implementers and will be routinely measured at the community, Health facility, district, and program levels.

- HMIS VHT 001: Referral tool
- HMIS VHT 002: Commodity product issue log
- HMIS VHT 003: Commodity consumption log
- HMIS VHT 004: Summary form for consumption and requisition
- HMIS VHT 005: Magic Calculaton
- HMIS VHT 006: iCCM Register
- HMIS VHT 007: Quarterly household summary
- HMIS VHT 008: Quarterly village summary
- HMIS VHT 009: Quarterly Health Unit VHT iCCM Summary
- HMIS 097b: VHT iCCM Quarterly summary

Table 2: Overview of priority data elements for monitoring program performance by frequency of collection

	Primary Data Source	Frequency
1. Core elements required to generate numerators:		
1.1. Number of VHTs reporting	HMIS 097b	Quarterly
1.2. Number of VHT treatments by condition	HMIS 097b	Quarterly
1.3. Number of children visiting a VHT	HMIS 097b	Quarterly
1.4. Number of health facility treatments by condition	DHIS2	Quarterly
1.5. Number of children referred by VHTs	HMIS VHT 009	Quarterly
1.6. Number of VHTs reporting no stock-outs by commodity	HMIS VHT 004	Quarterly
1.7. Number of VHT supervision visits conducted	HMIS VHT 009	Quarterly
1.8. Number of RDT–tested fevers	HMIS 097b	Quarterly
1.9. Number of RDT+ fevers	HMIS 097b	Quarterly
1.10. Number of treatments for confirmed malaria	HMIS 097b	Quarterly
1.11. Number of treatments for presumptive malaria	HMIS 097b	Quarterly
2. Data elements are captured periodically updated to generate denominators.		
2.1. Number of children U5 overall	UBOS	Annually
2.2. Number of children U5 and in iCCM target areas	District reports	Annually
2.3. Number of expected cases by iCCM condition overall	DHIS 2	Annually
2.4. Number of expected cases by iCCM condition in iCCM target areas	DHIS 2	Annually
2.5. Number of VHTs trained	District registers	Annually
2.6. Number of VHTs trained and deployed to provide iCCM	Training register	Annually
3. Data is captured through household or VHT surveys and special studies.		
3.1. Gender of cases treated.	HMIS 097b	Bi-annually
3.2. Follow–up visits for cases treated by VHTs	HMIS 097b	Bi-annually
3.3. Referral completion and outcomes	LQAS	Annually
3.4. Skills/knowledge of VHTs	HMIS VHT 009	Bi-annually
3.5. Quality of care by provider type	HMIS VHT 009	Bi-annually
3.6. Care–seeking behavior	UDHS, Malaria Indicator Survey (MIS	Bi-annually
3.7. Timeliness of care-seeking/treatment and source of treatment		Bi-annually
3.8. Child deaths (total or by cause)		Bi-annually
3.9. iCCM budget-related items	Costing studies	

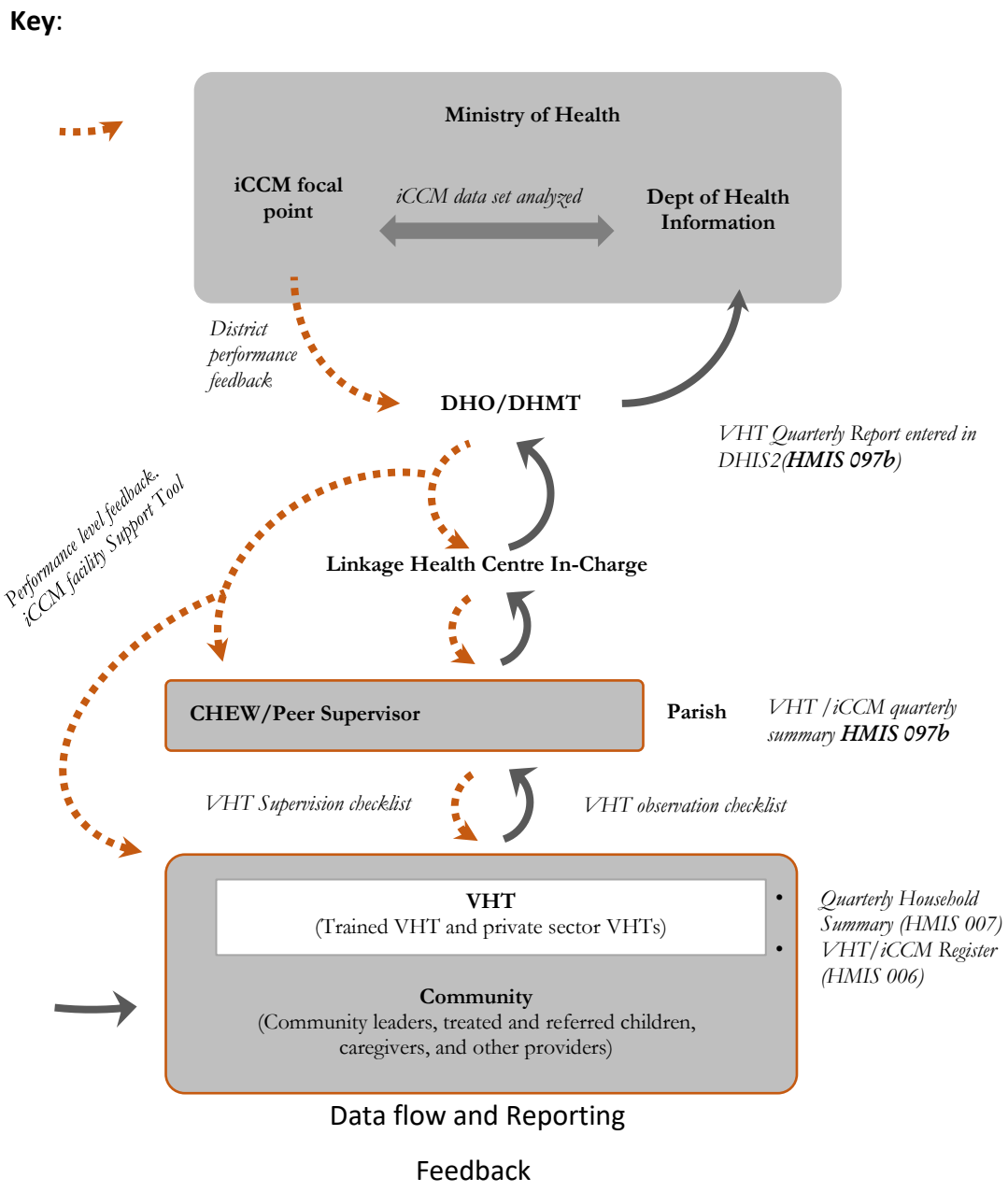
7.4.2 DATA FLOW

a) **The link between iCCM Facility HMIS and district within sector M&E System:** Proper linkages of community-based and health facility-based information systems must be in place. The iCCM focal point at the health facility will link the facility with the VHTs in the public and private sectors. The focal point will have a register and contacts for all VHTs, all CBOs involved in iCCM service provision at the health facility. Through this focal point, data collected in the community will be channelled through the health facility upward to the district.

At the district level, the District Bio-Statistician will enter community VHT/iCCM reports into DHIS2. The district iCCM focal person, together with the biostatistician, will do a quick data quality audit, analyze data to produce district indicators and interpret these indicators for planning and decision making during the monthly DHT and quarterly DHMT meetings, as well as provide monthly feedback to reporting health facilities and subsequently from the health facilities to VHTs and down to the community. This is expected to improve facility and community linkages.

Recording: VHTs use standardized reporting tools to record various data elements, disaggregated by age and sex, including births, deaths, disease intervention vaccinations, FP, home deliveries, and sanitation. They also maintain a village map to track where clients live and use this to identify vulnerable populations.

Figure 11: iCCM Data Flow diagram



VHTs consolidate data into a summary form every quarter and submit it to the peer VHT supervisor at the parish level, who submits it to the health facility they are linked to. The data from the different parishes served by that health facility is further aggregated into one community report (HMIS 097B) and sent to the district for entry into DHIS2. Health units at all levels of the system review data from the lower health facilities and use it to address problems to improve health services delivery. Grey arrows represent the flow of data through Uganda's health system in the Figure above.

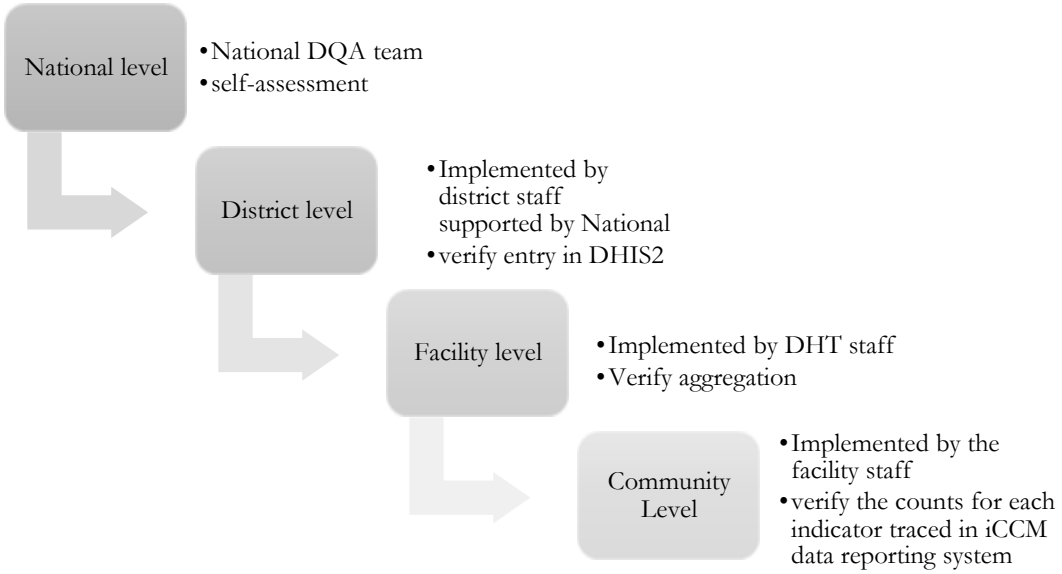
7.4.3 DATA USE

The term "data" refers to raw, unprocessed information, while "information," or "strategic information," usually refers to processed data or data presented in some context and is ready for use. Collecting data is

only meaningful and worthwhile if used for evidence-based decision-making from community to national levels. To be useful, information must be based on quality data, and it also must be communicated effectively to policymakers and other interested stakeholders. The iCCM M&E data thus needs to be manageable and timely, reliable, and specific to the activities in question, and the results need to be well understood. The key to effective iCCM data use involves linking the data to the decisions that need to be made and those making these decisions.

7.4.4 DATA QUALITY CHECKS

Good data should fulfill the data quality elements that include but are not limited to completeness, timeliness, reliability, accuracy, and integrity. The country still has community data management gaps, such as poor reporting rates and inadequate routine mechanisms to assess data quality and correct identified errors. The data quality checks will track VHT/iCCM data recorded by all VHTs who report to respective facilities. It will also help to check for community data flaws through the HMIS reporting system.



The audits will determine the availability, completeness, reliability, consistency, timeliness, and accuracy of data elements at all levels of care. If aggregation occurs at the parish level by VHT supervisors, this level will also be included. It will be performed by staff at the district and national level every quarter to assess data recorded by VHTs as data flows through the iCCM data reporting system to the central HMIS. It will also assess the iCCM data collection, reporting, and management system. The iCCM data review will be integrated into the district and national level quality assessment.

7.4.5 ANALYSIS AND DISAGGREGATION

Once all of the data has been collected and entered in the DHIS2, the district iCCM focal person and the district biostatistician will compile and analyze it to fill in a results table for internal review and give feedback to linked facilities and all key stakeholders, inclusive of the beneficiary community. Disaggregation of routine data will take place at the national, district, facility, and community levels to include:

- Reviewing trends over time to assess the implementation of the various components of the iCCM program at the different levels against set targets.
- Analyzing treatment data for each iCCM condition individually
- Comparing the number of cases treated to the expected number of cases
- Disaggregate treatments by point of service (community and health facility).

7.4.6 DISSEMINATION AND REPORTING

Translating data into action is the ultimate goal of iCCM M&E efforts. Data pertinent to iCCM will be translated, packaged, and disseminated into relevant information for decision-making by different key stakeholders. The timing of dissemination will fit into the existing health sector, programmatic and local government reporting, and review cycles. Internal dissemination of M&E reports will be used to inform

iCCM stakeholders about the success and progress of the program. The data will help national, district, facility, and private sector players make modifications for effective program implementation.

Table 3: Reporting Timeframes and Responsibility Centres

REPORT TITLE	Date due
National	
Annual iCCM plan	June 30
Monthly Activity Reports	Monthly
HMIS Updates	Quarterly
Quarterly MCH TWG Reports	Quarterly
Annual iCCM performance Report	Sept 31
Quarterly iCCM HMIS reports	Monthly
Progress of Implementation of iCCM resolutions	Quarterly
Routine feedback reports to reporting entities	Quarterly
Progress of implementation of strategy	Quarterly
Meeting Minutes	PRN
iCCM PSM report	Quarterly
Research Agenda/ Operational Research Reports	Bi-annual
Map of National Partner Profiles	Quarterly
Quarterly iCCM Statistical Report	Quarterly
Rapid iCCM Data Quality Assessment Reports	Quarterly

External dissemination will advocate and mobilize support for coordinated iCCM action by stakeholders and donors outside the health sector at all levels. The Key M&E products are shown below.

Table 4: iCCM Strategic Plan Review Time frame

Report	When	Output	Focus	Level of monitoring and review
Progress reports	Monthly	Monthly progress report at district and national level	• Key activities reviewed against targets and planned activities in annual work plans	Process
Program Performance Assessment	Quarterly	Quarterly progress reports; transmitted to next higher level of supervision	• Done for Joint (public + private) iCCM Team • Recommendation Implementation Tracking report	Inputs, process, output
iCCM TWG Review meeting report	Quarterly	Progress report on iCCM activities submitted to all Partners	• Done by iCCM TWG and feed partner reports into one report • A review of progress against targets and planned activities.	Inputs, process, output
Joint RMNCAH review	Annually	Annual progress reports	• Done Jointly with Partner, key stakeholders, and planning entities from sub-district level onwards. • Review progress and evaluate recommendations, agreed follow-up actions, and status of these actions	Input, process, output, and outcome levels

7.4.7 THE MECHANISM FOR UPDATING THE PLAN

The M&E plan for iCCM will be updated regularly and reviewed every two years. The M&E sub-group of the National iCCM TWG will be responsible for bringing MOH and implementing partners together to share data, update the indicator matrix with available data, revise and refine indicators and M&E

activities, and workplan as needed. This M&E Action plan will be reviewed and updated under the leadership of the iCCM TWG.

7.4.8 M&E WORKPLAN

Activity	Timeline (Yrs)					Who	Collaborating agencies	Expected outcome	Key Assumptions
	1	2	3	4	5				
1. Presentation of iCCM M&E plan to the iCCM steering committee and SMEOR for approval	x					iCCM TWG	Partners	Approved plan	TWG meetings held buy-in from all stakeholders
2. Disseminate iCCM M&E implementation guide	x					iCCM TWG	Partners	Uniform implementation of M&E plan	Districts and facilities have the implementation capacity
3. Procurement of 2 Computers & accessories	x					iCCM TWG	Non	Computers & accessories procured	
4. Quarterly validation of routine data with other data sources	x	x	x	x	x	iCCM TWG	Partners	Validated data used in analysis and reporting	
5. Training of district bio-statisticians and iCCM focal points in iCCM M &E & Data use	x		x		x	iCCM TWG	Non	Improved data collection & management	Districts have data managers
6. Expanding mTRAC system to capture community data		x	x	x	x		Partners	Weekly - reporting	HMIS is ready to support newly introduced technologies
7. Production / dissemination of Quarterly & Annual iCCM reports	x	x	x	x	x	iCCM TWG	Partners	Quarterly and annual M&E reports disseminated	Stakeholders attend meetings
8. Quarterly district coordination and review meetings	x	x	x	x	x	iCCM TWG	LG IPs	Improved coordination	Stakeholders attend meetings
9. Quarterly supervision by Centre	x	x	x	x	x	iCCM TWG	IPs	Improved M&E planning and implementation	
10. Monthly supervision by Centre	x	x	x	x	x	iCCM TWG	IPs	Improved M&E planning and implementation	
11. Conducting baseline, annual, mid-and end evaluation			x			iCCM TWG	IPs	Improved implementation of M&E plan	The protocol developed and shared
12. Conducting data quality audits (DQA)	x	x	x	x	x	iCCM TWG	DHI	Improved Data quality	Incorporated in DHI
13. Short-term M&E Technical Assistance			x			iCCM TWG	IPs	TA procured	

7.5 KEY AREAS OF OPERATIONAL RESEARCH

Operational research for iCCM will be embedded in the community, District Health, and National Plans. Research findings will be effectively disseminated to relevant stakeholders for decision-making, planning, and problem-solving at the service delivery points. The iCCM steering committee will approve the research agenda.

A. VHTs

1. What are other roles that community-based health workers can play apart from managing the top killers, such as community-based surveillance, immunization, management of cholera, and preparing families for emergencies/outbreaks?
2. What are the best ways to improve and sustain the performance of VHTs?
3. What are the costs and performance of different training methods for (illiterate/literate) VHTs?
4. What is the optimal number of VHTs to give near-universal coverage to a given geographic area?
5. Which factors reduce attrition?
6. Which methods of remuneration/incentivization are effective and sustainable?
7. How can mobile telecommunication technology (mHealth) improve the quality of care and supervision of VHTs?

B. Implementation

1. What is the role of community monitoring and local accountability in iCCM implementation?
2. How can the private sector become involved in delivering iCCM, and what role can iCCM play in improving the quality of care in the private and informal sectors?
3. What are the health system effects of iCCM on referral patterns to and caseload and case mix at first-level health facilities?
4. How best can iCCM be implemented in emergency settings?

C. Management of illness

5. Can mHealth applications play a role in improving the adherence of VHTs to clinical diagnostic and treatment algorithms?
6. What treatment options are effective and safe in settings where referral is not possible?
7. What are the elements that facilitate family members to use CCM services?
8. Do family members follow treatment recommendations properly?
9. How can timely referral completion be facilitated for severely ill children?
10. Can mHealth applications be used to help family members recognize the disease, seek care, and adhere to treatment recommendations?
11. How does the prescription of multiple medicines for multiple diseases (e.g., malaria and pneumonia) impact adherence?
12. What key Knowledge and tools can be provided by VHTs to families so they can care for themselves at home in the event of an emergency (home care) if services are not accessible? How can families be best prepared for emergencies and outbreaks?

D. Impact

1. What is the impact of iCCM?
2. Does iCCM lead to increased penetration in terms of reaching the poor? (effective coverage)

8 SUMMARY OF ROLES AND RESPONSIBILITIES

	National level	District	Health Facility Level	Community
Leadership	• Monthly iCCM TWG meetings • Budget and plan for supervision, including transport, refresher training, and incentives • Data analysis and Reviews	• Quarterly review meetings Bottom-up iCCM planning • District weekly iCCM meetings • iCCM presentation in DHMT meeting	• Microplanning (Catchment area actions plans) • mapping village U5 population density and access for logistics and supply management. • VHT replacement guidance	• Selection of the VHT • Replacement of VHT
Advocacy, sensitization, and mobilization	• Develop and disseminate policy briefs, iCCM profiles, and messages • Partner and Districts sensitization, assessment, training plan • Formalizing Certification of iCCM Trainees • Guidelines aligned to national policies and available to VHT, health staff, and community. • Resource mobilisation	• Prioritize and own iCCM • Sensitization workshops for sub-County leaders and technical planning committees • Facilitate quarterly district iCCM stakeholder review meetings • Strengthen coordination and linkages with other stakeholders/ organizations/ departments • Promote Public-Private Partnerships in iCCM and accredit credible implementors	• Communication on awareness and importance of iCCM in outreach, patient visits • Disseminate the location of VHTs in the communities • Mobilize community resources to support/sustain iCCM activities, volunteerism, and providers	• monthly meetings of parish VHT for peer support • communities for iCCM sensitization meetings • Identify 2 VHT for iCCM • Six monthly village iCCM planning and review meetings • Provide information on iCCM to the community and the household
Service delivery	• National criteria for hard to reach	• facilitated referral system and referrals recorded. • Post-referral follow-up visits by VHT • The counter referral system is available to the health center for severe or chronic cases. •	• referral and counter-referral between VHTs and health facilities should be strengthened; orientation of all health workers at the facility • Strengthen community linkages and networking for especially OVC • Receiving facility well-stocked, sufficient staff trained in IMNCI and inpatient facilities	• mHealth to support consultation workflows, patient histories, and information on households. • VHTs have commodities to facilitate their work. • Timely reporting
Training incentives and retention	• Update and standardize basic iCCM training materials4 • Reorient national-level master trainers and supervisors in a 6-day training course • Train 6 district trainers/ supervisors per district • Institutionalising VHT • Maintain all training records.	• Develop district iCCM roll out plan • 3-day refresher training for health workers at high volume HC III-II, IV • Provide iCCM training to implementers, public and private VHT, and care providers.	• At least HWs trained on iCCM in a standard 6-day course. • Provide technical support to CBOs involved in iCCM • Training VHT	• At least 2 VHT per targeted village trained and certified by DHO for proper - Application of iCCM job aid - Filling of VHT registers and reporting - financial and Non-financial incentives like t-shirts, raincoats, umbrellas - Certificates.

[4] Facilitators Guide, iCCM video script, Sick Child Job Aid, VHT/iCCM Register, Community supply chain tools (Daily consumption log, summary form for consumption and requisition, magic calculator, product issue log), Sample medicines for iCCM, revised HMIS summary forms,

	National level	District	Health Facility Level	Community
				- Communities mobilisation for iCCM • Use RBF strategy.
Medicine and Commodity Supply Management for iCCM Public sector	• iCCM commodities included in credit line vote 116 • Ensure national buffer stocks at NMS • Move towards integrating iCCM kit in facility kits • Pooling iCCM procurement and distribution systems	• iCCM commodities in district procurement plan submitted to NMS • Forecasting and stocking districts buffer stocks • iCCM commodities distributed in the EMHS system • commodities redistributed to the respective health facilities	• Public sector iCCM commodities forecasting and ordering combined within the facility supply system • Quantification, order, and timely replenishment of VHT stocks based on consumption rates in the VHT register • Track and report adverse reactions to district • Ensure availability of IMNCI medicines	• Inventory management including re-ordering system to avoid stock-outs • Collect medicines regularly from their supervising health facility • Proper storage • Keeping updated VHT register • Reporting adverse reaction
Support Supervision and quality assurance	• Integrate iCCM in sector and department/technical SS strategies, guidelines, and activities • A pool of Master trainers/supervisors for optimal ratio of supervisors to the district. • Introduce mobile technology to monitor VHT performance and obtain accurate, timely information about cases and necessary supplies • Developing and disseminating the guidelines for support supervision	• Incorporate iCCM SS in district Quarterly technical supervision • SS to private sector iCCM (VHT/drug shops and clinics) • Update iCCM Worker Supervision Coverage Chart • the pool of trained district supervisors to ensure an optimal ratio of supervisors to Health facility. • community-level quality improvement (QI) collaboratives within districts	• Designated supervisors at the health facility • Conduct quarterly VHT meetings with representation from LC1 and HUMC • Conduct monthly one on one home visit SS to VHT using supervisor's Check-list and supervisor's summary form • Submit supervisor's summary form to DHO • Replenish VHW stocks as needed • Orient all staff to support the VHTs	• Supervision of VHTs by the parish coordinators. • Follow up of referred cases.
Monitoring, Evaluation, and Research	• Monitoring national iCCM implementation • Standardize registers and reporting documents • Conduct an iCCM survey every two years • Review Key Performance Indicators • Document and disseminate iCCM research agenda and convene a national research task force • Harmonize recording and reporting systems of health facilities and VHTs. • Use the data to improve programming	• Monitoring district iCCM implementation • Integrate iCCM monitoring in district M&E • Quarterly update of VHT coverage map • Establishing district iCCM referral and networking systems • Calculate, analyze and report on district iCCM indicators	• Use chart modification from HMIS forms 109 and 122 to chart all the names of the VHTs providing iCCM in each village • Provide feedback immediately and during the quarterly review meetings • iCCM data inclusion in DHIS2. • Calculate, analyze, and report facility and village level iCCM indicators	• Submit accurate, timely, and complete data.
Quality Assurance and Quality Control	• A national trainer should supervise all training. • Ministry of Health should ensure that MoUs are strictly adhered to. • Government should ensure that policies are adhered to.	• quality improvement collaboratives	• Continuous quality improvement •	• Continuous quality improvement • Feedback from community on facility referral

8.1 KEY ROLES

8.1.1 NATIONAL LEVEL

a) **Country-level Leadership:** The steering committee should convene and coordinate a unified iCCM framework and tools that reflect national ownership and guide country-led implementation processes. It will be the mechanism for common national iCCM policy dialogue, regulation, awareness building, consensus building, partner harmonization, and information sharing platform for national iCCM programming. Other core roles are
   - Articulate iCCM policies: set national iCCM norms and standards, shape the iCCM research agenda and monitor the national iCCM related policies and programs.
   - Strengthen the public-private partnership mechanism for iCCM at all levels.
   - Expand iCCM partnerships among all relevant stakeholders within the country, and across all sectors, including Ministries, Departments, and Agencies, civil society, multilateral and bilateral agencies, the private sector, business community, etc., where all members have an equal voice.
   - Advocate to increase access and quality of iCCM services for areas with limited access to facility-based child treatment services.
   - Mutual accountability of commitments made by individual partners for each iCCM benchmark.

b) **Planning, costing, and financing:** Ensure that the country has a current costed plan that shows the necessary resources to implement it and has secured funding. All partner and subnational activities aimed to support the implementation of iCCM should be harmonized according to the national scale-up plan.

c) **Human resources:** Stipulate clear and well-articulated roles and responsibilities for partners, private sector, district, Facility, VHTs, and communities in the iCCM management, support, and delivery. The core iCCM human resource mix, numbers, motivation, and retention will be determined and a comprehensive, basic, and refresher training plan implemented. Adequate in-country technical support for capacity building and support tools should be developed.

d) **Supply chain management:** Ensure that iCCM commodities are embedded in the national essential medicines list; integrated into existing national quantification, procurement, supply chain to the "last mile," inventory control, resupply, and logistics management information system (LMIS).

e) **Service delivery and referral:** Develop and disseminate appropriate case management guidelines, including plans for rational use of iCCM commodities; and referral and counter-referral system for iCCM. Integrate iCCM within existing quality improvement processes.

f) **Communication and social mobilization**: The TWG shall develop and use a communication and social mobilization plan and strategy and materials and messages for iCCM. The plan should also guide reporting and information flow to promote iCCM service demand, utilization, and feedback on iCCM management and service delivery quality in the country.

g) **Supervision and performance quality assurance:** The TWG will update appropriate tools to support adequate supervision for districts.

h) **Monitoring and evaluation and health information systems:** The TWG shall support the collection of quality iCCM data within the national HMIS, analysis of performance and impact, dissemination of iCCM reports to targeted audiences, and use of data for decision making. Identify best practices to scale up, identify iCCM targets at all levels and across partners, and develop operational research agenda for the program.

8.1.2 DISTRICT HEALTH TEAM

a) **Leadership**: The district will provide stewardship and coordination of iCCM implementation by stakeholders, including the private sector, guided by this guideline and approved tools. Districts will embed iCCM mentorship and support supervision within their districts plans; medicines and commodities within their procurement plans as part of the community and health facility activities. Awareness building and mobilization of local councils and other sectors to create Demand and utilization of iCCM services.

b) **Human Resource:** The district shall select a team of district trainers whom the national trainers will train and, after that, cascade training of health workers (VHT supervisors) responsible for training, supervision, and mentorship of the VHTs in the public and private sector. The district will establish and

update VHTs within the VHT registry to support selection, training, and retention. District context-specific incentives to motivate key actors, including facility managers, supervisors, VHTs, and the community, should be sought.

c) **Reporting and Data:** The district should quantify community HMIS tools. Ensure timely and complete reporting of community-level data/information (097b report) and reporting through HMIS into DHIS2. District to ensure community reporting is integrated into district performance reviews and feedback loops from health facilities to VHTs and communities should be established.
d) **Services**: Ensure adherence to national policies and iCCM referral protocols across the continuum of care and develop functional community/facility linkages. Regularly assess all targeted health facilities and their referral units to ensure quality and continuity of care between iCCM and IMNCI.
e) **Quality:** integrate iCCM in the facility and VHT supervision using quality audits, coaching, and mentorship mechanisms to enhance adequate coverage and quality of iCCM service delivery. Facilitate learning across communities (village to village, Facility to Facility) to promote and scale up best practices in iCCM
f) **Procurement and Supplies management:** iCCM commodities should be integrated into existing district quantification, procurement, supply chain to the "last mile," inventory control, resupply, and logistics management information system (LMIS). Standard operating procedures and tools should be adhered to to support sustainable supply chain management. The district will facilitate and monitor safe quality management, stocking, distribution- issuing and redistribution, reporting, and monitor adherence across the supply chain at all levels. In addition, the district should supervise the private sector partners to ensure adherence to the NDA guidelines.

8.1.3 HC IV/HSD Health Team

a) **Form iCCM stakeholder forums at the county.** It will embed iCCM supervision, supplies, and commodities within facility plans and budgets as part of the community health activities for each facility. Awareness building and mobilization of sub-county councils and other sectors to support iCCM services will be critical.
b) Conduct **integrated supportive supervision** at health center III
c) Ensure the **availability of appropriate IMNCI capacity at iCCM referral facilities** in the HSD
d) **Integrate iCCM in the facility and VHT supervision** using quality audits, coaching, and mentorship mechanisms to enhance effective coverage and quality of iCCM service delivery. Facilitate learning across communities (village to village, Facility to Facility) to promote and scale up best practices in iCCM
e) Provide **training, technical support and conduct capacity building activities** for VHT in iCCM and health center III staff in IMNCI
f) Establish and **update VHTs within the VHT registry** to support selection, training, and retention.
g) Utilize **existing quantification, forecasting, procurement, and supply chain** through to the "last mile" for iCCM commodities and establish sustainable long-term plans for their management

8.1.4 HC III & II

a) HC III & HC II is mainly responsible for the implementation and follow-up of the iCCM packages. Every iCCM activity carried out at the HC II level should be considered one major HC III service area.
b) All HC III & HC II collect, compile, and prepare periodic reports from and submit to the District health office and sub-county local government and provide feedback loops to lower health facilities, VHTs, and communities.
c) Plan, coordinate and monitor the iCCM program and evaluate its implementation at sub-county.
d) Identify skill gaps in VHT iCCM services, plan and provide on job capacity building.
e) Assign a staff from the health center III to cover VHT iCCM activities without the community health extension worker.
f) Support the preparation of the iCCM annual plan

g) Organize regular review meetings on VHT iCCM performance
h) Ensure the implementation of the iCCM packages as per the guideline.
i) Organize and conduct regular community satisfaction surveys.
j) Conduct integrated supportive supervision at health center II and community level.
k) Ensure appropriate resources are allocated to health center II and assure appropriate utilization.
l) Coordinate with sub-county local government on iCCM support
m) Collect, compile and prepare periodic reports and submit to the Health center IV and sub-county local government

8.1.5 iCCM Supervisor

a) Document periodic plans of VHT under his/her supervision;
b) Follow progress on the implementation of the iCCM activities during regular supervision
c) Provide onsite technical support and address any challenges and report any unaddressed issue to the higher authorities along the political and technical lines
d) Make random home visits to observe changes, identify problems, listen to community member reflections, and discuss iCCM related issues
e) Work closely with LC I and parish chairpersons in supporting the VHT
f) Receive monthly reports, compile and submit to the HC III in charge
g) Attend monthly VHT meetings at the sub-county level and provide inputs to consolidate the iCCM program
h) Participate in the performance evaluation of individual VHT within his/her catchment
i) Carry out periodic support supervision of the VHT
j) Plan and implement monthly or quarterly supervision of VHT;
k) Review VHT register and cross-check drug inventory to ensure that drugs are replenished regularly
l) Observe case management, if possible, or administer one or more case scenarios in proper sequence; provide performance feedback in a constructive way and provide extra coaching for those who need it
m) Complete supervisory checklist and aggregate iCCM workers' activities on the relevant form
n) Liaise with community leaders to solve any problems

8.2 Terms of Reference for iCCM VHTs

Any person serving as an iCCM service provider under the National iCCM program is expected to fulfill the following roles and responsibilities:

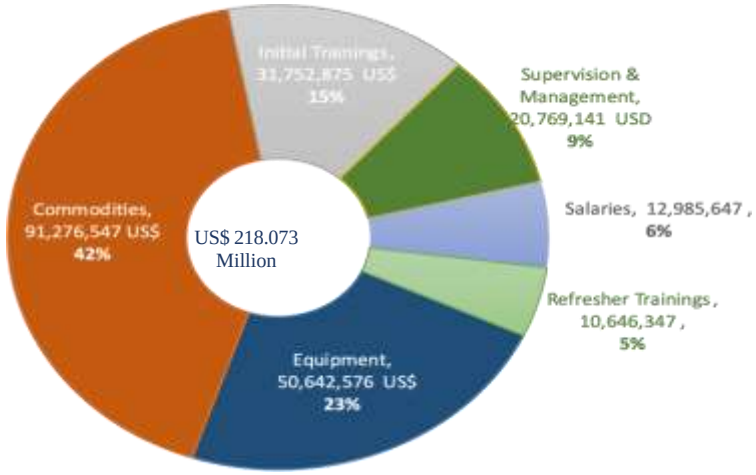
a) Actively participate in and potentially lead community mobilization and engagement for health. This includes participation in key community and national health campaigns to prevent malaria, diarrheoa, pneumonia, malnutrition, and newborn illnesses.
b) Apply interpersonal communication skills to reinforce key healthy behaviors and practices for families and households, including early care-seeking.
c) Assess the health situation of households, including availability, use, and practice of healthy behaviors, and identify gaps.
d) Conduct dialogues with families and communities, help identify solutions to address needs and monitor and support implementing such solutions.
e) Receive, assess and treat children ages 2 to 59 months with uncomplicated pneumonia, diarrheoa, or malaria
    - Plus: Identification and treatment of malaria (using rapid diagnostic testing) in older children and adults (entire population /over-fives)
    - Plus: Identification and provision of ORS for over-fives with diarrheoa and refer to the health facility.
f) Provide follow-up care for patients who are on treatment.
g) Ensure prompt referral of life-threatening cases and conditions and beyond their mandate for management at health facilities.

h) Screen children 6–59 months for moderate acute malnutrition (MAM) and severe acute malnutrition (SAM) through the use of mid-upper arm circumference [MUAC] measurement and refer to health facility observing correct referral protocols.
i) Conduct three postnatal home visits for both the mother and the baby on the 1st, 3rd, and 7th day after delivery to educate and counsel the mother and her family/spouse on recommended hygiene practices, essential newborn care practices, infant and young child feeding, immunization, danger signs for mothers and newborn.
j) Screen newborn and postnatal mothers for danger signs and promptly refer if identified.
k) Provide ongoing counseling on recommended IYCF practices to caregivers.
l) Attend monthly or quarterly meetings at the supervising facility
m) Ensure good stock management practices and meet expected accountability and reporting requirements for medicines and health supplies handled to execute their duties.
n) Report monthly to the designated supervisor using designated reporting tools as required
o) Submit reports on time to the parish coordinator or the supervising health facility in charge (monthly and more frequently for notifiable diseases)

9 Costing of iCCM implementation

Total Cost of Scaling up iCCM Implementation in Uganda

While the iCCM program offers a strong ROI, as demonstrated in section 1.4 of the investment case, national scale-up in Uganda has been generally hampered by many challenges, of which lack of clear costing information is among the most significant. Using the CHPCT, the total costs for scaling up and institutionalizing iCCM in Uganda by 2026 is approximately US$ 218.07 million, of which US$ 215.17 million is recurrent, and US$ 2.91 million is startup. The recurrent costs are repeated on an ongoing basis and, in this costing, include medicines and supplies, salaries, equipment, management, supervision and, training (initial/replacement and refresher). Startup costs include one-time expenses over the five years, such as procurement of HMIS materials and program assessment.



Annual Costs in US$ '000 for iCCM Scale-up 2021/2 -2025/6, Uganda

iCCM Program Component	iCCM Need, Financing Committed, and Gap by Year (US$ '000)																	
	2021			2022			2023			2024			2025			2026		
	Need	Financing Committed	Financing Gap	Need	Financing Committed	Financing Gap	Need	Financing Committed	Financing Gap	Need	Financing Committed	FinancingGap	Need	Financing Committed	FinancingGap	Need	Financing Committed	Financing Gap
VHT Salaries	839	365	474	968	365	603	1,321	365	957	1,396	346	1,050	1,675	346	1,329	1,861	346	1,515
VHT Equipment	1,623	723	900	5,535	275	5,260	9,454	268	9,186	7,232	261	6,970	14,270	261	14,009	11,814	261	11,553
Medicines and supplies	5,678	4,361	1,317	8,162	6,398	1,764	11,250	6,922	4,327	15,022	2,229	12,794	22,801	4,074	18,726	28,364	6,099	22,265
Supervision Salaries	360	360	-	707	707	-	749	749	-	901	901	-	982	982	-	1,087	1,087	-
Supervision Equipment	-	10	(10)	-	1	(1)	87	-	87	256	-	256	161	-	161	207	-	207
Supervision Visits	751	524	226	1,206	854	352	1,320	906	414	1,641	-	1,641	1,847	-	1,847	2,111	-	2,111
Recurrent Training (VHTs)	2,244	462	1,782	633	1,994	(1,361)	-	415	(415)	4,765	406	4,359	-	406	(406)	1,411	406	1,005
Recurrent Training (S'or)	366	235	132	-	172	(172)	-	-	-	956	-	956	-	-	-	-	-	-
Recurrent Training (M'ger)	98	46	53	-	41	(41)	-	-	-	172	-	172	-	-	-	-	-	-
Management Salaries	17	17	-	21	21	-	22	22	-	25	25	-	27	27	-	29	29	-
Management Equipment	-	-	-	2	-	2	2	-	2	-	-	-	-	-	-	-	-	-
Management Meetings	277	2,311	(2,035)	437	3,000	(2,563)	458	3,000	(2,542)	543	-	543	585	-	585	640	-	640
Other Recurrent Costs	523	315	208	821	440	381	898	488	410	1,116	-	1,116	1,256	-	1,256	1,435	-	1,435
Initial Training (VHTs)	-	169	(169)	3,081	169	2,912	5,467	169	5,297	3,575	169	3,406	5,994	169	5,825	5,721	169	5,552
Initial Training (S'visors)	-	-	-	2,321	-	2,321	497	-	497	1,384	-	1,384	897	-	897	1,144	-	1,144
Initial Training (Managers)	45	-	45	250	-	250	258	-	258	335	-	335	364	-	364	419	-	419
Startup Costs	98	1,243	(1,145)	2,222	-	2,222	586	-	586	-	-	-	-	-	-	-	-	-
Capital Costs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	12,919	11,141	1,778	26,365	14,436	11,928	32,367	13,304	19,063	39,320	4,339	34,981	50,859	6,267	44,592	56,244	8,399	47,845

Tool Kit

Annex 1: National and District Stakeholders Mapping Guide

Steps to fill the Stakeholder Matrix

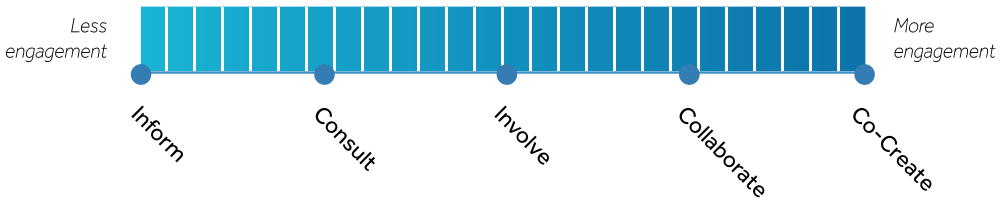
A. Identify key stakeholders in iCCM service delivery
List everyone/agency who may be interested in the current iCCM objectives now and potentially in the future. It may not be practical or necessary to engage with all stakeholder groups with the same level of intensity all of the time. This list is likely to change over time.

B. Map the relationships between objectives and other stakeholder roles,
Consider how each identified stakeholder in (A) may contribute to helping to achieve the iCCM Benchmark component.

C. Analyze stakeholder perspectives, interests, roles, and engagement in iCCM implementation.
Consider: What is the stakeholder's primary contribution towards iCCM? What is the desired outcome of their efforts? What motivates their work? What is their capacity to engage implementation? Are they supportive or critical of the iCCM proposed implementation process?

D. Prioritizing stakeholder engagement should be directly informed by an analysis of stakeholders.
Those with a high level of influence may be prioritized to engage with at the outset of the implementation process. All stakeholders contribute to implementing the iCCM; however, it is important to consider the level (see the spectrum in Figure below) and the phase they should be engaged.

SPECTRUM OF ENGAGEMENT KEY



Inform – provide information

Consult – to obtain feedback

Involve – to ensure that concerns are consistently understood and considered

Collaborative – to partner in each aspect of decision-making

Co-Create – to empower to make decisions

Stakeholder Matrix

Component	Key Partner. (A)	level of influence (B)	Priority of engagement and activities (C)	Role and type of engagement and location (D)
Policy and coordination	*UN (UNICEF, WHO, UNAIDS)*	*High*	*Important (Inform, consult, collaborate, …*	*Leading the process Continuous engagement Feedback Loop*
Costing and finance				
Human resources				
Supply chain management				
Service Delivery and referral				
Communication and Social Mobilization				
Supervision & Performance Quality Assurance				
M & E and Health Information Systems				
Other				

Annex 2: Plan-Do-Study-Act (PDSA) Cycle TOOL to Implement iCCM

Rapid-cycle problem solving is a method advocated for the MoH to facilitate quick, incremental improvements and solve urgent problems as a new process is being implemented – for example, implementing revised iCCM guidelines. It is a technique that helps the managing and implementing people become comfortable with just "enough" planning to avoid the expectation of having a new process be "perfect" before it is implemented. That is, a new set of practices or a new program must get started to get better. Careful and quick attention by the people involved, and the use of a "Plan, Do, Study, Act" process (described below) helps avoid letting implementation problems get worse and helps prevent abandoning new ways of work in place of familiar but less effective practices. A "Plan, Do, Study, Act Cycle" is a step-wise, cyclic way to make improvements and changes in a system to facilitate delivery of iCCM scale-up, implementation, sustainability, and impact

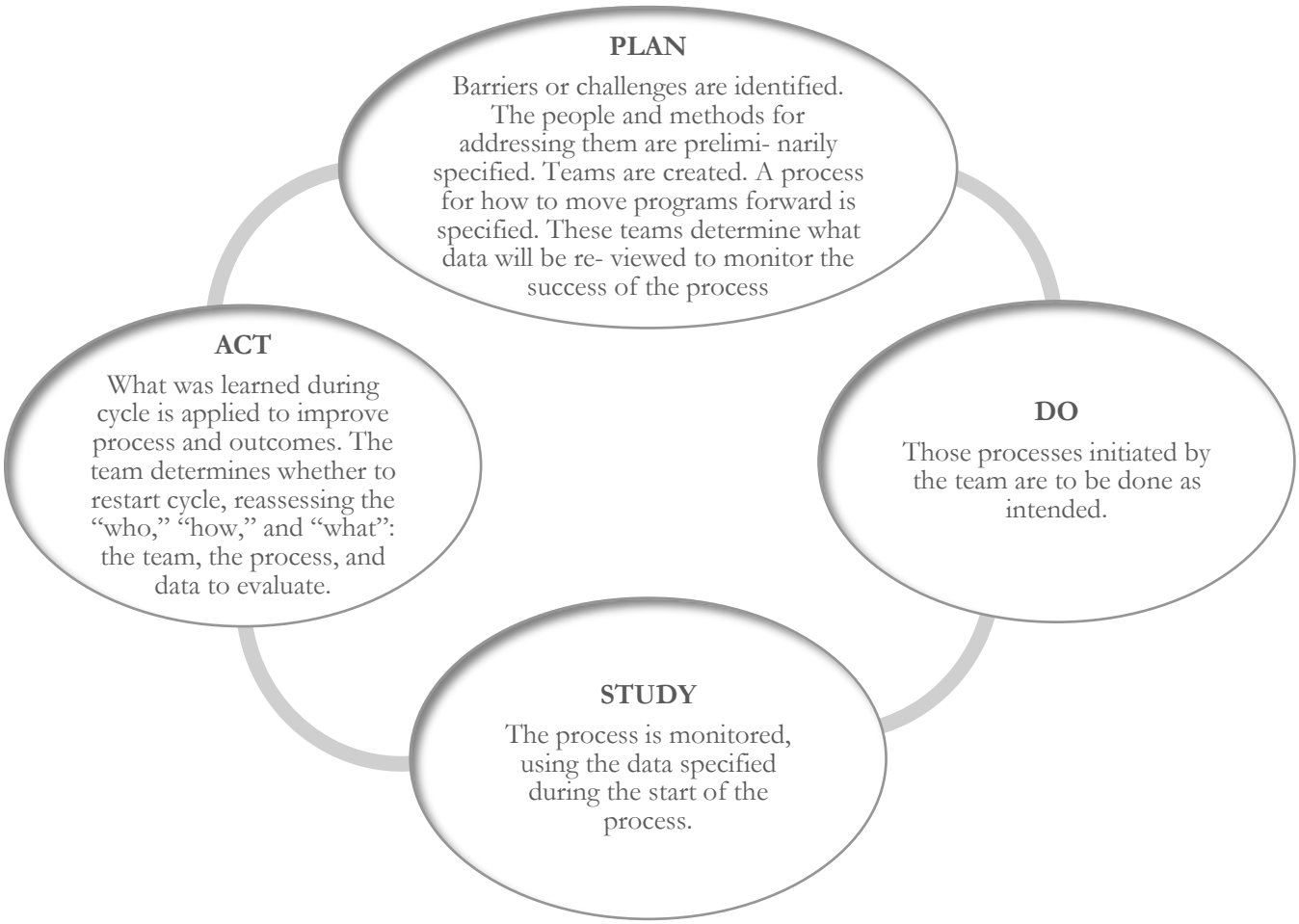
Who: Rapid-cycle problem solving needs a team of people

- Identify a leader who will take responsibility for pulling together a team, organizing the process, and following the process through to a conclusion.
- Who else should be on the team? These should be people with a stake in the outcome, expertise, and information relevant to the problem, and the authority to make necessary changes to solve the problem or access decision-makers. The team does not need to be large.
- To whom should the team report problems, challenges, and successes

How: Problems and challenges in implementing a new process, program, or policy are normal. The team should answer the following to determine how these should be addressed.

- What schedule and process should be used to report problems and challenges?
- What are the new aspects of the process to be implemented?
- What is the desired outcome?
- What are the team's best guesses about what might work to implement the process?

Figure 12: The "Plan, Do, Study, Act Cycle" in iCCM implementation



What: In order to understand and solve problems, the problems need to be measured. The team should ascertain what information is necessary to measure and solve the issues and the next steps once the improvement process has been initiated.

- What data will be collected and reviewed to determine if the improvement process worked as intended?

- Was the improvement process carried out as intended? Which changes were achieved?
- Is a repeat PDSA cycle is required, or do we start a new PDSA on a new process?

Annex 3: Disseminating National iCCM updated guidelines

Dissemination is the purposeful distribution of information and materials to a specific audience influencing iCCM delivery. The intent is to spread standard country iCCM information and tools at policy, practice, and provider levels.
Before using this tool, (i) identify the stakeholders who will require the information using the Stakeholder Mapping Guide Tool, (ii) Understand why dissemination of the guidelines is important and how it works, (iii) Define expectations of dissemination to specific stakeholders by understanding the outcomes and, (iv) Determine indicators by which to measure successful dissemination. Write your target measurements in the boxes on the third page of this tool.
For dissemination to work, there should be a "who, what, and how." The "who" is the stakeholder – the person or organization that benefits. The "what" is the outcome – the reason that dissemination is occurring. The "how" is the indicator, i.e., the way that the dissemination is measured. For each level, the implementation team should determine the best way to obtain feedback regarding the indicators.
Identify the stakeholders and place each under the appropriate category who will require the information using the Stakeholder Mapping Guide Tool.

- Policymakers: Readiness for implementation by the other departments and programs
- Providers: Change of practice
- Professional and health service delivery organizations, academia, and other partners: Increased awareness, Knowledge, advocate, be part of the timely update, feedback on content and usability, impact on policy.

Annex 4: VHT supervisory visit

VHTs are volunteers, so supervision should be planned when they are available. Before a supervisory visit, a supervisor should prepare to enable him or her to be thorough and helpful.

- Review past performance of the VHT
- Collect appropriate checklists and reporting forms to use during the supervision and the report from the previous visit.
- Collect supplies, equipment, and/or materials that the VHT needs.
- Know dates of any refresher training, plans (immunization days campaigns, outreach activities), or changes
- Collect materials to take they will be prepared for problem-solving, such as training materials, IEC, or counselling cards.

Good practices

Problem-solving: Supervisors teach and involve the VHT in how to improve quality. The supportive approach to supervision recognizes that more than 75% of problems are due to overly complex or faulty processes or systems—not to the people who try to implement these processes or systems. The quality of iCCM services should be regularly monitored, and problem areas should constantly be identified and improved using the PDSA tool. The approach to problem-solving should encourage.

- A spirit of ownership for iCCM implementation and results by the supervisee
- Teamwork with everyone contributing to a better quality of iCCM services.

Giving feedback during a supervisory visit: The specific topics covered during feedback depend on the positive and negative findings. It is important to provide comments in a supportive way that will make the feedback effective. Comments should be:

- Task-related. Talk about what has been seen during the visit. Comment on the observed tasks or problems that were noted.
- Immediate. Give feedback during the visit, after observing how the VHT performs tasks, or after reviewing registers or medicines and supplies.
- Motivating. Always start with the positive findings and then move on to what needs improvement.
- Action-oriented. Focus on improvements that VHT can make through their efforts.
- Constructive. For each item that needs improvement, discuss with the VHT how improvements could be made and offer support, such as on-the-job training.

Annex 5: District Readiness Assessment Tool-Draft

This tool guides through important considerations for implementing iCCM in districts and facilities with community health programs. Use the prompting questions to explore whether the iCCM is a good fit and feasible for existing context and circumstances. Use the checklist to collect all the information about the community health program or practice you need to have an informed response to each of the guiding questions. There are no right or wrong answers to the questions. Instead, they should be used to guide research and thinking about what program or practice to implement at your agency or service.

STAFF & TRAINING SUPPORT
Staffing (VHTs, Health Assistants, facility-based iCCM supervisors)
How many staff will be needed (at a minimum) to deliver the program or practice successfully over time?
Are the staff needed already employed, or will new staff need to be recruited or redeployed?
How will staff turnover be addressed? What approach will you take to ensure any new staff members have the required training and support to deliver the program or practice?
Training
What training is required (IMNCI, VHT, iCCM) for staff to deliver the iCCM?
Can this training be delivered internally, or will it require external support?
Supervision / Coaching
What existing supervision and coaching practices and processes (e.g., opportunities for reflective practice, regular case review meetings, role-playing practice issues, etc.) are already used?
Could district/facility integrate iCCM supervision/coaching into existing processes?
Who will need to deliver the iCCM supervision and coaching?
Do you require changes in your approach to supervision and/or coaching for staff involved in the delivery of iCCM?
Does the district have supervisors and coaches? What qualifications do internal supervisors and coaches currently have?
Do supervisors and coaches require additional training and/ or professional development before and during iCCM delivery?
Do you have the capacity to meet the supervision and coaching requirements for iCCM?
PROGRAM / PRACTICE CHARACTERISTICS
Target population
Is iCCM designed for use with the target population you want to use it with?
Is there evidence to support the effectiveness of iCCM when used with the target population?
Referral pathways
How many referrals do you currently receive a year, and what are your referral pathways from the community?
Does the current HMIS specify the number of ongoing referrals needed?
Does the district have the capacity to meet the referral requirements of iCCM? How will these referrals be secured?
Do referral pathways depend on the involvement of partner organizations?
Community health details
Is the VHT, and how it is approached, described in a manual or guide in a sufficiently detailed way for iCCM service to integrate it into daily practice?
Are the community health materials accessible?
How well does the iCCM description fit with your current services, priorities, and values, and mandate?
Costs
Are there costs associated with acquiring and using iCCM?
What funding is available to cover 2–3 years of iCCM implementation costs?
Adaptability
Does iCCM require local contextual adaptations?
What are the non-negotiable iCCM core components that cannot be adapted locally and/or for particular target populations?
PROGRAM / PRACTICE SYSTEM AND IMPLEMENTATION
Tools and systems
What community data collection tools, data management systems, and processes do you currently use?
What additional tools and systems are needed?
Do you have the capacity to collect the data that is required by iCCM?
Implementation model

Annex 6: List of Materials, Equipment, and Supplies needed for iCCM training

Item	Number
1. Video / DVD exercises	1 set / room
2. VCR equipment, videotape, or DVD	1 set/room
3. Flip chart	1 set / room
4. Masking tape	2
5. Markers	6
6. Pens	One person
7. Measuring containers litre (500 ml water bottle), spoons, cups	1 set per room
8. Dolls	1 per room
9. MUAC Tape	
10. Timers	
Medicine and supplies	
11. mRDT	
12. ORS sachets	3 / participant
13. Zinc tablets	Two packs /person
14. ACTs tablets(blue and yellow)	24 tabs/ person
15. Amoxicillin	Three doses/person
16. Rectal Artesunate	One pack/person
17. Medicine containers (ACT, zinc, antibiotic)	6-12 / room
18. Cup and spoons for preparing medicine	1/person
Materials	
19. Workshop Agenda	1 per participant
20. Registration Form(s)	1 per day
21. Sick Child Job Aid; VHT Register; Referral Forms	20 photocopies for practice
22. Large Sick child job aid – Wall Chart	1 set per room
23. Facilitator Guide, Photo Book,	1 set / facilitator
24. Timers	1 per person
25. Post-Tests	1 per participant
26. Certificates	1 per person
27. Referral note	20 copies
Additional Logistics	
28. Electricity source	1
29. Tables and chairs	

Annex 8: Monitoring and Evaluation workplan

Activity Summary	Indicators	Target	Means of Verification	Who	Years					Risks / Assumptions
					1	2	3	4	5	
Goal										
To increase to at least 80% the proportion of children under-five years receiving appropriate treatment for malaria, pneumonia, and diarrhoea within 24 hours of the onset of illness	The proportion of children under-five years receiving appropriate treatment for malaria, pneumonia, and diarrhoea within 24 hours of the onset of illness	80%	Baseline Activity reports	MoH						
Outcome 1										
Increased access to iCCM among hard to reach communities	The proportion of newborn who receive a home visit within 48 hours of birth by a trained VHT administers the danger signs checklist for the newborn and mother, counsels, or refers as necessary.	80%	Baseline and Activity reports							
	The proportion of children with severe malaria, pneumonia, diarrheoa, TB, and HIV or; newborn with danger signs and children with acute malnutrition whom VHT promptly refers to health facilities.	80%	Baseline and Activity reports	MoH						
Output 1.1										
District capacity to deliver iCCM services at scale strengthened	The proportion of hard to reach villages in iCCM implementing districts with at least two trained and fully equipped iCCM service providers	100%	Evaluation report	MOH, Districts						Availability of funding through GOU & Development Partners
Activity 1.1.1. Orient district, sub-county, and parish leaders in districts on iCCM guideline	Number of districts, sub-county, and parish leaders oriented on the revised iCCM guidelines	1,900	Activity reports	MOH, District						To scale up to 95 districts by 2025. 20 persons per district
Activity 1.1.2. Conduct iCCM services availability mapping and readiness assessment in the districts	Number of districts with complete service availability mapping and readiness assessments	95	Activity reports	MOH, Partners						
Activity 1.1.3. Develop iCCM micro-plans for districts	Number of districts with iCCM micro plans	95	Activity reports	District						
Activity 1.1.4. Hold biannual regional level iCCM review meetings in 95 districts	Number of biannual iCCM review meetings held at the district level	95	Activity reports	MOH, Partners						Three persons per district. To cost for targeted districts
Output 1.2										
VHT capacity strengthened (HW/VHTS)	The proportion of iCCM service providers trained	100%	Evaluation report	MOH, Districts, Partners						Availability of funding through GOU & Development Partners
Activity 1.2.1. Conduct TOT for district-level iCCM trainers and supervisors	Number of iCCM trainers and supervisors trained	576	Training reports	MOH, Partners						At least 6 per district)
Activity 1.2.2. Procure updated training materials for TOTs & district cascade training for districts	Number of districts with updated training materials for TOTs and cascade training	700	Training reports	MOH, Partners						
Activity 1.2.3. Train facility-based VHT supervisors	Number of facility-based VHT supervisors trained	6300	Training reports	Districts,						
Activity 1.2.4. Select and or validate/map two iCCM VHT members by village (45980 Villages)	Number of villages with two validated iCCM VHT members	45,980	Validation reports	Districts,						484 villages per district
Activity 1.2.5. Train/Retrain VHTs on updated iCCM guidelines	Number of VHTs trained on updated iCCM guidelines	101,960	Training reports	Districts,						2 VHTs per village and 10,000 private VHT
Activity 1.2.6. Conduct Post-training follow up visits within one month of training completion	Number of post-training follow up visits conducted	95	Activity reports	Districts,						2 HWs per HF and two district trainers
Output 1.3										
IMNCI Service provider capacity strengthened	The proportion of IMNCI Service providers trained	100%	Evaluation report	MOH, Districts, Partners						Availability of funding through GOU & Development Partners
Activity 1.3.1. Conduct TOT for district-level IMNCI trainers and supervisors (at least 6 per district)	Number of district-level IMNCI trainers and supervisors trained	405	Training reports	MOH, Districts, Partners						
Activity 1.3.2. Procure training materials and job aids for IMNCI	Number of training materials and job aids procured	1000 copies	Training reports	MOH, Districts, Partners						Target 2 HWs per HF for five days and CMEs
Activity 1.3.3. Train 6,850 health facility staff from 2280 HC II& HC III on IMNCI (3,425 per year over two years)	Number of health facility staff trained on IMNCI	6850	Training reports	MOH, Districts, Partners						
Outcome 2										

Activity Summary	Indicators	Target	Means of Verification	Who	Years					Risks / Assumptions
					1	2	3	4	5	
Improved quality of iCCM services	The proportion of VHTs with zero stock-outs of first-line treatment and diagnostics for malaria, pneumonia, and diarrheoa.	75%	Evaluation report							
	The proportion of VHTs giving standard treatment for malaria, pneumonia, and diarrheoa.	80%	Evaluation report							
	The proportion of VHTs that receive quarterly support supervision, mentorship, and coaching	80%	Evaluation report							
	The proportion of health facilities implementing iCCM that have CQI projects and well-documented journals	80%	Evaluation report							
Output 2.1 Functional iCCM supply chain management system established	The proportion of trained VHTs have zero stock-outs of first-line treatment of drugs for malaria, pneumonia, and diarrheoa.	60%	Supervision reports	MOH, NMS						Availability of funding through GOU & Development Partners
Activity 2.1.1. Conduct annual procurement planning for iCCM	Number of annual procurement plans	5	Approved annual Procurement plan	MOH, Partners						
Activity 2.1.2. Procure iCCM medicines and health supplies	Number of annual procurement plans fully implemented	5	Approved annual Procurement plan	MOH, Partners						
Activity 2.1.3. Pack and distribute iCCM kits to health facilities	Number of health facilities receiving iCCM kits timely	5	Supervision reports	MOH, Partners						To be conducted bi-monthly.
Activity 2.1.4. Ongoing analytic support to QPPU for management of the iCCM supply plan, including iCCM kit adjustments and gap analysis	Number of analytical reports produced and utilized by QPPU	10	Analytic reports	MOH, Partners						Bi-annual
Output 2.2 Functional iCCM supervision system established	The proportion of trained iCCM service providers supervised in the last quarter	80%	Supervision reports	Districts, Partners						
Activity 2.2.1. Procure supervision tools for facility-based iCCM supervisors	Number of supervision tools procured	7000	Supervision reports	MoH						Booklets to be procured per facility and VHT parish.
Activity 2.2.2. Distribute supervision tools for facility-based iCCM supervisors	Number of iCCM supervisors equipped with supervision tools	6300	Supervision reports	District						Distribution cost to be incurred
Activity 2.2.3. Conduct quarterly VHT meetings at the health facility	Number of VHTs receiving quarterly support supervision	9,1960	Supervision reports	Facility staff						Quarterly
Activity 2.2.3 Conduct preplanning meetings for HF	Number of HF staff attending the preplanning meeting		Supervision reports	District						2 HWs per health facility
Activity 2.2.4. Facilitate quarterly districts review meetings in supported districts	Number of districts conducting iCCM review meetings	95	Supervision reports	District						2 iCCM supervisors from the HF (I/C& iCCM FP)
Activity 2.2.5. Facilitate quarterly districts review meetings for private sectors in supported districts	Facilitate quarterly districts review meetings in supported districts		Supervision reports	District						
Activity 2.2.6. To conduct home visits within the communities	Number of home visits conducted by the health worker			Facility staff						Ten home visits per facility per quarter
Outcome 3 Increased Knowledge of and Demand for iCCM	The proportion of caregivers and community members have positive health behaviors and practices (e.g., ITN use, completed referral for pneumonia, hand-washing, safe disposal of infant fecal matter, exclusive breastfeeding).	80%	Evaluation report							
Output 3.1 Communities mobilized for appropriate care-seeking	The proportion of sick children who were taken to an appropriate provider (appropriate provider and aspects of timeliness defined by country protocols) (reported separately for each iCCM condition)	80%	Evaluation report	Districts, Partners						Communities willing to participate in iCCM

ACTIVITY SUMMARY	INDICATORS	TARGET	MEANS OF VERIFICATION	WHO	YEARS					RISKS / ASSUMPTIONS
					1	2	3	4	5	
Activity 3.1.1. Develop and disseminate an iCCM communication strategy	Number of approved communication strategies	1	Approved communication strategy	MOH, Partners						To develop a strategy in year one to be integrated into the national communication strategy. Dissemination to be done throughout the years
Activity 3.1.2. Print and disseminate guidelines for sensitization and mobilization for iCCM at all levels	The number of guidelines disseminated.		Activity reports	MOH, Partners						
Activity 3.1.3. Conduct sensitization meetings for traditional and civic leaders regarding iCCM	Number of sensitization meetings conducted	1,920	Activity reports	MOH, Partners						20 leaders per district
Activity 3.1.4. Conduct targeted quarterly iCCM dialogue meetings within communities	Number of iCCM dialogues conducted	200	Activity reports	HF staff VHTs						Target to have at least one dialogue by the HF/VHT
Outcome 4										
The strong implementation supports to facilitate scale-up and sustain iCCM	The proportion of trained VHTs deployed for iCCM and working	80%	Evaluation report							
	The proportion of trained VHTs with the supply of vital iCCM drugs in the last three months (items reported individually)	80%	Evaluation report							
	The proportion of trained VHTs supervised in iCCM in the last three months	80%	Evaluation report							
	The proportion of districts that have accurate and timely reporting on identified iCCM indicators at least Private sector engaged in iCCM delivery	90%	Evaluation report							
Output 4.1										
National oversight and accountability for iCCM strengthened	The proportion of iCCM partners aligning with the mini-investment case?		Evaluation report	MOH, Partners						Partner funding priorities aligned with GOU
Activity 4.1.2. Monthly technical working group meetings of the national iCCM TWG	Number of technical working group meetings held	60	TWG minutes	MOH, Partners						
Activity 4.1.3. Conduct annual national iCCM stakeholder review meeting	Number of national yearly stakeholder review meetings held	5	Review meeting minutes	MOH						One district representative per district
Activity 4.1.4. Develop, finalize and disseminate mini-investment case for iCCM	Number of approved mini-investment cases for iCCM	1	Approved mini-investment case	MOH						
Activity 4.1.5. Development, testing, and dissemination of standardized iCCM Implementation toolkit for public and private sector iCCM managers	Number of approved iCCM Implementation toolkits	1	Approved implementation tool kit	MOH						
Activity 4.1.6. Biannual Support Supervision	Number of biannual support supervision visits conducted from the national level	10	Supervision reports	MOH						A team of 30 MOH officials for two weeks
Activity 4.1.7. Baseline, Midterm, and End line survey	Number of evaluation studies conducted	2	Evaluation report	MOH						To incorporate key indicators
Activity 4.1.8. Dissemination meetings	Number of dissemination meetings held	5	Meeting proceedings	MOH						
Activity 4.1.10. Procure and distribute updated iCCM toolkits and job aids to 101,960 VHTs	Number of toolkits and job aids distributed		Distribution reports	MOH						Tool kit to be defined
Output 4.2										
iCCM information management system strengthened	The proportion of districts submitting timely, complete, and accurate iCCM reports	90%	HMIS/DHIS2 database	Districts						Districts have the necessary capacity for information management
Activity 4.2.1. Procure and distribute HMIS Tools	Number of HMIS tools distributed	9,1960	Distribution reports	MOH						
Activity 4.2.2. Analyze HMIS/DHIS2 data and track VHT performance	Number of analytic reports produced and utilized by national and sub-national structures		Analytic reports	MOH						To be conducted quarterly and annually
Activity 4.2.3. Quarterly feedback meetings with VHT supervisors	Number of quarterly feedback meetings held	60	Meeting proceedings	MOH						To be done quarterly alongside the HF quarterly iCCM meeting

ACTIVITY SUMMARY	INDICATORS	TARGET	MEANS OF VERIFICATION	WHO	YEARS					RISKS / ASSUMPTIONS
					1	2	3	4	5	
Activity 4.2.4. Ensure compilation of i-HRIS & community i-HRIS by partners to track training coverage	Number of partners updating i-HRIS to track training of iCCM service providers	10	i-HRIS database	MOH						To be done annually
Activity 4.2.5. Conduct implementation research on iCCM roll-out	Number of approved research studies completed	2	Research reports	MOH						
Activity 4.2.6 Dissemination of implementation research findings	Number of research dissemination meetings held	5	Meeting proceedings	MOH						

4.1 References

1. iCCM implementation guidelines 2010
2. Ministry of Health, *Health Sector Strategic Plan III***,** 2020-2025
3. Uganda Bureau of Statistics, *Uganda Demographic and Health Survey*,2016
4. The Constitution of the Republic of Uganda, 1995
5. United Nation Children's Fund, *Countdown to 2015:* m*aternal, newborn and child Survival*: Tracking Progress in Maternal, Newborn and Child Survival, The 2008 Report
6. Ministry of Health, *Annual Health Sector Performance Report,* Financial Year 2008/2009
7. Ministry of Health, *Uganda Service Provision Assessment Survey 2007*, Macro International Inc., 2008
8. Ministry of Health, *Home Based Care Report* 2008
9. RMNCAH sharpened plan,2016
10. VHT strategy 2010-2015