iCCM Program Costing: Cameroon, DRC, Sierra Leone, South Sudan, and Zambia

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iCCM 2014

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Objectives

- Understand the impact of the iCCM model and contextual factors on program costs
- Understand the impact of iCCM utilization on treatment costs and cost-effectiveness

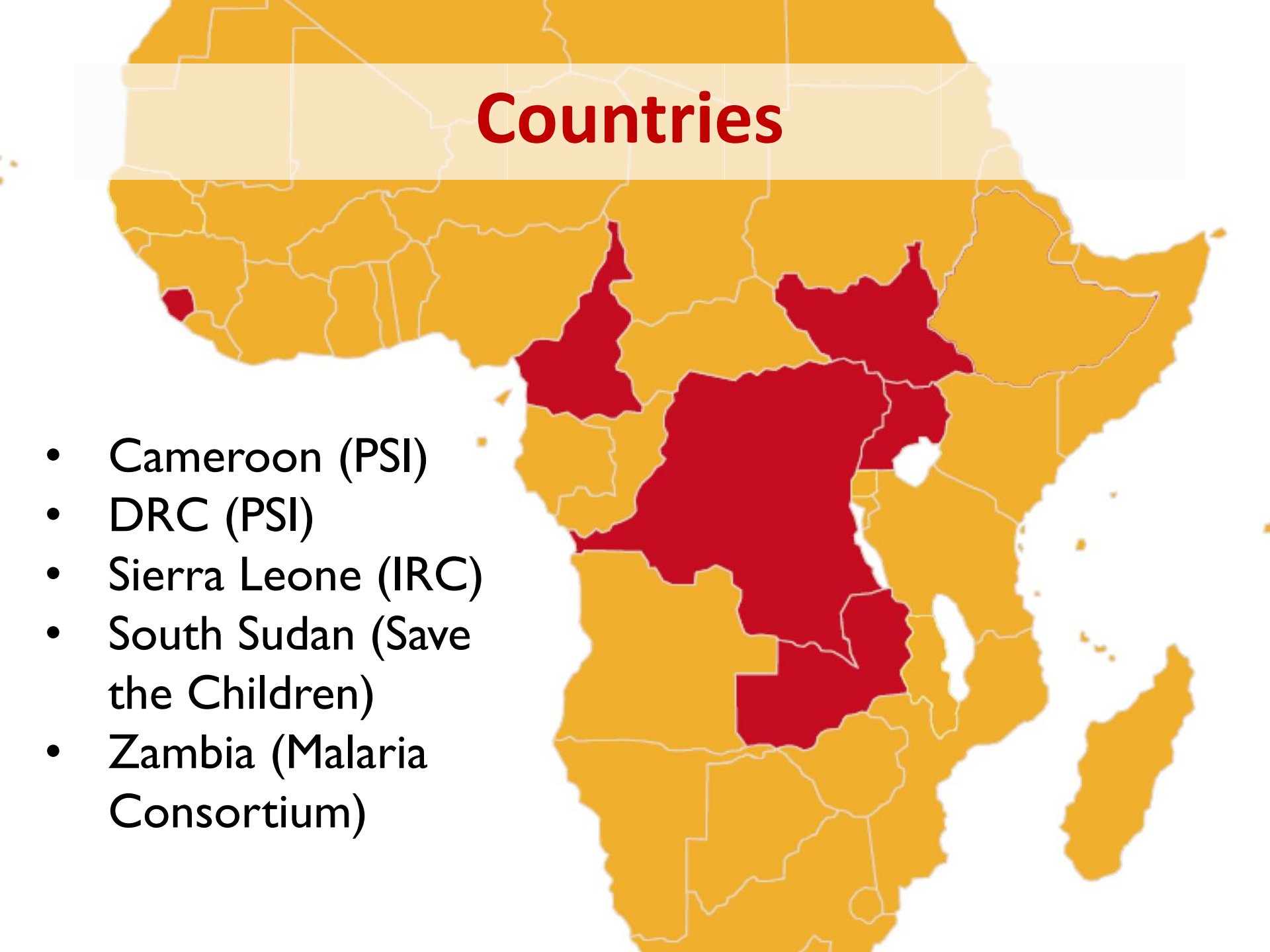
Methodology

- iCCM Costing and Financing Tool, developed under USAID TRAction Project
- NGO-implemented iCCM Programs in sub-national regions
- Costing based on actual number of iCCM treatments and a mix of standard and actual costs
- Include all iCCM program costs: medicines and commodities, CHW salary (if applicable), training, program management, supervision

Methodology

- Include costs covered through other budgets (i.e. health center supervisor salaries)
- Separate costs by recurrent (i.e. medicines, management, supervision) and start-up (i.e. initial CHW training and equipment)
- All data shown for 2012 and in USD
- ***Caution – preliminary analysis/provisional data***

Countries



- Cameroon (PSI)
- DRC (PSI)
- Sierra Leone (IRC)
- South Sudan (Save the Children)
- Zambia (Malaria Consortium)

iCCM Program Overview

	Cameroon	DRC	Sierra Leone	South Sudan	Zambia
Geographic areas studied	2 Districts (Doume and Nka)	1 District (Sud-Ubangi)	1 District (Kono)	10 Counties in 5 States	1 Province (Luapula)
iCCM region target	Rural/ Remote	Rural/ Remote	Rural/ Remote	Rural/ Remote	Rural/ Remote
Total population covered	139,520	926,843	206,430	919,564	741,373
Population 2-59 covered	25,114	138,100	31,584	160,004	137,895
children 2-59 as % of total pop	18%	15%	15%	17%	19%

CHW Profile

	Cameroon	DRC	Sierra Leone	South Sudan	Zambia
Name	ASC (agent de santé communautaire)	RECO (relais communautaire)	CHW (community health worker)	CBD (community-based distributor)	CHW (community health worker)
Number of CHWs	419	805	840	891	1,332
Total population per CHW	333	1,151	246	1,032	557
Children (2-59 mos) per CHW	60	172	38	180	104
Paid or Volunteer	Volunteer	Volunteer	Volunteer	Volunteer	Volunteer

iCCM Package of Services

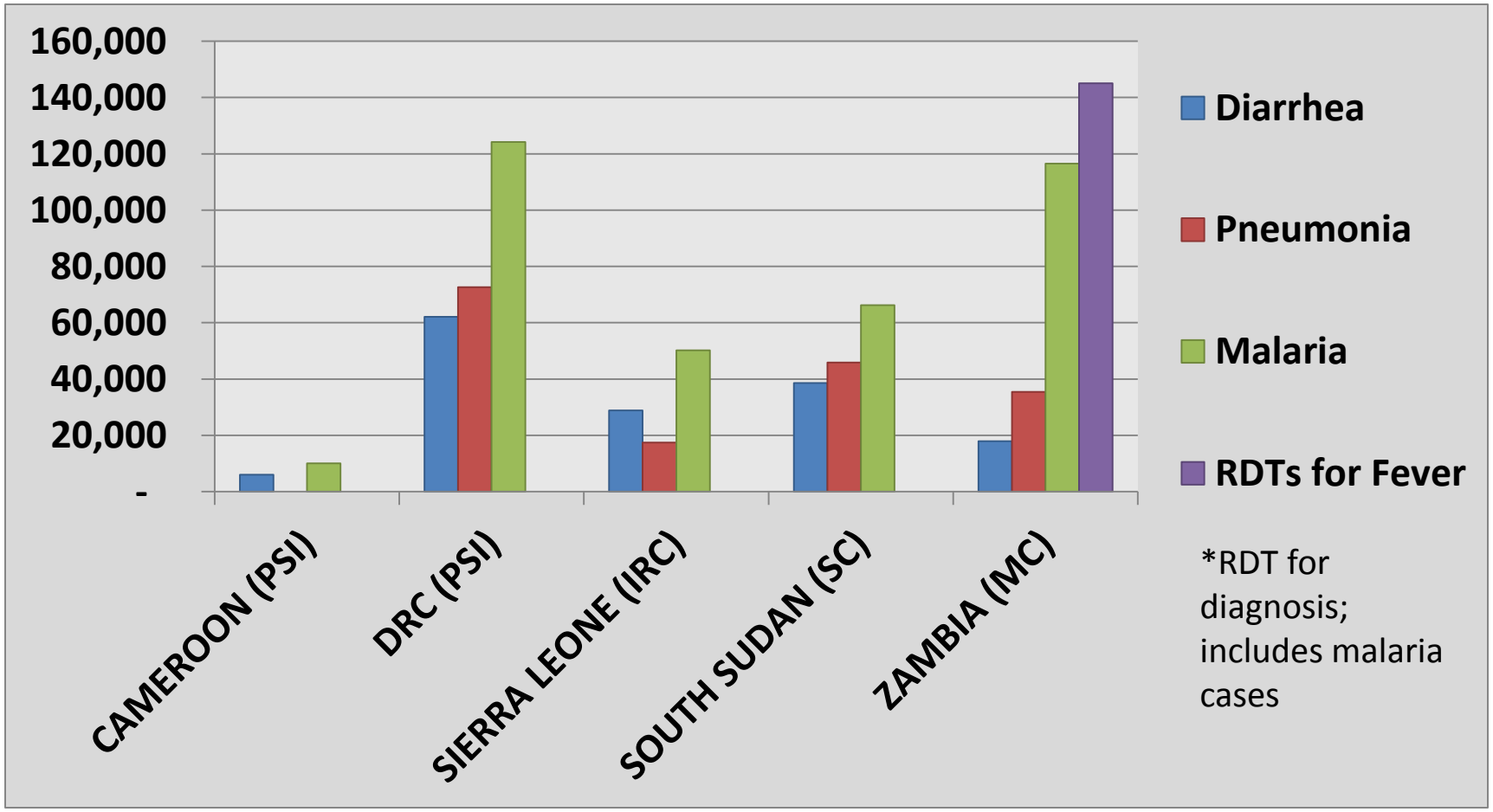
	Cameroon	DRC	Sierra Leone	South Sudan	Zambia
Diarrhea	• Yes • ORS • Zinc	• Yes • ORS • Zinc	• Yes • ORS • Zinc	• Yes • ORS • Zinc	• Yes • ORS • Zinc
Pneumonia	• No (started in 2013)	• Yes • Co-trimoxazole	• Yes • Co-trimoxazole	• Yes • Amoxicillin	• Yes • Amoxicillin
Malaria	• Yes • ACT - Presumptive treatment • (RDTs in 2013)	• Yes • ACT - Presumptive treatment	• Yes • ACT - Presumptive treatment	• Yes • ACT - Presumptive treatment	• Yes • RDT for fever • ACT for confirmed malaria
Other	• Referral	• Referral • Cough • Malnutrition	• Referral	• Referral	• Referral

Supervision & Training

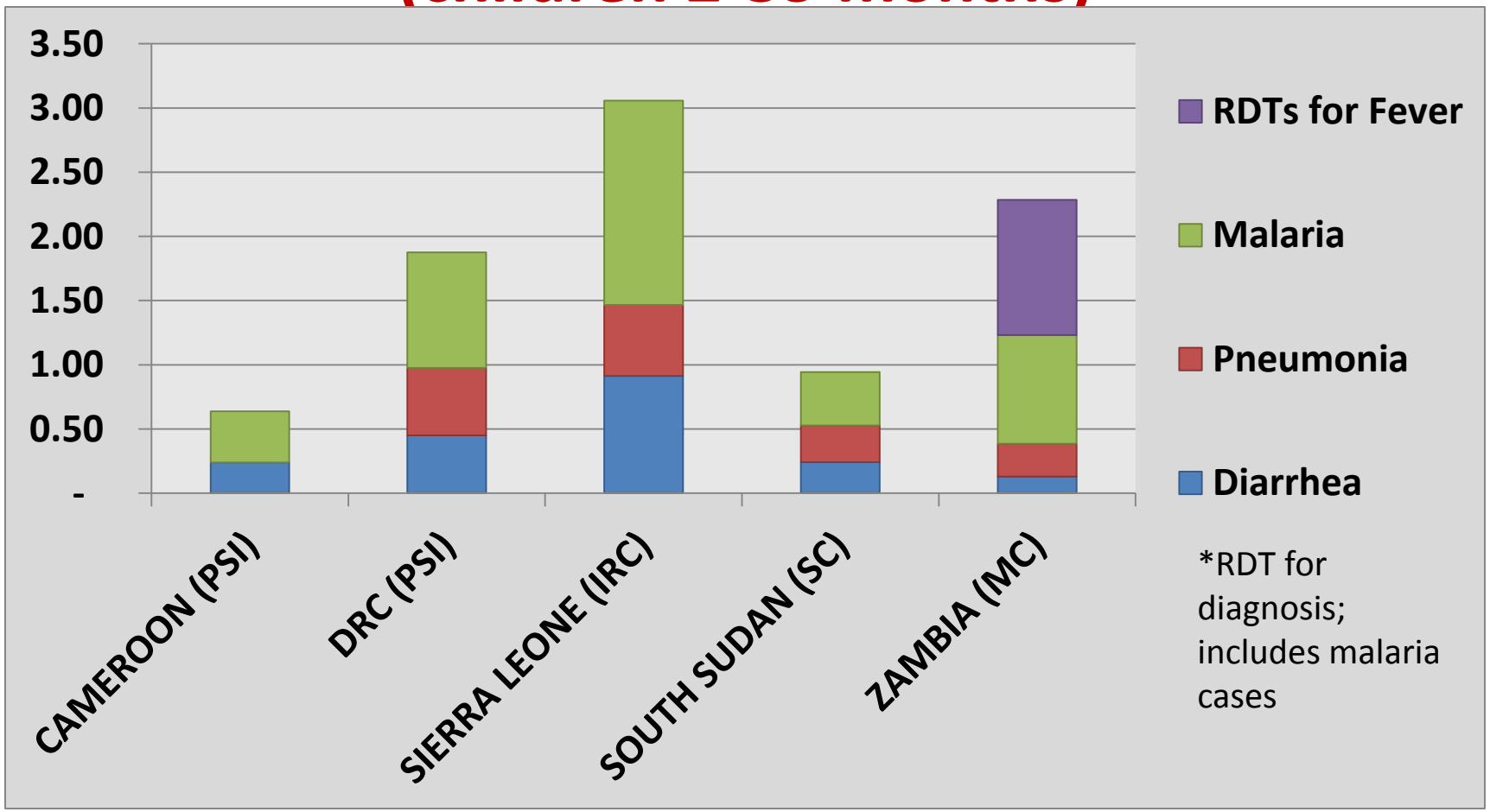
	Cameroon	DRC	Sierra Leone	South Sudan	Zambia
Primary Supervisor	ASC Supervisor (NGO)	Infirmier Titulaire (MOH)	CHW Supervisor (NGO)	CBD Supervisor (NGO)	Health Center In-Charge (MOH)
Number of NGO Supervisors	23	126	78	82	77
CHWs per Supervisor	18	6	11	11	17
Initial CHW Training	3-day training on malaria and diarrhea	5-day training on iCCM	6-day training on iCCM	5-day training on iCCM	6-day training on iCCM
Refresher CHW Training	Annual 3-day refresher	No refresher training in 2012	No refresher training in 2012	Biannual 3-day refresher	Annual 3-day refresher

RESULTS

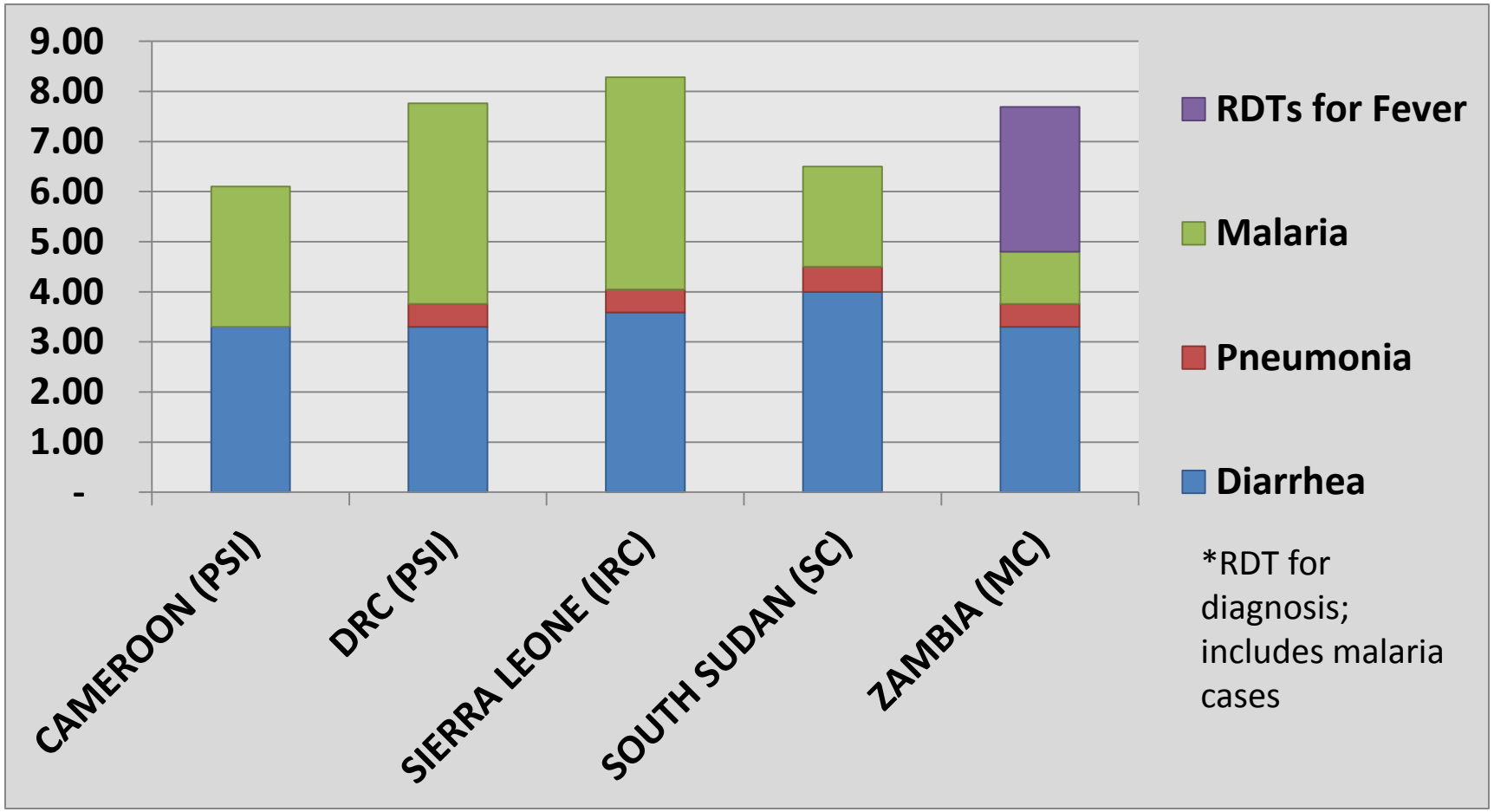
Total iCCM Treatments, 2012



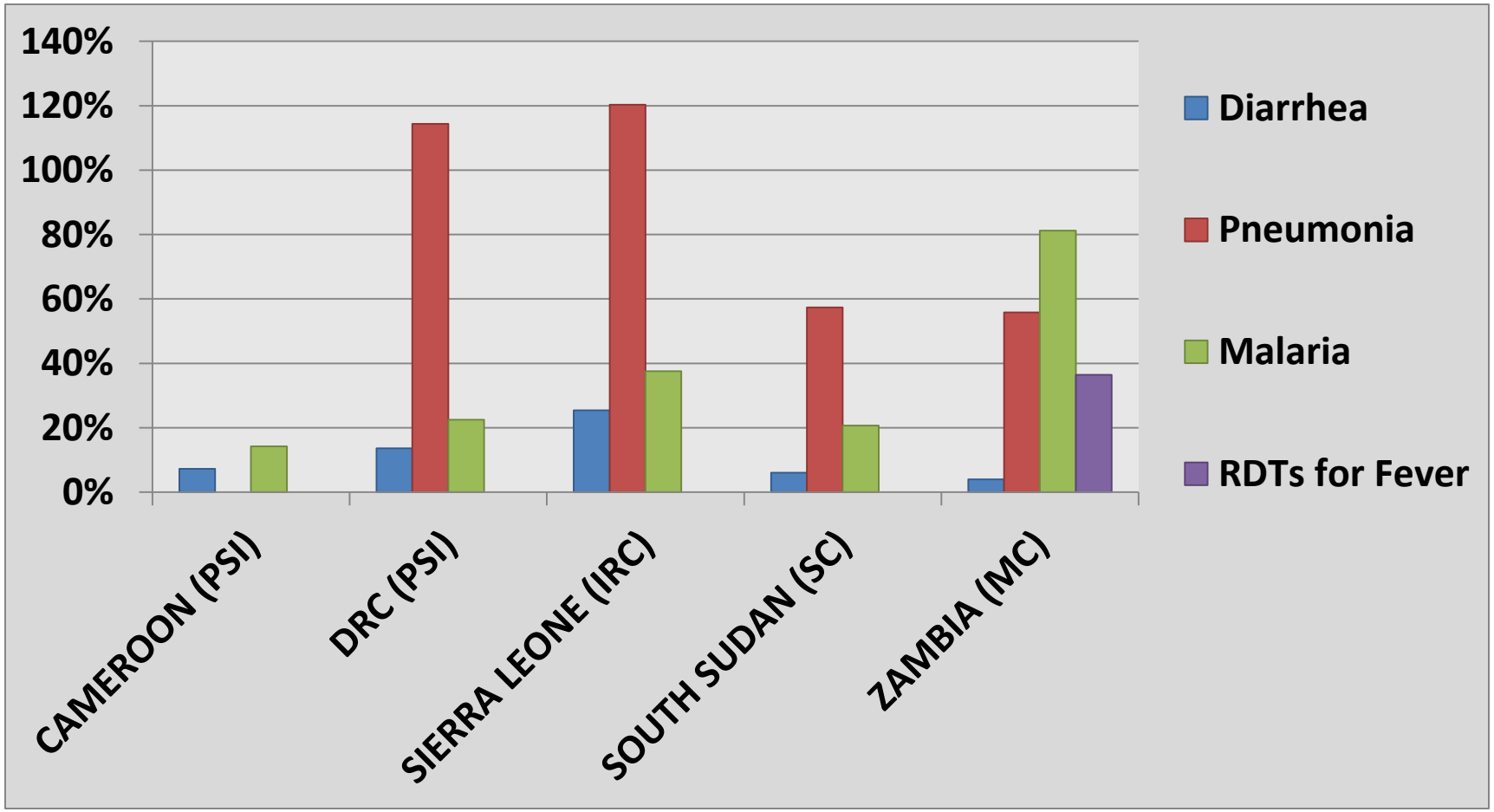
Actual iCCM Cases per Capita
(children 2-59 months)



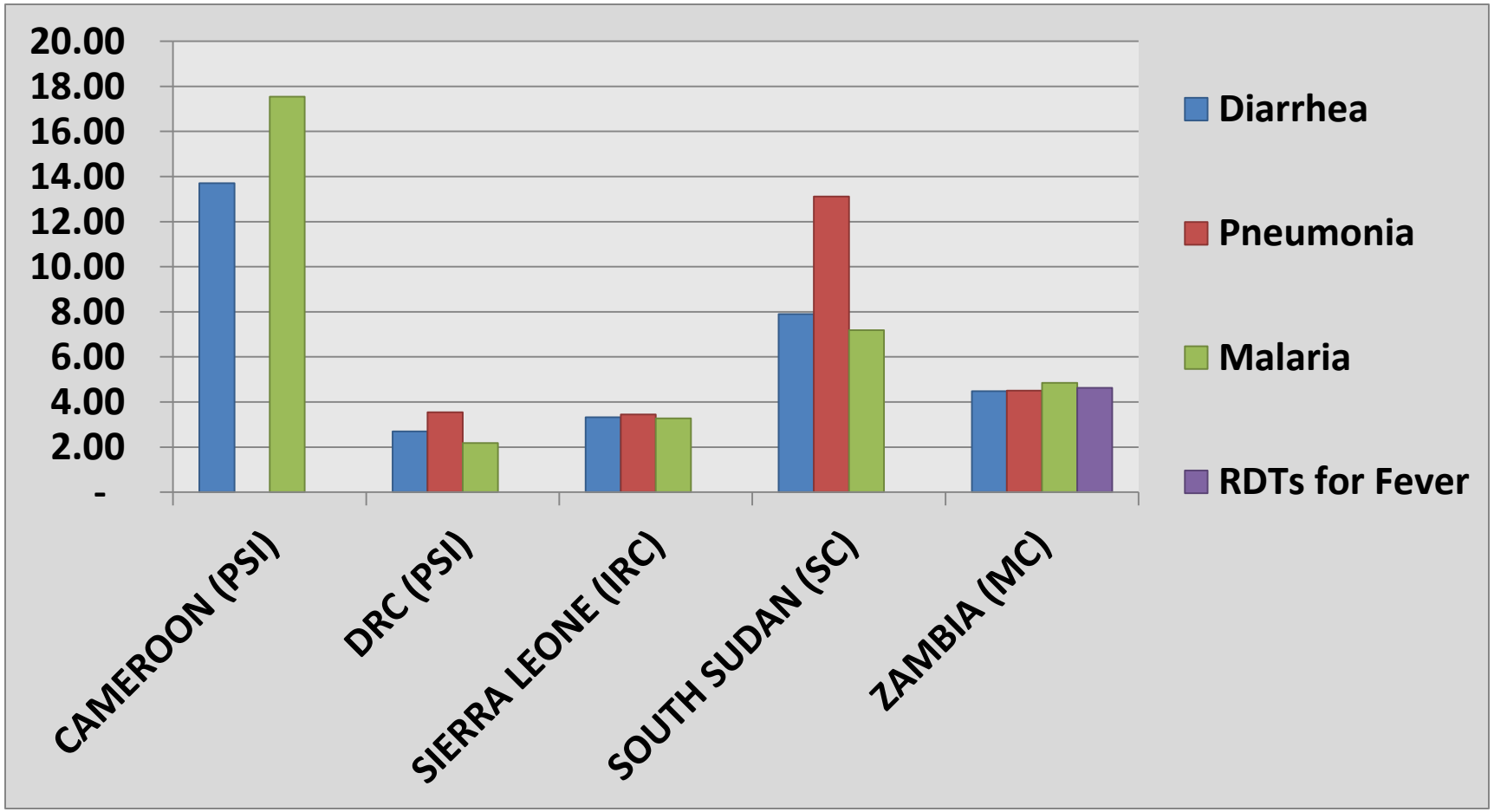
“Expected” iCCM Cases per Capita



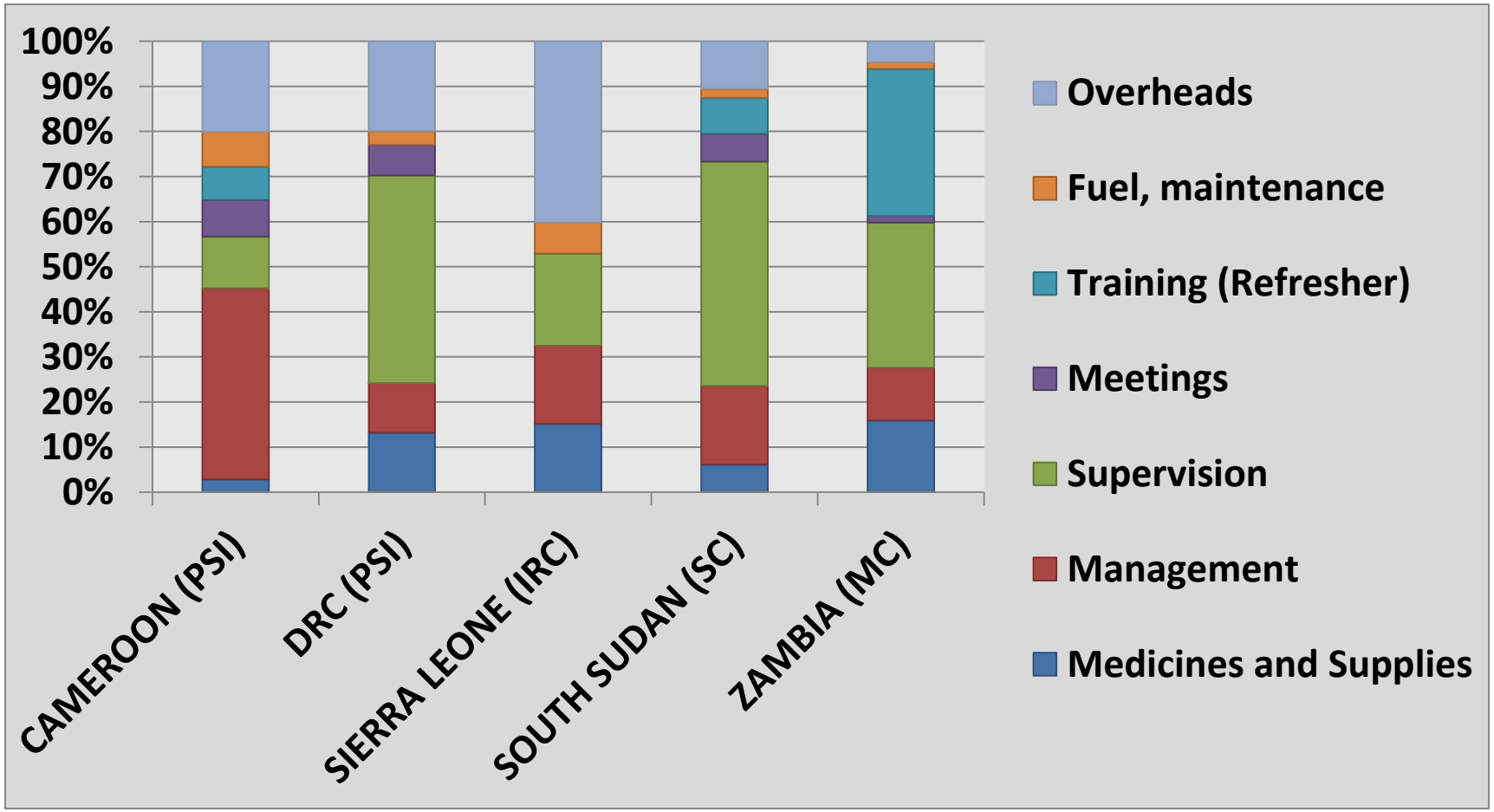
Treated vs. Expected Cases



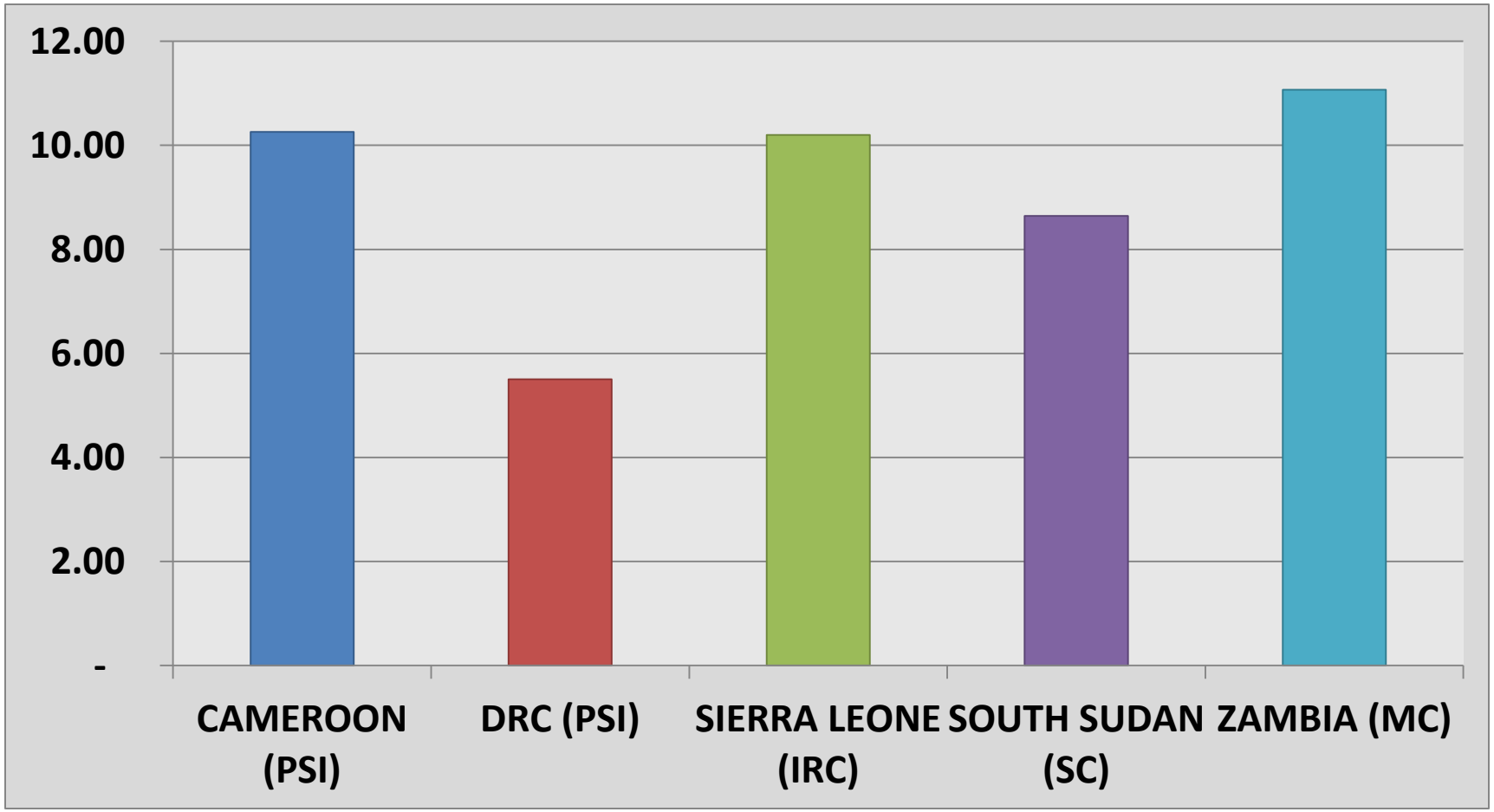
Cost per iCCM Treatment/Diagnosis, USD



iCCM Program Cost Distribution



Cost per Capita (2-59 months), USD



Discussion

- Variations in iCCM program models are important considerations of cost
- Supervision and management costs were key cost drivers
- Higher costs per service due to lower utilization; fixed program costs are distributed over fewer services
- As programs mature, costs per service should decrease as utilization increases, as should cost-effectiveness

Lessons Learned

- iCCM programs should be well-utilized to improve cost-effectiveness
- iCCM programs require investments in the health system – supervision, HR, supply chain
- More evidence on cost-effectiveness needed; tie cost data in with impact evaluations, compare with facility-based costs
- Demand side and patient costs should be taken into consideration

ACKNOWLEDGEMENT

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THANK YOU!

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