Ministry of Health

Republic of Uganda

Building Accountable Community Level Commodity Supply Systems Responsive to Reproductive, Maternal, Newborn, Child and Adolescent Health Needs in Uganda

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Conference Report

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ACRONYMS

CCM	community case management
CHEWs	community health extension workers
CHW	community health worker
EMHS	essential medicines and health supplies
HC	health center
HMIS	health management information system
iCCM	integrated community case management
IcSCI	incentives for community supply chain improvement
JMS	Joint Medical Store
MoH	Ministry of Health
NMS	National Medical Stores
PBF	performance-based financing
PNFP	private not-for-profit
RMNCAH	Reproductive, Maternal, Newborn, Child And Adolescent Health
RSP	standard resupply procedures
UHSC	Uganda Health Supply Chain Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund
USAID	US Agency For International Development
VHT	village health team

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BACKGROUND

The goal of the government of Uganda's National Drug Policy and National Pharmaceutical Sector Strategic Plan is to ensure "the availability and accessibility at all times of adequate quantities of affordable, efficacious, safe and good quality essential medicines and health supplies (EMHS) to all people who need them in the fulfillment of the basic requirement for the delivery of the Uganda National Minimum Health Care Package."

Since 2000, community-based village health team (VHT) have been an important component of the Uganda Ministry of Health's (MoH) strategies to improve access to medicines and health supplies in households facing geographic, financial, cultural, and other constraints to using formal health services. The MoH and more than 100 implementing partners currently support a wide range of community-based health services including integrated case management of diarrhea, pneumonia and malaria (iCCM), as well as newborn care, Family Planning and preventive interventions related to HIV, tuberculosis, immunization, neglected tropical diseases, nutrition, and sanitation take place in 90% of districts across the country. Planning is also underway to establish a new cadre of an estimated 15,000 community health extension workers (CHEWs) that will be formally integrated into the MoH staff structure.

The MoH is committed to increasing the coverage and improving the quality of community-based health services. VHTs are currently dispensing 20 basic medicines and health supplies; ensuring the regular availability of these health commodities is critical to the success of the community-level programs. These medicines reach the community level actors through both the recognized MoH structure as well as *ad hoc* arrangements through various implementing partners. Over the past 10 years, much has also been achieved at central, district, and facility level to strengthen and streamline the national supply chain system. Financing, quantification, procurement, and distribution are more efficient and transparent; information at all levels is more readily available for use in decision making and monitoring; functional coordination mechanisms exist between the government and donor partners, and; district and facility capacity in medicines management has improved greatly. The drive is to integrate the community level into the national supply chain system; this must be done to optimize the flow of products and information and to ensure sustainability.

PURPOSE

The USAID/Uganda Health Supply Chain Program (UHSC) recently completed a situation analysis of the supply chain for community-level health programs to support government of Uganda efforts to increase access to life-saving reproductive, maternal, Newborn, child and adolescent health (RMNCAH) commodities. The analysis examined national policies, financing and procurement, product selection, quantification, distribution, commodity management at facility and VHT level, and visibility of community-level data at national level. The MoH (Pharmacy Division and Child Health and Reproductive Health Division) decided that the time

was right to bring together a wide range of stakeholders to discuss the key challenges and develop a set of recommendations to guide the MoH's next steps in strengthening the community level supply chain.

The meeting, organized by the MoH in collaboration with UHSC, was held on March 3, 2016. The program included seven presentations on community level supply models and experiences from Uganda and Rwanda and a presentation of the findings from the Uganda community supply chain situation analysis. Group discussions were held to identify the key issues and recommendations for national, district, health facility and community/VHT levels.

The purpose of this document is to summarize the key experiences, lessons and findings from the eight presentations and the issues and recommendations identified in the group discussion sessions. The Annexes 1, 2 and 3 include the meeting agenda, list of participants and group discussion guides.

COMMUNITY LEVEL SUPPLY MODELS AND EXPERIENCES

Presentation: Uganda Experience: Kiryandongo District - Dr. Mutyaba Imaam, District Health Officer - Kiryandongo District

Dr. Mutyaba Imaam presented on the supply challenges experienced when an implementing partner's program support to iCCM in the district ended, and the district's approach to using the routine health facility supplies to supply VHTs, and keep them active and motivated.

Kiryandongo is a new district established in July 2010, with an estimated population of 268,000 of which 54,000 are children under five years of age. In 2010, the district began implementation of the iCCM program, as one of nine iCCM target districts.

During the period 2010 to 2013, the implementing partner Malaria Consortium procured the supplies for iCCM. The district received the supplies on a quarterly basis (though often supplies were delayed); through the district stores from where they were distributed to health centers. The VHTs would receive supplies from the health centers during the quarterly VHT meetings or deliveries when the health workers conducted supervisory VHT home visits. Reports generated by the VHTs would be collected by the Parish Coordinator and delivered to the health facilities, Districts and Malaria Consortium.

KEY ISSUES & SOLUTIONS DEVELOPED

After Malaria Consortium ended their support in 2013, iCCM supplies no longer were provided and quarterly visits and VHT meetings could not be sustained. VHTs were demotivated and became inactive.

However, many facilities had excess stock of some iCCM commodities from their regular supplies, primarily malaria rapid diagnostic test and artemisinin-based combination therapies.

The District implemented commodity redistribution from health facilities to the VHTs to enable them to continue their work.

After the iCCM program ended, because it was a felt need by the communities, the district wanted to continue using the VHTs trained under ICCM for child survival programmes. The challenge, however, was to find a reliable alternative source of iCCM supplies for the VHTs after the partner's support ended.

As an interim solution, the district implemented commodity redistribution from health facilities to the trained VHTs to continue to offer iCCM services in the community. Only facilities with sufficient stock from their regular supplies redistribute to the VHTs. By December 2015, 55% of all health facilities in Kiryandongo were engaged in redistribution to VHTs.

It was important that the redistribution process ensure community involvement and ownership, review of the quality of VHT services and proper accountability for the supplies at the health facility. VHTs raise their requisitions which are endorsed by the Local Council I chairperson of the area. Requisitions are reviewed by the health facility in-charges who authorizes supply from the facility store (*quality review*). VHTs acknowledge receipt of the items. Proper documentation is done with the authority from the chairpersons of the health unit management committee and the Local Council I chairperson witnesses on behalf of the community (*community involvement & ownership*). The transactions are recorded on the product stock cards at the health facility (*accountability*).

LESSONS LEARNED & RECOMMENDATIONS

The viability of iCCM depends on the VHT whose viability is greatly affected by the availability of commodities and supplies.

Redistribution to the communities is possible but requires good record management.

VHTs attached to health facility participating in redistribution have remained active and motivated. Some VHTs have mobilized themselves into other activities beyond iCCM (possible solution to sustainability?)

It was recommended that:

- The MoH, through National Medical Stores (NMS), take over supply of VHT commodities
- Guidelines been issued on redistribution of medicines from health facilities to the community level
- Local government needs to prioritize iCCM in their development plans.

The redistribution initiative has been a success. In two of the three areas that are engaged in redistribution of medicines to VHTs, the number of facility outpatient visits declined in 2013/2014. This is attributed to maintaining the community work of VHTs through medicine redistribution.

As a result of the Kiryandongo experience, in 2015, the MoH issued a circular instructing the district health team to support "redistribution of stock between health facilities and VHTs whenever need arises." The Pharmacy Division representative re-emphasized in the conference the importance of redistribution to VHTs where appropriate accountability is in place and sufficient supplies are available at facilities.

Presentation: Community Health Workers Supply System in Rwanda: Lessons Learnt - Deogratias Leopold, John Snow Incorporated, Rwanda

This presentation described the process and interventions to streamline community supplies management in Rwanda with support from the Supply Chain for Community Case Management Project

A 2010 baseline assessment of Rwanda's community health supply chain revealed some challenges, including among others, frequent stock outs of the community case management (CCM) commodities and lack of established procedures for resupplying community health workers (CHWs).

KEY ISSUES & SOLUTIONS DEVELOPED

The key challenges were

- Widespread stock outs of the five CCM medicines
- No standard formula to calculate resupply quantities or resupply process, CHWs report to multiple places

In Rwanda, standard resupply procedures (RSP) were designed that use simple tools and procedures. Trained CHWs were deployed and Cell Coordinators required to provide on job RSP training.

A pilot tested RSPs combined with one of two supply chain improvement approaches to identify the most effective approach.

Only 49% of CHWs had five CCM tracer medicines in stock on the day of visit (amoxicillin, oral rehydration solution, zinc, artemisinin-based combination therapies 1x6 and 2x6). There were no standard resupply procedures: no standard formulas for calculating resupply quantities for CHWs; flow of information was not streamlined or aligned with product flow; CHWs reported to multiple places, but often not to their resupply point. Many (18%) of the CHWs had insufficient storage for existing medicines and supplies. Transportation was difficult between resupply points: 88% of CHWs travel by foot, 10% bikes, 0.9% private vehicles, 0.3% public transport. CHWs also reported lack of motivation to travel to collect supplies as there was no compensation for time/travel.

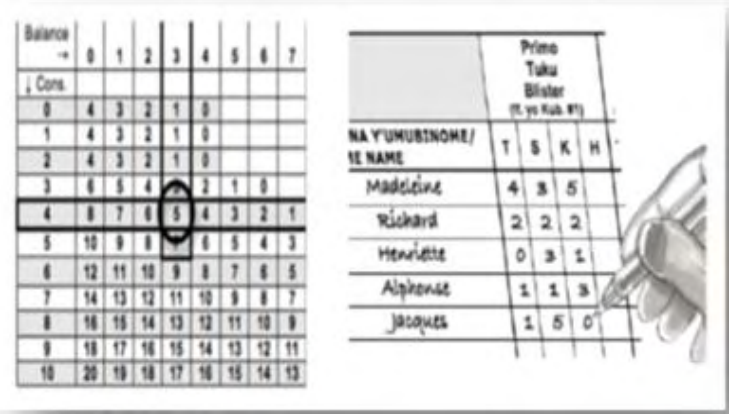


Figure 1: "Magic" resupply calculator

To reduce stock outs and improve product availability, two interventions were designed and evaluated. The cross-cutting foundation was the development of **standard resupply procedures (RSPs)** with simple tools and procedures designed to ensure that CHWs always have enough CCM products to serve clients. The core features of the RSPs were **Cell Coordinators** and three tools: **stock card, resupply worksheet and a "magic" resupply calculator.**

- A simplified stock card for the CHW to record quantities dispensed and stock on hand at the end of the month.

- The "magic calculator", a mathematical matrix that uses stock on hand and quantity dispensed in the previous month to determine the appropriate resupply quantity.
- A resupply worksheet to aggregate data for all CHWs in each month to submit to the health facility.

At Cell level: CHWs bring their stock cards and meet with the Cell Coordinator at a convenient venue within their area of coverage to report each month. Cell Coordinators are themselves VHTs. Cell Coordinators use each CHW stock card, magic calculator to determine how much resupply required, enter on resupply worksheet. At Health Center (HC) level: CHWs and Cell Coordinator attend HC monthly meeting. Cell Coordinators give HC Pharmacy Managers resupply worksheet. HC use resupply worksheet to prepare orders for all CHWs, give to Cell Coordinators; Cell Coordinators distributes quantities to CHWs, either at meeting or afterwards.

Intervention 1: **Incentives for community supply chain improvement (IcSCI)** aimed to build on and strengthen RSPs by using the existing community based performance-based financing (PBF) scheme for CHWs to incentivize CHWs to improve supply chain performance (see Figure 2).

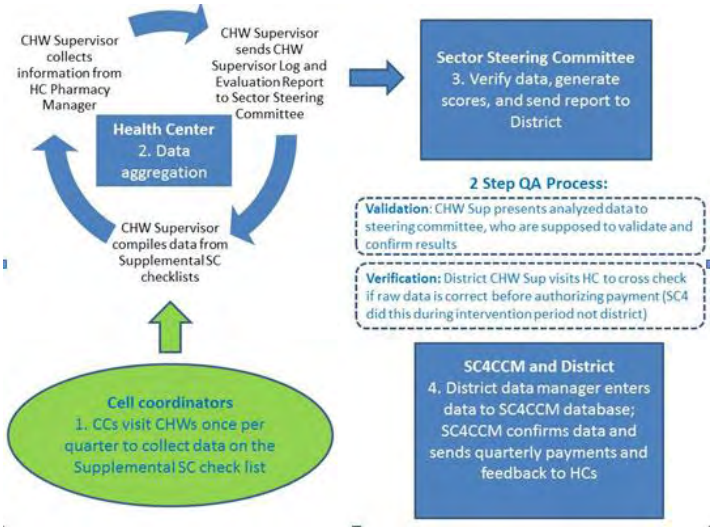
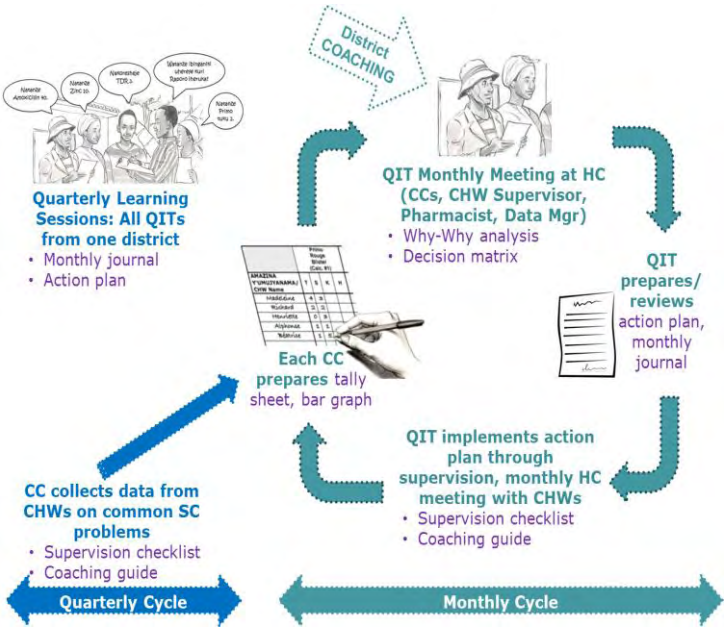


Figure 2: Overview of ICSCI implementation process

Intervention 2: **Quality Collaboratives for supply chain improvement** aimed to establish a network of health center-based quality improvement teams with shared objectives and indicators on how best to operationalize RSPs (see Figure 3).

Learning sessions and quality improvement teams were introduced to provide continuous on-the-job monitoring and supervision of staff and CHWs. The key Quality Collaboratives were **District Coaches (**District Hospital Monitoring and Evaluation Officer, Monitoring and Evaluation Officer from Mayor's Office, District Pharmacist, District Data Manager, and District CHW Supervisor) and **Health Center Quality Improvement Teams (**HW



Supervisors from HC level, Pharmacy Store Managers, Data Manager and all Cell Coordinators affiliated to that Health Center). Monthly allowances were given to District coaches for coaching and CCs to facilitate supervision.

Evaluation results showed that the Quality Collaboratives intervention worked better than the IcSCI intervention because of the continuous mentoring and training which lead to greater skills improvement and commitment by all players. There were a number of challenges faced in the implementation of the IcSCI and Quality Collaboratives interventions which should be considered in the design and implementation of similar interventions in other settings:

Validation and verification process not implemented as designed and limitations in data verification observed (as shown by verification)

Delays in transferring of reports required as proof before payments at HC, district and project levels delayed payments

Staff Quality Collaboratives turnover resulted in gaps in training.

LESSONS LEARNED & RECOMMENDATIONS

Standard Resupply Procedures (RSPs)

Transformed supply chain chaos into order

Enabled evidence-based decision making

Training is key for skills building, need to train other staff as well

Reduced waste of products, CHW travel time

The combination of RSPs with Quality Cooperatives was the most effective approach to increasing personnel skills and performance and improving commodity availability.

Coaching by district coaches was irregular primarily due to competing priorities at the district.

The conference participants were interested in knowing about the cost and sustainability of the interventions as well as more specific details about the evaluation results and the "magic" calculator.

Presentation: Global Experiences in Operationalizing RMNCAH Commodities Community Supply Chain - Christine Kajungu, UNFPA Uganda

This presentation described the experiences at global level on addressing data visibility from community level to improve overall planning in the supply chain system from national to community level.

UNFPA, the United Nations Population Fund, is the largest public sector procurer of contraceptives and related commodities for the developing world. UNFPA support has also included support for country community level programs. Examples of successful interventions from two countries were shared to show how supply chain information and product availability can be improved.

Bangladesh: In Bangladesh, the community family planning program had challenges related to monitoring, transparency and efficiency of the family planning commodity tracking system. In 2010, a centralized portal was implemented in parallel with the sub-district level system to enable electronic submission of stock on hand and consumption data by the community health workers/ sub-district managers, regional and central managers. The portal serves as an electronic

dashboard for communicating real time supply chain and procurement data. At the national level, the portal enables regular interactive discussions among partners to prepare, review, revise and update the national needs for contraceptives including forecasting, fund-gap analysis and supply planning. A 2013 evaluation concluded that there was an 85% reduction of potential stock outs in districts and service delivery points.

KEY ISSUES & SOLUTIONS DEVELOPED

Frequent stock outs at community level, poor availability, quality and visibility of logistics data at community, health facility, district and national levels in Malawi and Bangladesh.

Both developed electronic reporting solutions from community to central level.

In Bangladesh, a central information portal was developed to collect and report data on stock on hand and consumption from all levels.

Malawi designed and implemented c-Stock, a web-based reporting and resupply system receiving data through an SMS platform. Interactive dashboard presents real-time stock levels to district and central level.

Malawi: In Malawi, a 2010 evaluation of the community supply chain revealed that commodities were frequently unavailable at community level. To address the bottlenecks, transportation and management interventions were designed as well as the implementation of a logistics information portal called cStock

Presentation: Lessons Learnt from Global Community - Based Supply Chain Interventions - Dr. Fred Kagwire, UNICEF Uganda

Dr. Fred Kagwire presented UNICEF's experiences in supporting implementation and scale up of the iCCM program in Uganda and the global initiatives supporting the roll out, and possible lessons from other countries to improve community supply chain system

Globally, there is a move to integrate community supply chain management into national supply pipelines. Major international agreements like Paris Declaration (2005) emphasize need for strengthening country supply systems. Supplies do not reach CHWs in sufficient and reliable quantities due to supply chain management constraints.

KEY ISSUES & SOLUTIONS DEVELOPED

Frequent commodity stock outs at CHW level

Limited stock monitoring and tracking of commodities at CHW level

Last mile delivery challenges

Irregular replenishing, inadequate supply chain management skills at health facility and CHWs

Use lessons learned from other country approaches to improve community supply chain system.

The United Nations Children's Emergency Fund (UNICEF) team noted that recent progress has been made in Uganda on streamlining and strengthening the community supply chain system. As a result of the 2014 supply chain

management pilot, iCCM commodities have been integrated into NMS supply and distribution system; a VHT medicines kit was standardized and; VHT/iCCM commodities are pre-packed at health facility level not at NMS.

In December 2015, UNICEF and UNFPA carried out a procurement and supply management (PSM) mission to document successes and challenges in Uganda and other countries and the way forward. The lessons learned and recommendations from programs in other countries and Uganda were presented.

LESSONS LEARNED & RECOMMENDATIONS

Resource Mobilization

Strong government commitment and leadership are essential to drive national RMNCAH scale-up

Strengthen government capacity to direct and lead supply chain systems that RMNACH

Develop resource mobilization strategy for RMNCAH commodities. Leverage existing and future funding opportunities to advance the priorities articulated in the NPSSPIII e.g. GFF, Global Fund

Support the plan for long term sustainability that includes strategies to retain and motivate VHT. Salaried CHWs provide robust platform for programme implementation

Design of Supply System

A demand-based resupply system helps to ensure sustained product availability at community level

Capacity building for facility health workers and community health workers in managing supplies is a critical element

Community Level Information Systems

Capturing VHT commodity data into mainstream data systems provides more accurate and timely data for decision making and response

Consider innovations like mTrac and c-Stock to improve commodity ordering and reporting at community level

Modify and re-introduce community stock tracking tools

Presentation: Pilot to Mainstream iCCSM Supplies through National Medical Stores - Dr. Jesca Nsungwa, Ministry of Health, Uganda

Dr. Jesca Nsungwa elaborated on the design and implementation of a 2014-2015 pilot done in Uganda to mainstream supply through the national supply system, and discussed some of the key lessons to inform development of system strengthening strategies for community supply system

The government in Uganda has involved communities in health service delivery since the 1990s. Uganda introduced the Village Health Team Strategy in 2003 and this was revitalized and expanded in 2008. Building on the Home Based Management of Fever that was introduced in 2002, the iCCM program has been implemented since July 2010. However, several limitations affect the iCCM program

KEY ISSUES AND SOLUTIONS DEVELOPED

Limited geographic coverage of iCCM program

Supplies not integrated into the national supply chain

Non-governmental organizations led the training, supervision, monitoring and evaluation of VHT programs. These activities were not integrated into MoH systems

Unsustainable financing

Conduct pilot study to determine optimal approach for integration in national supply chain system

Limited geographic coverage: In 2014, 34 districts out of 112

Non-integrated supply chain: iCCM commodities are procured and distributed through various supply chains, most of them managed by non-governmental organizations. NMS was not involved. A reliable supply chain system is one of the strongest success factors in this program.

Program management: key programmatic components such as supervision, training, demand creation and monitoring and evaluation were led by non-governmental organizations and not integrated into MOH or district health office systems and structures.

Unsustainable financing: iCCM funding ended in mid-2014 for the central region and end of 2014 for the Western region.

The MoH, with support from partners, conducted a pilot study to see how best to address the key challenges of to the iCCM community supply chain. The goal of the pilot was to integrate supply chain into the national system and determine optimal model for national scale up. There were five areas of focus: Ensuring full supply of medicines; training; demand creation; supervision, and monitoring and evaluation.

LESSONS LEARNED & RECOMMENDATIONS

Government of Uganda is committed to making life-saving medicines and health supplies readily available (at national scale) to all children less than five years old

Recommendations on medicine quantities, kits, curricula for SCM, tools for reporting and tracking medicine use, support supervision, health facility & VHT linkages plus micro-planning tools, sharing data

It is feasible to remove barriers to access to medicines in a sustainable way

Government recommitment to ICCM: iCCM is an investment priority for RMNCAH

Interest in private sector models – discussions and research

Involving many stakeholders, various levels of service delivery is beneficial: national, district, constituency, community health facility Task Force

Need to strengthen HC level II support to manage and support VHT supply chain management – micro-plans, budget, data, skills reinforcement, catchment planning, engaging communities.

Presentation: Community Health Workers and Performance-Based Financing in Rwanda - Deogratias Leopold, John Snow, Incorporated, Rwanda

This presentation described Performance-Based Financing in Rwanda, and the incentives provided to CHWs to encourage reporting and service delivery at CHW level based on two models: i) – Supply Side Model where cooperatives received financial payments, and ii) – Demand Side Model where CHWs were given in-kind incentives

The goal of the national community performance-based financing is to create a community level governing structure that will allow funds to flow from central government and development partners through sector-level to the grass root community health workers to support existing efforts to improve the millennium development goals and Rwanda's vision 2020. The national community performance-based financing program is based on experience gained during the implementation of the health center and hospital performance based financing models between 2006 and 2008.

Supply-Side Model: CHW incentives

Pay-for-reporting**:** In this case CHW cooperatives receive a quarterly payment based on the timely submission of quality data reports related to 22 indicators

Pay-for-indicators: Payment of CHW cooperatives in this case is also made quarterly but the difference from the one above is that it is based on improvements in coverage for the seven (7) target indicators below.

Nutrition Monitoring:

- Number of children (6-59 months) monitored for the nutrition status

Antenatal care:

- Number of women accompanied to the health center for antenatal care before or during 4 month of pregnancy

Institutional Delivery:

- Number of women accompanied for delivery at health facility

Family Planning:

- Number of new family planning users referred by CHWs cooperatives to the health center
- Number of regular users of modern contraceptives at the health center

Tuberculosis:

- Number of TB-cases followed per month at home in the community-DOTS program
- Number of "real" TB-suspects referred to the health center

Demand-Side Model: In-kind incentives:

The purpose of the in-kind incentive is to encourage women in rural community to utilize essential maternal and child health services, specifically antenatal care, institutional delivery and

postnatal care. The aim is to improve performance of CHWs by motivating them to raise agreed upon performance indicators. Payments are made based on proof of the agreed level of performance. A Community PBF guide details management at different levels. A Sector Steering Committee oversees the implementation and approves payment to the CHW Cooperative. Performance indicators are entered at district level into web-based database after quarterly approval by the Sector Steering Committee with feedback. All CHWs are organized in cooperatives to ensure income generation and accountability of expected results. Community PBF payments used for cooperative income generating activities including poultry, cattle/goat/pig rearing, crop farming, basket making, etc.

A number of incentives are provided for motivating CHWs including:

- Trust and respect from community members, leaders etc.
- Support from supervisors and implementation partners help improve work;
- Regular trainings, meetings supervision
- In-country study tours to learn from peers in other districts
- Community performance-based financing (PBF);
- Membership in cooperatives for income generation.

Presentation: Community Health Extension Workers (CHEWs): Strategy and Implications for Supply Chain - Dr. Oleke Christopher, Ministry of Health, Uganda

Dr. Oleke Christopher described the progress of the Ministry of Health towards introducing Community Health Extension Workers (CHEWs), a new cadre of salaried personnel at the community level. The presentation included challenges of the existing VHT strategy, how these are addressed by CHEWs Strategy and the implications for supply chain management at community level

Uganda has been implementing the VHT Strategy since 2001. The VHT strategy was put in place to bridge the gap in service delivery between the community and the health systems and empower communities to improve their health. With 15 years of implementation of the VHT strategy, the health indicators to be monitored at the community level have largely remained poor. How do we improve health at the community level?

The MoH, with support from partners, conducted a comprehensive national assessment of the VHT implementation status (Nov. 2014 – March 2015). The main objective of the assessment was to establish whether the VHT strategy was achieving its intended objectives.

The majority of VHTs are concentrated in the Eastern region; Kampala, West Nile and Karamoja have the fewest VHTs. Two-thirds of VHTs are between the ages of 30-49 and 53% have achieved Ordinary Level education, 9% have higher than Ordinary Level while only 1% have no formal education at all. The duration of VHT training was 5-7 days which is inadequate to ensure VHTs have sufficient knowledge and skills to carry out their activities.

One-third (34%), about 60,000 VHTs, did not undergo the basic training. Refresher trainings, largely supported by implementing partners, were not harmonized, inconsistent, varied in coverage and dependant on presence of partners and their needs. Monitoring and supervision of VHT activities was irregular, there are no reports on VHT activities and no database for VHTs. Financial investment for VHTs is very low.

KEY ISSUES AND SOLUTIONS

There is need to review the entire strategy of VHT including selection, training, roles and responsibilities of VHTs.

Government should have a clear commitment to adequately finance and institutionalized the VHT strategy and ensure regular payments of VHTs for sustainability.

Ministry of Health should streamline training and retraining of VHTs to ensure quality, equity in capacity building for all VHTs.

Some Features of CHEWs Strategy:

- Two people from each parish will be selected using a set criteria and trained as CHEWs.
- The training for CHEWs will be 1 year and will be done in recognized Training Institutions in the country
- The CHEWs will be paid regular salary
- The CHEWs will be based at HC II

At the national level, resources have dwindled over the years to the point of having no money for VHT training; less than 20% of the districts committed funds in the district budget for VHTs. Motivation of VHTs was primarily given by implementing partners during activities; the facilitation varied from activity to activity and partner to partner, and cannot be tracked. All VHTs expressed the wish to be paid regularly for their services.

Following a MoH team visit to Ethiopia to learn from their experience in implementing a successful community health programme, a concept paper was developed on how to establish CHEW programme for Uganda. The detailed CHEW strategy has been costed at $100 million; mmobilization of start-up funds for CHEWs programme is underway. A total of 15,000 CHEWs will be trained, with actual training of the CHEWs proposed to commence in 2016/17.

LESSONS LEARNED & RECOMMENDATIONS

Implementation of the CHEW strategy will have implications for supply chain management;

- Transition will happen over a period of 5 years
- The VHTs who qualify will be absorbed in the CHEWs
- For the VHTs who will not qualify, their roles will be redefined
- Partners will have to re-align their support and intervention to the CHEW strategy

The CHEW concept paper and strategy is currently being shared through different consultative meetings across the country. The preparatory timeframe is shown in the table below.

Table 1. CHEW Programme: Preparatory Activities

KEY ACTIVITIES	TIME FRAME	SUPPORTED BY
Consultation with stakeholders on policy and strategy	November 2015 – March 2016	Global Alliance for Vaccines and Immunization
Development of training Curriculum	March 2016	GAVI HSS
Development of training manuals	October – December	UNICEF
Development of CHEW Handbook	January – March, 2016	UNICEF
Identification and accreditation of Training Centers	February – March, 2016	To be determined
Orientation of Tutors	April – May, 2016	To be determined
Mobilization and sensitization of districts on selecting, training; Mobilization of Resources	April – June, 2016	To be determined

SITUATIONAL ANALYSIS OF COMMUNITY LEVEL SUPPLY CHAIN SYSTEM IN UGANDA

Presentation: Eric Jemera Nabuguzi, USAID/Uganda Health Supply Chain Program

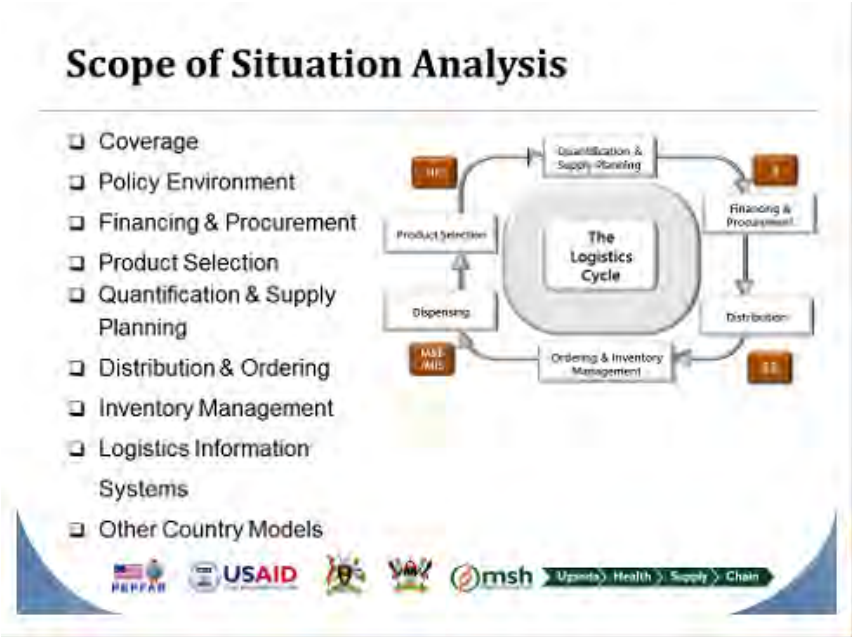
This presentation detailed the findings of the UHSC assessment of the VHT supply system through public and private not-for-profit (PNFP) health facilities in Uganda. The assessment was conducted between July and October 2015.

Findings and recommendations were presented from the recently completed situation assessment on the community level supply chain by the USAID-supported Uganda Health Supply Chain program. The objectives of the assessment were to:

- Document the policies, systems and resources that support the supply chain for community-level RMNCAH programs
- Identify important gaps and bottlenecks in the supply system affecting reliability of community-level commodity supply
- Make recommendations to build a well-functioning national supply chain for community-based programs.

The assessment examined key elements of the health commodity supply chain cycle. The focus was on the iCCM program and community-based family planning program (including Sayana Press). A combination of methods were used to obtain information:

- Document review: Policy and strategy documents, assessments by different partners (Path, UNFPA, Malaria Consortium, Securing Ugandans' Right to Essential Medicines and Health Supplies, MoH);
- Key informant interviews: MoH (Reproductive Health, Child Health and, Pharmacy Divisions, Malaria Program, Resource Center), Partners (Donors & Implementing), Districts, Health Facilities and VHTs;
- Focus Group Discussions with VHTs experienced with iCCM, community family planning program or both;



- Health facility and VHT records review.

The key issues and recommendations were presented by health commodity cycle components.

AREA	KEY ISSUES	SOLUTIONS
Community program coverage	• Coverage is not sustainable, all VHT programs heavily reliant on donor funding • Training is not harmonized; duration is insufficient to equip VHTs with skills on commodity management	• Need for national scale-up plan; • planning and resources need to reach all VHTs • Need to invest in capacity building of VHTs;
Policy Environment	• National Drug Policy & Authority Act 2000 prohibits VHTs and certain health cadres from prescribing antibiotics • VHTs are volunteers, no legal status or protection • There is no MoH strategy or guidance to local governments on how to transition VHT activities from donor-supported projects into locally sustained activities.	• Address legislative and policy support for VHT programs • Strategies are needed to address financial sustainability of VHT interventions
Financing and procurement	• Multiple funding streams for CHW programs, including supply chain • Funding is insufficient, and not predictable - high donor dependence • No financial tracking to optimize available resources at community level • Some IPs have *ad hoc* supply arrangements to health facilities and VHTs	• Systems to track financing and commodities down to community level • No budget line linked to VHT commodities for VHTs • Need to cost the roll-out/implementation of community level interventions • Mainstream financing and commodity flow by implementing partners: One Facility, One Supplier
Product Selection	There are no clear guidelines from the Quality Assurance Department or Pharmacy Division on how products are added to or removed from the list of products dispensed by VHTs.	All commodities handled by VHTs should be included in the EMHSLU (update due in 2016) Strengthen community level guidelines on commodities that can be used by VHTs Schedule for medicines used at

AREA	KEY ISSUES	SOLUTIONS
		community level
Quantification	• National quantifications do not adequately factor in community level requirements • Limited data, if any, reported on consumption and stock on hand at community level • Limited country experience in quantification for community level,	• MoH and partners support revision of health management information system (HMIS) tools to capture essential community-level logistics and improve reporting rates • Institutionalize data quality assessments to improve reliability of the data and national quantifications • Build capacity of MoH Quantification and Procurement Planning Unit and technical programs to conduct community level quantifications • Simplify and standardize the quantification methodology for VHT supplies.
Financing and procurement	No central mechanism exists for tracking multiple partner finance and commodity contributions, e.g. iCCM program Adequacy of commodity financing unknown for community-level programs because of insufficient data available on commodities dispensed	• Government of Uganda and partners need to support establishment and functioning of central commodity and tracking system to improve transparency and coordination
Distribution and delivery approaches	NMS third party logistics companies collect facilities orders at district health office level rather than directly from NMS central warehouse to facilities. This is less efficient. • Some implementing partners are delivering commodities themselves to districts or facilities, outside of established channels • NMS delivers pre-packed VHT kits of iCCM commodities to HC IIs and IIIs which also receive their EMHS in pre-packed kits.	• NMS could explore the feasibility of third party companies collecting orders from central warehouse and deliver directly to facilities • MoH needs to issue and enforce a directive to implementing partners to ensure all commodities are distributed only through mainstream structures • A structured monitoring system or study needs to be

AREA	KEY ISSUES	SOLUTIONS
	Neither kit content is based on demand which can result in stock outs and overstocking • NMS is contracted to supply of iCCM commodities to PNFP facilities. Joint Medical Store (JMS) is the established primary supplier of PNFPs. • "Adjusted" Push System in place for VHT commodities: pre-determined kit content but quantity adjusted based on number of VHTs linked to a health facility.	designed and implemented by stakeholders to evaluate the appropriateness and effect of the VHT kit vis-à-vis the EMHS kit • Funding agencies should evaluate the how best to ensure most cost-efficient, harmonized distribution of PNFP sector. • All evaluations show that demand-based system are the more efficient. Explore PULL system at HC III for all commodities.
Health facility inventory management	• Different approaches are being used by facilities to record commodities issued to VHTs. • Quantities issued and VHT stock on hand data are not systematically captured or reported. • Traceability/accountability is poor	• Standardized record(s) need to be developed to capture VHT commodities: issues, dispensed and stock on hand.
VHT resupply	• There are no established procedures or tools available for facilities to use in calculating correct quantities to resupply VHTs. • Resupply periods differ across programs and partners (e.g. monthly, bimonthly, quarterly) • Facility staff have limited time to review and calculate resupply quantities during VHT supervisory visits	• Develop standardized resupply formula and procedures with simple-to-use tools for use across all of the community-level programs. Adapt materials tested in other countries • Standardize resupply period across all community programs, e.g. monthly • Adopt model where VHT coordinator position is responsible for resupply calculations used a standardized tool before facility meetings
VHT reporting	• Family planning partners use different records and report formats: not all capture quantities dispensed and VHT stock on hand	• HMIS VHT tools must be revised to capture essential logistics data for all community programs

AREA	KEY ISSUES	SOLUTIONS
	• iCCM HMIS record and report format does not capture quantities dispensed or stock on hand • Visibility of community level data, specifically logistics data, is very poor at district and central level • Low and inconsistent facility reporting rates on community-level data	• User friendly dashboards should be developed to improve use at all levels. • MoH and partners to support roll-out of mobile electronic reporting tools • Strategies are needed to improve rate and quality of facility reporting
Supervision and Coordination	• No effective instrument of control over community health workers available to district health team or the health facility • Largely non- functional (documented) supervisory structure for VHTs • Where available, VHT supervision tools do not adequately cover logistics management • District medicine management supervisors support does not extend to community level • No written supervision guidelines/checklist or standard supervision training program • Some staff lack training in supervision of commodity management at community level	• Address legislative and policy support for VHT programs • Need to develop standardized supervision tools, guidelines and training program • VHT commodity management should be integrated into the medicine management supervisors and Supervision, Performance Assessment and Recognition Strategy program • Bridge gap of formal training of VHT supervisors

GROUP WORK SESSIONS

The following presentations were prepared by the four working groups in response to the group discussion guides for each level: national, district, health facility and VHT (see Annex 3). The discussions were divided into the main topic areas of: priority challenges, commodity flow, accountability, information and reporting, capacity and supervision needs, and standardization.

LEVEL	CHALLENGES	RECOMMENDATIONS
A. COMMODITY FLOW		
National	• Proper quantification of RMNCAH needs at the national level/ district level; methodology needs to revised • Strategy is not clear on budget line for RMNCAH commodities for VHTs • Review current strategy and operationalize it	• VHTs should be supplied through functionalizing the Pull system up to HC III i.e. according to their needs • Cost-effective with capacity building e.g. learn from Rwanda – magic calculator • Frequency of VHT supply should be monthly but consider demand of some supplies; can be changed • MoH & partners should provide stewardship and have a harmonized Commodity Supply Plan • Standardize Essential List of Supplies; Costed efforts; Coordinate efforts with Warehouses (NMS, JMS, Uganda Health Marketing Group) • Order and resupply of VHT supplies at the health facilities be integrated in routine supply • If need for color coding- have different order lines • VHT supplies be planned in line with facility supplies • There is need for better planning to reduce wastage
District	• Lack of capacity at district level to quantify for VHTs or health facilities • VHT commodity requirements are not included in procurement plans of health facilities • No guidelines of how excess commodities from health facilities can be redistributed to VHTs	• Warehouse should supply direct to the health facilities through third party (Cease direct partner delivery to health facilities/ districts and districts enforce) • DHOs considered it important that the office is involved in the verification at district is critical • Initially, continue to use a Push from the NMS to lower level facilities (HC II and HC III) as capacity is being built to pull • VHTs should pull from the health facilities according to need • District should coordinate quantification for VHT

LEVEL	CHALLENGES	RECOMMENDATIONS
		• supplies
Health facility	• Quantification not properly done, frequent stock outs and overstocks at VHT level • Resupply system not well thought through • Lack of storage space • There should be redistribution at community level – no guidance	• Push system from warehouse to health facility initially. • Pull system at health facility to VHT: • Use consumption and stock on hand data from VHT reports to quantify • Receive Kits if it is a push system • Through aggregated requisition from the VHT • Facility to coordinate orders/resupply through monthly meetings, review/analyze data/reports
Village health team	• Quantification – lack of capacity to determine quantities needed • Lack of transport – VHTs actually carry the medicine boxes on their heads • Ideally they should have bags for carriage; the boxes are for storage at home	• Ideally a pull system is preferred when capacity has been built and built and is available at lower levels • Use a Pull system for health facility to VHT resupply • Quantification, ordering, ordering frequency and receipt • Minimum stock level – 2 weeks level • Maximum stock level – 2 months
B. ACCOUNTABILITY, INFORMATION AND REPORTING		

National	• No supportive policy in place. Clear roles and responsibility at each level
	• Critical gaps in logistics data on community level
	• Coordination at the national level is lacking
		• MoH should monitor VHT supplies using Model B tools (i.e. health facility stock card and stock book and issue/requisition voucher)
		• In future use Mobile platforms like mTrac with dashboard at district
		• National level indicators to be measured:
		  ○ Commodity Stock outs
		  ○ Rationalize vital information on HMIS 097
		  ○ Health facility procurement plans
		• MoH should improve information flow from community level to national level. In future, use mobile platforms like mTrac, providing a dashboard at district and national level
		• Develop user friendly easy-to-use reporting tools for the community level. Community level data should be reported quarterly to national level, but monthly to health facility level
		• MoH validate quality of data reported
		• Quality Improvement Teams e.g. Rwanda case

LEVEL	CHALLENGES	RECOMMENDATIONS
		• Explore supervision using medicine management supervisors system
District	• Lack of complete and quality VHT logistics data available at district level. Data not being used for quantification and planning for VHT commodities	• District health office to ensure accountability of VHT supplies through HMIS tools which need to be developed, rolled out, information analyzed and used to improve processes • Indicators proposed: • Commodity stock outs • VHTs stocked out • Consistency of kit content delivery • No. of facilities having procurement plans for VHT commodities • Percent of facilities with one staff know how to calculate reorder quantity for VHTs • Ensure reporting using national tools developed • Ensure routine validation of data quality from community level

Health facility	• Lack of/inaccurate data for planning – e.g. cases and non-utilization of the data	• Use available HMIS tools to record and account for VHT commodities
		• Monthly reporting
		• Stocks should be integrated since serving the same target population. However it should be possible to segregate records of consumption
		• Use existing tools
		• Report to the in-charge
		  ○ Cases attended
		  ○ Consumption
		  ○ Stock balances

Village health team	• Stock monitoring – VHTs are unable to track stock levels • Tracking consumption at VHT level is difficult • Stock outs and over stock of some commodities	**Accountability** • Stock cards at the health facility and VHT level • Client register for Family planning commodities. Assign a client number • Client cards **Items Recorded** • Records should include the item description, quantity received, conditions/cases treated, number of clients treated, stock on hand • For family planning – assign client number, record item and quantity dispensed and return date • For other cases – record names, age, condition, item and quantity dispensed • Stock card – record every transaction, no names of clients **Reporting**

LEVEL	CHALLENGES	RECOMMENDATIONS
		• Standardized reporting is required • Ensure VHTs report to the nearest health facility at least once each month
C. CAPACITY AND SUPERVISION NEEDS		
National	• Supervision structure weak • Disjointed activities affecting work plans	• Ensure effective coordination of the VHT logistics system, including involvement of quality Assurance Department and Resource Center at MoH • Develop structured performance assessment tools for the VHT logistics system • Well structure in place (QA and HMIS) • Performance assessments • Use a standardized set of indicators to routinely monitor the VHT logistics system performance • Ensure VHT reports are captured and reported through the existing platforms like DHIS2 • Integrate use of Mobile platforms • Explore linking VHT supply chain system performance to the MoH Annual Health Sector Performance Report District League table indicators ○ MoH link VHT supply management using performance indicators (rewards / sanctions) • Ensure integrated management of VHT supplies within the existing system for EMHS
District	• No structured support supervision of VHTs. Facilitation is absent	• Ensure effective coordination of supplies and supply management through regular supervision system • VHT logistics system performance- Regular monitoring and evaluation • Explore how to link VHT supply management to performance-based framework and how integrate into health facility supervision, performance assessment and recognition strategy
Health facility	• Lack of effective supervision • Lack of incentive for VHTs to pick resupplies	• In charge, Health Unit Management Committee, Medicines management supervisor should check stores and records of VHT supplies • In-charge stores does the recording • Record as soon as commodities are issued • Validation: Data quality checks through supervision, data quality assessments, supervision, reports • Storage infrastructure – space, shelves • Basic skills in medicine management • Needs identification- focused support supervision, needs assessment

LEVEL	CHALLENGES	RECOMMENDATIONS
Village health team	• No mechanism of supervision; most VHT supervisors are at sub-county level • Facilitation – VHTs move hungry to the patients' homes. Facilitation is on quarterly basis yet they work on a daily basis	**Capacity needs** • Address capacity gaps in logistics management, particularly in stock and storage management as well as records management • Ensure there are structured programs/activities for identifying capacity needs of VHTs and health workers. This includes the supervision activities **Supervision** • Ensure each health facility has a trained focal person to oversee the activities of the VHTs • Ensure regular routine supervision for the VHTs – monthly recommended – and follow up of action items from each supervision visit • Identify budgets and allocate money/transport for supervision to the health facility's VHT focal person • Ensure monthly meetings at the health facility for report submission and updates to VHTs • Provide supervision books to ensure supervision of VHTs can be validated. The books should be used to record signature and date of the visit, actions taken or required, recommendations so they are systematically followed up **Resupply of commodities** • Ensure resupply is tagged to the reporting • Explore feasibility of using VHT team leader to pick the supplies from the health facility on behalf of the rest of the team • Provide suitable storage facilities for VHT supplies: medicines and supplies boxes or lockable cupboards at their homes, together with a bag to carry smaller quantities during their routine work • Provide adequate recording tools for use at both health facility and for the VHTs. These should include health facility stock card, dispensing logs and VHT registers
D. STANDARDISATION		
National	• Lack of legal instrument or framework in place for the VHTs • No regulatory framework in place • Harmonize different pilot programs/systems under	There was consensus across all four working groups that community supply chain tools, processes, policies, training, practices and facilitation should be standardized to ensure quality control and optimal use of limited resources. Specifically, the groups recommended that the following be standardized: **Tools**

LEVEL	CHALLENGES	RECOMMENDATIONS
	one house	• Data collection, client register • Supervision tools • Logistics management and reporting tools: stock cards, order forms, facility summary reports **Processes** • Selection criteria, replacement and discontinuation • Supervision process • Data quality assessments • Distribution of implementing partners **Policies** • Harmonize standard treatment guidelines with new policy positions **Practices** • Inventory management • Dispensing **Training** • Training packages: curriculum, duration, frequency, materials review • Refresher trainings **Facilitation** • Financial incentives, rewards
District	• Lack of facilitation for VHT team leaders (parish coordinators).	
Health facility		
Village health team	• Standard number of VHTs per village – some villages (with many households) have few VHTs, leading to work overload, leading to limited access to medicines by the community • Different partners support particular sub-counties leaving out others	

CLOSING REMARKS

The successful implementation of the proposals [to strengthen the community level supply system] from the meeting will largely depend on how well we capacitate and facilitate VHTs, the health workers and the district. … We've heard experiences from other countries, but we must domesticate them to work in our context.

—Morries Seru, Ag. Commissioner Pharmacy Division

Prof. Anthony Mbonye, Director Health Services (Clinical and Community) in a group photo with the conference participants at Protea Hotel on March 3rd, 2016.

ANNEX

Annex 1: Conference Agenda

TIME	SESSION	RESOURCE PERSON
8:00am - 9:00am	Arrival & Registration of Participants	Secretariat
Chairperson - Morning Session: Dr. Jesca Nsungwa		
9:00am - 9.20am	Opening Remarks Pharmacy Division - Ministry of Health Director Health Services (Community and Clinical)	 Morries Seru Prof. Anthony Mbonye
9.20am - 10.00am	Panel Discussion: Community Level Supply Models & Experiences - Lessons Learnt Uganda Experience: Kiryandongo District Community Health Workers Supply System in Rwanda: Lessons Learnt Global Experiences in Operationalizing RMNCAH Commodities' Community Supply Chain Lessons Learnt from Global Community-Based Supply Chain Interventions	 Dr. Mutyaba Imaam (DHO - Kiryandongo) Deogratias Leopold (JSI, Rwanda) Dr. Kidane Abraha (UNFPA) Dr. Fred Kagwire (UNICEF)
10.00am - 10.45am	Questions & Clarifications	ALL
10.45am - 11.30am	Panel Discussion: Community Level Supply Models & Experiences - Lessons Learnt Pilot to mainstream iCCM supplies through NMS Community Health Workers & Performance-Based Financing in Rwanda Community Health Extension Workers (CHEWs) Strategy & Implications for Supply Chain	 Dr. Jesca Nsungwa (MoH) Deogratias Leopold (JSI, Rwanda) Dr. Oleke Christopher (Ministry of Health)
11.30am - 12.15pm	Questions & Clarifications	ALL
12.15pm - 1.00pm	Situational Analysis - The Village Health Team Supply System in Uganda	Eric Jemera (USAID/UHSC Program)
1.00pm - 1.10pm	Questions & Clarifications	ALL
1:10pm - 2:10pm	Lunch	
Chairperson - Afternoon Session: Morries Seru		
2.10pm - 3.30pm	Group Breakout Sessions	Martin Oteba
3.30pm - 4:30pm	Plenary Presentations from Group Work	Dr. Mihayo Placid (MoH)
4:30pm - 5.00pm	Wrap-up & Closing Remarks	Dr. Blandina Nakiganda (MoH)
5.00pm	Afternoon Tea & Departure	

Annex 2: List of Participants

	NAME	TITLE	ORGANISATION
1	Namwabira Mabel	Senior Quality Improvement Advisor	ASSIST
2	Christine Ikomera	Capacity Building Coordinator	BRAC, Uganda
3	Lorraine Kabunga	Integrated Child Health Program Coordinator	CHAI
4	Dr. Emmanuel Otto	District Health Officer	DHO Agago
5	Mugabe Robert	District Health Officer	DHO Kyenjojo
6	Dr. Bakamuturaki Richard	District Health Officer	DHO Ntungamo
7	Angela Akol	Country Director	FHI360
8	Mubiru Fredrick	Program Manager	FHI360
9	Mugabi Dan		HEPS Uganda
10	Emmanuel Higenyi	Director Technical Services	JMS
11	Deogratias Leopold	M&E Advisor	JSI Rwanda
12	January Superior	VHT Member	Kamwenge
13	Dr. Mutyaba Imaam	District Health Officer	Kiryandongo DLG
14	Opio Henry	Health facility In-Charge, Karuma HC II	Kiryandongo DLG
15	Ssekonde Walter	Senior Clinical Officer; Malaria Focal Person	Kiryandongo DLG
16	Kibikyabu Paul	Senior Health Inspector	Kyenjojo DLG
17	Dr. Agaba Mukama	Senior Medical Officer	Luwero DLG
18	Nuwa Anthony	Country Technical Coordinator	Malaria Consortium
19	Prof. Mbonye K. Anthony	Director Health Services (Clinical and Community)	Ministry of Health
20	Seru Morries	Ag. Assistant Commissioner Pharmacy Division	Ministry of Health
21	Dr. Jesca Nsungwa	Assistant Commissioner Child Health	Ministry of Health
22	Dr. Christopher Oleke	Principal Health Educationist	Ministry of Health
23	Namugeere M.	Principal Nursing Officer	Ministry of Health
24	Namulindwa N.	Secretary Pharmacy Division	Ministry of Health
25	Lawrence Were	RHCS Coordinator	MoH/UNFPA
26	Daraus Bukenya	Country Representative	MSH

	NAME	TITLE	ORGANISATION
27	Noeline Nalwoga	VHT Member	Mubende
28	Munanura Apollo	Customer Care Representative	National Medical Stores
29	Agaro Caroline	District Health Officer	Oyam DLG
30	Goretti Masadde	Head Social Marketing	PACE
31	Cornelia Asiimwe	Program Officer	Samasha
32	Kaggwa David	Technical Advisor	Samasha
33	Denis Okwar	Chief of Party	SDS
34	Dr. Isabirye Fredrick	Technical Advisor -Malaria	TASO
35	Christine Kajungu	Program Analyst	UNFPA
36	Dr. Flavia Mpanga	Health Specialist	UNICEF
37	Dr. Fred Kagwire	Health Specialist	UNICEF
38	Dr. Christine Mugasha	Program Management Specialist -MCH	USAID
39	Suzan Nakawunde	Program Management Specialist (Health Commodities)	USAID
40	Amony Nancy	Principal Technical Advisor -SCM	USAID/UHSC
41	Anthony Kirunda	Technical Advisor	USAID/UHSC
42	Belinda Blick	Technical Advisor Strategic Information	USAID/UHSC
43	Dr. Birna Trap	Chief of Party	USAID/UHSC
44	Denis Okidi	Senior Technical Advisor	USAID/UHSC
45	Eric Jemera Nabuguzi	Principal Technical Advisor, RMNCH	USAID/UHSC
46	Juliet Nakiganda	Senior Technical Officer- Malaria	USAID/UHSC
47	Kato Joseph Sseruwu	Operations Intern	USAID/UHSC
48	Nabanoba Allen	Technical Officer, Child Health Division	USAID/UHSC
49	Oteba Martin	Deputy Chief of Party	USAID/UHSC
50	Rebecca Copeland	Consultant	USAID/UHSC
51	Samuel Balyejjusa	QPPU Technical Advisor	USAID/UHSC
52	Victoria Nakiganda	Senior Technical Advisor	USAID/UHSC
53	Laura Wando	Country Director	WellShare
54	Dr. Peter Ogwal	Health Specialist	World Bank

Annex 3: Group Work Discussion Guide

GROUP 1: VHT LEVEL

A. Challenges

What are the current challenges that need to be prioritized to improve RMNCAH commodity availability at community level? *(The 5-8 critical challenges)*

B. Recommendations, Key Activities & Responsible Actors

B1. Commodity Flow

- How VHTs should be supplied a) - Warehouse to health facility: Push/Pull?
- b) - Health facility to VHT: Push/Pull?
- How should the VHT quantify, order and receive supplies?
  What should be the frequency of ordering?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B2. Accountability, Reporting and Information

- How should supplies to VHTs be accounted for? What should they record? What should they report?
- How should VHT data be reported? (Tools? Reporting lines? Responsibilities? etc.)
- What should be the frequency of reporting?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B3. Supervision & capacity needs

- What are the capacity needs (knowledge, skills) for VHTs to be in a strong position to handle and account for the supplies they receive? How should these needs be identified?
- What are the requirements for storage and recording of VHT supplies at the community level?
- Who should supervise how VHTs store and record the supplies they handle? How should this be done? How will this be validated?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B4. Standardization

- Key considerations: What tools, processes, policies, training, practices, support should be standardized? What are the risks/what could go wrong? How can these be mitigated?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

GROUP 2: HEALTH FACILITY LEVEL

A. Challenges

What are the current challenges that need to be prioritized to improve RMNCAH commodity availability at community level? *(The 5-8 critical challenges)*

B. Recommendations, Key Activities & Responsible Actors

B1. Commodity Flow

- How VHTs should be supplied a) - Warehouse to health facility: Push/Pull?
  b) - Health facility to VHT: Push/Pull?
- How should the heath facility quantify, order and receive VHT supplies?
- How should the health facility determine the quantity? How should the health facility handle and issue VHT stock?
- How should the health facility coordinate the order and resupply of VHTs?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B2. Accountability, Reporting and Information

- How should the health facility account for VHT supplies? What should they record? What should they report?
- What should be the frequency of reporting? Should VHT supplies be kept separate from facility supplies? Do we need new tools for VHT supplies at health facility?
- To whom should the VHT report and what should they report?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B3. Supervision & capacity needs

- Who checks how heath facility stores, records the VHT supplies they handle? How should this be done? How will this be validated?
- What are the capacity needs (knowledge, skills, hardware) for health workers to support supplies management by VHTs and account for VHT supplies received? How should these needs be identified?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B4. Standardization

- Key considerations: What tools, processes, policies, training, practices, support should be standardized? What are the risks/what could go wrong? How can these be mitigated?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

GROUP 3: DISTRICT LEVEL

A. Challenges

B. Recommendations, Key Activities & Responsible Actors

B1. Commodity Flow

- How VHTs should be supplied a) - Warehouse to health facility: Push/Pull?
  b) - Health facility to VHT: Push/Pull?
- How should the district level quantify and coordinate ordering of VHT supplies?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B2. Accountability, Reporting and Information

- How should the District Health Office monitor accountability for VHT supplies?
- What district/national level indicators should be measured to monitor VHT supplies? How should the required data be collected?
- How should District Health Office and partners improve the flow of information from the community to national level?
- How can the district level validate the quality of data reported from lower levels?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B3. Supervision & Capacity Needs

- How can we ensure effective coordination of supplies and supply management for VHTs by the district health office level?
- How should VHT logistics system performance be monitored at the district health office?
- How should the district health office link VHT supply management to performance-based framework?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B4. Standardization

- Key considerations: What tools, processes, policies, training, practices, support should be standardized? What are the risks/what could go wrong? How can these be mitigated?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

GROUP 4: NATIONAL LEVEL

A. Challenges

What are the current challenges that need to be prioritized to improve RMNCAH commodity availability at community level? *(The 5-8 critical challenges)*

B. Recommendations, Key Activities & Responsible Actors

B1. Commodity Flow

- How should VHTs be supplied a) - Warehouse to health facility: Push/Pull?
  b) - Health facility to VHT: Push/Pull? What should be the frequency?
- How should Ministry of Health and its partners coordinate the financing, procurement and supply of VHT supplies by the different partners & donors?
- How should the health facility coordinate the order and resupply of VHTs?
  Should orders be integrated with the routine health facility supply or separated?
- Should VHT supplies be planned for (quantification and allocation of financial resources) separately from facility supplies?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B2. Accountability, Reporting and Information

- How should the Ministry of Health monitor accountability for VHT supplies?
- What national level indicators should be measured to monitor VHT supplies?
  How should the required data be collected?
- How should Ministry of Health and partners improve the flow of information from the community to national level?
- How can the national level validate the quality of data reported from lower levels?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B3. Supervision & Capacity Needs

- How can we ensure effective coordination of supplies and supply management for VHTs at national level?
- How should VHT logistics system performance be monitored at national level?
- How should the Ministry of Health link VHT supply management to performance-based framework?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

B4. Standardization

- Key considerations: What tools, processes, policies, training, practices, support should be standardized? What are the risks/what could go wrong? How can these be mitigated?

RECOMMENDATIONS	KEY ACTIVITIES	WHO SHOULD BE INVOLVED?

Annex 4: Presentations

1. Continuity Of ICCM Program Through Commodity Redistribution - The Kiryandongo ICCM Experience – *Dr. Mutyaba Imaam*

CONTINUITY OF ICCM PROGRAM THROUGH COMMODITY REDISTRIBUTION

THE KIRYANDONGO ICCM EXPERIENCE

Dr. Mutyaba Imaam
DHO - Kiryandongo

March 3, 2016
Protea Hotel

Building Accountable Community Level Health Commodity Supply Systems Responsive to RMNCAH Needs in Uganda

OUTLINE OF THE PRESENTATION

- Introduction
- Background to community redistribution as a stop gap to stock out of ICCM commodities
- Challenges
- Lessons learnt
- Recommendations

INTRODUCTION (1)

INTRODUCTION /2

Population	268,188
Children <5yr	54,174
No s/Counties	4
No T/C	3
Parishes	12

- Kiryandongo has been in existence since July 2010
- Its one of the 9 ICCM Districts since 2010

HEALTH FACILITY BY LEVEL & NO. OF VHTS

Health Facility Level	Ownership		Total	No of VHT supervised
	Public	PNFP		
Hospital	**1**	**0**	**1**	42
Health Centre III	**5**	**3**	**8**	132
Health Centre II	**13**	**-**	**13**	216
Total	**19**	**3**	**22**	390

THE ICCM PROGRAM IN KIRYANDONGO

- ICCM is an important opportunity to address the felt need in our communities
- And because it addresses the felt needs of our people we have used the VHTs trained under ICCM for the other child survival programmes
- Availability of medicines and supplies is critical for sustaining ICCM

THE iCCM PROGRAM IN KIRYANDONGO /2

- Malaria consortium procured supplies for ICCM from Dec 2010 up to 2013.
- The district received supplies on a quarterly basis though often supplies delayed
- Through the District stores, supplies would be distributed to the VHTs at the Health Centres.

The supplies

- Prepacked and color coded ACTs (Yellow and Blue)
- Amoxicillin tables (Pink and Green)
- ORS + Zinc
- Gloves and Cotton wool
- Respirators

THE iCCM PROGRAM IN KIRYANDONGO /3

- The VHTs would receive supplies during the quarterly VHT meeting or deliveries when the HW conducted VHT Home visits to support the VHTs
- Reports generated by the VHTs would be collected by the Parish Coordinator and delivered to both the Health Facility and to the District and MC

CHALLENGES POST-MC SUPPORT

- The Supplies were not regular and as a result VHTs would experience stock out.
- Resupply was often not based on proper quantification leading to stock out of commodities
- The quarterly visits and VHT meetings were facilitated by MC therefore could not be sustained.

OUR SOLUTION…

- As an interim solution District implemented commodity redistribution from the Health facilities to the community VHTs.
- This is majorly for RDTS and ACTs

METHODOLOGY FOR REDISTRIBUTION

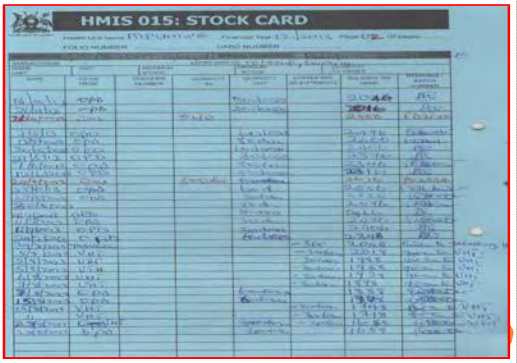
- VHTs raise their requisitions which are endorsed by the LC I C/person of the area.
- Requisition reviewed by the H/F I/C authorizes supply from the store
- VHT acknowledges receipt of the items.

DOCUMENTATION FOR REDISTRIBUTION

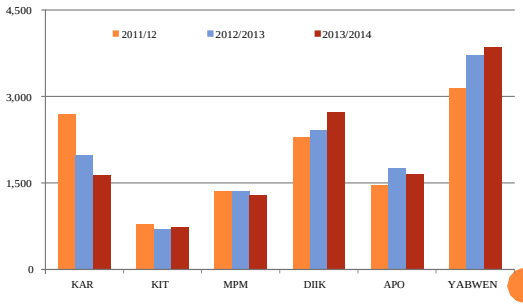
- Proper documentation is done with the authority from the Chair persons of the HUMC and the LC 1 Chairperson witnesses on behalf of the community
- The right adjustments are made on the Stock cards by the I/C of the Health facility.

DOCUMENTATION FOR REDISTRIBUTION /2

DOCUMENTATION FOR REDISTRIBUTION /3



LESSONS LEARNT : OPD TRENDS



EXPERIENCES AND LESSONS LEARNT /2

- 55% of the Health facilities are involved in the medicine redistribution.
- The Active I/C have been the most involved.
- The VHTs where redistribution is happening have remained active
- Have been able to organize themselves for other social economic benefits.

EXPERIENCES AND LESSONS LEARNT /3

- VHTs attached to H/F participating in redistribution have remained active & motivated.
- Some VHTs assist the facility staff in performing RDTs especially on heavy clinic days
- VHTs have mobilized themselves into other activities beyond ICCM *possible solution to sustainability??*

EXPERIENCES AND LESSONS LEARNT /4

- Redistribution to the communities is possible but requires good record management.
- The viability of ICCM depends on the VHT and whose viability is greatly affected by the availability of commodities and supplies.

CHALLENGES

- Only 55% of the facilities have been redistributing to the ICCM VHT
- Only H/F with adequate supplies have been able to redistribute to the VHTs
- Only ACTs & RDTs are redistributed
- Late or none reporting by some VHTs.
- Reporting by VHTs linked to the availability of the commodities.

RECOMMENDATIONS

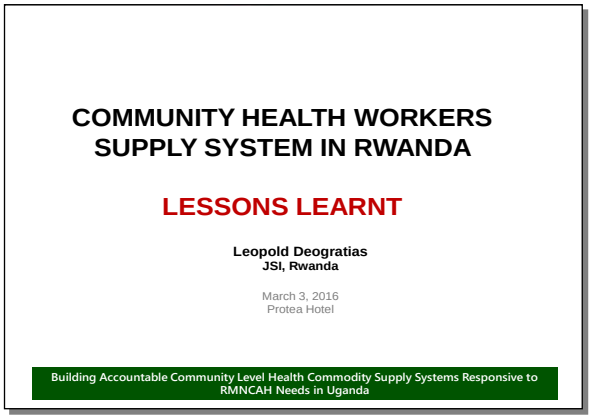
- MoH Through NMS to take over supply of medicines
- Guideline on redistribution of medicines from HFs to the Community level.
- The local government to prioritize ICCM in their development plans

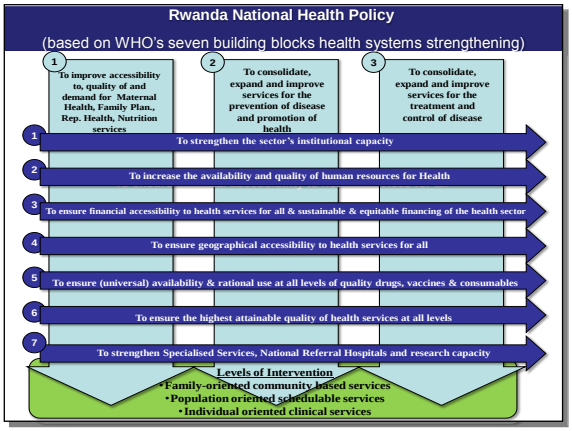
ACKNOWLEDGEMENT

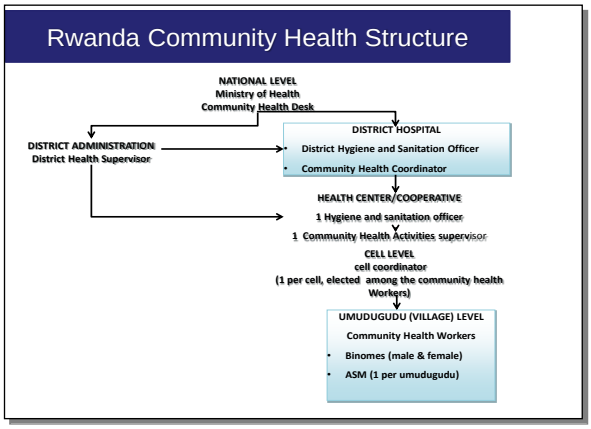
- Min of Health and Government of Uganda
- Malaria Consortium for the enormous support
- Kiryandongo district local government for the enabling environment
- The VHTs

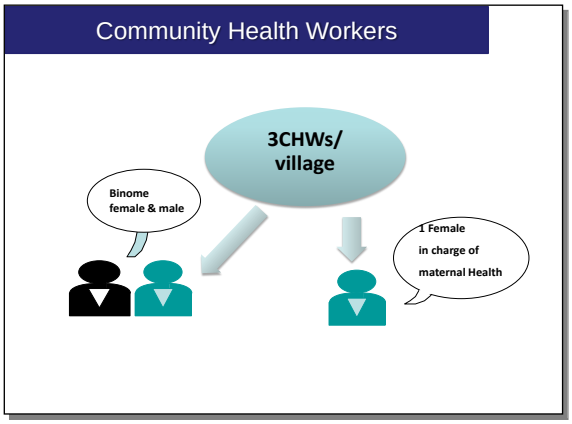
ICCM VISITORS

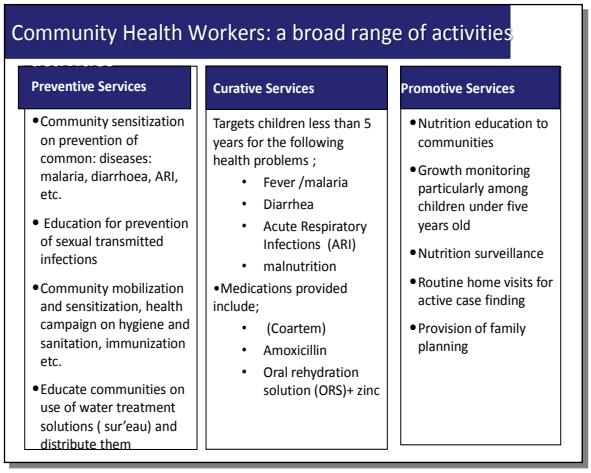
2. Community Health Workers Supply System in Rwanda: Lessons Learned – *Leopold Deogratias, JSI Rwanda*

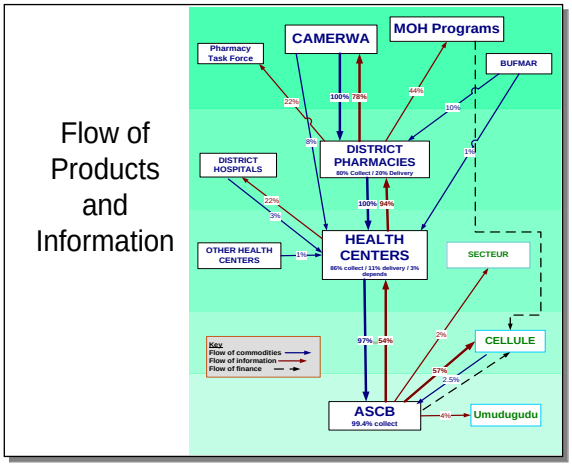












CCM Supply Chain Baseline Assessment Rwanda 2010

Methodology

Both qualitative and quantitative methods were applied:

- Logistics System Assessment Tool (LSAT)
  - 40 participants, 24 from MOH institutions/districts, 16 from partner organizations
- Key informant interviews
- Logistics Indicators Assessment Tool (LIAT)
  - Mobile phones
  - 10 DPs, 100 HC and 321CHWs
  - Build local capacity partnering with local evaluation group: National University of Rwanda, School of Public Health (SPH)

Tracer Products

1. Amoxicillin 250mg dispersible tablets
2. Primo Rouge (ACT 1x6) tablets
3. Primo Jaune (ACT 2x6) tablets
4. Malaria Rapid Diagnostic Tests (RDTs)
5. Zinc 20 mg tablets
6. ORS sachets

Baseline Results

Baseline Assessment (2010)

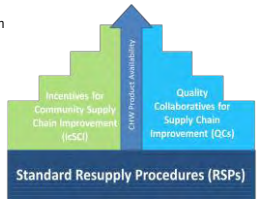
- **49% of CHWs** who manage health products had **five CCM tracer drugs** in stock on day of visit (amoxicillin, ORS, zinc, ACT 1x6, ACT 2x6)
- **No Standard Resupply Procedures**
  - No standard formulas for calculating resupply quantities for CHWs
  - Flow of information was not streamlined or aligned with product flow
  - CHWs report to multiple places, but often not to their resupply point
- **CHWs lack sufficient storage and organization for existing medicines and supplies**
  - 18% of CHWs observed had insufficient storage for existing medicines and supplies
- **Transportation is difficult between resupply points and CHWs**
  - 88% of CHWs travel by foot, 10% bikes, 0.9% private vehicles, 0.3% public transport
  - CHWs reported lack of motivation to travel to collect supplies as there was no compensation for time/travel

Improving Product Availability

Two Interventions to operationalize RSPs

Foundational (cross-cutting) Intervention: **Standard Resupply Procedures (RSP)**, simple tools and procedures designed to ensure that CHWs always have enough CCM products to serve clients

IcSCI aims to build on and strengthen RSPs by using the existing community based performance-based financing (PBF) scheme for CHWs to incentivize CHWs to improve supply chain performance



QCs aim to establish a network of health center-based quality improvement teams with shared objectives and indicators on how best to operationalize RSPs

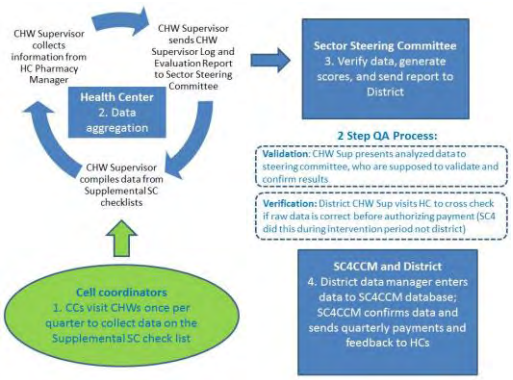
…both with the goal of **reducing stockouts** and **improving product availability**

RSPs: Core Features

Cell Coordinators are the key players. **Three tools**: stock card (🖃), resupply worksheet (≐) ,"magic" resupply calculator (🖩)

- **Cell level**: CHWs bring their stock cards and meet at Cell Coordinator's (CC) house or other convenient venue to report each month
  - CCs use each CHW stock card, magic calculator to determine how much resupply required, enter on resupply worksheet
- **HC level**: CHWs and CC attend HC monthly meeting
  - CCs give HC Pharmacy Managers resupply worksheet
  - HC use resupply worksheet to prepare orders for all CHWs, give to CCs
  - CC distributes quantities to CHWs, either at meeting or afterwards

ICSCI implementation Process:

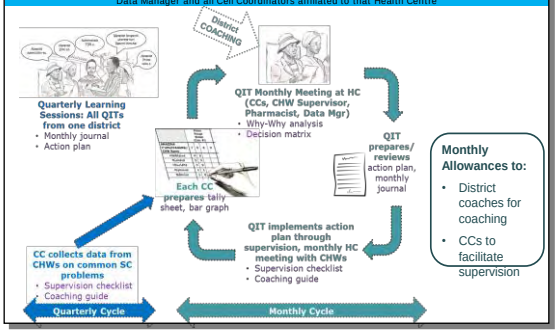


Quality Collaboratives

District Coaches: District Hospital Monitoring and Evaluation Officer, Monitoring and Evaluation Officer from Mayor's Office, District Pharmacist, District Data Manager, District CHW Supervisor

QIT Members

Health Centre QIT team members: CHW Supervisors from HC level, Pharmacy Store Managers, Data Manager and all Cell Coordinators affiliated to that Health Centre



Midline findings

FGDs: RSPs Summary

Transformed SC chaos into order

FGDs: Before the JSI project, there was no proper procedure and CHWs could come to the pharmacy any time to request for products. It was total chaos. (CHW Supervisor, Huye)

Enable evidence-based decision making

FGDs: Using the FdC helps the HCs to know exactly how much products are required. Without it everyone will be lost because the CHWs can demand anything leading to wastage and misuse of scarce resources. It helps the CC to know who needs what and when. (CHW Supervisor, Nyabihu)

Training key to skills building, need to train other staff as well

FGDs: We have now mastered the process for requesting for drugs following the training from JSI. Originally the going was slow as people were challenged due to slow learning. The forms are very easy and binomes have no problem filling them. (Pharmacy Manager, Rutsiro)

Fiche de Calcul perceived as quick and easy to use. Only one group suggested any change - increasing quantity amounts

Reduces waste of products, CHW travel time

FGDs: Yes, before the project, the CHWs would demand for products haphazardly and there was a lot of wastage of products, expiry etc.

There was also a lot of unnecessary movements of CHWs without a plan of when to obtain products, now much more organized. (CCs from Huye)

Smooth functioning challenged by stockouts at pharmacies

FGDs: Everyone submits their requests on time and they are accurately filled. The major challenge we face is shortage of Primo Yellow…(CC, Bugesera)

IcSCIs: Summary

uccesses

- process implemented as designed
- Feedback – generally provided as reported by respondents
- Incentive payments effected as planned
- Facilitation payments identified as more important than incentives

Challenges

- Validation and verification process not implemented as designed and limitations in data verification observed (as shown by verification)
- Delays in transferring of reports required as proof before payments at HC, district and project levels delayed payments

QCs: Summary

Successes

- Implemented mostly as planned:
- High levels of training in QIT processes
- QITs met regularly and used the tools to help problem solve
- Revised, simplified tools were necessary, including procedures on holding/organizing the meeting (at the beginning meetings were 4-5 hours long, needed to help shorten them)
- Feedback suggests QIT process had positive impact on strengthening relationships as well as on supply chain practices

Challenges

- Staff turnover resulted in gaps in training
- Coaching by district based coaches was irregular primarily due to competing priorities at the district

FGDs: ...the QIT has built such a good relationship along the entire chain. For me the biggest prize has been to learn how to work on plan and be able to achieve it every month. (Pharmacy Manager, Ngoma)

Quarterly Learning Sessions

100% of those who attended LS reported learning something that helped **improve supply chain performance**

Source: QC Evaluation at 3rd Learning Session

FGDs: What we liked most in QC process was the L/S. In fact the L/S was one of the best schools I have ever attended. (Pharmacy Manager, Ngoma)

Enabled peer to peer learning

FGDs: Learning Sessions (L/S) were very important. Each group would exhibit their achievements and challenges. This allowed us to learn from those who had faced a similar challenge in the past and how they solved it… (CHW Supervisor, Nyabihu)

Enabled QIT self-assessment

FGDs: The L/S were a mirror in which we looked at ourselves and see our nakedness. They helped us learn how to work smart and pushed us to our service delivery every month. (CC, Ngoma)

Increased skills in advance planning, achievement of plan, problem prioritization and resolution

FGDs: They helped me learn the biggest problems facing various CHW groups and how to resolve them. We were able to learn what we could handle and what we should refer as one can never manage all problems. (CC, Ngoma)

LS were perceived to be very important, valuable and cited as the favorite part of the process

Motivating; a forum for MOH/district stakeholders to **resolve and be held accountable** for product availability

FGDs: Sometimes people from the district and Ministry of Health were always present during the learning sessions. This helped us as they worked to solve issues of products stock-out and would work to address most issues affecting supply chain of product, also to prevent what would put them to shame. (Data Manager, Ngoma)

THANK YOU

3 Global Experiences in Operationalizing RMNCAH Commodities' Community Supply Chain – Christine Kajungu, UNFPA Uganda

Global Experiences in Operationalizing RMNCAH Commodities' Community Supply Chain

Kampala, Uganda; 3rd March 2016

Presentation Outline

- UNFPA's Procurement Process
- Community Health
- Community Supply Chain Approaches
- Case Study 1- Family Welfare Assistants
- Case Study 2 - Health Surveillance Assistants
- Ways of Operation
- Challenges—Malawi
- Recommendations

Procurement Process

Procurement Process

Community Level Health

Community Supply Chain Approaches

- Vendor- Managed Inventory—Zimbabwe
- Community Health Extension Workers—Ethiopia
- Elementary Agents—Mozambique
- Family Welfare Assistants--- Bangladesh
- Health Surveillance Assistants --Malawi

Family Welfare Assistant—Bangladesh

- There were challenges related to monitoring, transparency, and efficiency of the family planning commodity tracking system.
- In 2010, electronic tools were deployed unevenly at the upazila (sub-district) levels
- The centralized portal was implemented in parallel with an upazila-level system for electronic submission of stock on hand and consumption data by the Family Welfare Assistants or upazila managers.
- Central, regional, and upazila-level managers enter data into the system, which is then consolidated and uploaded unto the portal.

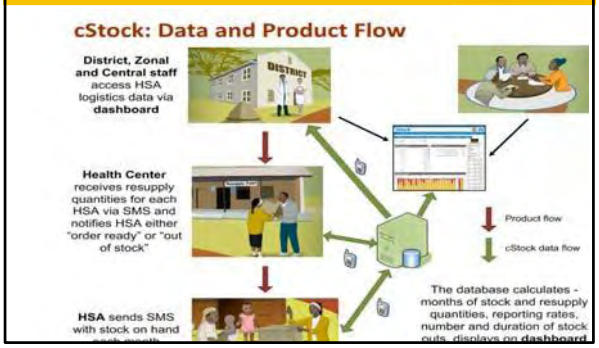
Family Welfare Assistant—Bangladesh

- The portal serves as an electronic dashboard for communicating real time supply chain and procurement data
- A 2013 evaluation on the project concluded that between 2009 and 2013, potential stock-outs (defined as less than 18 days of stock on hand) in districts and at SDPs were reduced by 85%
- The portal has also enabled data-based decision making
- At the national level, the portal enables regular interactive discussions among partners to prepare, review, revise, and update the national needs for contraceptives to revise forecasting, fund-gap analysis, and supply planning

Health Surveillance Assistants--Malawi

- In 2010, there were many problems regarding community supply chain that led to frequent unavailability of commodities at community level
- **Two main bottlenecks;**
  - Stock-outs at HSA resupply points
  - Difficulty transporting commodities between the resupply point and HSA catchment areas.
- **To address these bottlenecks;**
  - transportation and management interventions
  - logistics information portal called cStock

CStock



Health Surveillance Assistants--Malawi

cStock

- It's a web-based reporting and resupply system that collects stock data from HSAs via SMS messages
- These data are made available on an interactive dashboard that presents real-time stock levels and other metrics to districts and partners
- The cStock dashboard has been paired with the Enhancement Management approach

Health Surveillance Assistants--Malawi

cStock

- This approach with District Product Availability Teams (DPAT), composed of district management, health facility staff, and HSAs, work together on identifying and solving problems
- A 2013 midline evaluation showed that districts using cStock plus the Enhanced Management approach had higher reporting rates and had reduced lead times by half compared to districts using cStock alone
- DPAT meetings reduced tension, promoted trust, increased coordination among team members, encouraged problem solving, and improved performance.

Ways of Operation

- Community Health Workers in Bangladesh provide a voluntary service although they receive entrepreneurship incentives where possible
- In Malawi, the Community Health Workers are employed within the Environmental Health Department

Challenges --Malawi

- The HSAs get a lot of workload which affects the distribution of the commodities and routine reporting
- Competing priorities at the community level brought about by NGO's in the community
- The question on whether HSAs should play both preventive and curative roles or only preventive

- HSAs are trained to play community preventive roles
- Government and partners agreed that continued focus is needed in ensuring HSAs have access to vital resources such as transport, mobile phones and accommodation that would increase efficiency and capacity to perform the larger role
- Malawi MOH to increase 'control' to prevent the fragmentation of programmes, training and supervision

4. Lessons Learnt From Global Community - Based Supply Chain Interventions – *Fred Kagwire, UNICEF Uganda*

LESSONS LEARNT FROM GLOBAL COMMUNITY -BASED SUPPLY CHAIN INTERVENTIONS

Fred Kagwire, UNICEF Uganda

Presented at the RMNCAH Commodity Supply Chain Stakeholder Meeting

3rd March 2016, Protea Hotel, Kampala

Building Accountable Community Level Health Commodity Supply Systems Responsive to RMNCAH Needs in Uganda

CONTENT

- Background
- Challenges
- Progress in Uganda
- Lessons Learnt
- Current PSM system
- Way Forward

BACKGROUND

- Globally, there is a move to integrate community SCM into national supply pipelines
- Major international agreements like Paris Declaration (2005) emphasize need for strengthening country supply systems
- Supplies do not reach CHWs in sufficient and reliable quantities due to SCM constraints
- Uganda: PSM mainstreaming (NMS pipeline includes iCCM supplies; NPSSP III launched but costing of interventions not yet done)

CHALLENGES RELATED TO COMMUNITY SCM

- Frequent commodity stock outs at CHW level (funding gaps, quantification?)
- Limited stock monitoring and tracking of commodities at CHW level
- Last mile delivery challenges by national systems (funding gaps - Zambia; reported missing iCCM commodities - Uganda)
- Irregular replenishing of CHW commodities (transport, hard to reach areas, time constraints)

CHALLENGES…

- Majority of RMNACH supplies funded by donors (sustainability?)
- Inadequate skills for SCM at HF and community level (procurement / quantification / stores management)
- Low VHT data collection/ reporting levels
- Limited drug storage space with few shelves for proper drug storage

PROGRESS IN UGANDA

- SCM Pilot study – 2012
  - integration of ICCM commodities into the NMS supply & distribution system
  - VHT drug kit standardized
  - Regular VHT supervision, recording and reporting
- UNICEF transitioned from a vertical system of commodity distribution to the national supply chain pipeline (NMS)
- VHT / iCCM commodities are prepacked at H/Facility level not at NMS level
- PSM Mission UNICEF & UNFPA - December 2015
  - Documented successes, challenges and way forward

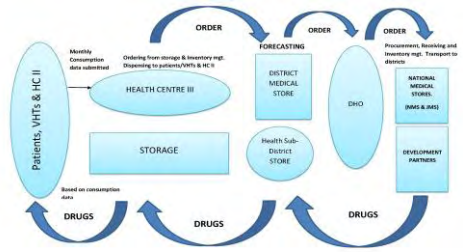
LESSONS LEARNT

- Strong government commitment and leadership are essential to drive a national RMNCAH scale up
- Presence of salaried HEWs provides a robust platform for programme implementation (Ethiopia iCCM)
- A demand-based resupply system helps to ensure sustained product availability at community level
- Capturing VHT commodity data into mainstream data systems provides more accurate and timely info. for decision making and response

LESSONS LEARNT…

- Piloted mTrac provides real time information on VHT stock levels but needs revitalization (Uganda)
- c-Stock, a rapid SMS reporting system linked to web-based performance management dashboard, helps CHWs and HFs to relay SMS messages on stock levels (Malawi)
- Capacity building for facility HWs and CHWs in managing supplies is a critical element of RMNCAH programme

CURRENT PSM SYSTEM IN UGANDA



STORAGE IN NMS

VHT MEDICINE BOX

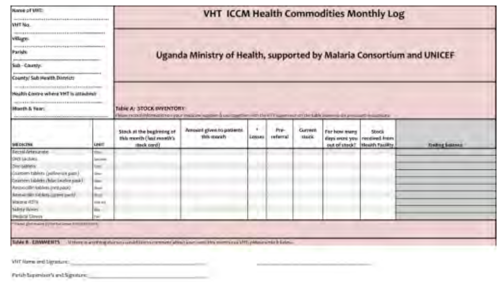
WAY FORWARD

- Finalize costing of the NPSSPIII
- Develop resource mobilization strategy for RMNCAH commodities
- Strengthen government capacity to direct and lead supply chain systems that prioritize key RMNACH interventions
- Support the plan for long term sustainability that includes strategies to retain and motivate VHTs

WAY FORWARD…

- Leverage existing and future funding opportunities to advance the priorities articulated in the NPSSPIII e.g. GFF, Global Fund, GAVI
- Consider innovations like mTrac and c-Stock to improve commodity ordering and reporting at community level
- Modify and re-introduce Community stock tracking tools

TOOL FOR RE-ORDERING



THANK YOU

5. Integrated Community Case Management (iCCM) Pilot: Assessing feasibility and scalability of distribution of iCCM commodities through National Medical Stores (NMS) – *Dr. Jesca Nsungwa*

Integrated Community Case Management (iCCM) Pilot

Assessing feasibility and scalability of distribution of ICCM commodities through National Medical Stores (NMS)

3rd Mar, 2016

iCCM background and key issues

- The government in Uganda has involved communities in health service delivery since the 90s.
- Uganda introduced the Village Health Team Strategy in 2003 and this was revitalized and expanded in 2008
  - Home Based Management of Fever (HBMF) in Uganda was introduced in 2002
  - Building on HBMF, the iCCM program has been implemented since July 2010
- However, several limitations affect the iCCM program
  - *Limited geographic coverage*: 34 districts out of 112
  - A reliable supply chain system is one of the strongest success factors in this program
  - *Non-integrated supply chain*: drugs are procured and distributed through various supply chains, most of them managed by NGO. NMS is not involved.
  - *Program management:* key programmatic components such as supervision, training, demand creation and M&E are led by NGO and lack integration into MOH or DHO systems and structures
  - *Unsustainable financing*: iCCM funding is ending in mid-2014 for the central region and end of 2014 for the Western region

Objectives of the iCCM pilot

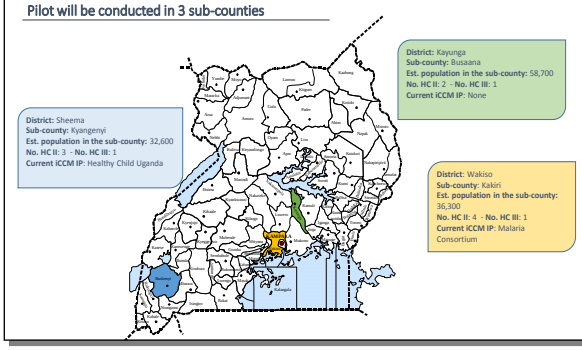
Key issues

- Lack of integration into the national supply chain
- Unsustainable funding notably for commodities
- Lack of integration of the program into MOH/DHO systems and structures

Goal: integrate supply chain into the national system and determine optimal model for national scale up in the following areas:

- Streamline and improve the process of ICCM commodities quantification at central level to mitigate stock outs and expiries at VHT level
- Integrate storage and distribution of ICCM commodities into NMS essential medicines kit processes.
- Implement training programs and processes to encourage rational use of medicines at VHT level.
- Implement cost-effective and clear supervision processes at DHO and health facility level.
- Implement waste management and infection prevention practices at VHT level.
- Understand effect of ICCM program on case burden at health facility level, as well as the total increase in number of cases diagnosed, treated and referred in the pilot area, within

Pilot will be conducted in 3 sub-counties



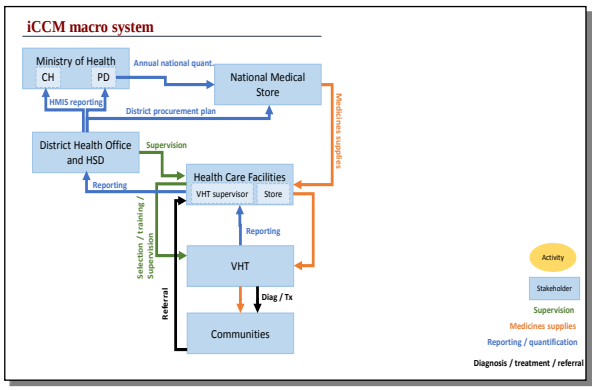
Medicines required for ICCM Pilot

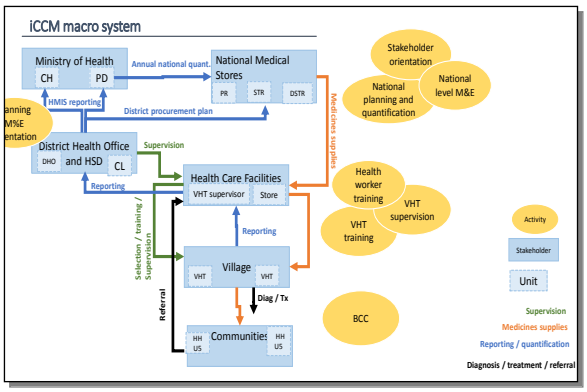
Commodity	Unit	Average Quantity per VHT per cycle (Two months)
Malaria Rapid Diagnostic Test	1	20
Artemether-Lumenfatrine 20/120mg TABLET Yellow (6x1)	6 tabs	7
Artemether-Lumenfatrine 20/120mg TABLET Blue(6x2)	12 tabs	7
Amoxicillin 125mg CAPSULE	20 capsules	5
Amoxicillin 125mg CAPSULE	30 capsules	9
ORS/Zinc Co Pack	10x20mg Zinc tabs 2 1 Litre sachet	5

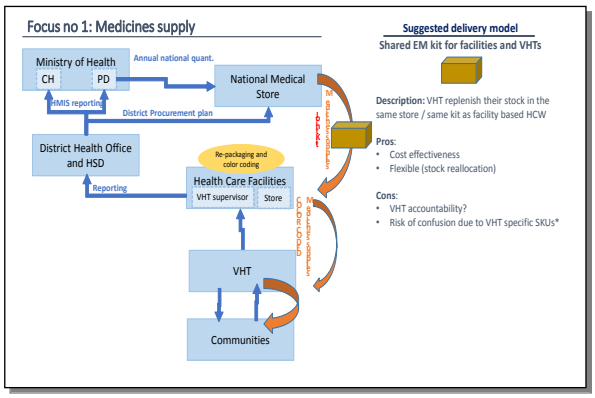
*Plus 30% *buffer*
**Source: ICCM Commodity National Quantification, Pharmacy Division (2013)*

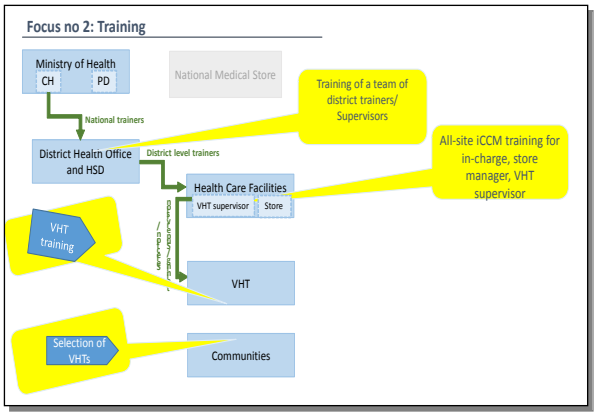
Five major areas of focus

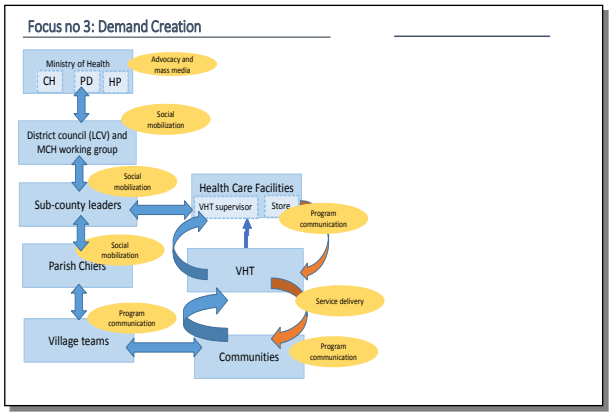
- Ensuring full supply of medicines
- Training
- Demand creation
- Supervision
- Monitoring and Evaluation

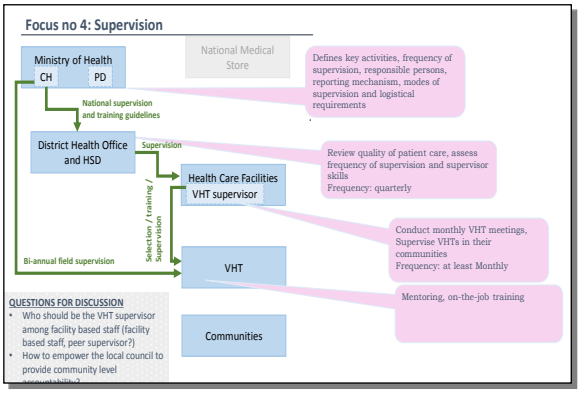


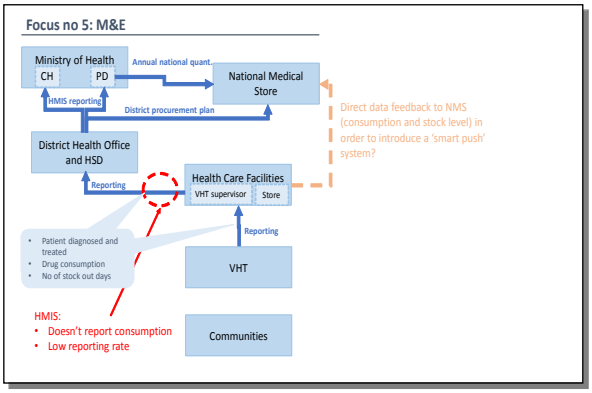












Lessons and Conclusion

- The government of Uganda is committed to making life saving medicines and health supplies readily available (at national scale) to all children less than five years old
  - Recommendations on medicine quantities, kits, curricula for SCM, tools for reporting and tracking medicine use, support supervision, health facility & VHT linkages plus micro-planning tools, sharing data
- It is feasible to remove barriers to access to medicines in a sustainable way
  - Government recommitment to ICCM – iCCM an investment priority for RMNCAH
  - Interest in private sector models – discussions and research
- Involving many stakeholders, various levels of service delivery is beneficial
  - National, District, Constituency Community Health Facility Task Force
- Need to strengthen HC level II to support to manage and support VHT SCs – micro-plans, budget, data, skills reinforcement, catchment planning, engaging communities e.g. CHTF

Acknowledge the partnership

- Malaria consortium
- UNICEF
- WHO
- CHAI
- World Vision
- Pilot districts
- NMS
- MoH Programs

THANK YOU FOR YOUR ATTENTION

"If you want to go fast, go alone but if you want to far, go many"

6. Community Health Workers & Performance – Based financing in Rwanda – *Leopold Deogratias, JSI Rwanda*

COMMUNITY HEALTH WORKERS & PERFORMANCE-BASED FINANCING IN RWANDA

Leopold Deogratias
JSI, Rwanda

March 3, 2016
Protea Hotel

Building Accountable Community Level Health Commodity Supply Systems Responsive to RMNCAH Needs in Uganda

Rwanda Community PBF

- The goal of the national CPBF is to create a community level governing structure that will allow sector-level CPBF funds to flow from central government and development partners to the grass root community health workers to support existing efforts to improve MDGs and Rwanda's vision 2020.
- The national CPBF program is based on experience gained during the implementation of the health center and hospital PBF models between 2006 and 2008

Rwanda Community PBF model

- **Supply-side Model:** CHW incentives

- Pay-for-reporting: CHW cooperatives receive a quarterly payment based on the timely submission of quality data reports related to 22 indicators

-Pay-for-indicators: CHW cooperatives will receive a quarterly payment based on improvements in coverage for 7 target indicators

Rwanda Community PBF model

1. **Nutrition Monitoring**: number of children (6-59 months) monitored for the nutrition status
2. **Antenatal care**: number of women accompanied to the health center for antenatal care before or during 4 month of pregnancy,
3. **Institutional Delivery**: number of women accompanied for delivery at health facility
4. **Family Planning**: number of new family planning users referred by CHWs cooperatives to the health center,

Rwanda Community PBF model

5. **Family Planning:** number of regular users of modern contraceptives at the health center.
6. **Tuberculosis:** number of TB-cases followed per month at home in the community-DOTS program
7. **Tuberculosis:** number of "real"* TB-suspects referred to the health center

Rwanda Community PBF model

- **Demand-side Model:** In-kind incentives

-The purpose of the in-kind incentive is to encourage women in rural community to utilize essential maternal and child health services:

1. **Antenatal Care**: Increase the number of pregnant women consulting the health center for prenatal care visit
2. **Institutional Delivery**: Increase number of women delivering in the health facilities
3. **Postnatal Care**: Increase the number of mother-child pairs receiving postnatal care at HC within 10 days of birth/discharge

Community-PBF/www.pbfrwanda.org/siscom

Improves performance of CHWs by motivating them to raise agreed upon performance indicators

Payments made when proof of the agreed level of performance

Community PBF guide details management at different levels

The Sector Steering Committee oversees the implementation and approves payment to the **CHW Cooperative**.

Indicators entered at district level into **web-based database** after quarterly approval by committee with feedback

CHWs COOPERATIVEs

All CHWs organized in cooperatives to ensure **income generation** and **accountability** of expected results

Community PBF payments used for cooperative income generating activities including:

poultry, cattle/goat/pig rearing, crop farming, basket making, etc.

Incentives and motivation for CHWs

- Trust and respect from community members, leaders etc…
- Support from **Supervisors** and implementation **partners** help improve work;
- Regular **trainings**, **meetings supervision**
- In-country **study tours** to learn from peers in other districts
- **Community performance-based financing (PBF);**
  - Membership in **cooperatives** for income generation

THANK YOU

7. Community health extension workers (CHEWs) Programme for Uganda – *Dr Christopher Oleke*

Ministry of Health

COMMUNITY HEALTH EXTENSION WORKERS (CHEWs) PROGRAMME FOR UGANDA

Dr. Christopher Oleke

March 3, 2016
Protea Hotel

Building Accountable Community Level Health Commodity Supply Systems Responsive to RMNCAH Needs in Uganda

INTRODUCTION

- Uganda has been implementing the VHT Strategy since 2001.
- The VHT strategy was put in place to bridge the gap in service delivery between the community and the health systems and empower communities to improve their health
- With 15 years of implementation of the VHT strategy, the health indicators to be monitored at the community level have largely remained poor
- How do we improve health at the community level ??

DEVELOPMENT OF IMPROVEMENT FRAMEWORK

Slide 5

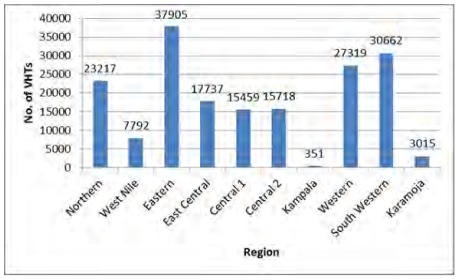
- A team from MoH visited Ethiopia to learn from their experience in implementing a successful community Health Programme
- A concept Paper on how to establish Community Health Extension Workers programme (CHEWs) for Uganda was developed
- MoH with support from partners conducted a comprehensive national assessment of the VHT implementation status (Nov. 2014 – March 2015)
- Main objective of the assessment was to establish whether the VHT strategy was achieving its intended objectives

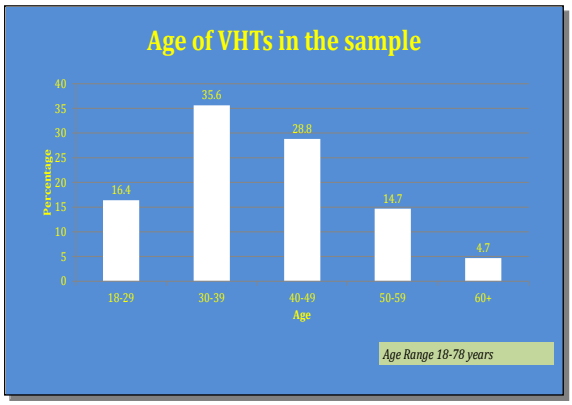
FINDINGS FROM THE VHT ASSESSMENT

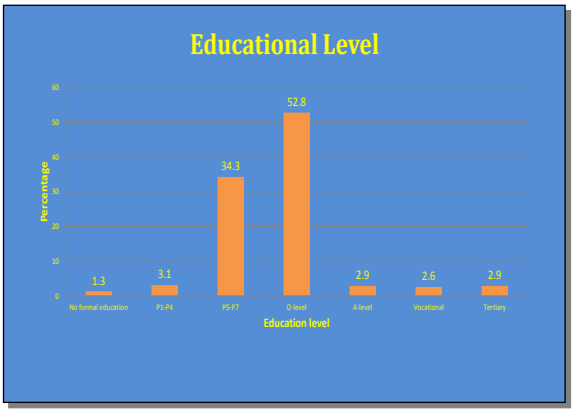
Number of VHTs in Uganda

- Overall number of VHTs = 179,175
  - Males - 54%
  - Females - 46%

REGIONAL DISTRIBUTION OF VHTS IN UGANDA







FINDINGS cont'

- The duration of training was 5-7 days which is inadequate
- 34% (about 60,000) of the VHTs did not undergo the basic training.
- Refresher trainings – not harmonized, inconsistent, varied in coverage and dependant on presence of partners and their needs
- Monitoring and supervision of VHT activities – irregular, no report on VHT activities, no data base for VHTs.

FINDINGS cont'

- Investment for VHTs – At the national level, resources have dwindled over the years to point of having no money for VHT training
- Less than 20% of the districts committed funds in the district budget for VHT
- Motivation of VHTs mainly given by IPs during activities, varied from activity to activity/ partner to partner, inconsistent and cannot be tracked.
- All VHTs expressed the wish to be paid regularly for their services

RECOMMEDATIONS

1. There is need to review the entire strategy of VHT including selection, training, roles and responsibilities of VHTs.
2. Government should have a clear commitment to adequately finance and institutionalized the VHT strategy and ensure regular payments of VHTs for sustainability.
3. Establish a strong VHT coordination structure as well as clear monitoring and supervision mechanisms at all levels.

RECOMMEDATIONS cont'

4. The Ministry of Health should establish an accurate data base for VHTs at the national level to aid monitoring and supervision of the programme. Each district should also be helped to create district specific VHT data base.
5. Ministry of Health should streamline training and retraining of VHTs to ensure quality, equity in capacity building for all VHTs.
6. Lastly, government and all relevant stakeholders should avail conducive working environment for VHTs. This should include efforts to improve working relationships between VHTs and health workers and supporting economic development opportunities for VHTs.

WAY FORWARD

- MoH has developed a CHEW Policy.
- A detailed and costed CHEW strategy has also been developed and is being shared through different meetings
- Mobilization of Funds for CHEWs programme to start is being undertaken
- Actual training of the CHEWs to commence 2016/17
- Total number of CHEWs to train – 15,000

SOME KEY ISSUES IN CHEW STRATEGY

- The training of CHEWs will be done in recognized Training Institutions
- Two people from each parish will be trained as CHEWs
- Using a set criteria, the community will identify and nominate people to be trained and final selection to be done by the training Institution
- The training for CHEWs will be 1 year
- The CHEWs will be based at the Health Centre II
- In urban settings, public health nurses
- The CHEWs will be paid regular salary

PREPARATORY WORK

KEY ACTIVITIES	TIME FRAME	SUPPORTED BY
Consultation with stakeholders on policy and strategy	November 2015 – March 2016	GAVI HSS
Development of Training Curriculum	March 2016	GAVI HSS
Development of training manuals	October – December	UNICEF
Development of CHEW Handbook	January – March, 2016	UNICEF
Identification and accreditation of Training Centres	February – March,	??
Orientation of Tutors	April - May	??
Mobilization and sensitization of districts on selecting, training Mobilization of Resources	April – June	??

IMPLICATIONS FOR SUPPLY CHAIN MANAGEMENT

- Transition will happen over a period of 5 years
- The VHTs who qualify will be absorbed in the CHEWs
- For the VHTs who will not qualify, their roles will be redefined

IMPLICATIONS cont'

- CHEW will use the Model Family approach
- Partners will have to re-align their support and intervention to the CHEW strategy

COST OF THE COMMUNITY EXTENSION WORKERS PROGRAM IN UGANDA (SUMMARY)

Major initiatives	FY15	FY16	FY17	FY18	FY19	FY20	GRAND TOTAL
CHEW Tools, Equipment and Supply	-	829,112	2,144,444	4,917,502	5,978,374	4,831,292	18,700,724
HEWs basic and refresher Training	1,937,945	3,854,035	7,964,727	6,834,121	299,421	749,379	21,639,627
Coordination and Supervision of CHEWs program	122,201	659,216	1,174,832	2,503,245	2,388,062	989,787	7,837,343
CHEW Salaries and Allowances	-	1,540,037	4,758,715	11,436,778	16,828,402	17,333,254	51,897,187
Electronic Information Systems Development and Maintenance	13,200	1,360	1,400	1,442	1,486	1,530	20,418
Total Cost	**2,073,345**	**6,883,760**	**16,044,118**	**25,693,089**	**25,495,744**	**23,905,242**	**100,095,299**

Thank You

8. Situational Analysis of Community Level Supply Chain System in Uganda - *Eric Jemera Nabuguzi, USAID/UHSC Program*

Uganda Health Supply Chain

Situational Analysis of Community Level Supply Chain System in Uganda

Eric Jemera Nabuguzi
USAID/UHSC Program

March 3, 2016
Protea Hotel

Building Accountable Community Level Health Commodity Supply Systems Responsive to RMNCAH Needs in Uganda

PEPFAR USAID msh

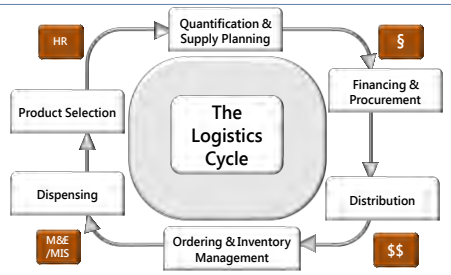
BACKGROUND

- Health facility births has stagnated around 57% - 58% – *UDHS 2011*
- High unmet need for contraception (34% for married women) – *UDHS 2011*
- Up to 35% of deaths in children <5 years caused by diarrhea, pneumonia and malaria – *Sharpened Plan*
- 70% of VHTs stock out of atleast 1/3 key medicines in the iCCM program in the past 12 months – *Mubiru et. al (2015)*

OBJECTIVES OF THE ASSESSMENT

- Document the policies, systems and resources that support the supply chain for community-level RMNCH programs
- Identify important gaps and bottlenecks in the supply system affecting reliability of community-level commodity supply
- Make recommendations to build a well-functioning national supply chain for community-based programs

SCOPE OF THE ASSESSMENT



- Excluded analysis appropriate diagnosis, treatment, medicines use and dispensing by VHTs

METHODOLOGY

Used a combination of methods:

- **Document review**: Policy and Strategy documents, assessments by different partners (PATH, UNFPA, Malaria Consortium, SURE, MoH)
- 35 **interviews**: MoH (RH, CH, Pharmacy, Malaria Program, Resource Center), Partners (Donors & Implementing), Districts, Health Facilities and VHTs
- Two (2) **Focus Group Discussions** with VHTs experienced with iCCM, community FP program or both
- **Health facility** and **VHT records review**

ICCM & SAYANA PRESS PROGRAM

Program	iCCM	Sayana Press Program
Program Type	Scaling-up; 78 districts by 2016	Pilot in 28 districts (Partial coverage)
Period	Adopted by MoH as policy in 2010	Start: 2014 End: March 2017
VHTs trained by Sep. 2015	Approx. 30,000	Approx. 2,000
Target No. of VHTs for training	Approx. 60,000	Approx. 6,000

ICCM & SAYANA PRESS PROGRAM

Commodities handled by VHTs

- Amoxicillin 250mg dispersible
- Malaria RDT
- ACTs
- Rectal artesunate
- ORS/Zinc
- Gloves
- Safety box
- ARI Timer

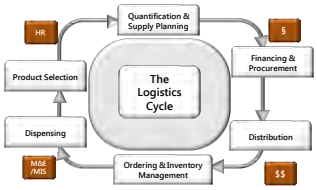
iCCM

- Male & female condom
- DPMA, Sayana Press®
- Progestin-only
- Combined oral pills
- Emergency contraceptive pill

Community FP Program

FINDINGS

- Coverage
- Policy Environment
- Financing & Procurement
- Product Selection
- Quantification & Supply Planning
- Distribution & Ordering
- Inventory Management
- Logistics Information Systems
- Other Country Models



COVERAGE OF iCCM & SAYANA PRESS PROGRAMS

- Approx. 72% (81 districts) have either a community family planning or iCCM. 17% (19 districts) have both
- Approx. 180,000 VHTs; approx. 30,000 VHTs trained for iCCM & 2,000 VHTs trained for FP Program.
- Compare with estimated target of 15,000 CHEWs

TRAINING OF VHTs

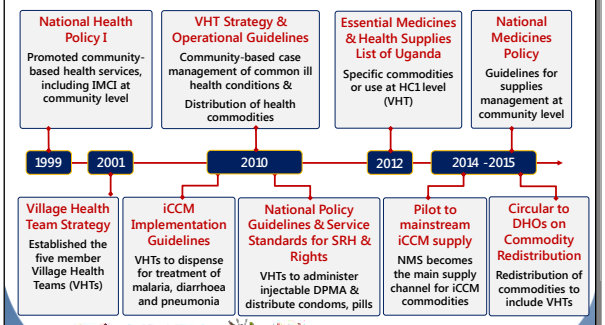
- VHT Basic Package (6 days) - Coverage is >90% (MoH 2015)
- Duration of training is not harmonized, and is based on individual programs
  - iCCM (5 days)
  - Community-based FP services (7–13 days)
- Training duration may not adequately address supplies management (VHT Assessment 2015)

COVERAGE & TRAINING OF VHT PROGRAMS

Implications of Findings

- High geographical coverage of the two programs. Need for nation-wide scale-up plans
- Planning & resource needs to reach all VHTs
  - Need to invest in capacity building for VHTs; iCCM has reached 25% of target of approx. 120,000 VHTs

POLICIES ON VHT PROGRAMS



POLICY ENVIRONMENT – Key Issues

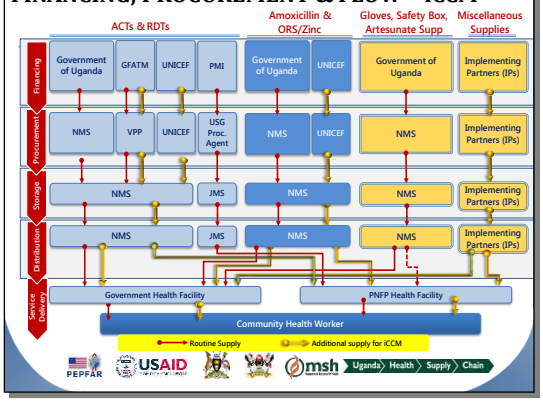
- NDA Act 2000 prohibits VHTs and certain health cadres from prescribing antibiotics – Policy coherence needed
- VHTs are volunteers;
  - Legal status? Protection?
  - Guidelines to mainstream and sustain commodities initially supplied through projects for VHT programs lacking

POLICY ENVIRONMENT – Key Issues

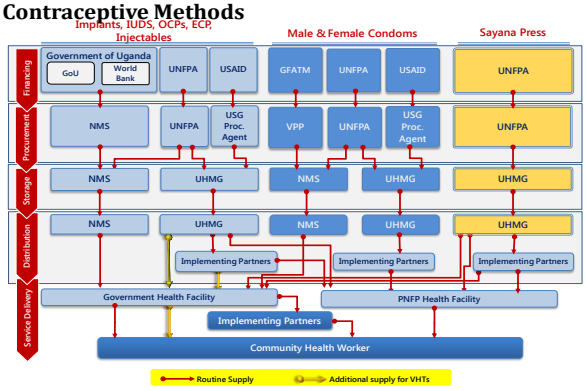
Implications of Findings

- Address legislative and policy support for VHT programs
- Strategies that address financial sustainability of VHT interventions needed

FINANCING, PROCUREMENT & FLOW – iCCM



FINANCING, PROCUREMENT & FLOW –Modern Contraceptive Methods



FINANCING & PROCUREMENT

- Multiple funding streams for CHW programs, including supply chain
- Funding is insufficient, and not predictable - high donor dependence
- No financial tracking to optimize available resources at community level
- IPs have *ad hoc* supply arrangements to health facilities and VHTs

FINANCING & PROCUREMENT (Cont'd)

Implications of Findings

- Systems to track financing and commodities down to community level
  - No budget line linked to commodities for VHTs attached to health facilities.
- Need to cost the roll-out/implementation of community level interventions
  - For iCCM, approx. 25% increase for malaria, diarrhea and pneumonia commodities at health facility level
- Mainstream financing and commodity flow by implementing partners – One Facility, One Supplier

PRODUCT SELECTION

- Addition to and/or removal from list of commodities dispensed by VHTs is *ad hoc*
  - These are not currently reviewed and approved by Medicines Technical Working Group
- Need to align positions with the NDA Act on medicines that can be dispensed by VHTs

PRODUCT SELECTION

Implications of Findings

- All commodities handled by VHTs should be included in the EMHSLU (update due in 2016)
- Strengthen community level guidelines on commodities that can be used by VHTs
- Need for a schedule for medicines used at community level

QUANTIFICATION

- Limited data, if any, reported on clients reached or consumption and stock on hand at community level
- Limited country experience in quantification for community level, except contraceptives & iCCM program
  - Homapak experience where massive expiries occurred
- Except for iCCM & Sayana Press, it is not clear what the commodity requirements are for community level programs

QUANTIFICATION

Implications of Findings

- Need for mechanisms to collect, report and account for commodities supplied and used at community level
- Need for reliable national quantification of community level requirements
- Need to institutionalize data quality assessments to improve reliability of the data and national quantifications

SUPPLY PLANNING

- Multiple funding and procurement sources of commodities for community programs, that need strong coordination by MoH
- Limited data available for supply planning

Implications of Findings

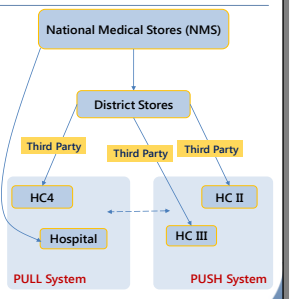
- Tracking and monitoring RMNCH commodities in the routine national stock status reports and CSG, TWG meetings
- Adherence to national procurement plans

DISTRIBUTION

- Main distribution mechanisms for iCCM and FP commodities - NMS, JMS & UHMG

National Medical Stores

- Last mile delivery using a bimonthly (HCII- IV) and monthly (Hospitals) distribution schedule
- NMS directly delivers to hospitals; uses third party agents to deliver from District stores to lower levels
- PULL & PUSH systems used



DISTRIBUTION

Uganda Health Marketing Group (UHMG)

- Distributes directly to 10/28 districts on defined schedule in the Sayana Press Program
- IPs pick and deliver to 18 districts in the Sayana Press Program
- Alternative Distribution System to reach private and NGO sector; there has not been distribution to facilities
  - Started distribution to some regions in July 2015
- IPs pick FP stock from UHMG and deliver to both gov't and PNFP facilities

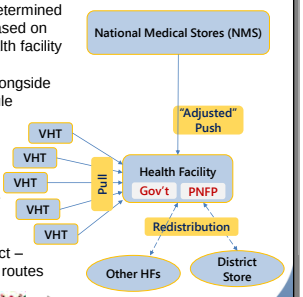
DISTRIBUTION (cont'd)

Implications of Findings

- Distribution should be directly to health facility – eliminates distribution challenges for districts & simplifies accountability
- Integration of VHTs commodities' distribution with routine health facility delivery plans

SUPPLY MECHANISMS – ICCM

- "Adjusted" Push System: pre-determined kit content, quantity adjusted based on number of VHTs linked to a health facility
- VHT commodities distributed alongside HF supplies in the NMS schedule
- VHTs pick stock from the health facility
- HC3s have limited capacity e.g. ARVs, HIV test kits
- PNFPs pick supplies from district – PNFPs not part of routine NMS routes



STOCK LEVELS OF HCII & HCIIIs

Product	April - June 2015** (Months of Stock)				July – September 2015** (Months of Stock)			
	0	<2	2 - 2.9	>3	0	<2	2 - 2.9	>3
	Percent of Facilities				Percent of Facilities			
Artemether/lumefantrine 20/120mg (adult dose)	8%	34%	10%	49%	13%	55%	5%	27%
Depo-Provera vials	19%	8%	2%	72%	17%	8%	1%	74%
Malaria rapid diagnostic test	9%	44%	2%	45%	15%	39%	3%	43%
Microgynon	60%	17%	0%	23%	48%	21%	6%	26%
ORS sachet	19%	30%	16%	35%	20%	37%	4%	39%

ORDERING (cont'd)

Implications of Findings

- Need for standardized procedures for resupply of VHTs by health facility
- Explore PULL system at HCIII for all commodities
- Establish guidelines for quantifying and including VHT requirements at facility level

INVENTORY MANAGEMENT (cont'd)

Differences in management of commodities at health facility and resupply of VHTs

iCCM	Sayana Press Program
Is not integrated ▪ Separate stock cards	Is integrated ▪ Use the same stock card
Resupply to VHTs is Monthly & Quarterly	Resupply to VHTs is Monthly
Health worker determines the quantity to issue to VHT	Health worker determines the quantity to issue to VHT, though VHTs can "negotiate"
No standard resupply calculation	No standard resupply calculation

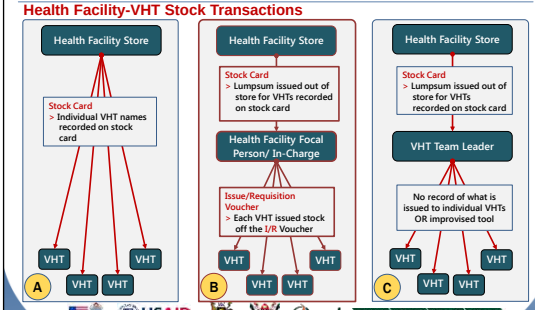
INVENTORY MANAGEMENT (cont'd)

Implications of Findings

- ❑ Need to standardize resupply calculation to determine appropriate quantity for a VHT across programs
- ❑ Need for a standard resupply process or procedure for resupply to VHTs
- ❑ Need to harmonize training and practice on management of VHT stock at health facility

INVENTORY MANAGEMENT AT HF

Health Facility-VHT Stock Transactions



INVENTORY MANAGEMENT

Implications of Findings

- ❑ Establish a mechanism that ensures traceability of, and accountability for commodities issued to VHTs
  - Individual VHTs need to be traceable
  - Record of stock issued to and consumed by VHTs
  - Record of number of cases treated
  - A health facility's VHT focal person

LOGISTICS MANAGEMENT INFORMATION SYSTEM

Limitations of Existing HMIS Tools

HMIS Tool	Data Reported	Observation
HMIS 097 VHT/iCCM Register	▪ Reports on Number of under-five clients served	▪ Stock on Hand not captured ▪ Consumption is a "tick" (not numeric)
HMIS 097b VHT Quarterly Report	▪ Reports on number of villages stocked out	
HMIS 105 Monthly HF Report	▪ Reports on community based distribution of FP commodities	▪ Monthly reporting for HMIS 105 vs. Quarterly reporting for CHWs

LOGISTICS MANAGEMENT INFORMATION SYSTEM (3)

Reporting into DHIS2

- ❑ **Low reporting rates** for data collected from community level in DHIS2
  - Average <10% reporting of 097b in 2014
  - Between 5-40% of VHTs submitted a quarterly report to the health facility, but no way of reflecting this in DHIS2
- ❑ Available data is of **low quality**

LOGISTICS MANAGEMENT INFORMATION SYSTEM (2)

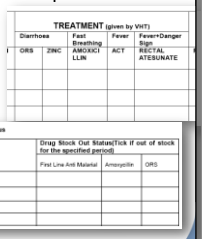
Community-based FP Program - Multiple tools used

- ❑ Partners use different tools due to inadequacies of the existing HMIS tools
- ❑ The tools capture Quantity Dispensed by VHTs and Stock on Hand, but not reported in DHIS2
- ❑ HMIS 105 reports community-based distribution of OCPs, injectables
- ❑ Stock cards are given to VHTs

LOGISTICS MANAGEMENT INFORMATION SYSTEM (4)

Implications of Findings

- Need to review and harmonize tools to capture and report key logistics data
- Need to harmonize frequency of reporting from community level


TREATMENT (given by VHT)

Diarrhoea		Fast Breathing	Fever	Fever+Danger Sign
ORS	ZINC	AMOXICILLIN	ACT	RECTAL ATESUNATE

Drug Availability Status

Name of Village	Drug Stock Out Status(Tick if out of stock for the specified period)		
	First Line Anti Malarial	Amoxycillin	ORS

SUPERVISION & COORDINATION

Key Issues at District Level

- No effective instrument of control over community health workers available to DHT or the health facility
- Largely non- functional (documented) supervisory structure for VHTs
- Where available, VHT supervision tools do not adequately cover logistics management
- District Medicine Management Supervisors (MMS) support does not extend to community level

SUPERVISION & COORDINATION (cont'd)

Key Issues at Health Facility

- Acute staff & infrastructure challenges at HCIIs/HCIIIs; >90% linked here
- No written supervision guidelines/checklist or standard supervision training program
- Some lack training in supervision of commodity management at community level

SUPERVISION & COORDINATION (cont'd)

Implications of Findings

- Need for an instrument of power over VHTs to impact commodity management at that level
- Need to develop standardized supervision tools, guidelines and training program
- Bridge gap of formal training of VHT supervisors

COMPARING WITH OTHER COUNTRY MODELS…

Country	Frequency of Resupply
Rwanda ▪ CHW is a volunteer, with 4 weeks training; 6-12 products	Monthly
Malawi ▪ CHW is a paid cadre, with 12 weeks training; 8-19 products	Monthly
Ethiopia ▪ CHW is a paid cadre, with one year training; 55+ products	Monthly
Uganda iCCM	▪Quarterly (Global Fund) ▪ Monthly (UNICEF)
Sayana Press Pilot Program	▪Monthly

COMPARING WITH OTHER COUNTRY MODELS…

Country	Logistics data reported by CHW
Rwanda ▪ 6-12 products	▪ Stock on Hand, Quantity dispensed
Malawi ▪ 8-19 products	▪ Stock on Hand at CHW, Quantity issued by health worker to CHW
Ethiopia ▪ 55+ products	▪ Beginning Balance, Quantity Received, Losses/adjustments, Stock on Hand
Uganda iCCM	▪ Number of clients tested or treated by disease
Sayana Press Pilot Program	▪ Quantity Dispensed in all 28 districts ▪ Quantities received, Losses/ Adjustments & stock on hand in 18 districts

COMPARING WITH OTHER COUNTRY MODELS…

Country	Resupply calculation	CHW Resupply Calculation Tool(s)
Rwanda	Standard resupply calculation formula	▪ CHW Stock Card ▪ "Magic Calculator" ▪ Resupply Worksheet
Malawi	Standard resupply calculation formula	▪ cStock (An SMS-based reporting used for calculating resupply)
Ethiopia	Standard resupply calculation formula	▪ Health Post Monthly Report & Request Form
Uganda iCCM	No standard calculation	None
Sayana Press Pilot Program	No standard calculation	None