Scaling up integrated Community Case Management in the context of the UNICEF - GFATM Memorandum of Understanding

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MEETING REPORT

March 2016

Executive Summary

A workshop convened in Nairobi, Kenya in February 2016 brought together key stakeholders from global, regional and country level to share knowledge, lessons learned and experiences across countries in scaling up iCCM in the context of the Global Fund's new funding model (NFM) and the 2014 UNICEF-Global Fund Memorandum of Understanding (MoU). Over 140 participants from 23 countries, including 19 country teams from sub-Saharan Africa, attended the meeting.

During Phase 1 of its work (2014/2015), the iCCM Financing Task Team (FTT) – an inter-agency collaboration led by UNICEF - focused its efforts on supporting countries to 1) revise/strengthen national strategies for iCCM; 2) undertake iCCM gap analyses; and 3) incorporate iCCM funding requests into strong, technically sound Global Fund malaria and health systems strengthening (HSS) concept notes. During Phase 2 (2015/2016), the FTT focused its efforts on assisting countries in successfully navigating the Global Fund's grant approval and grant-making processes as well as ensuring maximum value for money and the optimal implementation of integrated delivery through effective implementation planning.

In addition to sharing experiences and promoting South-to-South exchange, the purpose of the workshop was also to identify how countries can most effectively accelerate progress from approved grants to integrated iCCM programming and implementation on the ground as well as how partners can support this process.

Key Successes

- Twenty-three (23) countries were supported by the iCCM FTT for the integration of iCCM into Global Fund malaria and HSS concept notes; 21 countries submitted concept notes, which included an iCCM component.
- A compendium of over 10 tools for quantifying and costing expanded iCCM services and the process of integrating iCCM into concept notes as well as for iCCM implementation planning, iCCM PSM planning, resource mobilization, and iCCM advocacy has been developed.
- Approximately USD 200 million has been mobilized, from the Global Fund and co-funders, including domestic governments, for iCCM across an initial set of 12 countries (Burkina Faso, Burundi, Cote d'Ivoire, DRC, Ethiopia, Ghana, Malawi, Mali, Niger, Nigeria, Uganda, and Zambia).
- iCCM is clearly recognized on the global agenda as an essential evidence-based intervention for under-five morbidity and mortality reduction at the community level.
- Many countries are demonstrating strong government ownership, leadership and coordination of iCCM.
- In numerous countries iCCM has been increasingly integrated into national systems, particularly health management information systems (HMIS) and procurement and supply management (PSM) systems.

Key Constraints

- Despite leveraging approximately USD 200 million from the Global Fund and other partners, a financial gap of almost USD 200 million remains, primarily for procurement of non-malaria commodities, with consequences for the scale-up of some iCCM components, i.e., pneumonia and diarrhea treatment.
- Developing sustainable incentives (financial and non-financial) to motivate and retain community health workers (CHWs), which in many countries remain unpaid positions, is a challenge.
- Procurement and supply chain management challenges, especially in relation to ensuring that CHWs are re-supplied with medicines and other commodities in a timely manner, are common to several countries.

- There are insufficient human and/or financial resources at health facility level to undertake effective supportive supervision of CHWs.
- In a number of countries routine iCCM indicators have not yet been integrated with the national HMIS due to inadequate coordination at national level; inadequate engagement with HMIS technical working groups; and uncertainty about which key indicators to select and focus on. In some countries iCCM indicators have been integrated but challenges remain: lack of disaggregated data for iCCM versus facility IMCI; inadequate human resource capacity and mechanisms to support data quality and data use; too many tools, lengthy/heavy tools, and stock-outs of tools for front-line workers; and inadequate ICT equipment. Additionally few countries in SSA have supported periodic national georeferenced facility and CHW censuses/surveys and fully exploited their potential.

Key Outcomes

- Country experiences in iCCM implementation shared and documented.
- Country iCCM implementation plans peer reviewed.
- Country iCCM monitoring challenges and solutions identified, and (for some countries) technical assistance needs identified and timelines estimated as a step toward developing M&E action plans.
- Country PSM challenges and solutions identified as a step towards developing PSM action plans.
- Country resource mobilization strategy development initiated.
- Country action plans (draft) developed and technical assistance needs identified and shared with partners.

Lessons Learned

- Strong in-country partnerships are key to driving effective implementation planning and the integrated financing for iCCM agenda forward
- Co-financing discussions should take place as early as possible to ensure sufficient funding is available for full iCCM implementation (malaria and non-malaria components and commodities)
- PSM planning is a vital component of iCCM planning that needs to be conducted from the beginning of the process. It is also important to ensure that, in addition to the costs of the non-malaria iCCM commodities, the costs of the supply chain itself (storage, transport, tariffs, etc.), which can be significant, are reflected in plans and budgets.
- Monitoring iCCM program performance and outcomes is critical. Countries should focus on priority routine indicators (see Session 4 summary) even though Global Fund grants only monitor select iCCM indicators; ensure integration of the priority iCCM routine indicators with the national HMIS; ensure disaggregation of the priority indicators by facility and community platforms; and strengthening human resource capacity, HMIS/DHIS2 functionality, and mechanisms for improving data quality (completeness, timeliness, and accuracy) and data use.
- As an extension of primary health care facilities, the community health platform and community health workers are an integral component of building stronger and more resilient national health delivery systems. Strengthening primary health care facilities to provide core services, and capacitating PHC staff to supervise community health workers is key to the success of iCCM and the community health platform.
- Community health financing requires a long-term vision with both strong leadership and investment from government. Given the remaining funding gap, there is a clear need to explore new and innovative funding sources (including the private sector), especially in relation to co-financing for non-malaria commodities.
- Projecting resource needs and costs, ensuring cost-effectiveness, and developing resource mobilization strategies and comprehensive investment cases will be critical for mobilizing sustainable financing for the iCCM platform.

- Motivation and financial incentives/remuneration of CHWs is critical for ensuring the sustainability of the iCCM platform and needs to be factored into long-term community health financing strategies.

Recommendations

In order to move forward with scaling up ICCM in the context of the Global Fund and with the goal of promoting long tern sustainability, it is strongly recommended that country teams:

- **Strengthen national leadership and in-country partnerships** to track progress, identify challenges and solutions, and monitor iCCM as an integrated program.

- **Institute quarterly program reviews to track implementation status** of their iCCM Global Fund grants through existing coordination mechanisms. Where implementation progress is sub-optimal, bottlenecks should be identified and resolved at the earliest opportunity to avoid potential re-programming of funds allocated for iCCM.

- **Strengthen country coordination mechanisms and national systems** for improved PSM for iCCM

- **Integrate priority routine iCCM indicators into national HMIS, while also e**nsuring that data is disaggregated from facility-based treatment indicators to enable monitoring of both service delivery platforms.

- **Institutionalize community health worker platforms** as part of the health system and ensure community health is fully integrated into the national primary health care system.

- **Develop investment cases,** which include incentives and/or remuneration of CHWs, to mobilize long-term, sustainable financing for iCCM and to strengthen the community health platform.

Background

In April 2014, the Global Fund and UNICEF signed a Memorandum of Understanding (MoU) to better coordinate efforts aimed at reducing the burden of HIV, tuberculosis and malaria and improving the health of mothers, newborns, and children in a select number of high burden countries. UNICEF and the Global Fund agreed to work together in the context of the Global Fund's new funding model (NFM) to include support for a complementary and comprehensive Maternal, Neonatal, and Child Health intervention package in line with national strategies for maternal and child survival. More specifically, for child health, the collaboration is aimed at supporting governments to secure and deliver additional basic child health commodities - antibiotics for pneumonia and oral rehydration salts (ORS) and zinc for diarrhea – in addition to antimalarial medicines and diagnostics, through integrated community case management (iCCM).

During Phase 1 of its work (2014/2015), the iCCM Financing Task Team (FTT) - a multi-organizational collaboration led by UNICEF - focused its efforts on supporting countries to 1) revise/strengthen national strategies for iCCM; 2) undertake iCCM gap analyses and 3) incorporate iCCM funding requests into strong, technically sound Global Fund malaria and health systems strengthening (HSS) concept notes. During Phase 2 (2015/2016), the FTT focused its efforts on assisting countries in successfully navigating the Global Fund's grant approval and grant-making processes as well as ensuring maximum value for money and the optimal implementation of integrated delivery, which includes a strong focus on procurement and supply chain management (PSM) and community health systems strengthening (HSS).

Phase 1: Integrating iCCM into National Child Health Strategies and Global Fund Concept Notes

Phase 1 has been a success, generating some important results:
- 23 countries were supported by the iCCM FTT for strategy development and gap analyses for the integration of iCCM into malaria and health systems strengthening concept notes.
- 21 countries submitted concept notes, which included an iCCM component
- As of January 2016, 13 countries have signed Global Fund grants and are moving into the implementation phase.
- As a result of the UNICEF - Global Fund MoU, approximately USD 200 million has been mobilized for iCCM across the initial set of 12 countries: Burkina Faso, Burundi, Cote d'Ivoire, DRC, Ethiopia, Ghana, Malawi, Mali, Niger, Nigeria, Uganda, and Zambia. This includes resources from the Global Fund's NFM as well as from national governments (domestic resources), UNICEF, other partners and other funding mechanisms.
- Work on integrated PSM has included dissemination of the December 2014 UNICEF-Global Fund-UNFPA PSM communiqué, the development of various PSM tools and guidelines to support implementation, as well as the development of strong intra- and inter-agency mechanisms to coordinate the process.

Phase 2: Supporting iCCM Implementation

Following grant signature, grants sometimes fall short during implementation vis-a-vis approved plans as well as documentation and reporting of achievements. Within this context, it is particularly important to share early experiences of iCCM implementation within the context of the Global Fund's NFM, discuss challenges faced, and jointly come up with innovative solutions to ensure grants are implemented in accordance with agreed upon plans and timelines.

Purpose of the Workshop

The purpose of the workshop was to bring key stakeholders from global, regional and country levels together to share knowledge, lessons learned and experiences across countries to accelerate progress from approved grants to integrated iCCM programming and implementation on the ground (see detailed agenda in Appendix A).

Specific Objectives

1. Review implementation planning and monitoring of the iCCM component of Global Fund malaria and HSS grants to:
   a. share lessons learned/experiences across countries;
   b. define key constraints and identify potential solutions;
2. To increase understanding of priority iCCM indicators, processes for integration into national HMIS, and best practices to support data quality and use and support the development of country-specific iCCM M&E action plans;
3. Share country experiences with integrating iCCM supplies into national PSM systems and develop draft country action plans, which identify key bottlenecks, solutions, and actions for fostering this integration, including PSM capacitation/strengthening;
4. Assist country teams to develop resource mobilization strategies for co-financing needed as described in the concept notes; and
5. Identify technical assistance needs for ongoing support for implementation and scale-up of iCCM-Global Fund grants.

Expected Outcomes

- Synthesis of country experiences and lessons learned during early implementation of Global Fund-supported iCCM programming
- Challenges, solutions and technical assistance needs identified for strengthening iCCM monitoring and HMIS systems in preparation for development of monitoring action plans.
- Draft country strategies for PSM capacitation/strengthening, resource mobilization for co-financing, and technical assistance needs to support iCCM program implementation and monitoring.

Participants

Approximately 140 participants from across nineteen countries (19) in sub-Saharan African as well as regional and global level colleagues participated in the meeting.

Participating countries included Burkina Faso, Burundi, Cameroon, Cote d'Ivoire, DRC, Ethiopia, Ghana, Kenya, Madagascar, Malawi, Mali, Mozambique, Niger, Nigeria, Somalia, South Sudan, Tanzania, Uganda, and Zambia. Country delegations varied in size and composition, but generally included UNICEF Health/iCCM focal points; Ministry of Health officials (Child Health; National Malaria Control program; Community Health), GFATM PRs/SRs, and key implementing partner(s). The average delegation size was 5, although some countries only sent 1 representative (e.g. Nigeria), while Kenya (as the host country) had an especially large delegation, which additionally included community health workers.

From the **regional and global levels**, UNICEF HQ, ESARO and WCARO Health, iCCM, malaria, and SD focal points; WHO-HQ and AFRO child health and global malaria program focal points; core members of iCCM Financing Task Team (WHO, Save the Children, USAID/MCSP; the USAID funded SIAPS program of MSH)); GFATM colleagues (HSS; M&E; FPM); Roll Back Malaria, African Leaders Malaria Alliance (ALMA), and HWG colleagues; the Bill and Melinda Gates Foundation; One Million Community Health Worker Campaign; World

Bank; French Development Agency; Novartis; Living Goods; JSI; USAID; and CHAI participated in the meeting.

The meeting was hosted by UNICEF ESARO and was held in French and English with simultaneous interpretation. Special thanks to administrative and IT staff who supported the meeting: Beatrice Ruria, Evelyn Chege, Joseph Kirunyu, Adam Muktar, Christiopher Njoroge (ESARO PD) and Rokhaya Diop (WCARO PD).

For the complete participant list, see Annex B.

Meeting Summary

Opening Ceremony

Dr. Annah Wamai, Head of Clinical Services in the Ministry of Health, Kenya, representing the Principal Secretary of the Ministry of Health, Dr Nicholas Muraguri opened the meeting. Mr Mark Hereward, Deputy Regional Director, UNICEF East and Southern Africa Regional Office welcomed the participants.

Session 1: Overview of ICCM Implementation under the New Funding Model

Session One : Overview of ICCM Implementation under the New Funding Model Chair: Dyness Kasungami (MCSP/USAID grantee)	
Objectives To review iCCM implementation under the Global Fund's NFM in order to: 1) Share experiences/lessons learned across countries 2) Identify key constraints 3) Identify common themes and potential solutions across countries	**Expected Outputs** Synthesis of country experiences and lessons learned during early implementation of Global Fund-supported iCCM programming
Presentations and Group Work	
- The Big Picture: An Overview of Progress to Date - Mark Young (UNICEF HQ/iCCM FTT) and Kate Wilczynska-Ketende (iCCM FTT) - iCCM Country Experiences – Panel 1: Zambia, Uganda and Malawi Country Teams - iCCM Country Experiences – Panel 2: Burkina Faso, DRC and Cote d'Ivoire Country Teams - Summary of Country Experiences and Key Themes - Dyness Kasungami (MCSP/USAID grantee)	

Session One began with an overview of iCCM progress to date under the auspices of the Global Fund - UNICEF MoU followed by country teams sharing their experiences and lessons learned during early implementation of Global Fund-supported iCCM programming.

Experiences and Key Successes

Key successes include:
- Countries have successfully mobilized resources through the Global Fund's NFM. 23 countries were assisted in integrating iCCM into Global Fund malaria and HSS concept notes, and 21 countries submitted concept notes with iCCM components integrated, resulting in mobilization of approximately USD 200 million for iCCM across 12 countries.
- iCCM is on the global agenda as an essential evidence-based intervention for under-five morbidity and mortality reduction at the community level. There is a better understanding of diarrhea, pneumonia, and malaria as leading causes of preventable child deaths that need to be addressed as a package, and enhanced cooperation and collaboration between child health and malaria teams within Ministries of Health.

- Many countries are demonstrating strong government ownership, leadership and coordination of iCCM through Technical Working Groups and other structures.
- iCCM is increasingly integrated into national systems, particularly Health Management Information Systems (e.g., in Cote d'Ivoire, Malawi, Uganda, and Zambia) and procurement and supply management systems; however, funding for iCCM implementation comes predominantly from external sources.

Key Constraints

- Despite leveraging approximately USD 200 million from the Global Fund, domestic governments, and co-funders for iCCM across an initial set of 12[1] countries of the 21 countries that submitted malaria and HSS concept notes with iCCM components, a financial gap of almost USD 200 million remains, primarily for procurement of non-malaria commodities. This is negatively affecting scale-up of some iCCM components, i.e., pneumonia and diarrhea treatment.
- Procurement and supply management challenges, especially in relation to ensuring that CHWs are re-supplied with medicines and other commodities in a timely manner, are common to several countries (e.g., Cote d'Ivoire, DRC, and Zambia).
- Identifying effective approaches to ensure sustainable motivation of CHWs remains a challenge. In some countries CHWs are on the government payroll and receive salaries (e.g., Cote d'Ivoire [monthly stipend], Ethiopia, Malawi, Zambia [some cadres]), in other countries they are unpaid volunteers (e.g., Burkina Faso, Uganda), and in some cases they receive financial incentives from development partners or communities (e.g., DRC, Mali).
- Recruitment and training of an adequate number of CHWs to implement the planned interventions at scale is time-consuming (e.g., Malawi, Zambia).
- The collection and submission of quality community-level data in a timely fashion is a challenge in several countries (e.g., Burkina Faso, Cote d'Ivoire, Zambia), as a result of poor communications infrastructure and low motivation of CHWs to collect and submit data.
- There is a lack of human and/or financial resources at health facility level to undertake effective supportive supervision of CHWs (e.g., Cote d'Ivoire, Zambia).
- Coordination of multiple partners, especially in relation to incentives provided to CHWs, is challenging.
- Lengthy contractual processes and delays in funds disbursement (e.g.,Uganda) have been encountered.
- No requirement by the GF for indicators to monitor iCCM as an integrated program created an impression that malaria program managers (including PRs and SRs) are only accountable for malaria specific indicators.

Lessons Learned and Way Forward

- While iCCM FTT and partners can support, strong in-country partnerships are key to driving effective implementation planning and integrated financing for iCCM agenda forward.
- Given the remaining funding gap (approximately US$ 200 million), there is a clear need to explore new and innovative funding sources, including mobilizing domestic resources.
- Government financial contributions for iCCM implementation need to be better quantified and captured.

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[1] $200 million is based on GFATM concept notes and discussions with teams from the initial 12 supported countries for which the data on committed funds is available. Figures for remaining countries will be forthcoming with signing of grants and validations of commitments.

- Co-financing arrangements for non-malaria commodities should ideally be identified prior to concept note submission to ensure funding for malaria and non-malaria iCCM components is available simultaneously.
- There is a need to further explore both financial and non-financial incentives - including supportive supervision and mentoring - and the potential roles that communities can play in motivating CHWs towards ensuring attrition rates are minimized.
- Expanding the use of mobile technology to collect and submit community-level data can address data reporting constraints, but there are currently issues with network coverage and the relatively high cost of handsets (e.g., Burkina Faso).
- Implementation research is vital to inform scale-up plans.

Session Two: Implementation Planning

Session Two: Implementation Planning Chair: Samira Aboubaker (WHO HQ)	
Objectives 1. To review key components of writing strong iCCM implementation plans, identifying common processes, challenges, and solutions 2. For country teams to engage in peer review of iCCM implementation plans and offer suggestions for strengthening/improvement.	**Expected Outputs** Countries have an enhanced understanding of key components of strong iCCM implementation plans and have received practical feedback from their peers on their plans.
Presentations and Group Work	
• What Constitutes a Strong National iCCM Implementation Plan? - Dyness Kasungami (MCSP/USAID grantee) • National iCCM Plans/Strategies: Key Components and Implementation Challenges – Ethiopia and Ghana Country Teams • Group Work - Peer Review of Implementation Plans – Facilitated by Teshome Desta Woldehanna	

This session included a presentation on the key components of strong national iCCM implementation plans, which can be stand-alone documents or integrated into existing plans. A strong iCCM plan includes a situation analysis that assesses the existing program; identifies measurable objectives, activities, and inputs with timeframes and assigned responsibilities; sets performance target(s); includes an inventory of resources and gaps and; is costed. The objective of iCCM is to increase access to, and utilization of, quality services. Planning for scale-up involves consolidating regional into national programs, harmonizing across implementing partners, allowing the adoption of 'promising practices', identifying gaps and providing solutions, and providing for a continuum of care from community to facility. Specific sections that could form part of an ideal implementation plan include: coordination and policy setting; costing and financing; human resources; supply chain management; service delivery and referral; communication and social mobilization; supervision and performance quality assurance; M&E and health management information systems (including operations research).

iCCM planning resources are available at www.ccmcentral.com, including a planning handbook, iCCM indicator guide, country plans, iCCM publications and outputs from iCCM Task Force sub groups.

During the second part of the session, Ghana and Ethiopia, two countries that have relatively well-developed and mature iCCM programmes, presented their experiences in iCCM planning and implementation, as summarized below. Following the country presentations, country teams worked in pairs to conduct a preliminary review of each other's iCCM implementation plans.

	GHANA	ETHIOPIA
BACKGROUND	• iCCM commenced with home-based management of malaria pilot project in 1999. In 2008, the package was expanded to include the management of acute respiratory infection and diarrhea. • iCCM in Ghana is delivered to underserved communities in all 10 regions of the country and 81 per cent (176) of the 216 districts	• iCCM built on the Health Extension Program with its 35,000 Health Extension Workers (HEWs) and the Health Development Army (community volunteers). • National strategy intended to cover 100 per cent of rural areas (both agrarian and pastoralist communities).
STRATEGIC FRAMEWORK AND PLANS	• National iCCM implementation plan exists.	• National iCCM implementation plan and National CBNC implementation plan that includes iCCM/IMNCI. • iCCM a component of Health Sector Development Plan IV (2010-2015) and Health Sector Transformation Plan (2015-2020). • iCCM a delivery modality for National Newborn and Child Survival Strategy (2015-2020).
COORDINATION	• National coordination by the Ghana Health Service / National Malaria Control Programme and FHD and other partners, Committees and Working Groups. • Regional and District levels involved in planning and implementation; communities engaged in selection, introduction, supervision, and motivation of CHWs. • Monitoring and supervision conducted by National, Regional, District and sub-district levels and communities	• Federal Ministry of Health responsible for policy guidance and leadership, resource mobilization and allocation at national level. • iCCM-Technical Working Group led by MOH gives technical guidance and support for implementation, M & E at national, Regional and Zonal levels. • Regional Health Bureaus guide zonal and Woreda Health Offices. Woreda Health Offices lead implementation, M&E and support. • Non-governmental partners provide technical and financial support for implementation, M&E
CHALLENGES	• Funding gaps • Procurement delays • Dwindling partner commitments • Affordability of remuneration of CHWs • Lack of transport for supervisors • Non-availability of medicines for ARI and diarrhea in seven regions • Erratic supply of ACTs • Shortages of community registers	• Turnover of trained HEW and supervisors • Weak supply chain system (IPLS) • Weak health system and highly mobile communities in pastoralist regions • Limited resources to sustain and expand implementation

Session Three: The Importance of Integrated PSM for Effective iCCM Implementation

Session Three: The Importance of Integrated PSM for Effective iCCM Implementation Chair: Atieno Ojoo (UNICEF Supply Division)	
Objectives 1. To discuss integrated PSM planning for iCCM implementation, including common challenges and possible solutions, and share PSM tools and resources with country teams 2. To develop country-specific PSM action plans to support effective iCCM implementation	**Expected outputs** Country action plans for PSM strengthening/capacitation to ensure successful iCCM implementation
Presentations and Group Work	
• Why Integrated PSM planning? - Thomas Sorensen (UNICEF SD ESARO) • Common PSM Challenges for ICCM Implementation - Jane Briggs (SIAPS/MSH) • Review of integrated PSM resources and tools - Upjeet Chandan (iCCM FTT) • Group Work on PSM planning, challenges and solutions	

Session Three commenced with presentations on the importance of integrated PSM planning for effective iCCM implementation and common PSM challenges affecting iCCM. Working towards program objectives while also strengthening national supply systems (rather than creating parallel systems for iCCM) and PSM planning for ICCM early on grant application and implementation was emphasized. The success of iCCM program relies on the consistent availability of commodities at the community level; yet there are PSM challenges common across countries that preclude this from happening. These include remote rural areas/difficult geography; limited or challenging transportation networks; reliance on a volunteer cadre of health worker; being at the end of the supply chain/last mile. These are also a range of other issues/challenges specific to selection, quantification, procurement, distribution, rational use, LMIS, and coordination/integration, which are essential to consider during the PSM planning process.

Three countries - Burkina Faso, Uganda, and Zambia- presented their experiences in procurement and supply management for iCCM. Some successes and common challenges faced by the three countries are listed below.

	SUCCESSES	CHALLENGES
BURKINA FASO	• PSM plan for iCCM commodities available (ORS, Zinc, amoxicillin, etc.) • Quantification and planning conducted annually for ACTs and RDTs • CHW training on iCCM includes PSM component • ORS, zinc, ACTs, RDTs all available at central medical stores(CAMEG)	• Funding for procurement of non-malaria commodities (ORS-Zinc, amoxicillin) • Integration of amoxicillin in the CAMEG supply system • Sustaining CHW motivation • Supplying CHWs regularly • Providing regular supervision of CHWs by health workers

	SUCCESSES	CHALLENGES
UGANDA	• Solid foundation for iCCM programming (national strategies, plans, and coordination mechanisms) • Strong partner engagement and skills • PSM strategy well articulated in National Pharmaceutical Sector Plan (NPSSP) 2015-2020, including iCCM commodities • Government and partners seizing funding opportunities to scale up iCCM (DFID, GF NFM, GFF) • PSM reforms over past 5 years (central funding, informed push) have strengthened PSM system. iCCM commodities are distributed through the National Medical stores and not by partners. • Improvements in PSM performance indicators (improved stock availability of tracer items up to 64% in 2014)	• While iCCM activities are included in the National Pharmaceutical Sector Strategic Plan, the costing of NPSSP not yet completed • Heavy donor dependency and very significant funding gaps for iCCM commodities • Implementation delays (procurement, low absorptive capacity) • Kit system increases risk of over-supply and expiry of some commodities • iCCM commodities available for 15 districts but critical tools (job aids, registers, etc.) not yet available. • Funding gap probable for iCCM implementation under GF grant • Human resources – Limited skills, competencies and motivation of health workers to undertake procurement / quantification / stores management – is very limited
ZAMBIA	• National Supply Chain Strategy 2013-2016, with implementation plan • Annual quantification at national level based on issues, consumption data and epidemiological data from HMIS • Medical Stores Ltd and MOH implementing new order management system (EMLIP) at health facilities, allowing facilities to 'pull' products from MSL • Testing of e-health technologies with supply chain functions through DHIS2 mobile	• New responsibilities given to MSL (e.g., last mile delivery) without commensurate funding • Unreliable stock of amoxicillin / ORS / zinc at health facility level • CHWs face challenges in accessing drugs and supplies from health centres • Lack of funds for pneumonia and diarrhea commodities

PSM resources developed by the iCCM FTT and UNICEF were shared with participants, including: iCCM PSM Checklist, Guide to iCCM PSM Planning for Global Fund Grants, and an iCCM Product Selection Guide, all of which are available on www.ccmcentral.com. In addition, UNICEF SD has also developed the following resource - *A Process Guide and Toolkit Supply Chain for Strengthening Public Health Supply Chains through Capacity Development* – to support countries with supply chain strengthening activities.

Following the formal presentations, country teams worked in groups to review their specific PSM challenges and identify potential solutions using a template as a tool towards developing country PSM action plans (see Annex C). **Note:** Most countries did not complete the task in the allotted time and many indicated they would continue the analysis of challenges and solutions in their countries with a larger team.

Summary of Discussions and Group Work

• The majority of countries are facing difficulties in securing financing for non-malaria iCCM commodities, which are not covered under Global Fund grants. Some countries experienced delays in disbursements. There is a real risk that the funding already secured for iCCM through the Global Fund could be subject to reprogramming if countries fail to demonstrate progress in implementing iCCM in accordance with

workplans. Where possible, funding streams should be aligned and more resource mobilisation is needed to assure procurement of non-malaria iCCM commodities

- As a result of the above, countries are facing coordination challenges due to different donors funding different iCCM commodities. Countries need to make a stronger case for integrating and rationalising PSM across all iCCM commodities. There are clear benefits to having a single procurement agent and a single distribution mechanism. Countries identified a lack of competence to conduct integrated PSM planning for iCCM. Some countries have coordination units, but not all are functional.
- Stock-outs are an issue for most countries. It is important to plan distribution to the last mile carefully, and many countries mentioned challenges in distribution mechanisms and capacity of staff to carry out supply chain tasks. There is also a need to monitor expiry of medicines as an indicator of PSM effectiveness. Global Fund has noted that they have incorporated expiry in the latest reporting requirements.
- Engagement of the private sector at lower levels of the health system can yield benefits. Some iCCM commodities are available over-the-counter and this could potentially give a role to the private sector in service delivery and supply. The role of proprietary medicine vendors can be significant in some countries and needs to better defined and managed to ensure that they are not competing with CHWs.
- PSM planning is a vital component of iCCM planning that needs to be conducted from the beginning of the process. iCCM programmes, in addition to non malaria iCCM commodities also need to consider other non-medicine commodities, e.g., job aids, community registers, etc. There is a need to ensure that the costs of the supply chain itself (storage, transport, tariffs, etc.), which can be significant, are reflected in plans and budgets.
- National and sub-national structures for quantification and PSM planning exist in many countries, but in several countries they are not functional or are functioning sub-optimally.
- Lack of consumption data from the community level was cited as a problem for quantification and monitoring iCCM due to poor reporting or lack of integration of the community level into the national information system. The use of m-health interventions in supply chain is an encouraging option but not without challenges.

Session Four: Adopting an Integrated Monitoring and Evaluation Framework and Strengthening Community Health Information Systems

Session Four: Adopting an Integrated Monitoring and Evaluation Framework and Strengthening Community Health Information Systems Chair: Eric Swedberg (Save the Children US)	
Objectives: 1. To increase understanding of priority iCCM indicators, processes for integration into national HMIS, and best practices to support data quality and use 2. To revise and update existing GF program monitoring plans as appropriate 3. To develop country-specific action plans for the integration of priority iCCM indicators into national HMIS and supporting data quality and data use	**Expected outputs:** Country action plans for strengthening iCCM monitoring (developed or revised as appropriate)
Presentations and Group Work	
- Challenges and opportunities for an integrated M&E Framework and Community Health Information Systems: A Global Fund perspective - Miriam Sabin (Global Fund) - Overview of recommended iCCM indicators and priority indicators for incorporation within the national HMIS, and supporting tools - Eric Swedberg (Save the Children) and Dyness Kasungami (MCSP/USAID grantee) - Country Presentations: Ethiopia and Niger - Emergent trends and best practices for strengthening community health information systems, data quality and data use - Nicholas Oliphant (UNICEF HQ) - Group Work	

Session 4 commenced with the Global Fund's perspective on challenges and opportunities for an integrated M&E framework and community health information systems. Miriam Lewis Sabin of the Global Fund highlighted the importance of scaling up and strengthening M&E systems for community health interventions and described how the Global Fund measures grant performance including utilizing performance frameworks (PFs) and work plan tracking measures (WPTMs). This was followed by an update, provided by Eric Swedberg of Save the Children and Dyness Kasungami of MCSP on the indicators currently recommended for reporting on iCCM implementation; priority indicators that should be integrated within national HMIS; and best practices for supporting iCCM data quality and data use as a mechanism for strengthening broader community health information systems and HMIS in the context of the funding received from the Global Fund.

Overview of recommended iCCM indicators and emergent trends and best practices for strengthening community health information systems, data quality and data use

In 2013, the iCCM Task Force published an Indicator Guide for M&E of iCCM that lists 48 indicators across the eight programme components and phases to "encourage the consistent use of standardized definitions and metrics". The list is not intended as a prescriptive set of indicators for all programmes but rather a menu that MOH and partners can use to identify the most appropriate indicators for their specific programmes and contexts.

The Monitoring and Evaluation sub group of the global iCCM Task Force has reviewed the list of indicators and proposed a set of 12 core indicators to be collected through routine health information systems, plus an additional six that should be collected through special studies. The sub group urges countries to identify opportunities to include these high value iCCM indicators in the DHIS or other national HMIS.

Table 2: Recommended Core Indicators for Monitoring iCCM[2]

COMPONENT	INDICATOR
Service Delivery	Case load by CHW: # cases treated by CHW by reporting period (total and disaggregated by disease)
	CCM treatment rate: # of CCM conditions treated per 1000 children under 5 in target areas in a given time period (5.1)
	Percent of expected cases treated: # of CCM conditions treated/Number of expected cases for population and time period
	RDT positivity rate: % of fever cases presenting to CHW who were tested with RDT and received a positive result
Supply Chain/Logistics	Medicine and diagnostic continuous stock (1): % of CCM sites with no stock out of each CCM commodity over the period (disaggregated by commodity) (recommended by the SCM group/optional)
	Medicine and diagnostic availability (2): % of CCM sites with all key CCM medicines and diagnostics in stock on last day of reporting period (more common because easier to collect) (4.2)
Referrals	Referral rate: # cases referred per 100 cases seen by CHWs (5.3)
Reporting	Reporting: % of CHWs / HFs / districts submitting report on iCCM during time period (disaggregated by level) (8.3)
Supervision	Completed versus expected supervision activity: proportion of expected supervision activities (to be defined locally) completed during reported period (similar to 7.4)
Outcome Indicators (from household surveys every 3-5 years)	Diagnosis: % of children under 5 years old with fever in the last 2 weeks who had a finger/heel stick for malaria testing
	Treatment malaria: % of confirmed outpatient malaria cases that received firstline antimalarial treatment according to national policy
	Treatment Diarrhea: % of diarrhea cases among children under five that received ORS according to national policy
	Treatment Diarrhea: % of diarrhea cases among children under five that received zinc according to national policy (5.4)
	Treatment Pneumonia: % of suspected pneumonia cases among children under five that received antibiotics according to national policy (similar to 5.4)
	Treatment Pneumonia: % of suspected pneumonia cases among children under five who sought care from an appropriate provider

Quality of care is a vital component of iCCM service delivery, but its assessment generally relies on direct observation and expert review using specific studies that are resource-intensive. However, there is potential to adapt some indicators to measure quality from routine data. For example, the proportion of children testing negative for malaria that still receive an ACT would indicate incorrect case management.

One of the objectives of implementing community health information systems (CHIS) is to improve the use of information; however, this improved use of information tends to primarily occur at management levels with relatively few examples of data feedback to and use by communities. Innovative approaches are needed to ensure that community data are used at community level. Community dialogue, community scorecards, and UNICEF's Monitoring Results for Equity Systems (MoRES) are examples.

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[2] USAID (2013). Indicator Guide. Monitoring and Evaluating Integrated Community Case Management

Although it was not discussed at the meeting, it must be noted that few countries in SSA have supported periodic national georeferenced facility and CHW censuses/surveys and fully exploited their potential. These periodic assessments (e.g., at beginning/end of health sector development plans and at midterm reviews) are important for triangulating with data from routine HMIS, triggering and targeting corrective actions in implementation, triggering adjustments to policy, and triangulating/linking with household survey data to provide a comprehensive picture of service provision and coverage.

Country Presentations

Ethiopia and Niger presented their experiences in strengthening community health information systems and improving data quality and data use.

COUNTRY	SUCCESSES	CHALLENGES
ETHIOPIA	- CHIS rolled out to 77% of health posts - Unified data collection tool (Family Folder) for every household - E-HMIS in 3,000 facilities	- Some health posts using other registers, even though the official iCCM register is the only register permitted at health post level - Completeness and timeliness problems - Health posts failing to update Family Folder data - No clear guidance on how to manage data at health post level in pastoral and semi-pastoral areas - Some health extension workers (HEWs) are not performing the Lot Quality Assurance Sampling as per the standard - Shortages and high turnover of trained staff in e-HMIS - Low coverage and frequent interruptions in power supply negatively affecting implementation of e-HMIS - Poor internet connectivity for e-HMIS implementation
NIGER	- iCCM integrated into HMIS - Annual SMART / KAP surveys - Data used for performance monitoring on limited scale - Health centre dashboards - Geo-referencing of service delivery sites - Piloting m-Health for iCCM and nutrition data - Introduction of DHIS2	- Some partners continue to use own data collection tools - Aggregated data only available from HD to central level - No reliable archiving at community level - DHIS2 in very early stage of implementation - Delays in access to data for decision-making - Few indicators relating to CHWs and iCCM

During group work, country teams reviewed their existing monitoring plans, with a view to identifying challenges, solutions and technical assistance needs as the basis for strengthening the monitoring plans. See the results of the group work by country delegation in the Annex D In brief the challenges could be grouped into the following areas: inadequate integration with national HMIS (e.g. inadequate coordination and engagement with HMIS technical working group and the "gate keepers" of the HMIS; inadequate focus on priority iCCM indicators and end-users needs (e.g. too many/heavy and complex tools; stockouts of tools for front-line workers); inadequate human resource capacity and mechanisms to support data quality and data use (e.g. inadequate training / institutionalization of capacity and inadequate review and use of data as a part of existing meetings e.g. quarterly and annual reviews); lack of disaggregated data on iCCM versus facility IMCI; and inadequate ICT equipment/infrastructure for HMIS.

Session Five: Mobilizing Resources and Investing in CHW platforms

Session Five: Mobilizing Resources and Investing in CHW Platforms Chair: Olga Bornemisza (Global Fund)	
Objectives 1. Present the latest evidence in strengthening and financing CHW platforms 2. Understand existing and future global financing opportunities for iCCM, CHW and community health system strengthening 3. Develop resource mobilization strategies	**Expected outputs** Country-specific resource mobilization strategies are developed and technical assistance needs are identified.
Presentations and Group Work	
• Resource Mobilization: Progress to Date – Mark Young (UNICEF HQ) • Scaling Up CHW Platforms: Building an Investment Case – Jerome Pfaffmann (UNICEF HQ) and David Collins (MSH) • Advocacy for Resource Mobilization – Lessons Learned from the Roll Back Malaria Toolkit – Valentina Buj (UNICEF HQ) • Panel Discussion: Resource Mobilization for Community Health: Building a Sustainable Financing Pathway (Paulin Basinga/Gates Foundation; Olga Bornemisza/The Global Fund; Liz Jarmin/Living Goods; Anthony Gitau/Novartis) – Facilitator: Valentina Buj (UNICEF HQ) • Group Work: Developing country-specific resource mobilization strategies	

Session Five provided participants with an update on country support provided by the iCCM FTT in leveraging resources through the Global Fund NFM and the principal recommendations for investing in CHW platforms.

Within the context of the UNICEF - Global Fund MoU, approximately USD 200 million has been mobilized for iCCM across the initial set of 12 countries. This includes resources mobilized from the Global Fund's NFM as well as co-financing from national governments (domestic resources), UNICEF, other partners and other funding mechanisms. A financing gap of around USD 200 million remains.

The lack of secured funding to procure non-malaria commodities highlights the need for co-financing discussions to take place as early as possible, and definitely prior to concept note submission, to ensure sufficient funding is available for full iCCM implementation. Wherever possible, efforts should be made to align co-financers and Global Fund's grant-making cycles.

Scaling Up CHW Platforms: Building an Investment Case and Advocacy Case

Management Sciences for Health (MSH) is currently developing and piloting a comprehensive costing approach for community health services, including iCCM. The tool is designed for costing current programs and scaling-up community health services, comparing cost-effectiveness, and developing sound investment cases. The tool is currently being piloted in Malawi and Sierra Leone and should be available to countries in the latter half of 2016.

At the Financing for Development meeting held in Ethiopia in July 2015, a report outlining the case for investment in CHWs, and identifying financing mechanisms and pathways and principles of best-practice for CHW systems was launched. Adherence to 10 best practice principles is expected to yield a return on investment of up to 10:1. Alongside donor funding and domestic resources, several new and emerging funding sources have been identified, including: private sector funds (e.g., trust funds or healthcare companies, local manufacturers or private health providers); bonds to access capital markets; The World Bank Global Financing Facility (GFF); and entrepreneurial selling of products (revenue generation through CHWs).

The next steps in securing financing for CHW programs include establishing a Community Health Financing Support Unit (FSU), undertaking a comprehensive costing of the CHW platform and developing country specific resource mobilization strategies.

In addition, Roll Back Malaria (RBM) has developed an [Advocacy for Resource Mobilization (ARM) guide and toolkit](), which comprises a systematic technical implementation guide; a description of traditional and innovative financing streams; case studies; example of key messages to mobilize domestic resources, and fund-raising templates. Although developed for the malaria community, the tools can be adapted to any resource mobilization context. The toolkit is available at:

A panel of experts comprising representatives of the World Bank, the Bill and Melinda Gates Foundation, the Global Fund, Living Goods (NGO) and Novartis, with country perspectives provided by Malawi, discussed financing opportunities for iCCM both in the short term in relation to Global Fund grants and longer term financing of iCCM to inform the development of country delegations' resource mobilization strategies.

Key Issues

- The Global Financing Facility is the financing arm of Every Woman Every Child and has been in place since June 2015. The GFF is a country-driven process that emphasises the development of integrated reproductive, maternal, neonatal, child and adolescent health investment cases that focus on results and scalability and prioritise underserved marginal populations. Kenya is an example of a country that has developed an investment case that includes a fully costed community health component.
- The Global Fund can provide funding to cover CHW salaries or incentives. However, it is moving away from this, as outlined in its 2014 budgeting guidelines, as human resource costs should be covered by governments. Very strong justification for CHW incentives, together with a transition plan to allow for full government funding, are required before the Global Fund will cover these costs.
- Sustainability of financing to support CHWs in receipt of government salaries or other financial incentives is a major issue for resource-constrained countries. However, it is important to work towards this, as the evidence indicates that for a sustainable community platform, CHW should be remunerated for their labour. To this end, costed and prioritized HRH plans, community health financing strategies or health system plans that include paid CHW should be developed. Several countries are successfully exploring ways to fund their CHWs, including Ethiopia, Rwanda, and Malawi. These approaches include salary payments and contracting of CHW cooperatives by governments, amongst others.
- The key to accessing private sector funding for community health is to ensure that proposals focus on the core objectives of the private sector entity, which will usually revolve around increasing access to and use of the company's products.

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Session Six: Country Action Plans and Technical Assistance Needs

Session Five: Workshop Synthesis	
Objectives 1. To develop iCCM country action plans 2. To identify technical assistance needs	**Expected outputs** • Country action plans • Compendium of country technical assistance requirements
Presentations and Group Work	
• Panel Presentation and Discussion: Representatives of the Community Health System, Kenya – Facilitated by Janet Kayita (UNICEF ESARO) • Group Work: Country Action Plans and TA needs – Facilitated by Kate Wilczynska-Ketende • Meeting Summary – Mark Young (UNICEF HQ) • Meeting Closure – Luwei Pearson (UNICEF ESARO) and Olga Bornemisza (The Global Fund)	

Community Health Worker Panel

Session 6 commenced with a panel presentation by members of the community health system in Kenya. The panel comprised Community Health Volunteers (Homa Bay and Siaya Counties), a Community Health Assistant (Siaya), an iCCM County Coordinator (Siaya), a Chief County Officer (Siaya) and a Deputy Public Health Director (Turkana County).

The panellists described successes, challenges and visions for the future of community health services from their own perspectives and in their respective counties. Jenipher Koraro, a volunteer CHW from Homa Bay acknowledged that the CHW training she received had raised her status in the community and helped her gain the trust and acceptance of the community in her role treating children under 5 in their homes. Sarafi Wachir from Siaya County appreciated the fact that his workload of around three household visits per week enabled him to pursue his private farming activities. He noted that the reporting tools and patient registers are too large and bulky for easy transport and storage and hoped to see an alternative system in place.

Amos Odwouor, a CHW supervisor in Siaya County, described how he meets with his CHWs every month to develop a common workplan and to identify any gaps or challenges. He also reported a reduced workload at the health facility as community members could be screened or treated within the community. Erratic supply of commodities to CHWs remains a problem, as when stocks are short, the health facility staff are reluctant to offer them to CHWs.

Elizabeth Omondi, an iCCM Coordinator in Siaya County, is responsible for advocacy and lobbying for support from the county governor and county assembly, which has been successful in securing buy-in and support from communities. A community focal person conducts sub-county level supervision of CHWs monthly and county level supervision is conducted on a quarterly basis. Monthly data quality audits and follow-up are also conducted. Elizabeth Omondi noted that it can take 15 days for stock management data to pass through the system from the CHW to district level, and a digital stock management system would help fill gaps. She also expressed a desire to introduce a performance-based stipend system for those exceeding 60% of targets.

Dorothy Owino, a Chief Officer in Siaya County, noted that Siaya is a county with a high disease burden. The county government in consultation with stakeholders identified community health services as the key intervention. The county administration committed to pay stipends to 2,147 CHWs in July 2014 and stipends are included as a line item in the county budget. The county has also paid for enrolment of CHWs in the National Health Insurance

Fund and encourages them to advocate for others to join. County officials are also looking at developing linkages with agriculture and with the income-generating activities agenda.

Alfred Ikeny Emaniman, a Deputy Public Health Director in Turkana County, has responsibility for advocating for community health services, including preparing budgets and defending them in the County Assembly. Turkana County faces unique challenges as it has a low population density, with average distances from households to health facilities of around 35km. CHWs, who do not receive stipends, must travel long distances between households such that transport for CHWs is critical. To date, the County has been unable to allocate resources to CHWs and this has led to high attrition rates.

Group Work: Country Action Plans and Technical Assistance requests

Following the panel session, country teams prepared country action plans and based on these identified their technical assistance requirements for sharing with partners. A summary of TA requests and the status of countries' ICCM plans, strategies, and program packages are included in Annex E and F, respectively.

Meeting Summary

Mark Young, Senior Health Specialist at UNICEF HQ, provided summary remarks. The four focus areas for successful iCCM implementation, and key lessons learned and recommendations around these include:

1) **Implementation Planning:** The profile of iCCM has been raised on global and national health agendas. Moving forward, building and leveraging strong in-country partnerships are key to ensuring successful implementation. Successful integration entails working with and through national systems (for M&E, PSM, and financing). Across countries, the financial gap for non-malaria commodities is an enduring challenge, and will require a broad based and diversified approach to financing.

2) **PSM for iCCM:** Establishing or strengthening existing coordination mechanisms to integrate PSM for iCCM into the national PSM system is essential for promoting integrated supply chains and long-term sustainability. Collectively, we must also continue to advocate for integrated financing for iCCM commodities (including their supply chain costs); identify mechanisms to strengthen CHWs and health care workers at the re-supply point in their supply chain and reporting tasks; and work to integrate iCCM logistics information into national LMIS.

3) **iCCM M&E/HMIS:** Monitoring iCCM program performance and outcomes is critical. Moving forward, countries should focus on priority routine indicators; ensure the integration of the priority routine indicators with the national HMIS; and ensure disaggregation of the priority indicators by facility and community platforms. It is also necessary to ensure timeliness of reporting and rapid feedback loops: leverage mobile technology connected to national HMIS; support data use and quality through child health program reviews (national and sub-national levels) and data quality audits/assessments; and ensure that the needs of community health services (including iCCM) are voiced at the national HMIS TWGs and in the planning committees of household surveys. National georeferenced facility censuses (e.g. SARA, SPA) and CHW censuses should be conducted periodically (e.g., at the beginning/end of health sector development plans and at midterm reviews) -- potentially as combined georeferenced facility/CHW censuses – and used in combination with data from routine HMIS and household surveys to provide a comprehensive picture of child health service provision and coverage that can be used to inform health sector development planning and implementation.

4) **Resource mobilization & CHW Platforms:** As an extension of primary health care facilities, the community health platform and community health workers are an integral component of building stronger and more resilient national health delivery systems. Strengthening primary health care facilities to provide core services, and capacitating PHC staff to supervise community health workers is key to the success of iCCM and the community health platform.

Community health financing requires a long-term vision with both strong leadership and investment from government. In addition, motivation and financial incentives/remuneration of CHWs are critical for ensuring the sustainability of iCCM platforms and will need to be factored into long-term community health financing strategies. Given the remaining funding gap, there is a clear need to explore new and innovative funding sources (including the private sector), especially in relation to co-financing for non-malaria commodities. Donor funding is not sustainable and countries need to develop resource mobilization strategies for community health using existing evidence, tools, and methodologies to attract new investments. Projecting resource needs and costs, ensuring cost-effectiveness, and developing resource mobilization strategies and comprehensive investment cases will be critical for mobilizing sustainable financing for the iCCM platform.

Meeting Closure

Luwei Pearson, Regional Health Advisor UNICEF East and Southern Africa Regional Office closed the meeting. Olga Bornemisza of the Global Fund also provided closing comments.