Reducing Childhood Deaths through Integrated Community Case Management (iCCM)

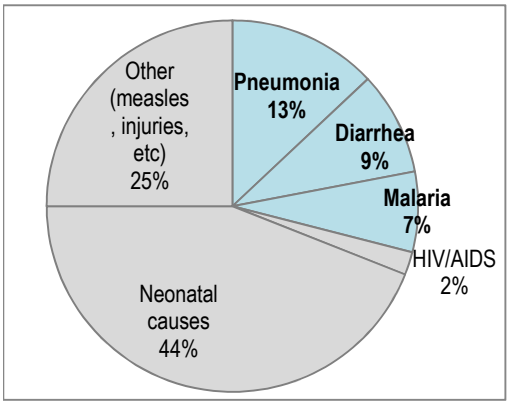
Approximately $200 million still needed to ensure full life saving impact of iCCM across 12 countries in sub-Saharan Africa

***DRAFT** January 2016*

Background

Each year over 6 million children die before their fifth birthday. Pneumonia, diarrhea, and malaria account for nearly one-third of these deaths (see Figure 1). While life-saving treatments exist, few children are receiving them. Geographic accessibility, shortage of skilled human resources, weak supply chains, and financial and social/cultural barriers remain major challenges.

Figure 1. Deaths Among Children Under 5 (%)
Source: UNICEF, A Promise Renewed Progress Report 2013



Integrated Community Case Management

In 2012, UNICEF and WHO issued a joint statement for Integrated Community Case Management (iCCM), an equity-focused strategy to increase access to effective case management and treatment for children with malaria, pneumonia, and diarrhea, especially in hard-to-reach areas. To provide iCCM, community healthcare workers (CHWs) are equipped, trained, supported, and supervised to deliver life-saving treatments to improve outcomes for children. Programmatic experience shows that iCCM can be a cost-effective approach if well implemented. ***To date, 28 countries in sub-Saharan Africa are implementing iCCM at national or sub-national levels.***[1]

Key benefits of iCCM[2,3] include:

- **Increases geographic and financial accessibility** by providing care in the community and reducing out of pocket expenses for transport to health facilites as well as opportunity costs in terms of caregivers' time
- **Increases timely care-seeking and integrated treatment and care** for pneumonia, diarrhea and malaria
- **Improves quality of care** and health worker skills to correctly and safely diagnose and manage these common childhood illnesses
- **Reduces inappropriate use** of artemisinin combination therapy (ACTs) and antibiotics thereby **maximizing efficiency of resources** and lowering the potential of developing antimalarial and antimicrobial drug resistance
- **Contributes to resilience** by strenghtening community health systems (e.g., in response to outbreaks such as Ebola, natural disasters, conflict and other emergencies)[4]

The Opportunity

In 2013, the Global Fund to Fight AIDS, TB, and Malaria (GFATM) announced a strong endorsement for iCCM by allowing countries to apply for funding to support selected components of the iCCM package under the New Funding Model (NFM)[5]. In early 2014, the iCCM Financing Task Team—a multi-organizational team of global partners led by UNICEF—was formed to provide technical assistance to priority countries interested in integrating iCCM into their malaria and/or health systems strengthening NFM concept notes (CN).

---

[1] Rasanathan K. Community case management of childhood illness in sub-Saharan Africa: Findings from a cross-sectional survey on policy and implementation. *J Glob Health*. 2014; 4:020401.
[2] UNICEF-WHO. Overview and Latest Update on ICCM: Potential Benefit to Malaria Programmes. February 2015.
[3] iCCM Evidence Review: Meeting Report. 2014.
[4] Rasanathan K. Where to from here? Policy and financing of iCCM of childhood illinesses in sub-Saharan Africa. 2014. *J of Glob Health*; 4(2): 020304.
[5] Eligible components include CHW training and salaries, malaria commodities, supportive supervision, as well as supply chain and health information system strengthening activities.

With support from the iCCM Financing Task Team, an **estimated USD 204 million across 12 countries** has been committed by GFATM to support iCCM and additional "co-financing" has been leveraged from other donors—including UNICEF, DFATD, the RMNCH Trust Fund, PMI, the Japanese government, as well as recipient Governments. This co-financing supports requisite iCCM commodities that are not eligible for GFATM funding and supports large-scale iCCM expansion. The iCCM Financing Task team has supported additional countries with their concept note submissions to GFATM for iCCM expansion, and final figures for resources mobilized will be available in due course following GFATM approvals/grant signing and co-financing commitments.

A summary of progress made to date for selected countries is summarized in Table 1 and Figure 2 based on data from original GFATM concept notes and country discussions. This includes the 'overall need' which represents a country's total funding request to GFATM for iCCM and the expected implementation timeframe.[6] It should be noted that the geographic scope and iCCM coverage targets vary by country. For example, the overall need for Zambia (USD 50 million) represents the funding needed to support iCCM scale-up in the entire country while the need for Burkina Faso (USD 16.6 million) is the funding needed to scale-up iCCM in selected regions. The estimated funding committed—from GFATM and other sources—and the remaining financial gap are also provided. (**Note:** All estimates are subject to change during the operationalization process with GFATM. In particular, funding requests and remaining gap estimates will be updated following expenditures analyses scheduled for Q1/Q2 2016.)

TABLE 1: Estimated iCCM Funding Committed and Gap (in USD millions), by Country (*estimates as of Dec 2015- subject to change)*

Country	Under 5 mortality*	Overall need**	Implementation timeframe**	iCCM geographical scope*	Target iCCM coverage (%)	Est. Funding Committed			Remaining Gap
						GFATM	*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	July'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**

*UNICEF A Promise Renewed Report, 2014

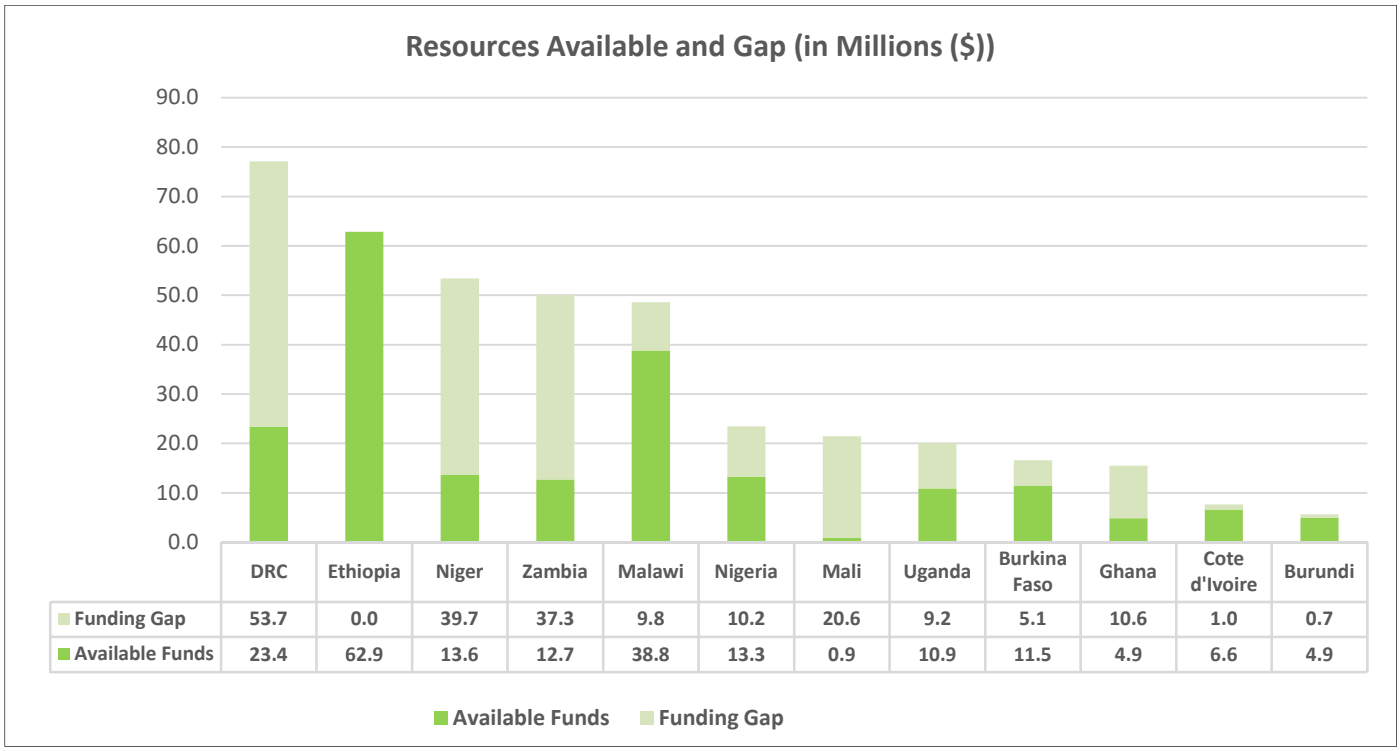
**Per original concept notes submitted to GFATM and country inputs

***GFATM funding requested for Mali and Niger and awaiting decision

****All target coverage by 2017, except for Niger (2018), Nigeria (2016) and Uganda (2016)

[6] The financial gaps were derived during the development of the Global Fund NFM Concept Note for Malaria and/or Health Systems Strengthening (HSS) applications. A generic iCCM gap analysis tool, developed by the iCCM Financing Task Team, was used to gather cost data and commitments from governments and partners. The process involved inputs from the MoH, National Malaria Control Program and Child Health departments, CCMs and partners, with technical assistance from the ICCM Financing Task Team. This deduction is at macro-level and may require further micro-level analysis in specific countries.

FIGURE 2. iCCM Funding Secured and Gap (in millions, USD), by Country *(estimates as of December 2015)*



	DRC	Ethiopia	Niger	Zambia	Malawi	Nigeria	Mali	Uganda	Burkina Faso	Ghana	Cote d'Ivoire	Burundi
Funding Gap	53.7	0.0	39.7	37.3	9.8	10.2	20.6	9.2	5.1	10.6	1.0	0.7
Available Funds	23.4	62.9	13.6	12.7	38.8	13.3	0.9	10.9	11.5	4.9	6.6	4.9

Note: Funding gap reflects the gap for the Global Fund-supported programs

What National Governments and International Donors Can Do

Significant funds have been mobilized to support iCCM in countries with high child mortality; however, **an approximate USD $200 million is still needed to ensure full life-saving impact of iCCM expansion across the 12 countries.** On average, funding for non-malaria commodities (i.e., amoxicillin for pneumonia and oral rehydration salts and zinc for diarrhea) accounts for approximately 20% of the total need in country. Other keys gaps include iCCM platform costs such as CHW training, essential equipment, supportive supervision, CHW motivation/incentives, monitoring and other supportive costs to ensure adequate delivery in hard-to-reach areas.

The impact of every health dollar invested in MNCH programmes and from the GFATM would increase exponentially if new investments both by national governments and international donors were made. New commitments are urgently needed as countries and governments have already started to implement iCCM efforts in 2015, whose reach could be limited if the outstanding unfunded areas are not filled. Mechanisms are already in place at global and country level to support the coordination of investments across individual donors and ensure effective and efficient roll out of iCCM activities across disease programmes.

Contact

For more information, please contact: Mark Young (myoung@unicef.org) and Kate Ketende (kwketende@gmail.com) as focal points within the iCCM Financing Task Team for this initiative.