Regional Meeting: Scaling up iCCM in the context of the UNICEF-Global Fund MoU

The Big Picture: iCCM Financing Task Team's Overview of Progress to Date

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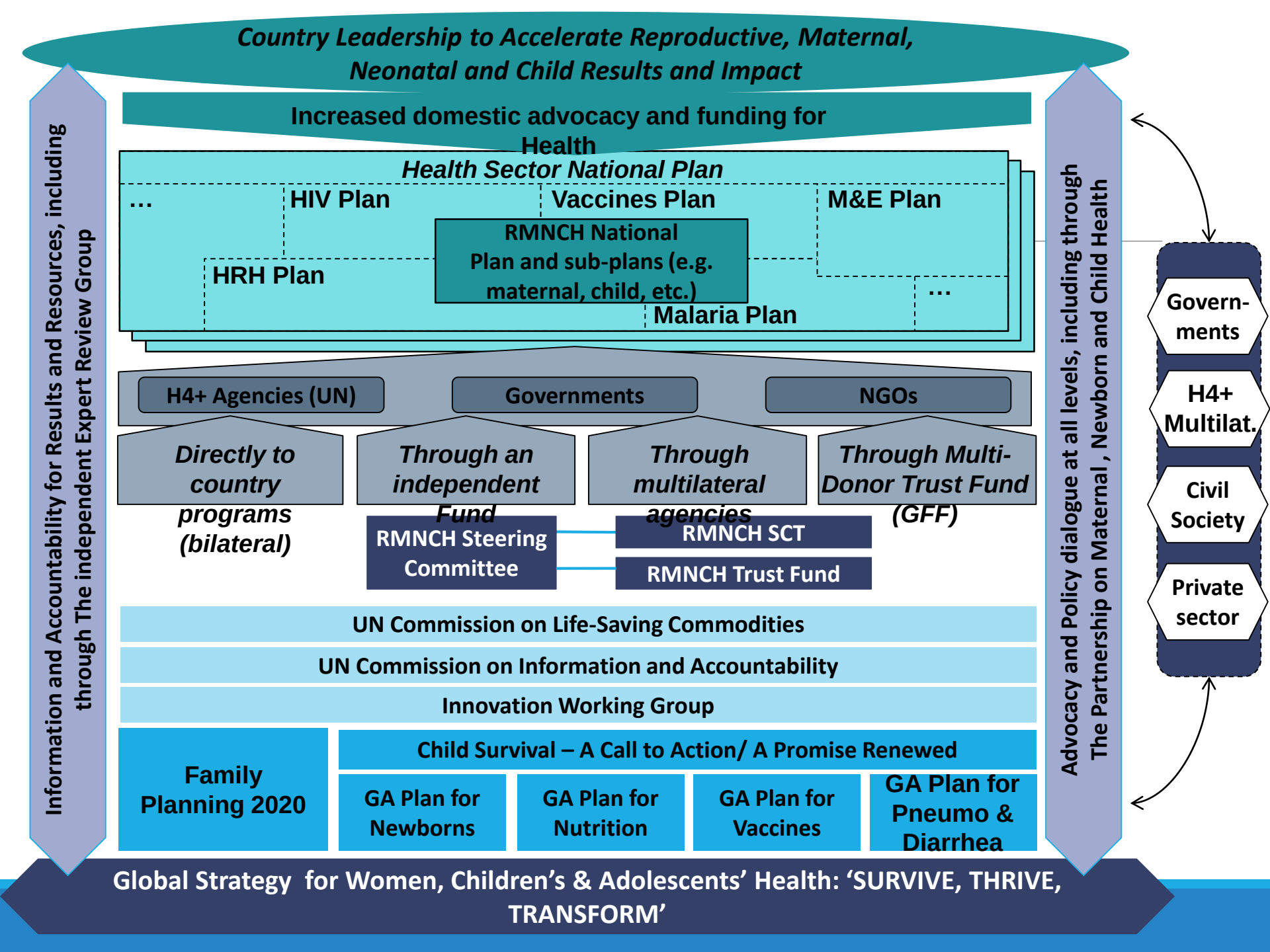
Nairobi, Kenya

Mark Young
Senior Health Specialist and Child Health Team Lead
UNICEF New York
iCCM Financing Task Team Chair
myoung@unicef.org

Kate Wilczynska-Ketende
iCCM Financing Task Team Lead
kwketende@gmail.com

Outline

- Scaling up of iCCM in the context of the GF NFM and GF-UNICEF MoU: Background and timeline 2013-2016
- iCCM FTT – progress, achievements, challenges, lessons learned
- Why are we here today? What is needed going forward for successful iCCM implementation at scale?

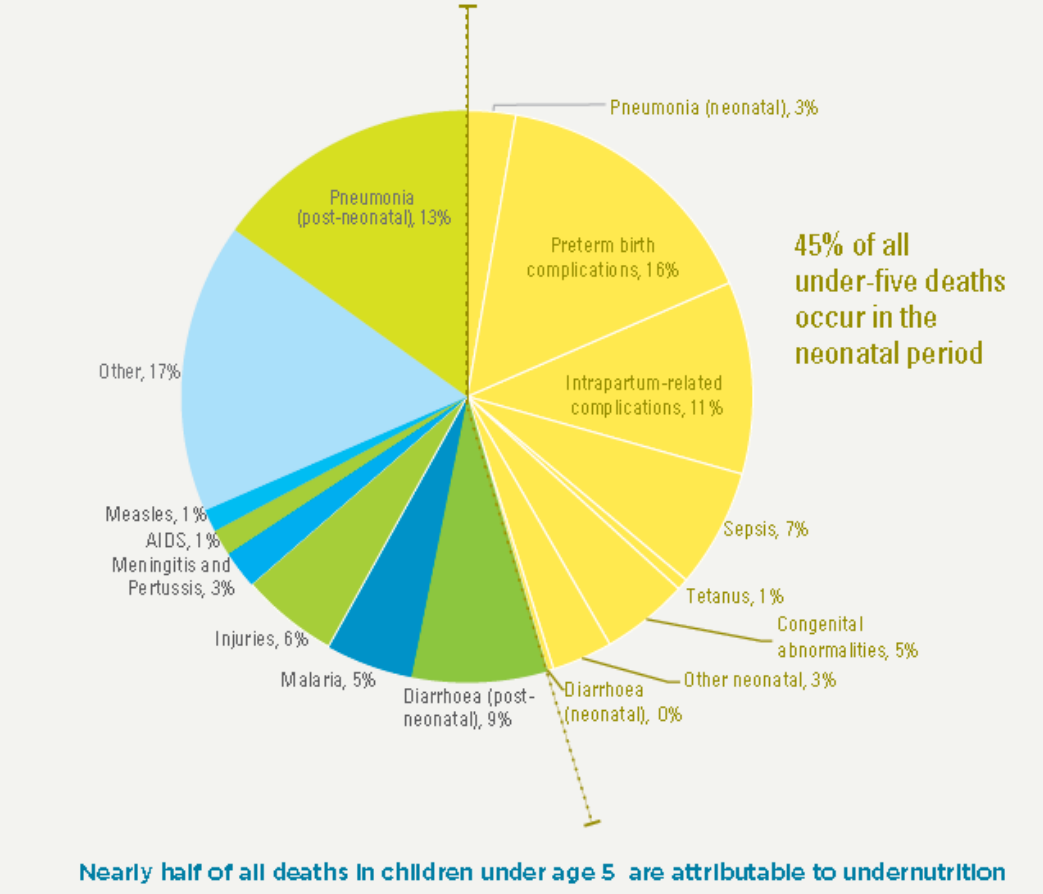

Country Leadership to Accelerate Reproductive, Maternal, Neonatal and Child Results and Impact
Increased domestic advocacy and funding for Health
Health Sector National Plan
…
HIV Plan
Vaccines Plan
M&E Plan
HRH Plan
RMNCH National Plan and sub-plans (e.g. maternal, child, etc.)
…
Malaria Plan
H4+ Agencies (UN)
Governments
NGOs
Directly to country programs (bilateral)
Through an independent Fund
Through multilateral agencies
Through Multi-Donor Trust Fund (GFF)
RMNCH Steering Committee
RMNCH SCT
RMNCH Trust Fund
UN Commission on Life-Saving Commodities
UN Commission on Information and Accountability
Innovation Working Group
Family Planning 2020
Child Survival – A Call to Action/ A Promise Renewed
GA Plan for Newborns
GA Plan for Nutrition
GA Plan for Vaccines
GA Plan for Pneumo & Diarrhea
Information and Accountability for Results and Resources, including through The independent Expert Review Group
Advocacy and Policy dialogue at all levels, including through The Partnership on Maternal , Newborn and Child Health
Govern-ments
H4+ Multilat.
Civil Society
Private sector
Global Strategy for Women, Children's & Adolescents' Health: 'SURVIVE, THRIVE, TRANSFORM'

Why and when under-five deaths occur

Most under-five deaths are still caused by diseases that are preventable or treatable

Pneumonia, diarrhoea and malaria are main killers of children under age 5; preterm birth and intrapartum-related complications are responsible for the majority of neonatal deaths

Global distribution of deaths among children under age 5 and among newborns, by cause, 2015



Source: WHO and maternal and Child Epidemiology Estimation Group (MCEE) provisional estimates 2015

Who is most at risk

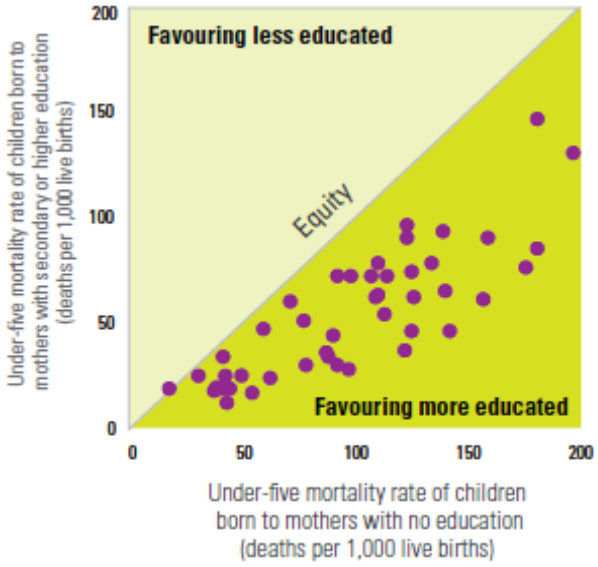
Children from poor, rural or low-maternal-education households are much more likely die before age five

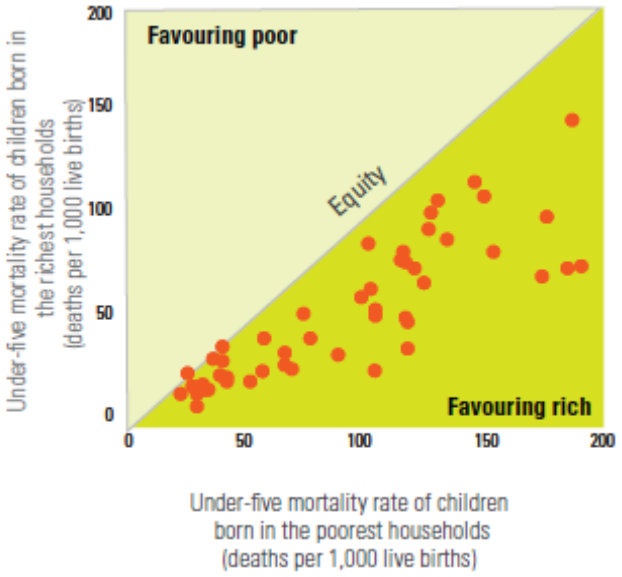
Mothers with no education vs secondary education: 2.8 times

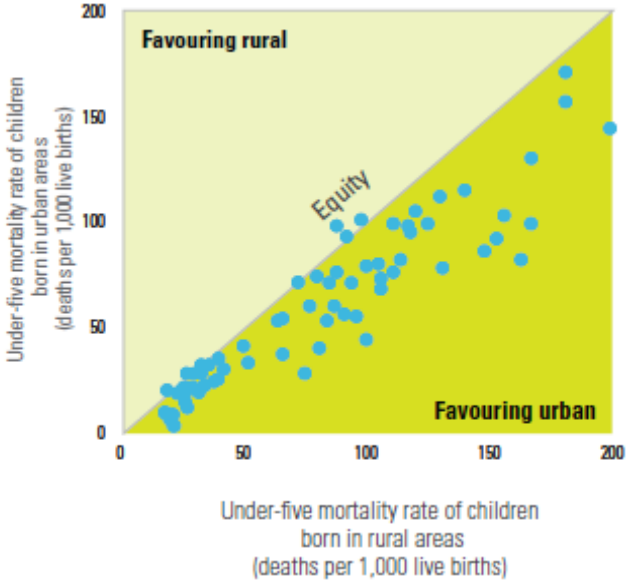
Poorest vs richest: 1.9 times as likely to die before the age of 5 as richest

Rural vs urban: 1.7 times

Under-five mortality rate by mother's education, wealth and residence, 2005-2010







Source: UNICEF analysis based on Demographic and Health Surveys, Multiple Indicator Cluster Surveys and other nationally representative sources

The Global Fund recognizes the importance of scaling up integrated approaches to improve the linkage between RMNCH and its current investments

"Exploring options to maximize synergies with maternal and child health, the Board ***strongly encourages Country Coordinating Mechanisms (CCMs) to identify opportunities to scale up an integrated health response*** *that includes maternal and child health in their applications for HIV/AIDS, TB, malaria and health systems strengthening."*

GFATM Board Recommendation 2010

NFM is a key opportunity for driving increased MNCH integration including iCCM scale-up

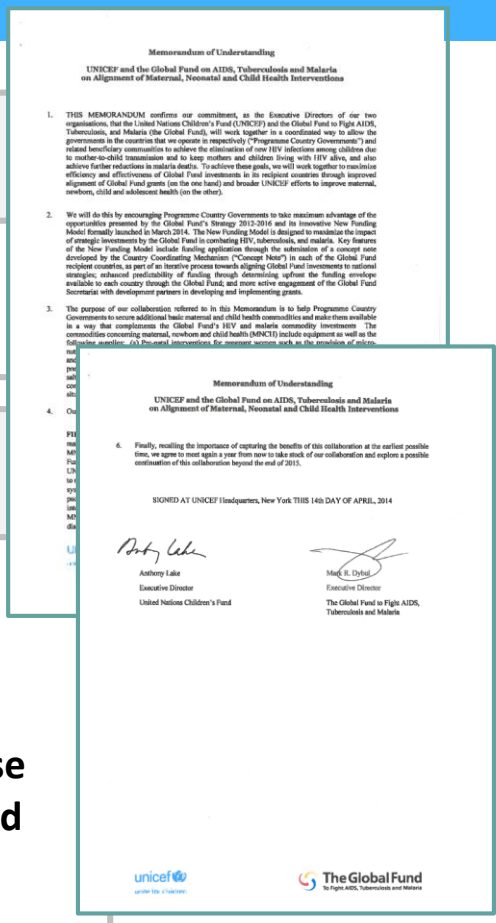
GF & UNICEF sign MOU in April/14 - commit to support iCCM and use 'best efforts' to fill funding gaps

UNICEF and GF will…

- **Targeting of countries:** Jointly work on support for countries where MNCH integration and strengthening makes sense

UNICEF will…

- **Technical assistance and support: Be available to gov'ts that wish to develop Concept Notes which align and integrate ATM and MNCH programming (e.g. iCCM or e-MTCT)**
- **Funding: "Use its best efforts" to mobilize the funding needed to purchase MNCH health supplies and equipment identified in national strategies and Concept Notes developed;**
- **Commodities: Continue to assist gov'ts to make MNCH commodities available to relevant beneficiaries**



Memorandum of Understanding

UNICEF and the Global Fund on AIDS, Tuberculosis and Malaria on Alignment of Maternal, Neonatal and Child Health Interventions

1. THIS MEMORANDUM confirms our commitment, as the Executive Directors of our two organisations, that the United Nations Children's Fund (UNICEF) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund), will work together in a coordinated way to allow the governments in the countries that we operate in respectively ("Programme Country Governments") and related beneficiary communities to achieve the elimination of new HIV infections among children due to mother-to-child transmission and to keep mothers and children living with HIV alive, and also achieve further reductions in malaria deaths. To achieve these goals, we will work together to maximize efficiency and effectiveness of Global Fund investments in its recipient countries through improved alignment of Global Fund grants (on the one hand) and broader UNICEF efforts to improve maternal, newborn, child and adolescent health (on the other).

2. We will do this by encouraging Programme Country Governments to take maximum advantage of the opportunities presented by the Global Fund's Strategy 2012-2016 and its innovative New Funding Model formally launched in March 2014. The New Funding Model is designed to maximize the impact of strategic investments by the Global Fund in combating HIV, tuberculosis, and malaria. Key features of the New Funding Model include funding application through the submission of a concept note developed by the Country Coordinating Mechanism ("Concept Note") in each of the Global Fund recipient countries, as part of an iterative process towards aligning Global Fund investments to national strategies; enhanced predictability of funding through determining upfront the funding envelope available to each country through the Global Fund; and more active engagement of the Global Fund Secretariat with development partners in developing and implementing grants.

3. The purpose of our collaboration referred to in this Memorandum is to help Programme Country Governments to secure additional basic maternal and child health commodities and make them available in a way that complements the Global Fund's HIV and malaria commodity investments. The commodities concerning maternal, newborn and child health (MNCH) include equipment as well as the following supplies: (a) Pre-natal interventions for pregnant women such as the provision of micro-

Memorandum of Understanding

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6. Finally, recalling the importance of capturing the benefits of this collaboration at the earliest possible time, we agree to meet again a year from now to take stock of our collaboration and explore a possible continuation of this collaboration beyond the end of 2015.

SIGNED AT UNICEF Headquarters, New York THIS 14th DAY OF APRIL, 2014

Anthony Lake
Executive Director
United Nations Children's Fund

Mark R. Dybul
Executive Director
The Global Fund to Fight AIDS, Tuberculosis and Malaria

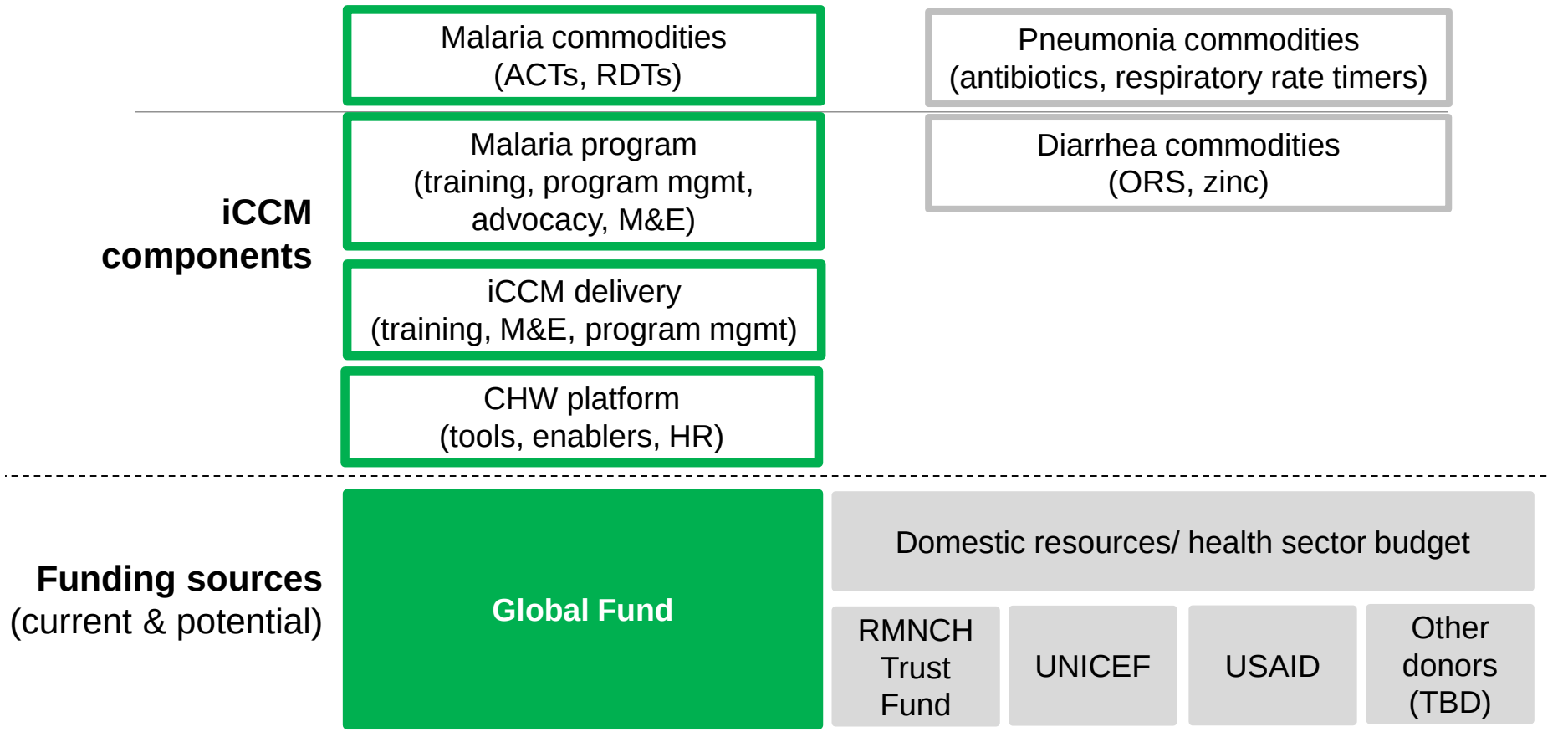
unicef

The Global Fund

Scope is child and maternal health, i.e. e-MTCT (ANC/PNC), pediatric AIDS and iCCM

unicef | 1,+++,+++ One Million Community Health Workers Campaign | USAID FROM THE AMERICAN PEOPLE | Save the Children. | THE MDG Health Alliance | SIAPS Systems for Improved Access to Pharmaceuticals and Services | Maternal and Child Survival Program | JSI | CLINTON HEALTH ACCESS INITIATIVE

Aligning these RMNCH funding streams with Global Fund investments can create a 'win-win' situation for malaria, HSS and MNCH



If successful, this iCCM co-financing platform can lead to improved child health outcomes, stronger integration of vertical programs, and leveraged donor resources

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An ‘iCCM Financing Task Team’ was established to coordinate and provide technical support

iCCM Financing Task Team: multi-organizational team of global partners

UNICEF — USAID — MCHIP/MCSP — MDGHA — WHO — MSH/SIAPS

1MCHW Campaign — CHAI — Save the Children — Red Cross — R4D

- UNICEF leading the team
- Funding support from BMGF

Project Management & Coordination

- Respond to country requests (MOH via UNICEF) for TA
- Ensure all TA is in place to support countries (training/deployment of consultants)
- Develop and share tools; package info
- Maintain country dashboard
- Set up local iCCM ‘point person’
- Analyze co-financing needs and opportunities

Relationship Management & Facilitation

- Engage with the Global Fund – FPMs & disease advisors
- Liaised with the HWG and the RMNCH TF: providing joint TA
- Engaged with donors on co-financing
- Coordinate with technical team – especially CCM Task Force
- Engage with the CHW + Steering Committee

The iCCM Financing Task Team: Phase I

➢**Aim**: iCCM integration into the GF NFM malaria and/or HSS CNs in order to mobilize $100mln from the GF and other donors to support iCCM across at least 10 high burden priority countries

➢**Targets**:

15 countries assisted in iCCM integration (current: 23)
10 countries submitting CNs w/iCCM elements (current: 21)
$100mln mobilized across 10 countries (current: $200mln across 12 countries)

➢**Technical assistance** included support to:

1) develop or review existing child health/iCCM strategies (especially those focused on pneumonia and diarrhea); 2) develop and/or finalize an iCCM gap analysis; and 3) draft the iCCM components of the Global Fund NFM malaria or HSS CNs

The iCCM Financing Task Team: Process – supported countries

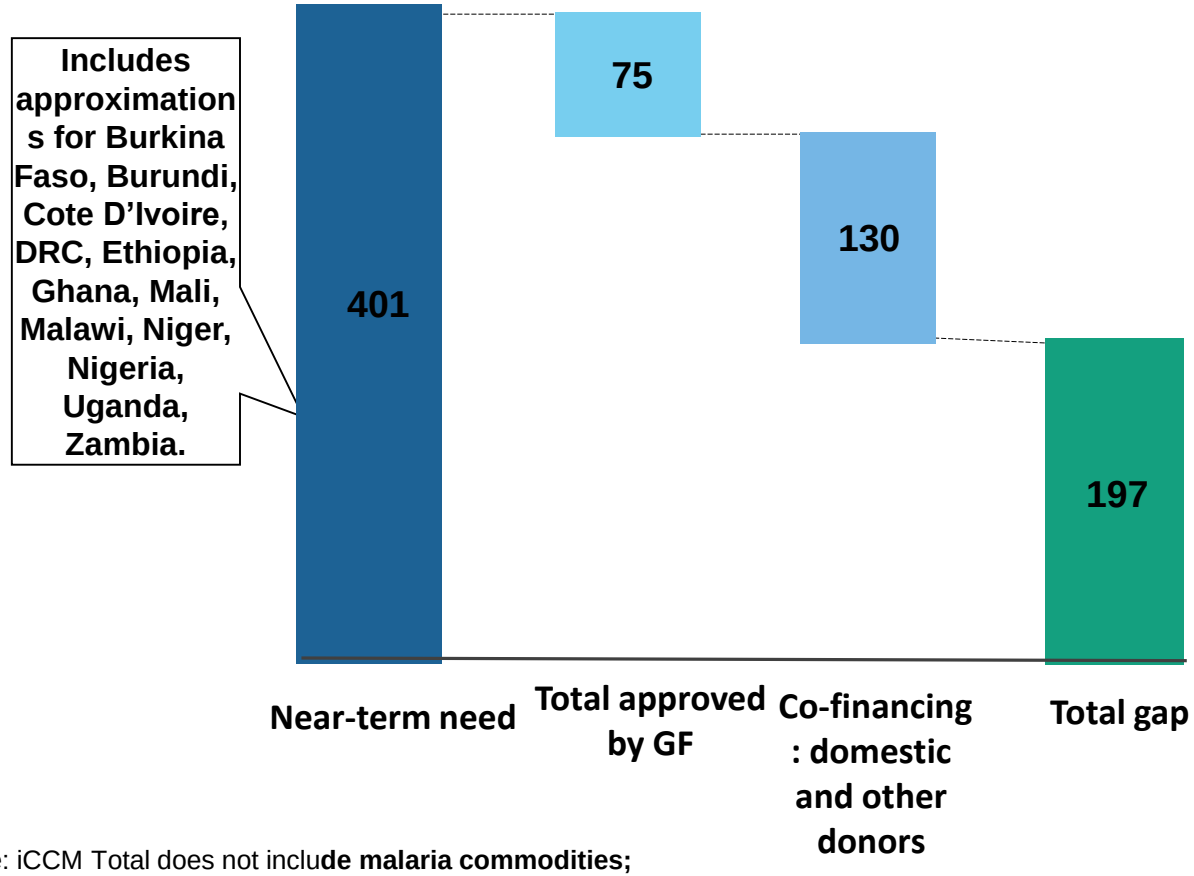
Eastern and Southern Africa Region	Western and Central Africa Region
Burundi	Burkina Faso
Ethiopia	**Central African Republic
Eritrea	Cote d'Ivoire
Comoros	Democratic Republic of the Congo
The Gambia	Ghana
**Kenya	Guinea Bissau
Madagascar	Mali
Malawi	Mauritania
Mozambique	Nigeria
Somalia	Niger
South Sudan	
Uganda	
Zambia	

Estimated iCCM Funding Committed and Gap (in USD millions), by Country *Estimates as of December 2015 – RMNC for review*

Country	Under 5 mortality*	Overall need**	Implementation timeframe**	iCCM geographical scope*	Target iCCM coverage (%)	Est. Funding Committed			Remaining Gap
						Global Fund	Co-financing	Total	
Burkina Faso	64,099	16.6	Jul'15 – Dec'17	Sub-national	80	10.6	0.9	11.5	5.1
Burundi	34,883	5.6	Jul'15 – Dec'17	National	75	1.0	3.9	4.9	0.7
Cote d'Ivoire	72,484	7.6	Jul'15 – Dec'17	Sub-national	75	6.5	0.1	6.6	1.0
DRC	319,977	77.1	Jul'15 – Dec'17	National	80	13.2	10.2	23.4	53.7
Ethiopia	195,504	61.5	Jan'15 – Dec'17	National	100	17.2	45.7	62.9	(1.4)
Ghana	61,530	15.5	Jul'15 – Dec'17	Sub-national	100	4.4	0.5	4.9	10.6
Malawi	41,039	48.6	Jul'15 – Dec'17	National	100	5.0	33.8	38.8	9.8
Mali	82,267	21.5	Jul'15 – Dec'17	National	100	TBD*	0.9	0.9	20.6
Niger	86,249	53.3	Jul'15 – Dec'17	National	100	TBD*	13.6	13.6	39.7
Nigeria	804,429	23.5	Jul'15 – Dec'16	Sub-national	28	2.8	10.5	13.3	10.2
Uganda	101,552	20.1	Feb'15 – Dec'16	Sub-national	60	5.8	5.1	10.9	9.2
Zambia	51,474	50.0	Jan'15 – Dec'16	National	100	8.2	4.5	12.7	37.3
TOTAL	1.915.487	401				75	130	204	197

FOR TWELVE COUNTRIES, NEAR-TERM ICCM COMMITMENTS BY THE GLOBAL FUND, MOHs, AND BILATERIAL CO-FINANCING OF ~$200M, REMAINING GAP OF ~$200M

iCCM TOTAL NEAR TERM NEED $401 MILLION (2015-2017)



Note: iCCM Total does not include **malaria commodities;**
Source: iCCM Financing Task Team Consultants**.** All numbers draft.

The iCCM Financing Task Team: Phase II

➢**Aim**: to ensure that the effort and investments made as a result of Phase I are not compromised during the negotiation phase of the GF grant award process, or thereafter, when governments implement their iCCM expansion plans

➢**Technical assistance** included support to:

1) ensure that sufficient grants are earmarked for iCCM in the final grant agreements
2) develop robust, costed implementation plans
3) promote integrated psm planning
4) Identify co-financing and mobilize funding for remaining gaps

The iCCM Financing Task Team: Achievements

- Provided TA to 23 countries, of which 21 submitted CNs containing iCCM
  - Built capacity (trained pool of 20 consultants)

- Helped to leverage ~$200mln across 12 countries

- Supported a set of priority countries through GF grant making process and implementation planning

- Catalyzed prioritization of iCCM at the global and country level
  - Working with partners, positioned iCCM on the global agenda as an essential evidence-based intervention for U5 morbidity and mortality reduction at the community level
  - Facilitated interactions between child health and malaria teams at the MOHs in the supported countries

The iCCM Financing Task Team: Achievements

- Reflected on the learnings and best practices stemming from our work
  - USAID's Ghana, Kenya, Nigeria, Uganda, Zambia case studies detailing support provided, challenges faced, lessons learned, and recommendations for future work: *"Leveraging GF-NFM for iCCM A Synthesis of Lessons Learned across Five Countries."*
  - Jointly with the BMGF and the GF commissioned a consulting firm to conduct an external review of the iCCM financing integration process and the development of an advocacy action plan aimed at further engaging policymakers donors, and countries to promote iCCM integrated financing and implementation: *Key findings report, iCCM advocacy action plan, iCCM Advocacy brief*
- Main funding for FTT work from BMGF; leveraged funding from partner organizations: USAID (Ghana, Kenya, Nigeria, Uganda, Zambia), MSH (Nigeria), Save the Children (PSM consultant), WHO (Eritrea)

The iCCM Financing Task Team: Achievements

- Developed a compendium of tools for quantifying and costing expanded iCCM services and the process of integrating iCCM into the CN as well as for iCCM implementation planning, resource mobilization, and iCCM advocacy

1) *iCCM GA tool*
2) *USAID-funded iCCM costing tool, developed by MSH*
3) *Guidelines for effective iCCM integration into the GF NFM CNs*
4) *iCCM indicators matrix*
5) *'ICCM Integration Guidelines for Government, Donors, and Partners' aimed at fostering alignment around 1) iCCM implementation planning, 2) iCCM indicators, 3) iCCM financing and the responsibility of the various partners*
6) *Guide to iCCM PSM planning for GF grants*
7) *iCCM PSM checklist*
8) *iCCM product selection guide*
9) *Resource Mobilization Concept Note*
10) *Benefits on integrating malaria case management and iCCM flyer*

The iCCM Financing Task Team: Challenges

- Breaking ground – new process for many – learning as we go
- Buy in from the Malaria Community
- Timeline often adjusted and readjusted: processes are country driven and so dependent on country readiness at various stages; TA often extended/rescheduled; grant making often took longer than expected
- Very few full/part time individuals dedicated to this process (most FTT members volunteering time/ competing priorities)
- Challenges of working remotely with country teams

The iCCM Financing Task Team: Lessons learned

- **Government Structures Are Not Always Enabling**

- **Strong in-country partnerships are needed to drive the integrated financing for iCCM agenda forward**

- **Co-financing for non-malaria commodities**

  1) MOU created confusion regarding UNICEF's role in filling the diarrhea and pneumonia funding gaps

  2) Lack of assured funds to procure non-malaria commodities made malaria program managers reluctant to commit to a program they did not have full control over

  3) Co-financing for non-malaria commodities should ideally be identified prior to concept note submission to ensure funding for both is available simultaneously

  4) Need to explore new and innovative funding sources (typical: UNICEF, UK/DFID, Canada/DFATD, the RMNCH Trust Fund, and state / national governments)

The iCCM Financing Task Team: Lessons learned

- **Monitoring and evaluation**

  - 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.

Agenda

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Why are we here today?

Much has been accomplished over the past 2 years and much remains to be done

– Where do we need to focus our efforts?

- ***Strong implementation plans in place*** (Session II)
  - *GF grant work plans should ideally be based on national implementation plans (where such exist); in many these are weak*
- ***Strong integrated PSM systems and plans*** (Session III)
  - *supply chains in many countries looking to implement and scale up iCCM may be weak (LMD)*
- ***Strong M&E plans*** (Session IV)
  - *need to promote use of indicators to monitor iCCM as a whole (DPM)*

Why are we here today?

Much has been accomplished over the past 2 years and much remains to be done – Where do we need to focus our efforts?

- ***Strategies for resource mobilization to fill the remaining gaps to scale up iCCM and to strengthen CHW platforms*** (Session V)

  - *considerable funding gap: new and innovative ways to fill it need to be identified*

  - *funding needs to be sustainable: governments need to willing to mobilize increased domestic financing for iCCM*

  - *integrate community health within the wider health systems strengthening and health financing agenda*

Why are we here today?

- Important to gather at this particular juncture to review experiences of the supported countries, to assess progress, challenges, promote south to south exchange, and together suggest solutions for ensuring effective implementation at scale

- Wonderful opportunity for the iCCM Financing Task Team to hear feedback and consider requests of further support (TA template) –(Session VI)

Collaborative effort – Thank you

Country teams

The Global Fund

Other donors (Recipient governments, RMNCH TF, PMI, DFATD, Japan, etc.)

Bill and Melinda Gates Foundation

UNICEF
WHO
Save the Children
MDGHA
MCSP/JSI
USAID
MSH/SIAPS
CHAI
One Million Community Health Worker Campaign
International Red Cross
R4D

Consultants