SOURCES AND MECHANISMS FOR ICCM FUNDING

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Institutionalizing Integrated Community Case Management (iCCM) to End Preventable Child Deaths
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Background: Funding landscape (2014 – to date)

Starting in the first GF NFM (2014-2017) and continuing into the second NFM (ending 31 Dec 2019) ***major donors and development partners increased their funding and technical support for iCCM implementation in the 18 countries considered under the GF iCCM evaluation***

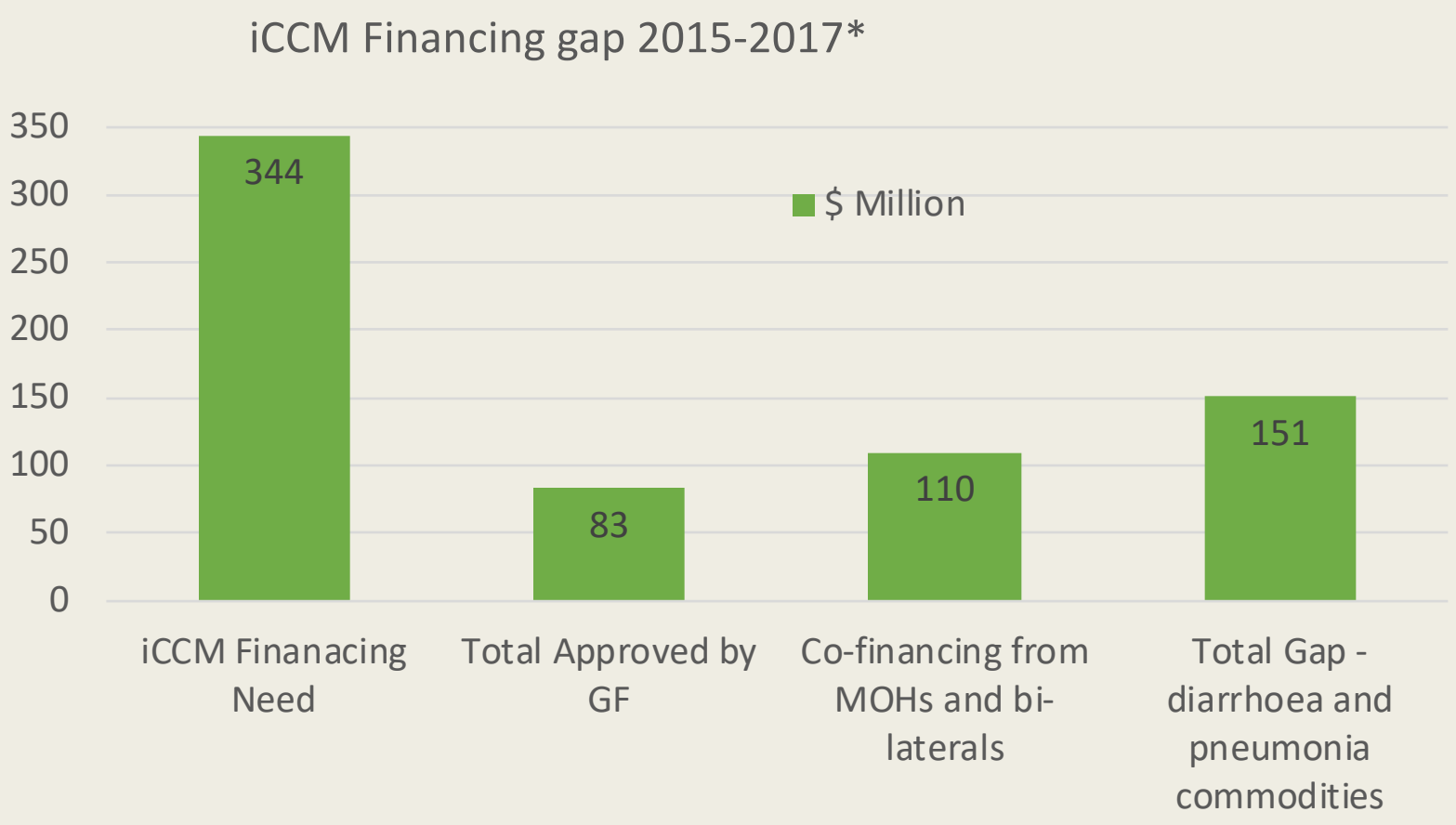
- ✓ RAcE Project: DRC, Malawi, Mozambique, Niger, and Nigeria
- ✓ iCCM Financing Task Team established in October 2016 greatly improved funding allocations for iCCM – supporting countries in inclusion of iCCM into their Global Fund NFM grants and facilitating co-financing options.
- ✓ Global Fund Support for iCCM
  - *Of the $3.4 billion in malaria grants from New Funding Mechanism, 14% for case management allocated to iCCM in 38 countries*

iCCM: Areas eligible for GF and PMI funding

Item	In GF grants?	Possible component
1. CHW – training, incentives, etc.	Yes	RSSH, Malaria
2. Supportive supervision & capacity development	Yes	Malaria, RSSH*
3. Community engagement, demand creation, BCC	Yes	Malaria, RSSH
4. Service delivery & quality, referral linkages, refresher training	Yes	Malaria, RSSH
5. Supply chain management	Yes	RSSH, Malaria
6. Community reporting, HMIS, M&E	Yes	RSSH, Malaria
7. Malaria commodities- RDTs, ACT	Yes	Malaria
8. Non-malaria commodities	No	NA

*RSSH note, given the transversal nature of RSSH support – discussion can and also should be held with the HIV/TB community

ICCM Aggregate Gap Analysis: 10 Countries



* Nigeria, DRC, Zambia, Uganda, Ethiopia, Ghana, S. Sudan, Burkina Faso, Malawi and Cote D'Ivoire.
Note: iCCM Total does not include malaria commodities;
Source: iCCM Financing Task Team Consultants

Costs and Costing (iCCM Implementation)

- Several previous multi-country costing and financing studies covering SSA (Cameroon, DRC, Malawi, Senegal, Sierra Leone, South Sudan and Zambia, 2015), documented that **iCCM utilization rate was generally low across countries** (range: 0.26 to 3.05 contacts per capita for children under five years per year for the three diseases treated by the program).
  - This translated to a range of 2.7% to 36.7% of the ***projected numbers*** of cases attendance per year.
- According to those studies, major cost drivers in iCCM implementation included:
  - Diarrhoea: US$ 2.44 to US$ 13.71 (recurrent cost per treatment);
  - Malaria: US$ 2.17 to US$ 17.54 (excluding rapid diagnostic testing);
  - Pneumonia: US$ 1.70 to US$ 12.94

Pneumonia and diarrhea commodity costs based on disease burden calculations

	Total population of children under five, 2016 (source: UNPD WPP 2017)	Estimated cases of diarrhoea among children under five, 2016 (source: IHME GBD 2017)	Estimated cases of pneumonia among children under five, 2015 (source: Wahl et al.)	Diarrhoea Estimated costs (commodities, per annum)	Pneumo Estimated costs (commodities, per annum)
Global	674,798,900	1,103,532,482	9,465,103	**$ 551,766,241**	**$ 7,090,084**

Initial Analysis non-malaria iCCM needs 2018-2020 in 23 countries

	Total per year (estimates or extrapolations from 2017 commitments)	Total for 2018-2020	Areas (examples)
Country Commodity & Platform Needs Totals	8,687,000	25,861,000	• Procurement of ORS/Zinc, Amox DT • Support regular community-based awareness and social mobilization initiatives. • Support capacity building for health professionals on community case management of simple diseases. • Development of simple community-based guides
Technical Assistance, M&E, etc	434,350	1,293,050	5% addition to the total for technical assistance, program management, supply chain management, and monitoring and evaluation, etc.
Totals (country needs)	9,121,350	27,154,050	

DRC	Needs 2018: 15.6 M; 2019: 20.3 M; 2020: 26.4 M	$44,030,000 (total for 2018-2020 for 133 HZ)

The GF-UNICEF MOU partnership has been strongly implemented in DRC and iCCM/IMCI-c is one of the important elements in the DRC/GF programme continuation proposal: "Objective 2: To set up resilient and sustainable health systems." UNICEF has committed to completing the iCCM package in 133 health zones covered by the Global Fund through its primary recipient (PR) for Malaria (SANRU) Within this framework, UNICEF is providing inputs for the management of diarrhea and pneumonia (ORS, Zinc and Amoxyciline 250 DT).

In 2017, the financial needs were estimated at $11,607,254 for the purchase of non-malaria commodities in the 133 ZS and the household-level family kits in 43 ZS. By 2018 there are currently no firm financial commitments to ensure the continuation of this program in spite of UNICEF's desire to maintain the gains and also scale-up beyond the current 133 health zones (out of the country's total of 516 health zones). ***Currently iCCM implementation is limited to 25% of the country due to financial limitations regardless of strong desire and imperative to scale-up to national scale.***

Note: Financial requirements are reported as per UNICEF country office (COs) communiques and represent the need to support iCCM scale-up as per national guidelines within the context of the UNICEF-GF MOU. In line with the Global Fund's differentiated financing modality (new allocations/grants to be implemented from 2018-2020), needs are presented for the new Global Fund period and are aligned with countries community health scale-up plans (e.g. scaling-up pilots to national level). ***The figures in this table reflect the estimated non-malaria essential commodity gaps required by countries in their programme districts, but are not complete nor cover the full non-malaria essential commodities gap required by the countries listed.***

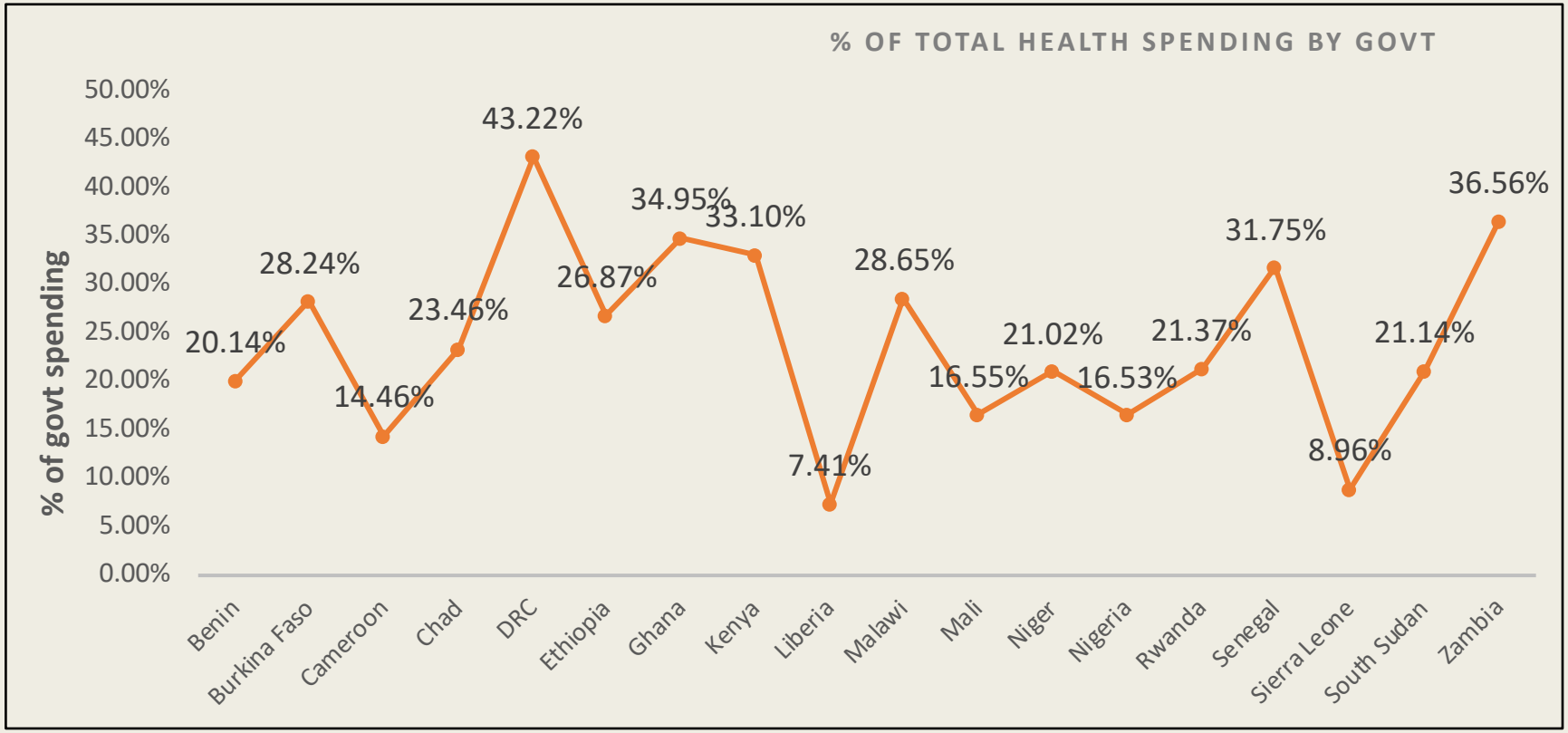
iCCM funding: Sources

- *Domestic annual allocations*
- *Donors and Development partners* (multilateral and bilateral): The Global Fund through NFM grants. UNICEF, WHO, GF, CIDA (Canada), USAID/PMI, DFID, World Bank and the Bill and Melinda Gates Foundation.
- NGOs implementing partners, operating at all levels of the programme i.e.. Supporting for country planning, financial resources and some logistical provision across all thematic areas of iCCM implementation.
- *Households and employment-out of pocket expenditure;*
- Private sector.

Health spending as a percentage (%) of total government spending

Countries with more domestic Govt spending in health achieved more iCCM national coverage compared with those with others.

Example: Ethiopia, Rwanda, Zambia, Malawi, Burkina Faso Ghana and DRC

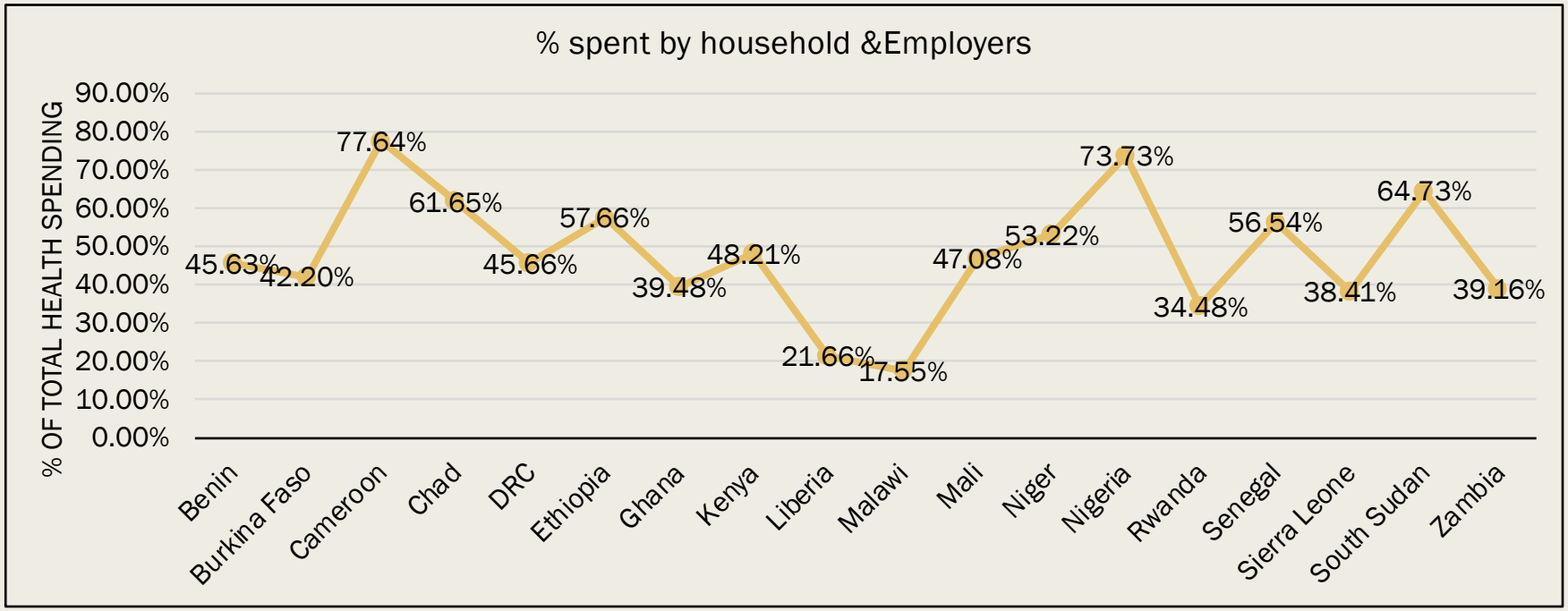


Governments domestic spending in health as a proportion of total expenditure by country ranged between 7 - 43%.

Low domestic contribution to the health programs/iCCM, poses key challenge to financial sustainability especially when external donors leave.

Out of pocket expenditure % of Total health spending

11 out of 18 countries covered by the study have households access health care services through own savings/expenditure or employment for those employed.

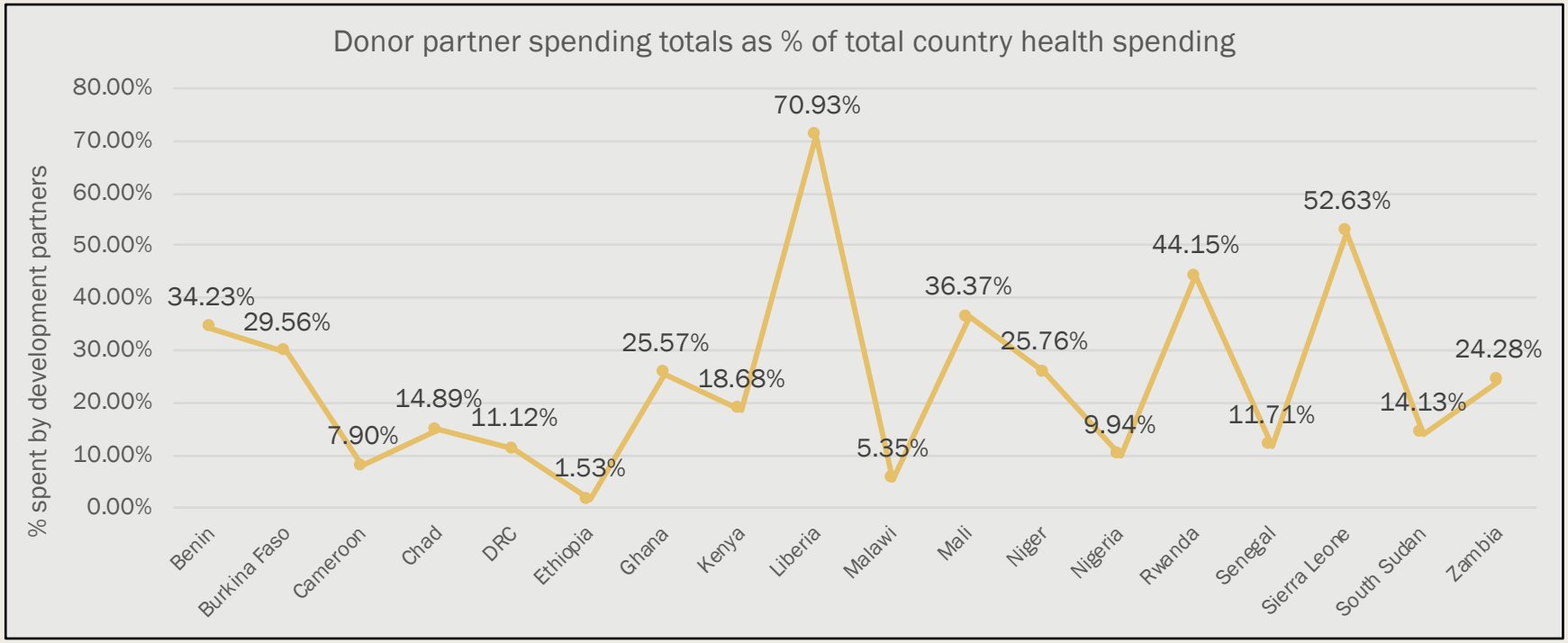


The implication of households/community co-financing of health care was that **poor families living >5Km from health facilities (iCCM coverage areas) found it difficult to buy non-malaria commodities**

(E.g Cameroon, where 77.9% of community buy drugs)

External partners contribution as a % of total health spending

- Most of study countries are dependent on external funding for health program implementation. ***In case of iCCM, external partners support almost 100% of program commodities including logistical requirements***.
- **Countries with wide funding base from both government and different partners performed better in iCCM expansion/national coverage compared with those with narrow funding sources.** *Example: Ethiopia, Rwanda, Zambia, Malawi, Burkina Faso Ghana and DRC*



iCCM Key external partners: GF, UNICEF, WHO, USAIDS/PMI, CIDA, World Bank, Bill and Melinda Gates, DFID. Main NGOs Implementing Partner include: Malaria Consortium, Save the Children Fund, IRC, PSI, JSI etc.

Challenges (1/2)

- **ICCM is often an "orphaned" or "patchwork" programme**
  - Ie – not necessarily in the malaria programme, nor in child health nor..
  - Community health is not always prioritized in the investment cases
  - Community health strategy are not part of a larger HRH strategy
  - Lack of coordination within and between donor agencies on malaria and MNCH (including iCCM)
- **Finite global and domestic financing of health and many competing priorities for this financing**
  - Within donor agencies, different programs may have specific "limited" mandates
  - iCCM is currently extremely external donor dependent and thus may be excluded from "local" funding in favor of programmes that donors will not finance
- **Not all country strategies are costed**
- **Lack of harmonization/coordination among donors for funding of iCCM eg. By location or disease**
  - Donors not actively participating and engaging in cooperative national and sub-national level planning and processes
  - Donors don't always align with country planning and budgeting cycles

Challenges (2 of 2)

- **Lack of clarity on where community health investments will be most cost effective**
  - The GF 18 country study noted that countries had poor understanding of prioritizing their resources to maximize impact in health interventions including planning and costing for needed resources to address disease interventions for iCCM services and health sector generally;
- **Strategies not anchored in a overarching national financing strategy that nests all the underlying strategies eg. Wider PHC strategy**
- The geographical nature of hard to reach areas covered by iCCM programme, have unique challenges, such as unavailability or non-functional:
  - physical infrastructures, roads and transport;
  - human resources & appropriate skills (recruitment, retention & training);
  - community awareness and social mobilization;
  - commodity procurements and distribution support;
  - programme management, supervision and monitoring among others.
- This study also established that **countries' capacity** for tracking the results and capturing data from community level on the performance of life-saving results of iCCM implementation has been a key a challenge for planning and resource investment.
- Limited engagement with the **private sector** for financing of iCCM

Lesson Learned: Success

- **Ghana**: detailed gap analysis, including for non-malaria commodities ensured increased joint funding from GoG ($512K) GF ($3.5M) and UNICEF ($600K) during 2015-2017.
- **Ethiopia**: Full domestic funding of HEW remuneration and training helped to free up significant funding from GF and partners to cover programmatic and commodity costs, ensuring implementation at full scale
- **South Sudan and Brundi**: flexible funding arrangements in the context of challenging operating environments has been key in securing uninterrupted supply of iCCM commodities.
- **Uganda**: Innovative approaches such as RMNCH Trust Fund highlight the potential for increased domestic resources
- **Nigeria**: Leverage funds from other programs, for example, the Subsidy Reinvestment Program,
- **Malawi**: Sustained increase in annual budgets to PHC. In 2016/2017, MOH allocated 20% of total health budget to PHC

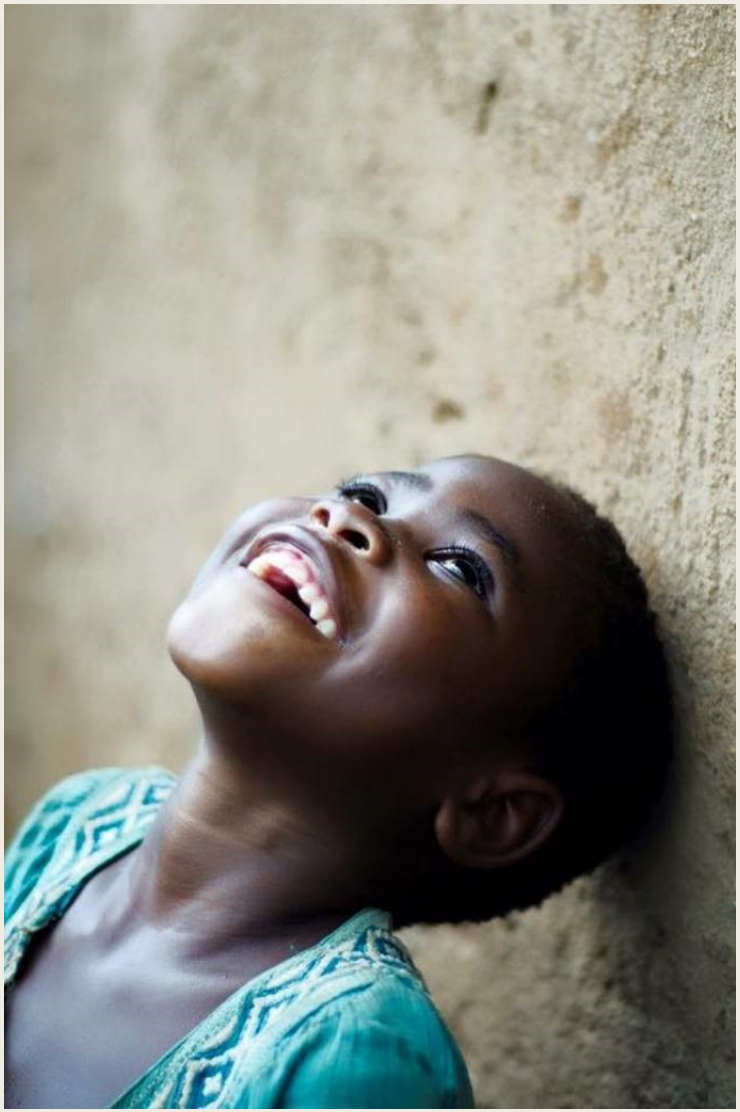
Opportunities going forward (1/2)

- Capitalize on institutionalizing community health discussions to **"give iCCM a home"** and consequent visibility and advocacy
  - *Support national authorities to articulate clearly the iCCM **value for money***
  - ***Position iCCM within larger PHC/UHC** advocacy efforts*
- Countries need capacity to understand costing and financing of iCCM program to **facilitate optimal planning and budgeting** and efficient allocation to maximize the program services based on costs-effectiveness analysis.
  - *Ministry of Health ensures that all iCCM stakeholders (eg. programs within the department of primary health care, sub-national and community) **are engaged** during the development of relevant country strategies*
  - *Ensure iCCM is built into the national costing tools and the annual sector budgeting processes including **specific budget lines***
  - *Support national authorities to **articulate the case for increased national budget allocation** for health*
- **Training and capacity support** for Programme managers and other implementers on appropriate tools for the programme financing, costing, and cost analysis is necessary to **inform decision making** and for improvement of the programme funding and cost-effectiveness.
  - *MOH is capacitated to **use emerging tools to map funding and track expenditures** on a regular basis to create accountability*

Opportunities going forward (2/2)

- Government (MOH, M. of Planning, MOF) explore possibilities to **use the investment cases** facilitated by GFF to strengthen country institutional capacity to drive strategy and coordinate partners
- MOH should **take advantage of established effective coordinating mechanisms** (eg. Malaria partnership, CCM etc…) to strengthen overall resource coordination at national level for iCCM
  - ***Donors commit to aligning their investments*** *according to national direction*
  - *Ministry of Health ensure that annual health program planning and budgeting at the* ***decentralized*** *levels include all the elements for operationalizing iCCM*
- **Development partners should provide technical assistance and support to build capacity** for the above processes
- **Global Fund** continued focus on **capitalizing RSSH & MNCH investments**
  - *Partners including UNICEF are reinvigorating the iCCM Financing Task Team for the GF 2020-2022 allocation period*

In conclusion



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Adequate sustained funding for iCCM depends upon clearly defined targeted population needs and fully inclusive costing, as well as demonstrated impact on higher level goals including UHC and the SDG and demonstrated ability of governments to contribute to and coordinate the diverse funding sources to support iCCM.

Thank You
Merci
Obrigado

For more information, please contact
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