Catalyzing the Scale-up of iCCM within the context of the Global Fund's new funding model (NFM) 2014-2016 Lessons Learned

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I. Background

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In April 2014, the Global Fund and UNICEF signed a Memorandum of Understanding and committed to working together in the context of the new funding model (NFM) to maximize opportunities for synergies between the Global Fund's investments in HIV, TB, and malaria and UNICEF's broader efforts to improve child and maternal health. Under the child health arm, the focus was on strengthening community health platforms and helping governments secure and deliver essential life-saving commodities for pneumonia, diarrhea, and malaria through Integrated Community Case Management of Childhood Illnesses (iCCM). Countries were encouraged to include select components associated with the development or expansion of iCCM approaches in diagnosing and treating non-malaria illness in their malaria and health system strengthening (HSS) NFM proposals. Eligible components included those below:

Essential iCCM Components	Global Fund Supported
Training and salary costs for CHWs	Yes, provided that the CHWs* are directly involved in malaria management
RDTs for malaria diagnosis	Yes
ACTs for malaria treatment	Yes
Respiratory timers for pneumonia diagnosis	No**
Antibiotics for pneumonia treatment and ORS and zinc for diarrhea treatment	No**
Supportive supervision	Yes
Supply chain system strengthening	Yes
Health information system strengthening	Yes

*CHWs=Community Health Workers

**Commodities not funded by the Global Fund provide a co-funding opportunity for governments or other development partners to invest in the iCCM platform.

The roll-out of the Global Fund's 3-year funding cycle spanning 2014-2017 (NFM) provided a unique opportunity to work with a priority set of high burden countries to sharpen community-based treatment strategies and plans and leverage the necessary resources – from the Global Fund and other potential sources of 'co-financing'. While various agencies (such as UNICEF, WHO, USAID/MCHIP, Save the Children and others) and networks (CCM Task Force, CHW+ Initiative, global Diarrhea/Pneumonia WG, 1MCHWC) had previously been supporting iCCM and resource mobilization, the condensed window of opportunity afforded by the GF-NFM created the need for a dedicated core group of individuals to lead and coordinate efforts. The iCCM Financing Task Team—a multi-organizational team of global partners led by UNICEF - was therefore formed in February 2014 to provide technical assistance to countries interested in integrating iCCM into their malaria and/or health systems strengthening (HSS) Global Fund NFM concept notes (CN). The team came together quickly to leverage the new opportunities for iCCM scale up and to support the coordination of technical inputs from various partners and donors. In addition to UNICEF, core partners on the iCCM Financing Task Team have included WHO, the MDG Health Alliance (MDGHA), Save the Children, USAID, USAID's Maternal and Child Survival flagship programs (USAID/MCHIP and USAID/MCSP), Clinton Health Access Initiative, Inc. (CHAI), USAID-funded Systems for Improved Access to Pharmaceuticals and Services (SIAPS), Results for Development (R4D), Micro-Nutrient Initiative, International Federation of Red Cross and Red Crescent Societies (IFRC), as well as core consultants who have provided a vital coordination role and technical assistance.

During Phase I (2014/2015), the iCCM Financing Task Team, with funding from the Bill and Melinda Gates Foundation as well as in-kind and financial contributions from partners, focused its efforts on supporting countries to: 1) undertake iCCM gap analyses and revise/strengthen national strategies for child health and iCCM; 2) develop strong, technically sound Global Fund concept notes and; 3) successfully navigate the Global Fund's grant approval and grant-making processes.

Between 2014-2016, twenty-eight (28) African countries, as listed in Box A, received direct or indirect technical assistance from the iCCM FTT, of which twenty-seven (27) submitted Global Fund concept notes with iCCM components. Technical assistance (TA) was provided either through dedicated trained consultants; core FTT members (i.e., directly by the FTT full time technical lead, staff from UNICEF and other partner organizations); and/or sharing of the various tools prepared by the iCCM FTT. The majority of these countries have since signed GFATM grants

Box A: Twenty-eight (28) countries supported by the iCCM FTT (2014-2016)

- Benin
- Burkina Faso
- Burundi
- Cameroon
- Central African Republic
- Comoros
- Cote d'Ivoire
- Democratic Republic of the Congo (DRC)
- Eritrea
- Ethiopia
- The Gambia
- Ghana
- Guinea Bissau
- Kenya
- Madagascar
- Malawi
- Mali
- Mauritania
- Mozambique
- Nigeria
- Niger
- Senegal
- Sierra Leone
- Somalia
- South Sudan
- Togo
- Uganda
- Zambia

** All countries except Kenya submitted Global Fund concept notes with an iCCM component.*


Photo credit: SIAPS

with iCCM components, and have moved into the grant implementation phase.

During Phase II (2015/2016), upon receipt of a supplemental grant from the Gates Foundation, the Task Team's overall objective expanded from the provision of TA to supporting in-country scale-up of a complete package of care for the febrile child at the community level as well as working to influence the broader iCCM integration agenda. The main focus during this time has been on supporting effective implementation of NFM-linked iCCM in a sub-set of 'early grant recipient' countries such as DRC, Ethiopia, Nigeria, Uganda, Zambia, and Burkina Faso. Support was nevertheless also provided - directly or indirectly - to other countries previously supported during Phase I. Technical assistance in Phase II has included support for monitoring and evaluation; resource mobilization; procurement and supply chain management (PSM)**;** advocacy; and implementation review and documentation.

II. Key Accomplishments – What has been the added value?

Over the past two years, the iCCM FTT has made numerous contributions to advancing iCCM programming at national, regional, and global levels. Key accomplishments of the FTT include the following:

- **Supported twenty-eight (28) countries in sub-Saharan Africa to integrate iCCM into Global Fund malaria and HSS concept notes of which twenty-seven (27) submitted** Global Fund concept notes which included an iCCM component. In addition, while focus on a certain set of priority countries has been to ensure that these receive the full-range of available support, there has been spill-on effect for other countries that have benefited from the development of tools as well as being encouraged to implement CCM – often by the Global Fund secretariat themselves (see Box A).
- **Contributed to mobilizing over USD80 million for iCCM through the Global Fund and co-funders across 12 countries**[1] (Burkina Faso, Burundi, Cote d'Ivoire, DRC, Ethiopia, Ghana, Malawi, Mali, Niger, Nigeria, Uganda, and Zambia).

1 These are the countries for which data is available for GF commitments as well as for some of the co-donor commitments. It is certain that considerably more than the USD80mln has been leveraged across those 12 countries. However, the exact funding from all the co-donors across the 12 countries has not been shared. In addition to the funds leveraged for those 12 countries, iCCM funding has been secured across the other 15 iCCM FTT-supported countries (amounts not validated). Thus, it is estimated that the overall funding leveraged for iCCM as part of the FTT work is significantly over USD80mln.

- **Developed and disseminated various iCCM program implementation tools** and guidance to strengthen the case and support for iCCM programming in a holistic and systematic manner (see Box B).
- **Established strong partnerships and coordination mechanisms between iCCM FTT members, UNICEF, the Global Fund, and other key stakeholders** on strengthening child health and community health platforms and building resilient health systems. For example, the FTT, UNICEF, and the Global Fund teams have worked closely to monitor grant progress in countries, address emerging challenges around M&E, PSM and other issues, and coordinate missions to countries.
- **Enhanced the visibility of iCCM on the global health agenda,** particularly among donors (including the Global Fund) to support iCCM as an integrated community health platform to address leading causes of morbidity and mortality in children under the age of five. In recognition of iCCM's role in addressing U5 mortality among children, the Global Fund is currently commissioning a review of iCCM implementation under the new funding model, with a focus on issues of access, speed, and quality of programming. The results of this assessment will inform the next funding cycle for Global Fund grants (2017-2019) and the scope for iCCM inclusion in those grants.
- **Catalyzed stronger linkages and partnerships between the child health and malaria communities at the global and national level** to work towards shared goals and a common vision. In countries that successfully integrated iCCM into Global Fund concept notes, agreement and consensus among key stakeholders—including child health and malaria program managers—about iCCM often had to be forged, and in many instances reluctance among the malaria community to share Global Fund malaria resources had to be overcome.
- **Strengthened support for iCCM M&E,** which had been lacking across many stakeholders, through the provision of tools as well as by ensuring continued M&E discussions at country level as well as during the Nairobi iCCM Cross-Regional Consultation in Kenya (see below).
- **Trained and oriented national and international consultants for Phase I and Phase II support,** thereby building capacity across various stakeholders and at country level.
- **Participated in joint inter-agency PSM missions to Zambia, Uganda, and Nigeria** to promote national supply chain strengthening and integration efforts for improved program results.
- **Convened the Nairobi iCCM Cross-Regional Consultation in Kenya** (16-18

Box B: Tools, Guidance, and Briefs developed by, or with contribution from, the iCCM FTT to support program planning and implementation

- *iCCM Gap Analysis Tool*
- *Guidance for Effective iCCM integration into the GF NFM concept notes*
- *iCCM Integration Guidelines for Government, Donors, and Partners*
- *iCCM and Maternal Health PSM checklist,*
- *iCCM Product Selection Guide,*
- *Guide to iCCM PSM planning for Global Fund Grants,*
- *iCCM indicators matrix*
- *WHO-UNICEF iCCM Evidence Update*
- *iCCM Integration Flyer*
- *ICCM Financing Integration Advocacy Brief*
- *iCCM Implementation under the Global Fund's New Funding Model (NFM): Program Implementation Documentation Protocol*

Available in English (and in French for selected tools) as well as online at www.ccmcentral.com

February 2016) as an extension of TA support to countries and in collaboration with UNICEF HQ, WCARO, and ESARO. The consultation brought together key stakeholders from global, regional, and country levels to share knowledge, lessons learned, and experiences across countries in scaling up iCCM in the context of the Global Fund's NFM (for additional information, see the Nairobi meeting report and supporting materials on CCM.central).

III. How were the Accomplishments Achieved?

These accomplishments were achieved through a mix of the following success factors:

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- **A dedicated task team of individuals from different organizations all committed to iCCM.** The successes of the iCCM Financing Task Team were based on the rapid response, unique and concentrated partner effort, the continuous leadership of UNICEF and a full time technical lead, with dedicated support for tracking key areas and activities. Despite a very small core team, continuous FTT member partner support - both technical and financial - and leveraging those with a strong country presence and donor flexibility allowed for rapid adaptation to the evolving needs of the countries being supported. The iCCM Financing Task Team has been successful by leveraging various resources (both human and financial) at all levels of the organizations that it encompasses. The FTT has proven to be not only an important coordination mechanism, but a valuable means of partnership-building among partner organizations, donors, and country teams as well. UNICEF was able to leverage this partnership to rapidly respond to the opportunity provided by the Global Fund's NFM to provide support and assistance to governments wishing to expand their resource base for iCCM of diarrhea, malaria and pneumonia in children under five.

- **Flexible funding which allowed for the rapid deployment of technical assistance.** The U.S. Fund for UNICEF served as the administrator for the flexible core grant from the Bill and Melinda Gates Foundation. In addition to the original grant, the FTT also received supplemental funding from the Gates Foundation to provide support beyond the initial set of countries as well as during grant making and implementation.
- **The Global Fund-UNICEF MoU** formalized a partnership and working relationships between the Global Fund and UNICEF to work closely on strengthening child and community health through iCCM. Support and prioritization from the GF RMNCAH team ensured that public health and M&E officers were sensitized to the iCCM opportunity and called upon the FTT when countries encountered challenges.
- **Visibility and active networking and relationship building** between child health and malaria communities both globally and nationally.

IV. Key Challenges – What difficulties have we encountered across country contexts?

Political Commitment and Country Ownership

There are varying levels of political commitment to, and country ownership of, iCCM. Countries demonstrating strong government ownership, leadership and coordination of iCCM include those with child health program managers with strong technical knowledge and influence to bring together program managers from child health, malaria, community health within the ministry of health (MOH) and from external partners and NGOs. These program managers also have access to high level leadership - technical directors and heads of departments - in the MOH. In these countries, iCCM is being increasingly integrated into national systems, particularly health management information systems (HMIS) and PSM systems. On the other hand, countries with weak technical capacity and program leadership for child health have struggled to coordinate the planning and start of implementation of an integrated program. In these countries, iCCM is viewed and treated as a donor-driven initiative with limited support and involvement of technical directors/heads of departments in the MOH. Although the problem is known, there are no resources allocated for capacity building for child health program managers in the latter countries.

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Parallel Financing

Parallel funding streams and vertical funding models have created many challenges for implementing iCCM as an integrated model. Many, if not most, existing funding mechanisms are disease-specific, creating multiple challenges for program implementation. The Global Fund, for example, is currently permitted by their Board to fund many components of iCCM, but not the pneumonia and diarrhea commodities. This is similar for the President's Malaria Initiative (PMI). Countries must, thus, identify co-financing for the non-malaria commodities and align that co-financing with those implementing under Global Fund and PMI to ensure that iCCM is delivered as an integrated program. Coordinating parallel financing to ensure joint implementation and the constant availability of all services and commodities in the package is complex especially when systems are not necessarily nimble or flexible. Vertical or disease-specific financing can also lead to a situation where national counterparts spend more time seeking and/or aligning financing than implementing programs.

Funding Gap

For iCCM programs under the Global Fund's NFM, one of the key challenges for countries has been securing co-financing for the non-malaria commodities, namely ORS and zinc for diarrhea, and amoxicillin for pneumonia. Although some countries have had greater success than others and over USD80 million has been mobilized for iCCM across 12 countries (through the Global Fund and other donors), more funding is still needed across these twelve countries to support iCCM implementation under the 2014-2017 grant cycle. As a result, in some cases countries have not been able to implement iCCM as stipulated in the Global Fund grants and are to date only implementing community case management of malaria. Lastly, while there have been positive strides toward country ownership and policy integration, many iCCM programs are still primarily funded by large international donors, with limited domestic investments. In order for iCCM to be sustainable over time, increased domestic investments are critical.

Lack of Integrated Indicators and a Joint Accountability Framework

The Global Fund NFM does not require grant recipients to report on the non-malaria indicators (pneumonia and diarrhea) as part of its modular template and performance framework despite the integrated funding. The iCCM FTT has advocated for monitoring the integrated program, and proposed a list of indicators for monitoring diarrhea and pneumonia to the Global Fund. There is a reticence on behalf of both the Global Fund secretariat and primary and sub-recipients of the grants (PRs/SRs) to be held accountable for diarrhea and pneumonia outcomes when they are not in control of the financing and provision for these commodities. While the iCCM FTT has recommended that national health ministries integrate priority routine iCCM indicators into the national HMIS, while also disaggregating data for community and facility levels, for many countries it will take time before this become a reality because there is no one demanding indicators of an integrated program.

Weak National PSM Coordination Mechanism and Supply Chain Systems

The success of an iCCM program relies on the consistent availability of commodities at the community level; yet there are numerous PSM challenges common across countries that preclude this from happening. There are unique PSM challenges presented by service delivery at the community level including remote locations at the end of the supply chain in rural areas or with difficult geography; limited or challenging transportation networks; reliance on a volunteer cadre of health worker; and inadequate reporting and re-supply mechanisms for CHWs. Weak national pharmaceutical systems

have challenges specific to quantification and procurement of iCCM commodities, their distribution and management of logistics information, which can be manifested by stock outs throughout the supply chain and especially felt at the community level. ICCM commodities should be integrated into existing pharmaceutical systems rather than being managed through parallel systems and resources for management of iCCM commodities should be used to strengthen those national systems. National pharmaceutical strategic plans and national and sub-national PSM coordination mechanisms exist in some countries and can help address these challenges, but these mechanisms are not always functional or function sub-optimally. The lack of functioning coordination mechanisms can create parallel PSM processes and structures in country with partners and stakeholders working at cross-purposes, and sometimes undermining national systems.

TA Provision

The TA model utilized by the iCCM FTT, modeled on that of the Roll Back Malaria's Harmonization Working Group, was fit for purpose and helped fill short term needs, particularly during Phase I in terms of providing technical assistance to undertake the iCCM gap analysis and ensure that iCCM (as determined by the country's priorities) was included in the Global Fund concept notes. The iCCM FTT maintained a roster of consultants that could be deployed with relative ease, and for discrete, highly focused tasks (review of national child health/iCCM strategies, iCCM gap analysis; inclusion of iCCM in Global Fund concept notes) it worked well. The consultants, where possible, were local and well versed in national iCCM context. However, in some instances, where this was not possible, the international consultants did not necessarily build internal capacity within countries or promote long-term sustainability or national ownership of iCCM.

Sustaining Momentum during the Grant Implementation Phase

During the grant implementation phase (Phase II), it has been difficult to sustain the momentum of Phase I support when the iCCM FTT and country teams were in close communication around the crafting and submission of the Global Fund concept notes. During Phase II, regular communication and information flow between global and national levels has been more of a challenge. Although the iCCM FTT has been on standby to provide support to country for implementation planning, TA requests have been far fewer as compared with Phase I. Some of this may be related to the lengthy time between concept note submission and the beginning of grant implementation. For many countries, it took much longer than anticipated between the submission of the concept notes and the signing of the grant agreements, contributing to the loss of momentum. In some cases, this created a lull while countries awaited their allocations. In addition, it must be acknowledged there are often competing national priorities, shifting political sands, as well as new opportunities, which can shift the attention away from iCCM programming to other health priorities. Partner coordination at both the national level and global level can also create inefficiencies and drag out processes unnecessarily. The Nairobi iCCM consultation was important in that it enabled country teams to come share experiences and challenges in-person and face-to-face. There was a strong consensus among country team participants that this was the first and very successful opportunity to exchange experiences in implementing iCCM -both under the Global Fund NFM as well as in general. It was also an important opportunity for the iCCM FTT (many of the core members attended the meeting) to sit down and work together with country teams in person, rather than remotely and to discuss continued

technical support provision. The iCCM FTT has continued to work with countries following the Nairobi meeting.

Challenges with Country Grant Implementation

In many country contexts, implementation of the iCCM components of the Global Fund grants has been slow. In some settings the challenges have been contractual, for example the negotiation of PR/SR grant agreements, which can be time-consuming especially when there are multiple SRs. In other contexts, such as Uganda for example, irregularities in local procurement practices have delayed the implementation of iCCM. Although community health workers had been trained and supplied with all the commodities they needed to deliver an integrated package of services, due to problems with local procurement they did not have the job aids and registers they needed to implement iCCM. In other instances, the lack of co-financing for the diarrhea and pneumonia commodities at the community level has meant that countries have only been able to implement community case management of malaria (e.g., Burundi)). In Nigeria, the Global Fund suspended disbursements for all of its grants (malaria, HIV, and TB) in May 2016 after the office of the inspector general (OIG), an arm of the Global Fund, reported findings of fraud. Additionally, the streamlining of implementation set up, i.e., newness of working together across child health and malaria teams and no aligned indicators for the Global Fund PRs, have contributed to the slow pace of implementation in most countries.

V. Lessons Learned & Ways Forward - How do we promote sustainability?

- **Actively support national iCCM champions and strengthen stakeholder coordination mechanisms for effective iCCM implementation.** Strong in-country leadership and partnerships are key to driving effective iCCM implementation and scale up. iCCM planning, implementation and monitoring should be part of existing interagency coordinating committees(ICC) for malaria or immunization in order to bring its benefits to the attention of the highest level of leadership in the MOH that chairs the ICC. High-level political and technical leadership is essential for sustaining the focus on iCCM as an equity-based strategy for under-served populations. Integration of iCCM commodities into strengthened national pharmaceutical systems and functional and effective in-country coordination mechanisms are

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especially important for keeping implementation on track, for course correction, for promoting accountability, as well as promoting alignment among stakeholders and development partners.

- **Position iCCM more strongly within the broader framework of primary health care and community health.** At its core, iCCM is an extension of the primary health care system, extending the reach of primary health care from the facility to the community level through trained, equipped and supervised community health care workers. However, iCCM runs the risk of being seen or constructed as a stand-alone or vertical program. It is important to counter this by explaining the linkages between primary health care facilities and the community health platform - of which iCCM is only one component - and emphasizing the importance of community health platforms for building strong and resilient health systems. This approach is currently being emphasized by UNICEF, WHO, and the Global Fund, among others. For instance UNICEF's new Health Strategy emphasizes community health system strengthening and the use of the CHW/iCCM platform to deliver a broader package of effective interventions for MNCH as defined by country plan and context. An overarching national community health strategy/plan is needed, where CHWs are recognized as an important component of the overall health system, providing critical links between communities and health facilities as part of a broader 'primary health care' approach.

- **Reframe support to countries to strengthen primary health care and community health, including iCCM, in the Global Fund funding requests for 2017-2019. Continue collaboration with the Global Fund to inform the next round of concept notes as well with other donors.** Community and health systems strengthening is becoming ever more central to the Global Fund's desire to make its investments sustainable. The ongoing review by the Global Fund on the success and challenges of iCCM investments will be central to decisions on how this component will be supported during the new funding cycle starting in Jan 2017. As the first NFM comes to end in December 2016 along with funding support for the iCCM FTT, it will be important to determine the best model - and financing - to ensure continued support for iCCM implementation and expansion.

- **Emphasize the need for securing co-financing as early as possible to ensure sufficient funding is available for full iCCM implementation (malaria & non-malaria components and commodities).** iCCM cannot be successful without the whole package of services and commodities. Integrating financing, with different donors funding different components of an integrated package of services, carries risks that select components may be funded, while others may not. Under the Global Fund NFM grants, this has been the case in some country contexts for the non-malaria commodities that are key for iCCM implementation. The lack of co-financing for the non-malaria commodities has meant that countries have not been able to implement iCCM as envisioned in their Global Fund grants as well as the converse when non-malaria commodities are available but the malaria component is delayed. Funding for iCCM commodities should also take into consideration the management of the iCCM commodities not just their procurement costs. Extensive discussions with potential co-donors from the onset - i.e., at concept note development - to ensure the availability of resources to implement iCCM in a timely and efficient manner which strengthens community health are essential. Ideally, funders would earmark existing funding for co-financing of non-malaria commodities and support

complementarity and alignment with the malaria components rather than the other way around. The investment cases of the Global Financing Facility present a unique opportunity for this holistic planning.

- **Prioritize adoption of joint accountability mechanisms and monitoring of iCCM as an integrated program.** This is important for documenting results and impact and evidence building. Since diarrhea, malaria and pneumonia are the leading causes of under five deaths, monitoring the integrated program is the only way to show how iCCM contributes to reducing these preventable deaths, particularly for under-served populations, in order to justify further investment in the strategy. It is also critical for promoting political ownership and sustainability of iCCM as a national program. All organizations funding the integrated package of interventions should also emphasize the need to adopt the proposed indicators.

- **Intensify support for grant implementation and documentation of implementation.** The ability to document and track implementation progress and scale up efforts is key to establishing and sustaining iCCM as a programmatic and financial priority for countries, donors, as well as the child health and malaria communities. We need to better understand successes and challenges during the grant implementation phase, both for course correction and joint learning. In addition, to sustaining momentum for iCCM, building the evidence base - in particular generating local data and evidence - is essential. Countries and donors continue to need evidence that iCCM works, in particular country contexts, and is a good investment for child and community health. The iCCM FTT has devised a protocol that can be adapted to the country context, for review and documentation of the early implementation progress.