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The Global Fund New Funding Model: Lessons from Kenya on iCCM Integration into the Malaria Concept Note

Final Report

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The Maternal and Child Survival Program (MCSP) is a global U.S. Agency for International Development (USAID) cooperative agreement to introduce and support high-impact health interventions in 24 priority countries with the ultimate goal of ending preventable child and maternal deaths (EPCMD) within a generation. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on health systems strengthening, household and community mobilization, gender integration and eHealth, among others. Visit www.mcsprogram.org to learn more.

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Abbreviations

ACT	Artemisinin-based Combination Therapy
AMREF	African Medical and Research Foundation
CCM	Community Case Management
CHAI	Clinton Health Access Initiative
CHEW	Community Health Extension Worker
CHS	Community Health Services
CHW	Community Health Worker
CHV	Community Health Volunteer
CSO	Civil Society Organization
DHS	Demographic and Health Surveys
ESARO	East and Southern Africa Region
FTT	Financing Task Team
ICC	Interagency Coordination Committee
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
KDHS	Kenya Demographic and Health Survey
KNMS	Kenya National Malaria Strategy
M&E	Methods and Evaluation
MCHIP	Maternal and Child Health Integrated Program
MCU	Malaria Control Unit
MOH	Ministry of Health
NFM	New Funding Model
ORS	Oral Rehydration Solution
RBM	Roll Back Malaria
RDT	Rapid Diagnostic Test
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

The Global Fund New Funding Model: Lessons from Kenya on iCCM Integration into the Malaria Concept Note

This case study reviews Kenya's experience with the Global Fund New Funding Model (NFM), specifically Kenya's efforts to incorporate integrated community case management (iCCM) into a malaria concept note. The iCCM strategy extends case management of childhood illness to populations underserved by health facilities so that more children have access to lifesaving treatments for the most common causes of mortality and morbidity[1]. Health sector stakeholders (international donors, government and health system policymakers, program managers, and health care providers) increasingly see iCCM as an important strategy to complement investments at the facility and other levels. As developing countries pilot or scale up iCCM, there is growing interest in integrating other interventions in the iCCM strategy and community platform. One mechanism for improving integration and scale-up of iCCM is the Global Fund NFM, which can support the platform costs of case management for child illness beyond malaria.

The report explores the experience of Kenya in considering whether and how to leverage malaria Global Fund money for iCCM. It reviews the challenges experienced during, and lessons learned from, the discussions between malaria and child health stakeholders. Additionally, it explores the reasons why, in Kenya's case, during this phase of application, financial and programmatic integration of iCCM and malaria through the NFM proved untenable. This case study is part of a series exploring iCCM integration in five countries: Ghana, Kenya, Nigeria, Uganda, and Zambia. The five country experiences are synthesized in "Leveraging the Global Fund New Funding Model for iCCM: A Synthesis of Lessons from Five Countries."

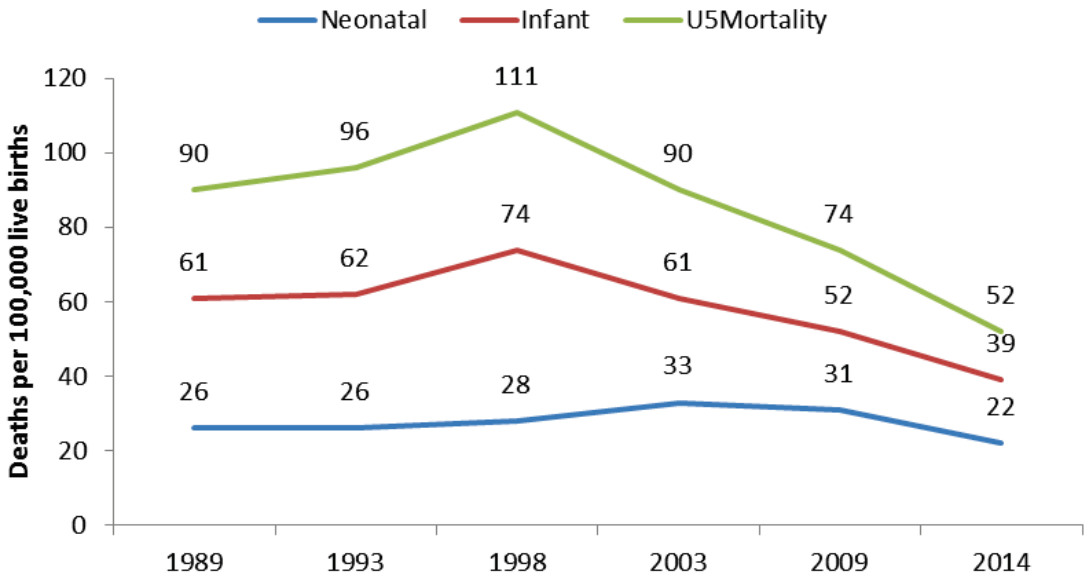
[1] WHO/UNICEF Joint Statement Integrated Community Case Management (iCCM), an equity-focused strategy to improve access to essential treatment services for children, June 2012.

Introduction: Kenya Health Context

Progress on Child Health

Kenya has made progress in reducing childhood mortality and morbidity during the last decade. The most recent Demographic and Health Survey (DHS) 2008-2009 shows that the under-five mortality rate decreased by 36 percent between 2003 and 2009, from 115/1,000 live births to 74/1,000, respectively, while the infant mortality rate decreased by 32 percent, from 77/1,000 in 2003 to 52/1,000 in 2009 (Kenya DHS 2003, 2008-2009). Neonatal mortality is 31 deaths per 1,000 live births, while post-neonatal mortality is 21 per 1,000 live births (KDHS 2008-2009).

Figure 1. Kenya 2014 Demographic and Health Survey



Much more remains to be done. One in every 19 children born in Kenya dies before their first birthday, and one in every 14 does not survive to age five (DHS 2009). In 2011, the World Health Organization (WHO) estimated that a total of 188,928 children under-five died in Kenya—out of this, 38,892 deaths were caused by diarrhea, 20,666 by malaria and 30,406 by pneumonia (WHO, 2011; and Kenya MOH 2013 a).

Despite gains in child health during the last decade, child mortality and morbidity—from preventable and treatable illness—remains unacceptably high. There are many factors driving this, including low access to lifesaving treatments. For example, it is estimated that only 50 percent of children in malaria-endemic regions of Nyanza and Western seek treatment from health facilities within 48 hours of developing a fever, with 11 percent taking the recommended antimalarial artemisinin combination therapy (ACT) (Kenya MOH 2013). Similarly, the Kenya Demographic and Health Survey (KDHS) 2008–2009 shows that only 56 percent of children with symptoms of pneumonia were taken to a health facility. Of these, 50 percent received antibiotic treatment.

Urban and rural disparities in Kenya are significant. The majority of the population (68 percent) resides in rural areas, and an estimated 18 percent of the population lives more than 5 kilometers from a health facility (Kenya National Bureau of Statistics, 2009). Disparities exist across regions as well, with the majority of individuals in rural areas and northern arid and semi-arid regions travelling more than 50 kilometers to access basic health

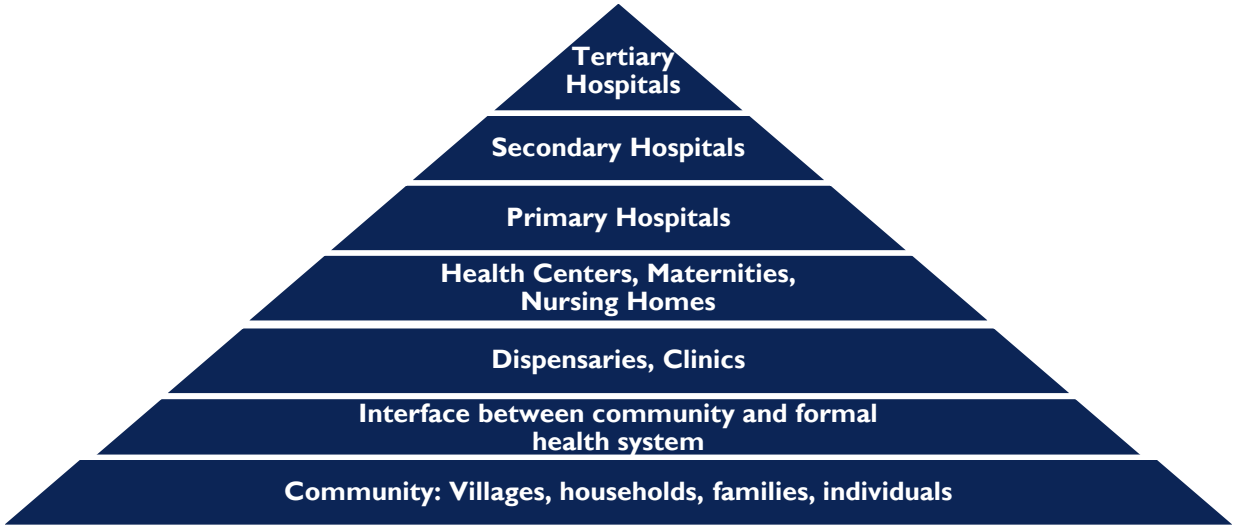
services. Access to recommended treatment/care for sick children is limited in Kenya, with low education, poverty, and residence in rural areas as the main social determinants of poor health (Kenya MOH 2013).

Improving child health requires meeting families where they are: providing services in the communities where they live. As the *National Framework and Plan of Action for Implementation of iCCM in Kenya* notes: "Improvements in care at health facilities are necessary but not sufficient. Children from rural communities and from the poorest families are less likely to be brought to health facilities. Therefore, the most appropriate way of increasing access to treatment for the common childhood illnesses is through a community-based approach, using human resources available at community level."

Health System Organization

Health services are delivered along a continuum of care in Kenya, beginning at the family/household level and ending at the country's main referral hospitals (see Figure 1 above). The new Constitution of Kenya (2010), created a new layer of government at the county level, which replaces the provincial, district, and local government administration system that were created when Kenya achieved independence. Previously, districts had authority for implementing health services, while standards and policies were set at the national level. Following national and county general elections in March 2013, Kenya began the process of devolution as set forth in the 2010 Constitution. The transition to 47 counties from seven provinces as the primary administrative unit is still taking shape (PMI 2014). This new government structure has implications for policymaking, with counties having the mandate, but not the capacity, to adapt national policy to suit county needs, affecting areas like community-level service delivery. At the national level, the new Ministry of Health (MOH) is the result of a merger between the Ministry of Medical Services and the Ministry of Public Health and Sanitation. The new ministry is in a state of change with a lot of staff in transition, and, therefore, poorly suited to make major policy decisions.

Figure 2. Health System Levels in Kenya



Key proposed national-level functions include health policy, overseeing national referral health facilities, reference laboratories, disease surveillance, health commodity procurement, capacity building, and technical assistance.

The Role of Integrated Community Case Management

Integrated community case management (iCCM), an important component of integrated management of childhood illness (IMCI) developed by WHO in the 1990s, is a strategy to extend case management of childhood illness beyond health facilities so that more children have access to lifesaving treatments for the most common causes of mortality and morbidity.[2] Building on progress made and lessons learned in the implementation of the primarily promotive community IMCI strategy, iCCM aims to augment health facility-based case management.

In the iCCM model, community health workers (CHWs) are identified and trained in classification and treatment of key childhood illnesses, and also in identifying children in need of immediate referral.[3] iCCM is an important strategy for reducing mortality, especially among marginalized children who otherwise have limited or no access to lifesaving treatments.

The community health platform exists to help reach children within their communities. The home management or community case management (CCM) of malaria has used the community platform to increase access to effective management of fever. The case for tackling the main causes of childhood mortality *together* as part of a common platform is compelling, for several reasons:

1. Co-infection (of malaria and pneumonia, for example) in children is common.
2. Symptoms of fever, cough/fast breathing and loose stool can be a manifestation of malaria, pneumonia, or diarrhea.
3. Ability to manage non-malaria fever reduces the risk of using anti-malarial treatment for non-malaria illness.
4. Potentially fatal conditions, such as pneumonia, are often brought to the attention of CHWs first, as first-line caregivers. Caregivers sometimes resist referral to a health facility when a CHW cannot manage a condition, which can lead to delayed treatment and worsening conditions. As a result of demand and pressure from a caregiver, or the need for a CHW to demonstrate competence, a CHW will often give anti-malarial treatment even if a malaria test is negative. Sick children thus benefit when CHWs are able to detect and treat other conditions besides malaria.

Integrated Community Case Management Integration Supported through the 'New Funding Model'

One mechanism for supporting iCCM integration is the Global Fund New Funding Model (NFM), approved in in October 2013 that allows for the use of Global Fund money beyond CCM of malaria to include support for the costs of things such as training CHWs, strengthening supply chain systems, monitoring and evaluation (M&E), and conducting operations research for the community case management of other childhood illnesses (such as diarrhea, pneumonia, malnutrition, etc.) supported by national policies and justified by epidemiologic evidence.

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[2] Newborn health and malnutrition are also commonly included as a part of iCCM.

[3] To learn more, see CCM Central and Gove 1997. iCCM is typically delivered by community health workers at the community level and encompasses treatment for (i) childhood pneumonia with antibiotics, (ii) diarrhea with zinc and oral rehydration salts (ORS) and (iii) malaria with artemisinin combination therapy (ACT). The joint statement on iCCM also supports the identification (but not treatment) of severe acute malnutrition and home visits (but not treatment) for newborns (UNICEF 2012) (see: Bennett et al).

To support countries to take advantage of the NFM opportunity, members of the iCCM Task Force, an association of multilateral and bilateral agencies and nongovernmental organizations working to promote integrated community-level management of childhood illness, established the Financing Task Team (FTT) for iCCM. With members including the United Nations Children's Fund (UNICEF), U.S. Agency for International Development (USAID), the One Million Community Health Worker Campaign, Save the Children, the American Red Cross, the Maternal and Child Integrated Program (MCHIP), the Clinton Health Access Initiative (CHAI), and the Office of the UN Special Envoy for Financing of the Health Millennium Development Goals, the FTT worked to ensure that countries received technical assistance to complete iCCM gap analyses and concept notes for the NFM.

Kenya was one of five countries supported by USAID to develop Global Fund malaria (or health systems strengthening) application concept notes with the goal of including iCCM.[4] Of the five countries, Kenya was the only country that did not include iCCM in its final application to the Global Fund for this round of the NFM process. Kenya submitted an application in January 2015 to reprogram malaria funds and is currently awaiting approval.

USAID, the country teams responsible for developing Global Fund NFM applications, and other agencies such as the Global Fund and UNICEF, have an interest in understanding how this first attempt to integrate malaria and iCCM programming into the Global Fund application fared and how the process can be improved going forward. This report reviews Kenya's experience with this process, specifically:

- The degree to which the process between malaria stakeholders and advocates of iCCM, including stakeholders in the child health and community health units of the central MOH, was/is collaborative (and how); what were the factors that either enabled or constrained collaboration and inclusion of iCCM in the malaria reprogramming request?
- What was the outcome of the process and what are plans for joint implementation?
- What areas stakeholders would like to see improved in the future to support implementation of integrated programs (malaria/iCCM)?

Methods

This report draws on a review of documents related to iCCM in Kenya and on key informant interviews conducted in Nairobi from January 19-23, 2015. The 17 respondents consisted of representatives from the Kenyan MOH, including the Malaria Control Unit, the Child Health Unit and the Community Health Services Unit; donor agencies (USAID and UNICEF); the African Medical and Research Foundation in Kenya (AMREF), one of two principal recipients of Global Fund financing, along with the Kenya Ministry of Finance; and consultants who supported the process of reviewing the malaria strategic plan and developing the Global Fund malaria reprogramming request. Interviews were guided by a semi-structured interview guide, which was reviewed by USAID during fieldwork. Seven interviews were conducted using the revised interview guide. Although not in final form, the initial guide covered all major areas of analysis and, as a qualitative, flexible instrument, was a useful guide for in-depth probing.

[4] UNICEF also supported technical assistance for 13 countries as of March 2014.

Limitations of this assessment include the lack of interviews with WHO, the head of the Community Health Services Unit, and the Country Coordinating Mechanism. In addition, several of the key interviews were short (approximately 30 minutes) because of scheduling conflicts with informants. Difficulty obtaining interviews and the limited time with some informants sheds light on why iCCM was not included in the malaria reprogramming request, suggesting that in addition to competing demand for informants' time, discussing the unsuccessful iCCM-malaria integration process may not have seemed worthwhile. In short, the length and depth of interviews varied because of factors outside the control of MCSP.

Findings

Integrated Community Case Management in Kenya

Since 2011, iCCM pilots have been implemented in Kenya. The iCCM strategy in Kenya includes training and supplying the community health volunteers (CHVs) to treat diarrhea with zinc and oral rehydration solution (ORS); conduct malaria rapid diagnostic tests (RDTs) and, after a positive RDT, provide ACTs, along with assessment and referral for suspected pneumonia; referral for malnutrition and newborn illness; and health promotion. UNICEF is conducting an operational research study on the use of antibiotics (specifically oral amoxicillin) by CHVs in Homa Bay, the results of which are forthcoming. MCSP is also studying the feasibility of implementing iCCM using the Kenya health system in Bondo District, which includes assessment and referral of suspected pneumonia. Preliminary results from MCSP's study in Bondo District suggest that CHVs are able to correctly manage diarrhea and fever. Final results from the study are expected in the summer of 2015. Kenya's global and national partners hope that positive results from these studies will encourage the Government of Kenya to change its policy to allow for dispensing of antibiotics at the community level by CHVs. Despite this, skepticism and concerns persist among the medical practitioners who believe that doing so will result in dispensing presumptively and will contribute to the problem of antibiotic resistance.

Box 1: Kenya iCCM Quick Facts

Year of iCCM pilot program introduction: 2011

iCCM package: Treatment of diarrhea (with zinc and ORS) and malaria (conduct malaria RDTs to diagnose and treat with ACTs), and assessment and referral for suspected pneumonia, referral for malnutrition and newborn illness and health promotion.

Coverage: Limited pilot programs with malaria more widespread than diarrhea (as of January 2014).

iCCM elements included in Global Fund malaria concept note: Training and supervision of CHWs, RDTs, and ACTs for malaria case management only.

Policy endorsement for iCCM has come more slowly in Kenya than in some other countries, with the national iCCM policy[5] only recently launched on February 23, 2015, as part of the Kenya Health and Leadership Congress 2015. A landscape analysis conducted by MCHIP concluded that "the single most hindering factor to early iCCM policy change in Kenya was a lack of political support from key high-level policymakers within the MOH. These policymakers resisted the idea of allowing CHVs to dispense

[5] Kenya launched the limited iCCM package at the Kenya Leadership and Health Congress on February 23, 2015. The approved iCCM package included: treat diarrhea with zinc and ORS; conduct malaria rapid diagnostic tests (RDTs) and, after a positive RDT, provide ACTs, along with assessment and referral for suspected pneumonia; and referral for malnutrition and newborn illness.

antibiotics for treating pneumonia in the community for fear of misusing the medicines. Other barriers to the iCCM policy change included resistance from other stakeholders including pharmacists, laboratory technicians, and other medical staff who were opposed to CHVs performing medical functions such as Rapid Diagnostic Tests (RDTs) for malaria and providing medicines in the community."[6]

In the lead-up to the iCCM policy launch in 2013, zinc was reclassified as an over-the-counter drug, which allowed non-clinical health care providers (such as CHVs) to treat children under five years, and in January 2014, CHVs were authorized to conduct RDTs. It is not clear how results from UNICEF's Homa Bay study will influence the policy on use of antibiotics at the community level.

The national iCCM policy builds on *The Integrated Community Case Management (iCCM) Implementation Framework and Plan of Action* (Kenya MOH 2013a) and *The Integrated Community Case Management (iCCM) M&E Plan* (Kenya MOH 2013b), both of which are anchored in the Community Health Strategy (MOPHS, 2006) and Kenya's National Health Sector Strategic Plan II (NHSSP II).[7] The NHSSP II highlights the limitations of focusing on formal, facility-based interventions to improve health outcomes and emphasizes promotion of individual and community health. The community health strategy supports development and expansion of the community health structure, which is made operational through a community unit, each of which serve a population of 5,000 and consist of 50 CHVs and one government-salaried community health extension worker (CHEW) to supervise the CHVs.

Background on Global Fund Grants in Kenya

Kenya has benefitted from several rounds of funding from the Global Fund. There are currently 13 active grants: six for HIV/AIDS, three for TB, and four for malaria. In the last round in 2010 (i.e., before the launch of the NFM), Kenya applied for and received support for HIV/AIDS prevention and for treatment and control of malaria. In Round 10 of the Global Fund grant funding for Kenya, the National Treasury (Ministry of Finance), and AMREF served as primary recipients of funds. Primary recipients then (a) receive grant funds from the Global Fund; (b) pass on most of this funding to sub-recipients to support implementation of the planned activities (i.e., Treasury passes on funding to the Malaria Control Unit, and AMREF to implementing non-governmental organizations and civil society organizations); and (c) are responsible for the overall project implementation, M&E and reporting on the grants performance to Global Fund in line with the grant agreement.[8] Treasury/the Malaria Control Unit (MCU) and AMREF/civil society organizations (CSOs) will continue to be principal recipients and sub-recipients for NFM funding.[9]

The Process of Developing the Global Fund Concept Note

In Kenya, the discussion about whether and how to include iCCM into the malaria concept note took place over the course of about a year, between December 2013 and January 2015. In December 2013, the Roll Back Malaria (RBM) Harmonization Working Group held a meeting in Nairobi with the first wave of

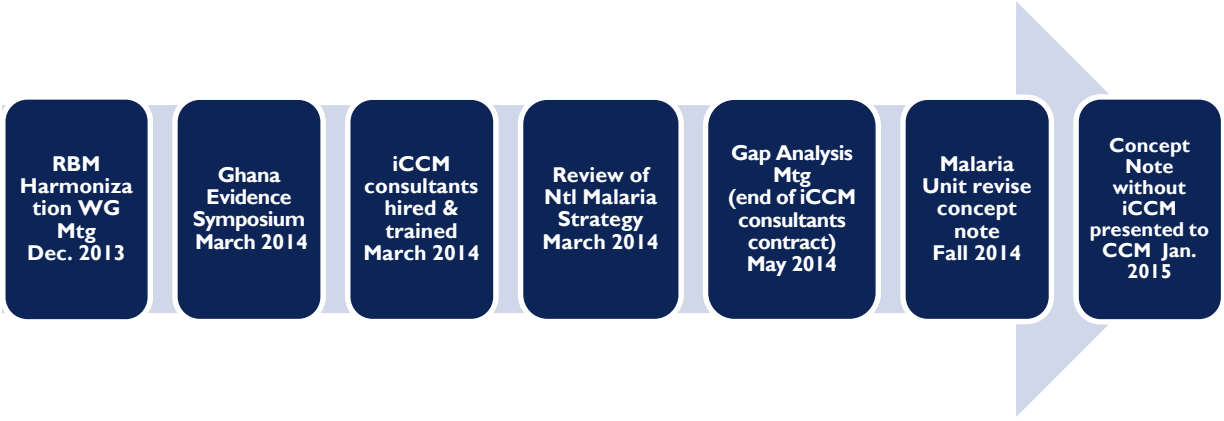
[6] To learn more, see MCHIP January 2015, which provides background on the iCCM policy space in Kenya.
[7] The latest Community Health Strategy was under revision at the time of this assessment.
[8] Source: Kenya Round 10 Proposal.
[9] The HIV & AIDS Project for round 10 also has one CSO PR: the Kenya Red Cross.

33 countries to inform them about the NFM and discuss issues of integration between malaria, diarrhea, and pneumonia. Key organizations at this meeting included WHO, UNICEF headquarters and the East and Southern Africa Region (ESARO) team, Millennium Development Goals Health Alliance, CHAI, USAID, Management Sciences for Health, and MCHIP. UNICEF also supported an additional meeting immediately after the RBM meeting in Nairobi for ESARO countries to work on malaria applications that integrated iCCM and to develop and to finalize their iCCM gap analyses.[10] Despite the meeting being in Nairobi, participation of the MCU and child health teams was limited because of competing schedules.

The opportunity to mobilize resources for iCCM scale-up through the Global Fund was also part of the discussions at a March 2014 iCCM Evidence Review Symposium in Ghana. The global Symposium, which was attended by representatives from the Kenya Child Health Unit, UNICEF, and MCHIP, as well as other NGOs, such as Save the Children, was intended to share lessons learned about iCCM in general, but the NFM was also highlighted as an opportunity to leverage Global Fund resources for scale-up of iCCM.[11]

To ensure integration of iCCM into the revised Kenya National Malaria Strategy (KNMS) and into the Global Fund concept note, the Kenya Ministry of Health requested technical assistance from USAID-MCHIP and UNICEF. Consultants for iCCM were then hired based on agreed terms of reference that covered three main areas: iCCM programmatic and financial gap analysis, advocacy for inclusion of iCCM, and ensuring appropriate iCCM language in the concept note. Prospective iCCM consultants (for Kenya and other countries) participated in a meeting in March 2014 in Nairobi to orient them to their potential assignment and to discuss availability.

Figure 3. Timeline of Events in Concept Note Development



Review of the Kenya National Malaria Strategy

National policies, strategies, and plans are the basis of Global Fund applications, therefore including iCCM in the malaria concept note requires that it also be included in the KNMS. With this in mind, stakeholders from the Child Health and Community Health Services (CHS) Units, along with the consultants hired by MCHIP to support Child Health, participated in meetings to review and revise the KNMS. These meetings were led by the MCU and supported with a consultant brought on by the RBM Harmonization Working Group.

[10] iCCM Gap Analyses started earlier during a 2012 UNICEF supported ESARO regional workshop.
[11] A presentation was made the Symposium by Mark Young (UNICEF), Colette Selman (Global Fund), and Pascal Bijleveld (RMNCH SCT) entitled: "*iCCM financing and the new Global Fund funding model.*"

The review meeting was held in Maanzoni, Machakos County from March 24 -28, 2014. About 70 people attended, including representatives from UNICEF, WHO, AMREF, and a representative from each of the 47 counties. The goal of the meeting was to refine the KNMS, which would then become the basis for the malaria Global Fund application. Each objective laid out in the KNMS is tied to tasks and activities that translate into funding. Dialogue between stakeholders at this meeting was intended to form the basis for shared understanding of, and commitment to, iCCM, which would in turn form the basis for a strategic plan and concept note that included the same.

Participation in the meetings of the two iCCM consultants supporting the Child Health Unit was challenging. The iCCM consultants were meant to be instrumental in the meetings and act as advocates for iCCM, yet they were uninformed by the Child Health Unit, as well as the local MCSP office, about when the KNMS review meeting began and thus missed the first two days of discussions. Said one informant who participated in the meeting, "Communication about how it was being conducted could have been better."

During the KNMS review meeting, the iCCM consultants worked with the team reviewing the case management objective of the KNMS, which includes community case management. As part of its efforts to expand malaria CCM, the malaria unit had previously worked with the government and partners to make RDTs and ACTs available to community health workers to discourage the use of informal drug outlets and to encourage diagnosis prior to treatment.[12]

Within the KNMS, malaria CCM is addressed under strategy 2.3 *"strengthening home management of malaria*" of objective 2 on case management. Proponents[13] (i.e., representatives from the Child and Community Health Units, MCHIP, UNICEF, and the iCCM consultants) of iCCM integration hoped that iCCM could be an expansion of the malaria CCM strategy. Specifically, informants at MCSP (Nairobi), as well as the iCCM consultant hired by MCHIP, noted that the goal for iCCM proponents is that the KNMS include:

- Language demonstrating the epidemiology of malaria, which shows that children under five in Kenya are a vulnerable group who need a clear and dedicated strategy;
- A clear statement that iCCM is part of the National Malaria Strategy for addressing malaria among children under five; and
- A clear acknowledgment of sharing resources, which would facilitate joint implementation.

iCCM resources from the Global Fund could then be used to support harmonizing CCM-malaria and iCCM training materials for CHVs, CHV training, payment of stipends, printing guidelines, and supervision. This would imply identification and inclusion of iCCM indicators as part of M&E efforts, and/or disaggregating malaria CCM data by age and by program. Not only would these activities be useful in themselves, but iCCM proponents also hoped that their inclusion as part of Global Fund programming would make it easier to secure funding from other donors for such things as commodities. Benefits for malaria were also highlighted. For example, RDT rollout through CHVs who lack the appropriate skills or medicines for comprehensive

[12] To improve home management of malaria, the NMS proposed that community health workers (CHWs) receive training and supportive supervision for malaria case management, prevention, BCC, record keeping and reporting. First-line malaria treatment and RDTs will be integrated into the CHW kit, and all CHWs will be linked to the nearest health facility for resupply of commodities, supervision, monitoring, and referral. (President's Malaria Initiative Kenya Malaria Operational Plan FY 2014)
[13] Note that this is not an exclusive list as informants were not asked to self-identify as advocates/proponents or otherwise of the inclusion of iCCM in the GF application. Only the iCCM consultants were hired with advocacy for iCCM as one of the objectives of the consultancy.

management can lead to sick children receiving inappropriate treatment (or no treatment), and wastage of ACTs when the RDT test is negative.

Issues Raised in Discussions about Integration

According to informants, there was significant push-back from malaria stakeholders regarding the proposals mentioned above during the Maanzoni meeting. One informant said, "iCCM didn't feature well," and, "whether iCCM could be incorporated into implementation of malaria CCM was much debated."

A key issue raised by malaria stakeholders was that iCCM targets children under five only, while CCM for malaria applies to children and adults. One MCU representative noted that RBM requires reporting on universal targets, whereas iCCM would require tracking progress on indicators related to things such as number of children treated/referred for pneumonia. "When you do under five only, it becomes a very contentious issue," he says. Some stakeholders suggested, however, that focus on the issue of differing targets was a non-issue that was "exploited."

AMREF, as the civil-society principal recipient responsible for managing community-level implementation (by way of sub-recipients), could have played a role in advocating an integrated approach to care of children under five through iCCM. However, several informants noted that AMREF representatives were noticeably quiet on the iCCM issue during negotiations. One informant attributes this to a desire "to be in good standing with the MCU so that they'd be chosen as the primary recipient. The MCU has influence on who gets chosen, so AMREF kept a low profile."

Some informants also noted that the limited advocacy role of WHO in the meeting hampered the chances of iCCM integration. WHO plays an important role in Kenya's malaria program and its reticence to advocate for iCCM was viewed as implicit support for the position of MCU—that integration was untenable.

Fundamentally, although malaria stakeholders recognized the technical relevance and importance of iCCM, they did not feel that it "belonged" in the KNMS. As many informants noted, "the MSP [malaria strategic plan] is about malaria." Another MCU representative noted: "Community health is where iCCM belongs."

Some iCCM proponents mentioned a mini-review of the KNMS that had been done in 2013 by the MCU, which was described by one informant as "very comprehensive"—to the point that some perceived that the strategy was already more or less final even before the KNMS review meeting began. One Child Health Unit informant said: "it was like getting on a bus when it's already on its journey."

Development of the Global Fund Malaria Concept Note—Limited Involvement from Integrated Community Case Management Proponents

Collaboration between iCCM stakeholders and the MCU was limited after the Maanzoni meeting. The malaria consultant continued to support the MCU, independent of the involvement of the Child Health Unit. Around the same time, a decision was made to defer the submission of the concept note from June 2014 to January 2015, thus slowing the momentum.

The iCCM consultants began a gap analysis and costing exercise, but it was hampered by lack of availability of key data.[14] Moreover, during the period when the gap analysis was being conducted, the CHS strategy was being revised, and thus, key assumptions that would underlie the gap analysis, such as number and type of CHVs, were in flux. Ultimately, the gap analysis was not completed.

In May 2014, the Child Health Unit organized an all-stakeholder meeting with representatives from UNICEF, MCHIP, and CHS to discuss progress on the gap analysis. The purpose was to broaden support for iCCM by discussing the relevance of a gap analysis and preliminary results. Key decision-makers from the MCU did not attend. This was due in part to a lack of commitment, according to an informant close to the process (i.e., malaria stakeholders had already decided at this point not to include iCCM in the reprogramming request) and also due to the fact that the Child Health Unit did not reach out to the head of Malaria Control Unit about the importance of the meeting. Given that the two units have traditionally operated independently, discussions during this process were perceived to be more about sharing Global Fund money and less about joint programming and the potential to increase efficiency and better health outcomes for children.

By the May 2014 meeting, the contract for the iCCM consultants had come to an end. One informant reported, "The consultants did a lot of work, but it didn't convince people." They had led the push for iCCM integration with what they felt was limited assistance from the expected custodians of the iCCM program at the MOH. As part of their final remarks to MCHIP, the iCCM consultants noted that participation of the CHS and Child Health Unit in the malaria strategy review meetings and Malaria Interagency Coordination Committee (ICC) had been weak. "Most of the time," they noted in their report, "the two units had not been invited in the meetings."

As to why key stakeholders from CHS and Child Health were not invited to meetings, one of the iCCM consultants said, "I suspect that the Malaria Control Unit had already made a decision not to include iCCM and didn't see the value of informing iCCM stakeholders or participating themselves. Essentially, they did not see the iCCM stakeholders as adding value to the process. There should have been a top decision involving the leadership of the Ministry at the start of the process." In essence, because the MCU was going to receive Global Fund financing regardless of the participation of the Child Health Unit, there was little incentive to work jointly.

In the absence of invitations to meetings from the MCU, iCCM proponents became frustrated and demotivated. One informant said, "It isn't clear the child health people even want to work with the MCU at this point. I think in some ways they have given up."

High-level collaboration between heads of the Child Health Unit, CHS, and the Malaria Control Unit was also limited. Each had been recently appointed to their position: the head of Child Health was particularly new in her role, and the MCU leadership had changed three times in three years. Indeed, it is notable that in the Acknowledgments section of the *iCCM Framework and Plan of Action* (August 2013), the heads of the MCU, CHS and Child Health were all different than those in these positions during the period described above. Moreover, the process of devolution left technical officers based in ministries in Nairobi, some of whom were part of initial iCCM advocacy efforts, in professional limbo. For example, there were rumors of child health program officers being potentially transferred to the counties. This environment of "shifting sands," as one informant called it, negatively affected the success of this process by diluting previous advocacy

[14] To include iCCM within a Global Fund malaria concept note, country teams must first complete an iCCM gap analysis. In Kenya, the child health consultants used the One Health tool. UNICEF conducted its own gap analysis using a different tool.

efforts for iCCM and lack of prior established relationships among the Child Health, Community, and Malaria Unit heads.

Moreover, the iCCM consultants themselves were not well-supported by the Child Health Unit about meetings. "We had to use our intelligence to know when and where meetings were being held," said one consultant. "They [Child Health] never even called us for a briefing after recruitment so as to agree on joint priorities. I met [the head of Child Health] later in the process."

At the May 2014 meeting, the iCCM consultants requested that the MCU share a roadmap for the finalization of the malaria strategy and development of the concept note, but this issue was not pressed by the head of Child Health and nothing was shared. In the end, iCCM was not included in the malaria reprogramming request. There was a suggestion by some informants that iCCM might be included in health/community systems strengthening activities supported by the Global Fund and proposed in the joint HIV/AIDS, TB, malaria concept note. However, it appears advocacy for this was not adequate, and at the time of writing, it was understood that no iCCM activities had been proposed as part of health/community systems strengthening either, nor was iCCM featured in the KNMS. At the time of fieldwork, the Global Fund team was in Nairobi to review the request before submission to the Country Coordinating Mechanism.

Looking Ahead

What's next for iCCM in Kenya? The adoption of the iCCM national policy in February 2015 may help child health and community health services stakeholders to advocate more strongly and effectively for funding for iCCM activities, and encourage iCCM advocacy at higher levels, possibly including a mandate to integrate iCCM into CCM for malaria.

One observer also cited the Kenyan First Lady's "Beyond Zero" campaign, which launched in January 2014 and targets improvements in maternal and child health, as a potential political opening for iCCM.

Another observer suggested that iCCM needed to be coordinated across all disease programs as part of the overall community health strategy. "Community is a horizontal platform, and CHWs should be viewed that way, as should iCCM. Until then, there is little financial or management incentive to cooperate, when performance is measured by their particular program."

Perhaps the biggest question centers around Kenya's experiment with devolution. As the process of devolution continues, it remains to be seen what counties will initiate in their community approaches. It is possible that counties will expand iCCM and mandate malaria CCM training to include management of other conditions. Siaya County, for example, has adopted the iCCM package to include management of diarrhea and referral for suspected pneumonia. In Bondo sub-county, all CHVs (as of December 2014) have been trained in this iCCM package as well. Over time, these and other counties and sub-counties will need to define an integrated supportive supervision strategy and commodity management and M&E strategy that includes sub-recipients supporting malaria CCM. Overall, the launch of the iCCM in Kenya (without treatment of pneumonia) may change the discussion in favor of an integrated package beyond malaria.

Analysis—What Worked Well and What Did Not?

What Worked Well?

Despite the lack of inclusion of iCCM, informants noted that there were some positive elements about the process, namely that the importance of iCCM as a technical strategy was recognized (i.e., the importance of reaching underserved families in their communities with treatments for diarrhea, malaria, and pneumonia as a complement to facility-based care). Although support for iCCM specifically was not included in the malaria reprogramming request, the revised malaria strategy does include support for establishing community health units. Community Health Units in turn support community health information systems, training, supportive supervision, and incentives for CHWs, and may form an entry point for iCCM activities, even if they are not directly supported through Global Fund funds.

What Did Not Work Well?

There were many challenges during the preparation of the Global Fund NFM concept note. What were the factors that constrained Kenya from integrating iCCM into the Global Fund malaria reprogramming request? Based on key informant interviews, there appear to be two fundamental issues: 1) weak financial and management incentives to integrate, and 2) weak leadership and country ownership among stakeholders in the Kenya MOH.

Weak Financial and Management Incentives for Integration

The funding and management structures between the Malaria, Child Health, and CHS units created disincentives for integration. Malaria is a traditionally well-funded unit that does not need the support of other departments to fund activities. Under the NFM, countries apply for a set amount of guaranteed money based on calculations of disease burden, need, and ability to pay, and are rewarded for disease-specific deliverables. iCCM activities can be proposed alongside malaria activities, so long as support for iCCM is woven into the malaria strategic plan, but, if approved, financing for iCCM comes out of a finite budget envelope. In other words, the NFM does not offer additional funds for iCCM—money for iCCM means less money exclusively for malaria. Additionally, Kenya was required to reprogram Round 10 funding and will receive little new Global Fund financing through the NFM for malaria. Some informants suggested that, given these realities, MCU stakeholders were reluctant to collaborate and compromise malaria funding for programs that also focus on diseases that they are not accountable for (i.e., diarrhea and pneumonia).

"The problem rests fundamentally on the issue of vertical program management and funding structures," said another informant. The division of family health has its own strategy and funders for child and community health, as does the division of communicable diseases supporting malaria and HIV. Each program has its own national strategy and funds and implements its strategy more or less separately from the other units. "There's selfishness among heads of departments," says one informant, "And everyone has their own donors, with different conditionalities, it all makes integration difficult."

In an environment where vertical funding dominates, integrated approaches can suffer. One stakeholder who participated in the review of the KNMS and was also involved in a similar process to integrate Emergency Triage Assessment and Treatment training into malaria activities said that the same discussions and objections

prevailed. Ultimately, Emergency Triage Assessment and Treatment was removed from the Global Fund reprogramming request for the NFM round.

One informant from the donor community echoes this point: "Integration is an English word that we play around with. But you're asking people to go beyond what they are paid to do—no one will say no, they'll say yes, and it will never happen. If you're employed by malaria, you do malaria. Integration also messes with power structures, and no one wants to interfere with the status quo."

Weak Leadership

Leadership to manage the process among stakeholders, to define roles and responsibilities, and to identify and address barriers, is critical to successful integration. Program managers for iCCM and malaria do not often work together, so extra efforts must be made to create a context that is conducive to joint planning and programming. In Kenya, leadership to manage the process (review meetings, stakeholder collaboration) and to champion the policy was weak. There was insufficient initial investment to generate buy-in among stakeholders, as noted above, the iCCM consultants led iCCM advocacy efforts with insufficient support. This was compounded by bureaucratic errors such as not ensuring people knew when meetings were being held and where. Ultimately, these factors plus weak coordination between health units and donors made success unlikely.

While iCCM was viewed as relevant to most informants, many noted the lack of strong, effective, well-placed "champions" and motivated leaders with a unified, strategic vision, and the absence of effective champions in crucial positions to take the idea forward and encourage others to do so. Evidence supporting the efficacy of iCCM in other countries was noted by informants to be unhelpful in Kenya because policymakers felt that differences in country context potentially undermine the transferability of lessons from elsewhere. The lack of an official national iCCM strategy during negotiations hampered advocacy efforts aimed at integration. For example, the lack of pneumonia policy (i.e., the prohibition against CHVs dispensing antibiotics) reduced the benefits of integration for reasons of combatting inappropriate treatment of malaria negative fevers, particularly when CHVs are pressured by caregivers to dispense some form of medicine to sick children. Historical lack of support for iCCM made it easy for the MCU and other stakeholders to dismiss iCCM during this process.[15]

Most informants agreed that the MCU was in charge of the process—i.e., managing and leading meetings related to review of the malaria strategic plan and development of the concept note. Leadership above the level of the MCU and other units at par with the MCU was needed if the iCCM agenda was going to be prioritized. For example, one informant suggested that a small, inclusive technical committee made up of the heads of the MCU, CHS, and Child Health should have driven the process from the start, but the MCU did not initiate such a committee, and no one higher up mandated it either.

As one MOH informant agreed: "here, the high offices weren't involved. So everyone was pulled by their own interests."

The character of the MCU also affected progress. One informant said, "In general, the malaria team are late adopters. They are only comfortable with pilots; they aren't in a rush. It's very different from other countries

[15] For example, the negative view on the part of some in the medical community around the merits of allowing CHVs to dispense antibiotics, as discussed earlier in this report. See MCHIP January 2015.

where there may be capacity limitations but they jump on it. Capacity is reasonable in Kenya, but there is a resistance to change."

Several informants noted that the process would have been improved if the three units—MCU, CHS, Child Health—had started the process together with full commitment and participation from the heads of the units, and conducted joint meetings throughout, but it was noted that leadership and championing of iCCM integration was needed at the level of the Head of the Child Health Unit, the Director of Medical Services, the Permanent Secretary, and the Minister of Health. Some suggested that it may have been helpful if malaria representatives had attended the iCCM Evidence Symposium in Ghana where the requests for technical assistance were developed. Another audience that could have been strategically tapped for advocacy at the review of the KNMS is the group of county representatives, especially those from rural counties with most underserved populations who would benefit most from introducing iCCM. At a minimum, stakeholders appear to agree that the process should have begun and been carried out jointly with a clear and shared sense of the goals.

A Global Push—Weak Country Ownership

Some noted that the move to integrate iCCM through the NFM felt externally pushed. Said one informant, "Malaria is used to huge investments that are all their own. In this case, people from the outside brought the Child Health people to the malaria people and said: integrate! The response was that we don't even have enough money for ACTs as it is. It takes advocacy to convince them. The major barrier is politics and ineffective leadership."

Global partners perceived that the "promise of money" for iCCM scale-up would speed up the policy process around iCCM in countries where it was perceived to be lagging, but in Kenya, it clearly did not. One consultant who participated in the process noted that, **"**The movement to integrate has taken off at the global level and been pushed on the malaria teams. iCCM is a global idea. The Ministry was encouraged to make the formal request for TA, but iCCM was essentially pushed on Kenya when they weren't ready for it."

Kenya did not have an approved National iCCM Policy in 2014, and many of the unit heads were still establishing themselves in their roles. Many informants said that leadership from higher up in the MOH was needed to champion iCCM in general and for integration via the NFM in particular. Instead, the push came mostly from the consultants, and secondly, (and ineffectively) from donors and their technical officers. Even then, the heads of relevant units rarely participated in meetings, but were represented by their subordinates.

"The Government needs to lead, not MCHIP or UNICEF," said one informant. Another informant echoed this point, "Movement, money and missions come and go. When there's no local champion, it won't take."

Conclusions and Recommendations

After the NFM was announced, consultants were sent to assist countries without careful understanding of and respect for local context—i.e., where countries were in the process of incorporating iCCM into their policies and platforms. The expectation from the iCCM FTT was that every country would automatically buy in, but as the Kenya case shows, this is not always the case. Without local champions, efforts to push iCCM in a country are likely to be both costly and unsuccessful.

To integrate iCCM into malaria NFM activities, stronger incentives were needed—both from the donors who provide funding and from high-level policymakers in-country—to enable and facilitate integration. A supportive policy for iCCM is also important. The recently-launched National iCCM Strategy may help iCCM stakeholders raise the profile of iCCM and advocate for funding for scale-up, but high-level leadership is still required to mandate programmatic integration at the national level (joint planning, for example), as MOH units are not accustomed to working together.

Mirroring experience in other countries detailed by Bennett et al. in Kenya, "The most critical actors in driving iCCM policy development were technical officers within the MOH, supported by key development partners, particularly WHO and UNICEF and, to a slightly lesser extent, USAID and its collaborating agencies. Often senior MOH policymakers, particularly those with a clinical background, were initially resistant to iCCM because of concerns about CHWs treating more complex conditions, and it took time and effort to convince them of the benefits of this strategy. Support for iCCM varied across different MOH technical units and depended on where responsibility for iCCM was located within the Ministry—where malaria control programs were well established, well-funded and distinct from iCCM—there were greater obstacles to progress on integration, as malaria control programs had little incentive to participate in iCCM when they were already providing home-based care for both children and adults." With the new national iCCM policy, it is hoped that high-level MOH leadership will be more inclined to encourage malaria and child/community health programs to work together.

To improve efforts to integrate iCCM in the future, both in Kenya, and other countries, we offer the following recommendations:

Recommendations to the Country—Kenya MOH:

- **Involve leadership above heads of program units**: Given the structure of the Kenyan health system, where different components of iCCM are placed under different programs/units, each with their own focus (i.e., iCCM spans child health, CHS and malaria), higher-level leadership to prioritize implementation of iCCM across the three units is necessary. A mandate to integrate is needed at the level of the Director of Medical Services or higher.

- **Prioritize and strengthen the strategy for Community Health**: Because iCCM involves case management of diseases from different programs using community health as a platform, an ICCM Coordinator (preferably in the CHS unit with an explicit mandate to coordinate across the three units) should be appointed to strengthen coordination.

- **The MOH should make a case for community health and iCCM to the leaders at the county level:** With the devolution, the counties should be helped to understand options for service delivery like the iCCM strategy to increase coverage of effective interventions, and assist them in their own planning and implementation.

- **Improve coordination across Child Health, Community Health, and the Malaria program:** Child health and community program managers should be included in the Malaria ICC to recognize the contribution of the malaria program to reducing under-five mortality and to build the working relationships required to strengthen joint programming and the potential to increase efficiency and better health outcomes for children through strategies like iCCM.

- **Adopt a comprehensive iCCM policy that favors technical integration:** Kenya should sanction the use of amoxicillin by CHVs to treat pneumonia, based on the promising results of the ability of trained and supported CHVs to implement iCCM from the Homa Bay and MCSP iCCM pilot studies. This will strengthen the case for integration among malaria stakeholders, because the treatment of pneumonia will reduce the likelihood of wastage of ACTs on non-malaria fever, while ensuring that children with pneumonia survive in cases of co-infection.

- **Conduct additional research**: Advocates for integration of iCCM and malaria should quantify and share broadly the benefits that the malaria program derives from the investment, such as overall increased care-seeking for all conditions and reducing ACT wastage.

Recommendations to Global Partners:

- **Ensure true buy-in for technical assistance and consultants:** Global efforts should include mechanisms that make the buy-in clear such as commitment to weekly meetings with the consultants, memorandum of understanding, etc.

- **Invest in both national and county governments to learn and use the tools for iCCM program costing and making an investment case:** To address the political prioritization question on the basis of program impact and cost argument, global partners should provide tools and skills for program managers to make the case to policymakers.

- **Invest in learning**: Global partners should also support Kenya to carry out documentation research and dissemination to better understand the challenges around and lessons learned from more than 20 years of implementation of components of the iCCM package in Kenya, as well as research to provide data on the cost benefit of iCCM and data to quantify the benefits of integration.

- **Integrate funding**: Finally, if ending preventable child and maternal deaths is to be achieved, donors accustomed to vertical funding structures must focus on this over-arching goal, as opposed to eliminating disease-specific mortality, which creates inherent disincentives for country program managers to integrate even when it makes the most technical sense. Integration is hampered when the funding streams remain vertical.

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