iCCM Implementation under the Global Fund's New Funding Model (NFM)

Program Implementation Documentation Protocol

Developed by the iCCM Financing Task Team
2016

Background

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). To support this process, the iCCM Financing Task Team—a multi-organizational team of global partners led by UNICEF[1]—was formed in early 2014 to provide technical assistance to priority countries interested in integrating iCCM into their malaria and/or health systems strengthening Global Fund NFM concept notes (CN).

During Phase 1 (2014/2015), the iCCM Financing Task Team focused its effort on supporting countries to 1) undertake gap analyses and revise/strengthen national strategies for iCCM; 2) develop strong, technically sound Global Fund concept notes, and 3) successfully navigate the Global Fund's grant approval and grant- making processes. While the iCCM Financing Task Team has been set up to support the financing integration, during Phase II (2015/2016), as countries begin to implement iCCM programming as part of their Global Fund grants, the iCCM FTT is providing selected support for effective and timely implementation, working with countries to problem solve challenges as they emerge. Between 2014-2015, twenty-eight (28) African countries received direct or indirect technical assistance from the FTT, and over twenty submitted Global Fund concept notes with iCCM components. To date, many countries have signed GFATM grants and have moved into the implementation phase, with others expected soon.

While Phase I support for integrating iCCM into malaria and/or health systems strengthening NFM concept notes have been well documented through USAID-funded case studies in 5 countries (Ghana, Kenya, Nigeria, Uganda and Zambia), it is also important for countries to document early implementation of iCCM under the New Funding Model to identify successes, challenges, and lessons learned and to inform the Global Fund, donors, implementers and other partners. The ability to finance select iCCM platform costs through the Global Fund represents a new financing opportunity for iCCM. Documenting the process across the NFM life cycle and understanding the strengths and weaknesses of this financing approach and

[1] Partners of the iCCM Financing Task Team include UNICEF, WHO, the MDG Health Alliance (MDGHA), USAID, Save the Children, USAID's Maternal and Child Survival Program (USAID/MCSP), Clinton Health Access Initiative, Inc. (CHAI), Systems for Improved Access to Pharmaceuticals and Services (USAID funded), Results for Development, the Micro-Nutrient Initiative, and others.

mechanism is thus important both for course correction and to mobilize future funding for iCCM.

Purpose of the Documentation and Target Audience

While the iCCM Financing TT doesn't have the capacity to conduct such reviews, it is offering this protocol, as well as readiness to work with countries to adapt it to the local context, to provide countries wanting to review their progress using a standard approach. The offered protocol presents a framework that can be used to document early implementation of iCCM through the Global Fund new funding model (NFM). A health systems approach to documenting early implementation is recommended, and the approach to reviewing iCCM program implementation is based on the 8 components of the iCCM benchmark matrix, as proposed in the McGorman et al. 2012. A Health Systems Approach to Integrated Community Case Management of Childhood Illnesses: Methods and Tools. *American Journal of Tropical Medicine and Hygiene* (suppl 5), pp. 69-76):

1. Coordination and policy setting;
2. Costing and financing:
3. Human resources;
4. Supply chain management;
5. Service delivery and referral;
6. Communication and social mobilization;
7. Supervision and performance quality assurance; and
8. Monitoring and evaluation and health information systems.

The ***target audience*** for this type of documentation includes:

1) Country teams: with the main aim of course correction
2) Global stakeholders: with the aim of building up evidence base on iCCM implementation, experience sharing, and mobilizing future funding for iCCM

Phased approach:

There are two parts to this documentation and review process:

Phase 1- recommended to be undertaken within 6 months of signing the Global Fund iCCM grant and should serve a preparatory purpose for phase 2.

Phase 2-recommended to be undertaken at least 12 months after service provision (CHWs trained, diagnosing and treating children) has started.

It is key to keep in mind that this is a one whole documentation process and the two phases simply relate to the sub-objectives and timeline.

General Objectives:

1. To assess the status of iCCM implementation at the country level both broadly (as a program) and specifically within the context of the Global Fund's NFM across the 8 components of the iCCM benchmark matrix as a guiding framework and to describe successes, challenges, areas for improvement, and corrective actions needed (if any) in each domain.

2. To contribute to the global iCCM evidence base and inform the Global Fund, other donors, implementers and partners on lessons learned, successes, and challenges faced by countries in implementing Global Fund iCCM grants within the context of the national iCCM programs.

Specific objectives: Phase 1:

1. To review the progress, identify challenges and make recommendations for strengthening early phase scale-up of iCCM under the GF grants.

2. To strengthen understanding and operationalization of GF grant management processes among stakeholders at country level including the government/MoH and district level management teams, the GF Principal and sub recipients, etc.

3. To review the progress and identify barriers to fulfilling the assumptions made during the GF concept note development, e.g., availability of non-malaria commodities and its impact on the scale-up process.

Specific Objectives: Phase 2:

1. To measure the implementation strength[2] including deployment, training of CHW, drug supply, supervision, etc.

2. To determine service utilization in the districts/zones implementing iCCM and to compare them with set targets articulated in the (a) Global Fund grant (b) other funding arrangements including domestic funds

3. To identify the lessons learned during early implementation of iCCM under the new funding model (NFM) and to develop technical recommendations to improve iCCM implementation and utilization at the country level.

2. Quantity/amount of a program implemented or services delivered

Expected Results:

- Validated quality documentation and review report
- Clear and actionable recommendations on how to strengthen the implementation process.

Methodology:

- Combination of desk review, stakeholder consultation (participatory approach), and review of HMIS/CMIS data

- Utilizes the iCCM benchmark matrix as a guiding framework to examine iCCM implementation from a health system's perspective

It is proposed that a phased approach to this documentation is undertaken with a focus on a systematic review of the iCCM program across the domains outlined in Annex B.

- **Phase 1:** ***Post-grant signing and pre implementation:*** looking at time and issues related to all the preparatory steps in the different categories. This phase will utilize desk review and stakeholder consultations.

- **Phase 2** ***Implementation***: defined as actual delivery of services to under-fives; It is recommended that countries only undertake phase 2 analysis after a year of delivering treatment to children as part of the Global Fund Malaria and HSS grants. Review of the programmatic data (actual service delivery) will be carried out.

  For phase 2, we recommend focusing on the implementation strength indicators as outlined in Annex C.

An attached document (Annex B -courtesy of David Marsh et al.) details the Benchmarks characterizing an iCCM program by component and was based on the benchmark matrix suggested by McGorman et al. in the iCCM supplement of the *American Journal of Tropical Medicine and Hygiene* (Nov 2012). As the document outlines: "The benchmarks are grouped into eight health system components. Within each component are benchmarks for advocacy/planning, pilot/early introduction, and scale-up. "As countries implement at different paces and sequences, this is a guiding document and should be adapted to the particular country's context.

Timeframe

The time required to carry out this documentation/review process in a given country will depend on whether Phase 1 review will be carried out earlier on and a subsequent Phase 2 following the one year of treatment of children or whether the full review will be carried out (looking at pre-implementation stages as well as early, i.e., first year, of services being delivered by CHWs to under-fives). Assessing Phase 1 accomplishments and examining challenges would allow for iterative learning and course correction. Countries that have carried out Phase 1 review previously can build upon it when preparing for Phase 2 review.

Annexes

Annex A: McGorman et al., 2012. A Health Systems Approach to Integrated Community Case Management of Childhood Illnesses: Methods and Tools. *American Journal of Tropical Medicine and Hygiene* (suppl 5); pp. 69-76

Annex B: Benchmarks for Community Case Management: Component x Program Phase (courtesy of David Marsh et al.)

Annex C: Recommended iCCM indicators for phase 2 reviews

Annex B: Benchmarks for Community Case Management:Component x Program Phase (refer to the accompanying excel file)

Component	Advocacy and Planning	Pilot and Early Implementation	Expansion/Scale-up
1: Coordination and Policy Setting	a) Mapping CCM partners conducted	f) MOH CCM leadership established	h) MOH leadership institutionalized
	b) Technical advisory group (TAG) established, including community leaders, CCM champion & CHW representation		
	c) Needs assessment and situation analysis conducted		
	d) Stakeholder meetings held to define roles and discuss policies	g) Policy discussions (if necessary) completed	i) Stakeholder meetings regularly held
	e) National policies and guidelines reviewed		
2: Costing and Financing	a) CCM costing estimates made based on all service requirements	c) Financing gap analysis completed	e) Long-term strategy developed for sustainability and financial viability
	b) Finances secured for CCM medicines, supplies, and all program costs	d) MOH funds invested in CCM	f) MOH investment sustained in CCM
3: Human Resources	a) Roles defined for CHWs, communities and referral service providers	e) Role and expectations of CHW made clear to community and referral service providers	h) Process for update and discussion of role/expectations for CHW in place
	b) Criteria defined for CHW recruitment	f) CHWs trained	i) CHWs refreshed
	c) Training plan developed for CHW training and refreshing (modules, training of trainers, monitoring and evaluation)		

	d) CHW retention strategies (incentive/motivation) developed	g) CHW retention strategies (incentive/motivation) implemented	j) CHW retention strategies reviewed and revised
			k) Advancement, promotion, retirement offered
4: Supply chain management	a) Medicines and supplies (i.e., RDTs) included in essential drug list and consistent with national policies	e) Medicines and supplies procured	g) Stocks of medicines & supplies monitored at all levels
	b) Quantifications completed for CCM medicines and supplies		
	c) Procurement plan developed for medicines and supplies		
	d) Inventory control and resupply logistic system developed	f) Systems implemented	h) Systems adapted and effective
5: Service Delivery and Referral	a) Plan developed for rational use of medicines (and RDTs)	d) Good quality CCM delivered	g) Timely receipt of CCM is the norm
	b) Guidelines developed for case management and referral	e) Guidelines reviewed and modified based on pilot	h) Guidelines reviewed and modified by experience
	c) Referral and counter referral system developed	f) Systems implemented	i) Systems working
6: Communi-cation and Social Mobilization	a) CSM strategies developed for policy makers, local leaders, health providers, CHWs, and communities	d) CSM plans implemented	g) CSM plan and implementation reviewed and refined
	b) CSM content for materials (training, job aids etc) developed	e) Materials produced	
	c) Messages, materials and targets for CCM defined	f) CHWs deliver messages	
7: Supervision & Performance Quality Assurance	a) Supervision checklists and other tools developed	d) Supervision every 1-3 months, with reviewing reports, monitoring of data	g) CHWs routinely supervised for QA and performance

	b) Supervision plan established	e) Supervisor visits community, makes home visits, coaches	h) Data from reports and community feed-back used for problem solving and coaching
	c) Supervisors trained and equipped with supervision tools	f) CCM supervision is part of supervisor's performance review	i) Yearly evaluation includes individual performance and coverage or monitoring data
8: M & E and Health Information Systems	a) Monitoring framework developed for all components with information sources	e) Monitoring framework tested & modified accordingly	h) Monitoring & evaluation on-going through HMIS data
	b) Registers and report forms standardized	f) Registers and forms reviewed	i) OR and external evaluations of CCM performed as necessary
	c) Indicators and standards for HMIS and CCM surveys defined	g) All levels trained to use framework,	
	d) Research agenda for CCM documented and circulated		

Annex C: Recommended iCCM indicators for phase 2 reviews

Overall comment: the CCM TF has recommended iCCM indicators for routine monitoring of program performance. We encourage countries to use these if the data elements are available. In particular, we understand that determining the target population remains a challenge due to lack of accurate and up to date census data or incomplete reporting. Countries can, in the short term, use optional and simpler measures of coverage while working towards strengthening and standardizing reporting on the recommended iCCM indicators. The program reviews should also attempt to quantify additional coverage achieved including improvements in quality of care and utilization resulting from the additional investment.

Component	Recommended indicator	Comments	Optional indicators
Human resources	1. **iCCM program coverage for target population**: Percentage of target population (target communities) with access to iCCM services 2. **CCM CHW density**: Number of CHWs trained and deployed for CCM per 1,000 children under five in target areas	Countries should attempt to specify additional coverage achieved as result of GF resources Countries should indicate additional CHWs trained using GF resources not just cumulative # of CHWs trained.	a. Proportion of iCCM trained CHWs who have seen a sick child in past 7 days c. Proportion of iCCM CHWs who are living in their catchment area d. Proportion of CHWs trained in iCCM (compare to target)
Supply chain management	3. **Medicine and diagnostic availability**: percentage of CCM sites with all key CCM medicines and diagnostics in stock on last day of reporting period	Countries should attempt to give a full picture especially on availability of non-malaria commodities	a. Proportion of iCCM CHWs with a supply of key iCCM drugs in last 3 months b. Proportion of working CCM-trained CHWs who reported no stock outs of any duration of life-saving medicines (Amox. DT/Cotrimoxizole, LA/ACT, ORS, zinc) in previous 3 months
Service delivery and referral	4. **Case load by CHW:** Number of cases treated by CHW by reporting period (total and disaggregated by disease) 5. **CCM treatment rate - Malaria:** Number of	Countries need to be consistent with what they adopt and consistent with what facility level is collecting. If CHWs not using RDTs, use fever; **Fever/Malaria cases treated by CHWs per 1,000 children under five in target areas**	a. Number of sick children who received care from a CHW during the reporting period; disaggregat

	RDT+ malaria cases treated by CHWs per 1,000 children under five in target areas in a given time period 6. **CCM treatment rate – Pneumonia**: Number of suspected pneumonia cases treated by CHWs per 1,000 children under five in target areas in a given time period 7. **CCM treatment rate – Diarrhea**: Number of diarrhea cases treated by CHWs per 1,000 children under five in target areas in a given time period 8. **RDT positivity rate:** percentage of fever cases presenting to CHW who were tested with RDT and received a positive result 9. **Referral rate**: number of cases referred per 100 cases seen by CHWs	**in a given time period** Countries may report # diarrhea cases treated with ORS and diarrhea cases treated with zinc consistent with DHIS2/HMIS data.	ed by disease (to be meaningful, can be compared to same period in the previous year for example) b. Proportion of sick children seen by CHWs over a period of time against those seen at HF (compare with same period before iCCM scale-up)
Supervision and performance quality assurance	10. **Clinical coaching/mentorship**: percentage of CHWs who received coaching/mentorship activities* during reporting period; (* eligible coaching or mentorship activities	Use expected clinical coaching/mentorship activities completed during reporting period.	

	should be defined locally)		
M&E and health management information systems	11. **Reporting**: percentage of CHWs/HFs/districts submitting reports on iCCM during time period		