Lessons Learned Document

Thematic Area	Costing, Cost-effectiveness and Financing
Description	This Lessons Learned document reviews the evidence on determining costs and financing of iCCM programmes.
Organizations documenting Lessons Learned	Management Sciences for Health (MSH)

Background

Despite the reported success of iCCM in several low-income settings, many countries have yet to implement or expand iCCM, partly due to uncertainty about the costs of iCCM programmes. Having a comprehensive understanding of the costs and financing needs of iCCM programmes will enable countries that are considering implementing or expanding programmes to advocate for the necessary funding and to plan for the efficient use of resources.

A comprehensive understanding of costs requires the collection of a range of information, including the number of communities and cases to be targeted, the number of CHWs to be deployed and the costs of initial policy development, equipment, training and supplies. On the financing side information is required on the source of funding and future commitments.

Measurement challenges abound, making it difficult to plan, budget and track progress against expenditure. Often, iCCM and CHW programmes are funded through multiple budgets and donors, and financial data are not consolidated. An understanding of total programme costs, as well as marginal costs of adding new services or expanding the programme, is needed but often not available.

This is a companion paper to the Lessons Learned Paper on Cost-Effectiveness prepared under the same thematic area.

Process for documentation

Through the USAID-funded TRAction project, Management Sciences for Health (MSH) developed the iCCM Costing and Financing Tool and applied it in Malawi, Rwanda and Senegal. With funding from the Bill & Melinda Gates Foundation, the tool was further applied in Cameroon, the Democratic Republic of Congo (DRC), Ethiopia, Sierra Leone, South Sudan, Uganda and Zambia. MSH collected and documented a number of lessons learned about implementing costing tools throughout this process. Additionally, a web-based search of existing tools and methodologies for iCCM costing and financing was conducted. The results of this research were used to inform the lessons learned and supplement the findings from the iCCM costing analyses.

Strategies that worked well

The following were identified as strategies that helped to successfully cost iCCM programmes.

- The key element to successfully costing iCCM programmes is the availability of good data. The ability to include all relevant programme costs, including start-up and recurring operational and costs, allows for the development of a detailed picture of the key cost drivers for each

programme. This **cost information should be linked to contextual factors** to understand why certain programmes spent more on supervision or others on training.

- **Equally important as cost data is programme output data,** including numbers of CHWs and supervisors trained and deployed, numbers of iCCM treatments provided and population coverage. An understanding of which of these programme elements drive costs is critical; for example, the more CHWs are recruited, the greater the training costs will be. As programme coverage increases, and more iCCM treatments are provided, the costs of medications increase proportionately. Throughout the process, clear **ownership of the iCCM programme**, as well as strong partnerships between implementing organizations, Ministries of Health, and local communities can facilitate data collection.

Strategies that did not work well

The following were identified as factors that hindered the ability to successfully cost iCCM programmes.

- Costing analyses that did not work well were primarily the result of poor data quality. **Lack of reliable and detailed expenditure data was a key issue**. Where iCCM programmes were fragmented, with various departments and/or implementing organizations funding different elements, it was difficult to assess the costs of the entire programme. In some cases, high staff and project turnover resulted in poor record-keeping and lack of historical cost data necessary to conduct the analysis.
- **Collecting financing data was another major challenge**; frequently, this information was unavailable. As many iCCM programmes are implemented by external agencies and NGOs, these programmes are often project-driven and have no sustainability plan in place. Also, in cases where the Ministry of Health was expected to take over the iCCM programme, there was a lack of understanding of the costs that would eventually need to be absorbed by the government.
- A particular challenge for determining costs is that of identifying how many hours a CHW spends on iCCM activities. Since observational studies are expensive and impractical, one must instead rely on CHW's recall, which can be faulty or biased.

Lessons Learned

- **Not all iCCM programmes are created equally; costing must accurately account for variations due to contextual factors and different iCCM models.** There is no generic, 'one size fits all' approach to iCCM. CHWs are paid and educated cadres in some countries, and volunteers with low literacy in others. Certain CHWs are embedded within their communities, offering services from their own houses, whereas other CHWs provide treatment during standard hours at a fixed health post. CHWs also offer a variety of services with some limited to iCCM and others providing family planning, HIV testing and other preventive services. The number of supervisors and the amount of supervision time they provide to CHWs varies considerably from programme to programme. Each of these varying contextual factors have an impact on programme costs; these factors must be clearly understood and explained when analysing costs and comparing costs across different programmes and countries.
- **Costing excercises must occur in conjunction with planning and policymaking.** The cost ramifications of certain policy issues can be instrumental in making decisions – for example, if CHWs are adequately recognized and remunerated, attrition will likely be low, which can ultimately result in the reduction of costs associated with constant retraining and replacement. Also, when setting targets, it is important to consider the resources that will be

needed to achieve these targets, and plan accordingly. If the resources are not made available, it will be highly unlikely that the targets are met.

- The importance of linking costs to progress through **good M&E is also crucial**. As iCCM is implemented, programme expenditures should be linked to outputs and impact, building a case for continued or increased investment in iCCM. Using cost analysis to show value for money – cost per life saved, for example – is an important advocacy tool for iCCM programmes. A strong M&E system is critical to demonstrate this impact.
- **Developing a clear and realistic financing plan is critical to achieving sustainability.** To adequately plan for a sustainable iCCM programme, costing should ensure that both up-front and recurrent costs are identified. iCCM programmes tend to be funded through multiple budgets with support from local communities, governments and external donors. Vertical programmes may fund specific elements of an iCCM programme – such as a malaria programme funding ACTs. An understanding of the source of funding is also crucial. In countries where NGOs provide major support to iCCM implementation, the costs of supervision, management, commodities and logistical support must be calculated if the government is expected to eventually take over the programme. Together with information on health benefits and lives saved, the figures can be used for advocacy with government at national and local levels . Proactive support should be provided to ensure that iCCM programme costs are also key inputs into national and local plans and budgets to ensure sustainability.
- As CHWs and iCCM programmes continue to receive international recognition, there is a growing understanding that these programmes are not simply a 'stopgap measure' but rather an integral and essential part of the health system. As such, iCCM programmes will require **adequate financing** in order to achieve their full potential and should not be relegated as an afterthought in national health budgets.