Cross-Country Roundtable of Experiences in iCCM Gap Analysis and Investment Cases

Summary of May 11, 2022 Meeting

Background

The *Cross-Country Roundtable of Experiences in Integrated Community Case Management (iCCM) Gap Analysis and Investment Cases* meeting was organized by the Institutionalizing iCCM Subgroup and Secretariat of the Child Health Task Force and took place virtually on May 11, 2022. Participants included ministry of health child health representatives from Malawi, Kenya and Uganda, as well as colleagues from USAID, WHO, Global Fund (GF), GFF, UNICEF, Save the Children, World Relief Malawi, and MOMENTUM Country and Global Leadership. The goal, objectives and results of the meeting are documented below.

Meeting Goal

To bring together global and country-level stakeholders from an initial, targeted set of countries to learn from recent country experiences of using the various tools and approaches to mobilize resources for iCCM and community health. This first meeting was intended to be part of a broader learning series that will include targeted meetings with other countries who are beginning the gap analysis and investment case process, with stakeholders working on community health systems and the private sector, and with the donor community.

Meeting Objectives

1. **Glean lessons learned** from the process of conducting iCCM gap analyses, developing investment cases and translating this work into financing of iCCM and community health.
2. **Identify successes, challenges and gaps in the use of the MSH/UNICEF Community Health Planning and Costing Tool version 2.0 (CHPCT 2.0) and other tools/approaches** employed in gap analysis and investment case development as well as resource mobilization.
3. **Identify key recommendations** to inform possible future efforts and approaches to mobilize resources for iCCM.
4. **Determine next steps** to support future efforts to mobilize resources for iCCM and community health.
5. **Receive input on the idea to hold additional meetings** (as a series) on conducting iCCM gap analyses and developing and using investment cases.

Key Messages

Utility of Tools

- The CHPCT 2.0 and the process of conducting the costing analysis and developing the investment case allowed for a detailed analysis of iCCM program data. In general, data are effective in detailed planning and costing for community health programs. The application of the tool built the capacity and skills for costing iCCM and community health programs.
- Challenges were encountered with data accessibility, availability and quality across the public and private sectors. These issues reinforced the overall need to strengthen the health system alongside the iCCM program and direct sufficient investment to enhance Health Management Information Systems (HMIS) in addition to service delivery, particularly at community level.
- There was a heavy reliance on consultants to use the tool and conduct the process. Participants noted a need to strengthen the capacity of key stakeholders in the costing, planning and budgeting process. There is also a need to use the costing tool to institutionalize the process within the national planning departments.
- Participants also noted the need to ensure the tool is clearly understood by local stakeholders and has full buy-in from ministry of health (MOH) leadership and decision makers at subnational levels, as well as the private sector and civil society organizations (CSOs).

Use of Investment Cases

- Plan for iCCM within a wider community health strategy to ensure that support systems exist for implementation.
- Use the investment cases to inform concept notes for funding opportunities such as through the Global Financing Facility and Global Fund mechanisms. To increase use, disaggregated costs and sub-national analyses are helpful.
- The tool and investment cases need to go beyond just costs to show some of the other economic benefits (and opportunity costs) and how investment in iCCM and community can benefit the entire health system.

Meeting Results

The results of the meeting are presented below grouped by the four main discussion areas: (1) Utility of Tools, (2) Use of Investment Case, (3) Stakeholder Engagement, and (4) Looking Forward (Support). Documented within each area are successes, challenges, and lessons learned/recommendations for future use of the costing analysis tools, process, and mobilizing resources in support of iCCM programs. The following information was gleaned from the country presentations, small group discussions, and large group plenary.

1. Utility of Tools (Inclusive of Data Collection, Analysis and Investment Case Development Process)

a. Successes

Country representatives noted that the use of the tool to conduct the costing analysis and develop the investment case allowed for a detailed analysis of iCCM program data. Thus, the tool has been effective overall for detailed planning and costing of community health programs. They also noted that the tool was appropriate for the work and appreciated that it was customizable to a country's context and could be used in a tiered government structure. All country representatives said they would use the CHPCT 2.0 again for the Global Fund's New Funding Model #4 (NFM4).

- **Collaboration:** The process itself encouraged teamwork and collaboration across stakeholders at national and sub-national levels and consensus on resources needed for iCCM. It also brought together diverse departments (TB, HIV, etc.) involved in the iCCM package which may enable access to additional funding for the iCCM program.
- **Capacity Development:** Using the tool helped to build capacity and skills for costing iCCM and community health programs and developing an investment case.
- **Functionality of the Tool:** Users noted that data entry is structured around various modules: program data, structure and scale-up, training, equipment, supportive supervision, service package, coverage targets, recurrent and start-up costs, and financing. Users made assumptions about program scale-up, community health service coverage, and CHW to population ratio, which were not always reliable. They noted that results can be used to assess program performance, conduct sensitivity analyses, develop investment cases and plan for future services. They also appreciated that the tool includes deaths averted (lives saved) estimated using the Lives Saved Tool (LiST), productivity benefits from estimated economic benefits from lives saved, and estimated economic multiplier effects of government spending on iCCM. Participants liked that the tool provides a detailed list of cost drivers and that you can play around with different scenarios based on the nuanced inputs you receive.

b. Challenges

- **Data Availability, Quality, and Reliability:** Data quality and accessibility were major concerns. The tool requires availability of rich operational and finance-related data which are not easily accessible in most settings, limiting the utility of the tool. In some cases, HMIS data were not very accurate with low reporting rates for iCCM and community health data, lack of community-level data in DHIS-2, challenges obtaining information on the number of services provided and few recent studies using childhood mortality and morbidity population data. There were also pandemic-related issues accessing community-level data when needed.
- **Limitations of Tool:** The tool does not take into consideration the effects of prevention programs. For example, it does not account for declines in malnutrition and diarrheal episodes due to preventative interventions. Some of the inbuilt graphs generated were not very informative and not used. There was concern that the pneumonia prevalence generated low cases compared to actual numbers recorded from the community. In addition, the tool was not able to capture pandemic/natural disaster (e.g., COVID-19) related data or nuances.

- **User Capacity Support:** Some users required support to understand the tool layout, internal linkages, automated fields and formulas and interpretation of some fields entered. Use of the tool required iterative consultations on data sources, acceptability and reliability.
- **Limitations with Technical Assistance:** Country representatives noted that there is a heavy reliance on consultants to use the tool and conduct the process. In one case, the consultant had limited capacity to deliver the assignment which resulted in dismissal and lengthened the timeline for the exercise. However, it was noted that existing MOH and partner staff already have full-time roles, so providing this technical assistance (TA) on top of their day-to-day responsibilities would be challenging.
- **COVID-19 Disruptions:** The pandemic caused meeting restrictions and competing priorities for team members actively engaged in the pandemic response.

c. *Lessons Learned*

i. Tool Structure and Functionality

- The structure and modules should recognize the country context. For example, in Malawi, community health has so many vertical sections within it, so it was difficult to harmonize bits and pieces while looking at the different sections of the tool.
- A need to reduce the number of tabs/spreadsheets within the tool to make it more user friendly; in addition, a need to provide more details on the automated figures in order to lessen the dependence on consultants.
- Add three- or five-year summaries to help reduce calculation errors.
- It would be helpful to capture what is being carried out by other preventive health programs (WASH, etc.).
- The tool separates urban and rural health, but does not break down by private and public so it is assumed that the private sector worked in the urban area and the public sector worked in the rural areas.
- No structured mechanism for privacy of data; need more/better mechanisms to bring the private sector on board and make sure that they contribute to iCCM.
- Uganda: Issues around salaries for Village Health Teams (VHTs) and how to harmonize the public and private sectors

ii. Process of using tools to develop an investment case

- Operationalize some of the definitions in the tool and basic definitions within the particular country context. This might help the tool to be more comparable across countries.
- Conduct a mid-term review to assess if program is on-track, anything has changed, or adjustments are needed to reach the five-year targets. Some guidance would be helpful for that kind of review and reflection.
- Ensure the tool is clearly understood by the local stakeholders.
- When adding data to the tool, should have the VHTs available to review and understand the data as they are actually delivering the iCCM service. Improve data quality assurance at community level.
- Conduct regularly scheduled meetings/check-ins; continue to improve coordination and collaboration.

- This process requires a dedicated consultant or team to complete.
- Full buy-in from the MOH leadership at the subnational level is necessary.
- Need investment in HMIS alongside services.

2. Use of Investment Case

a. Successes

- **Uganda**
  - For the first time, the country has a compendium on implementing an iCCM program (have been doing this before for GF). Now, it is a national document that can be easily referenced and adjusted depending on the context in which it would operate.
  - The community health strategy builds off of what was costed from the iCCM investment case.
  - The investment case provided the opportunity to incorporate integrated management of childhood illness (IMCI) into iCCM implementation.
- **Kenya**
  - The country is currently in the midst of costing the iCCM implementation framework (and monitoring and evaluation plan), and the investment case/CHPCT 2.0 was very instrumental.
  - The investment case helps to advocate for disaggregating the MOH health budget to show how much is needed for iCCM, demonstrating the value add and specific costs.
- **Malawi**
  - This activity coincided with the development of the National Child Health Strategy which was strategic.

b. Challenges

- There are many costing and planning tools as well as types of investment cases (e.g., RMNCAH-GFF investment cases). How do we bring these together to inform national health strategies? Do we know the universe of planning/costing tools and processes at the national level for child health? How are these harmonized for use at national/subnational level (e.g., in Malawi, where different tools were used for iCCM vs. child health costing)?
- One of the questions that countries face is whether to limit the costing/planning to iCCM or expand to include community health more broadly, noting that the CHPCT 2.0 is useful for broader community health planning.
- Importance of ensuring disaggregated inputs both programmatically and geographically

c. Lessons Learned

- Need start-up funds to get investment case development off the ground. It is important for people to know how much to expect from the government. This will help facilitate discussions on mobilizing domestic resources as well as aligning with donor models. Partners and districts need to plug in based on government resource allocation to be able to cover the entire district.
- Ensure that there is a national community health plan in place prior to investment case development. Plan iCCM within the broader community health system and develop a community health strategy that encompasses all community level interventions.

- Use the investment case to inform concept notes for funding opportunities such as through the Global Financing Facility and the Global Fund mechanisms. Integrate community health indicators into various models of funding including the Results-Based Financing for Health.
- To increase use, disaggregated costs and subnational analysis are helpful.
- Review and update the investment case every five years in line with the timing of developing other strategy documents.
- The tool and investment case needs to go beyond just costs to show some of the other economic benefits and how investment in iCCM and community can benefit the entire health system.
- **Uganda**
    - There was demand from the political and administrative leadership to scale up to more administrative units. Colleagues wanted to compare the costing figures to the national budget. Need to ensure the figures are within range, i.e., make sense in the broader context of the national budget. Subnational analysis and disaggregating the cost by district would be helpful (e.g., what it would take to implement iCCM at district level rather than at scale?).
    - The investment case has informed the ongoing development of the national community health strategy. Timing is key, especially where the investment case can feed into national budgeting processes.
- **Kenya**
    - The investment case can be a powerful advocacy tool at all levels including the lowest (i.e., subnational, county level and community-based organizations). However, alignment with the GF has not happened, and some iCCM components are still not funded. Pneumonia and diarrhea are weak links; additional efforts are needed to integrate the full package and find the funds to do this.
    - The gap analysis was timely and fed into the review of the implementation framework and monitoring and evaluation tools. It also informed the costing of the iCCM framework. As a next step, both the implementation framework and the investment case will be used to mobilize resources.

3. Stakeholder Engagement

a. Successes

- Uganda succeeded in involving government departments, including the budget controllers and the VHTs who shared lessons learned and challenges in real time.

b. Challenges

- Everyone had different questions to address, depending on their level and scope of work. The cost-benefit analysis was very important, i.e., is the money going where it is most needed? Some partners were concerned with training costs and other programmatic costs.
- As costs were very large (cost drivers included salaries, equipment, training and supervision), the question remains "are there ways of targeting these efforts to become more affordable?"
- iCCM is never a high priority at the resource allocation stage of national-level prioritization. Stakeholders require cost sharing for iCCM implementation and the percentage of contribution (by the government vs. donors) determines decision-making.

- **Uganda:** Some stakeholders needed convincing of the importance of investing at the community level. Needed to address the question, "if we put money into iCCM, how can we guarantee that money will be available at other levels of the health system?"

c. *Lessons Learned*

i. Ensure broad stakeholder engagement

- Be sure to engage decision makers at subnational levels in the process. The contributions of people directly involved in the implementation, including representatives of CHW, are key to assessing actual costs and bottlenecks.
- Decentralization is important to consider; there are stakeholders at subnational and national levels making important budget decisions. These people need to be consulted and buy-in at community, county and national level obtained.
- Ensure stakeholders understand the tool.
- Bring in additional partners, including in the data collection process, even if they were not part of the process before.
- Build the capacity of the parliamentary group and their knowledge of the investment case so that they can advocate on the floor.
- Leverage existing coordination platforms, e.g., national iCCM technical working groups, including to engage private sector and CSOs (Uganda has done this already). What is the role of civil society in advocating for the investment case? Need to bring in various actors to champion this.
- Need to involve people already implementing iCCM as well as those without an iCCM background in order understand how to gain their buy-in/interest. In Uganda, brought together malaria, community health, and other MOH departments, budget makers, and VHTs themselves.
- The partners that usually support the iCCM strategy should be engaged in using the tool and developing the investment case. Those that did not follow through did not have a vested interest in supporting iCCM.
- Community mobilization and monetary incentives: consider how incentives are structured in relation to the larger health system, particularly for performance-based financing programs.
- Fully engage donors for greater coordination and to avoid duplication.

ii. Need for advocacy

- Advocacy needed for the importance of investing at the community level.
- Need a plan for making the financing component of the investment case appeal to stakeholders at various levels. Timing of their engagement is important.
- Conduct advocacy meetings with key stakeholders involved in the budgeting process, especially members of parliament.

4. Recommendations: Looking Forward

a. *Technical Assistance*

- Provide technical assistance and capacity building to key stakeholders in the costing, planning and budgeting processes, including the use of the CHPCT 2.0 (and/or other tools).
- To roll out/disseminate the process to other countries, there is need for both technical and financial support. Previously, there was heavy reliance on TA from consultants.

b. Skills/capacity building

- Build the capacity of a diverse set of stakeholders at different levels of the health system.
- Establish a global pool of professionals experienced in the CHPCT 2.0 who could be available for short-term consultations. In additional, create regional and national pools of experts who can support and answer questions.
- User feedback is important; is there an opportunity to arrange this with the developers?
- Develop simple job aids to facilitate the use of the costing tool, including country adaptations of the terminologies used.
- Create a training video so that anyone using the tool could learn step-by-step (for visual/audio learners).

c. Resources – overall, need to strengthen the availability of data across public and private sectors

- Document the data collection process to help subsequent exercises avoid similar challenges.
- Need a critical mass of people to invest time upfront into agreeing on the data, making it easier to update in the future. It would take less time to update the baseline data than to return to the same argument (a lot of discussion leading up to this point).
- Community data does not get a lot of attention and is not utilized often in planning and decision-making processes. The investment case has helped highlight some of these gaps.
- Need financial and administrative partners (not just technical people), who understand the type of data required, to disaggregate iCCM-specific data.
- Build a critical mass of stakeholders who designate resources for iCCM in their program budgets.

d. Methodology for Measuring Progress

- Need to measure progress/successes particularly in resource mobilization that results in improved and scaled-up delivery of services with effective reduction in morbidity and mortality.

Next Steps

What is needed to move from costing to financing?

- Update the iCCM investment case routinely.
- Build capacity of the MOH to do the costing exercise without TA, and make it process part of their regular work flow.
- Promote the investment case as a key resource for funding requests (NFM4, etc.).
- Provide capacity strengthening for policymakers on the use of the investment case for advocacy.
- Map opportunities for financing and tailor content of the investment case to these financing opportunities.

- Build capacity to make use of the investment case data and results.

What is the best process of disseminating lessons learned in investment case development?

- Hold a webinar through the iCCM subgroup of the Child Health Task Force.
- Present at upcoming convenings, e.g., CHW Symposium (TBD, currently scheduled for September 2022), UNICEF ESARO health learning exchange meeting (September/early October 2022).
- Translate knowledge into a training or how-to guide.
- Provide more opportunities for country delegations to discuss where community health is most needed.
- Leverage existing coordination forums to share the learnings.

What input do you have for a possible series of learning meetings such as this?

- Developing investment cases for child health and iCCM: should this be done together, separately, or one before the other?
- How to monitor success of the investment case in mobilizing resources for iCCM?
- Expand to include other areas, such as nutrition.

Annexes

1. **Meeting Agenda**
2. **Meeting Participants**
3. **Meeting Concept Note**

Annex 1: Meeting Agenda

Cross-Country Roundtable on Experiences in iCCM Gap Analysis and Investment Cases

11 May 2022

Virtual Meeting, 8:00 EDT/12:00 GMT/14:00 CAT, CEST/15:00 EAT

Meeting Goal

To bring together global and country-level stakeholders from an initial targeted set of countries to learn from recent country experiences of using the various tools and approaches to mobilize resources for iCCM and community health. This first meeting is intended to be part of a broader learning series that will include targeted meetings with other countries who are beginning the gap analysis and investment case process, with stakeholders working on community health systems and the private sector, and with the donor community.

Meeting Objectives

1. Glean lessons learned from the process of conducting the iCCM gap analysis and developing the investment cases and results of this work in terms of translation to financing of iCCM and community health
2. Identify success, challenges and gaps with the use of use of the MSH/UNICEF Community Health Planning and Costing Tool and other tools/approaches employed in gap analysis and investment case development and resulting use of these products to mobilize resources
3. Identify key recommendations to inform possible future efforts and approaches to mobilize resources for iCCM
4. Determine next steps in supporting future efforts to mobilize resources for iCCM and community health
5. Receive input on concept for further meetings as a series on conducting CCM gap analysis and developing and using investment cases

Meeting Agenda

0:00 - 0:20	Meeting Opening Remarks and Introductions
0:20 - 1:20	Highlights: Country Experiences & Applications with iCCM Investment Case Development
1:20 - 1:30	Health Break
1:30 - 2:30	Small Group Work on Lessons Learned & Future Resource Mobilization Approaches
2:30 - 3:20	Plenary Discussion on Lessons Learned & Future Resource Mobilization Approaches
3:20 - 4:00	Next Steps

Annex 2: Meeting Participants

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Annex 3: Meeting Concept Note

Cross-Country Roundtable on Experiences with iCCM Gap Analyses and Investment Cases
Meeting Concept Note

Background

Integrated community case management (iCCM) is a strategy to increase access to timely and effective case management of malaria, pneumonia, and diarrhea in children living in hard-to-reach areas who otherwise have limited or no access to facility-based, life-saving treatments. It is a cost-effective strategy implemented by community health workers (CHWs) or community health volunteers (CHVs) who are selected from their respective communities, trained in diagnosis and treatment of childhood illnesses and in identifying children in need of immediate referral. The World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) recommend iCCM as a key public health strategy to increase coverage of high-quality, life-saving treatment services for children, especially in malaria-endemic countries.[1],[2]

Many countries, particularly in sub-Saharan Africa, widely adopted iCCM and documented its contribution to improved child health outcomes. However, evidence suggests that even with these positive child health outcomes, iCCM implementation has been suboptimal over the years. Programmatic experiences show that iCCM implementation is not easy, considering weak health systems and conflicting policies that affect the availability of trained and motivated CHWs/CHVs and drugs and supplies. Thus, funding for key activities during a given period facilitate implementation of iCCM activities. Furthermore, across different ministry of health (MOH) technical units, support for iCCM varies and depends on where the responsibility of a particular component of iCCM is assigned. In some contexts, the better-funded malaria control programs provide an opportunity for integration and yet, the lack of non-malaria commodities (mainly amoxicillin, ORS and zinc) poses a challenge to integration. Conversely, limited integration of the iCCM program into health systems inhibits the program's ability to achieve the intended goals and expected outcomes of the nationwide primary healthcare system. While the MOH may sometimes engage other ministries, the ministries of finance are not always involved in iCCM policy discussions in many African countries.[3] Furthermore, child health program managers are not well-versed in resource mobilization nor engagement with the national budgeting processes. These challenges contribute to limited financing for iCCM in the national healthcare planning and resource allocation systems, which negatively impacts availability of drugs and supplies. It also decreases incentives for the CHWs/CHVs and their supervisors to provide quality services and to engage the communities in demand generation activities.

Context for the Gap Analyses and Investment Cases

Increasing sustainable financing for health, particularly investments in primary health care (PHC), inclusive of the community health program, is a prerequisite for achieving the Sustainable Development Goal 3 targets and Universal Health Coverage. Yet, notable inadequacy of efforts to outline the status, gaps and investments for iCCM persists in low- and middle-income countries.

Over the past several years, extensive efforts have been made in multiple countries to utilize existing tools to analyze gaps and develop investment cases for iCCM. These efforts aimed to attract new and existing

sources of domestic and external development assistance for health as well as to prioritize, optimize and coordinate where and how resources are used.

USAID, through the Africa Bureau President's Malaria Initiative and Global Health Bureau, funded three iCCM funding gap analyses and investment cases in Kenya, Malawi, and Uganda. The gap analyses and investment cases were developed by consultants in collaboration with national government authorities, cooperating partners supporting children health programs (Multilateral, bilateral, local and international NGOs) and managed by Save the Children country offices. The experiences of the three countries have the potential to guide future development and use of funding gap analyses and investment cases for resource mobilization for child health and iCCM specifically.

Meeting Objective

The objective of this roundtable discussion is to bring together global and country-level colleagues who were involved in the development of the investment cases to glean lessons learned from the process in each country. Secondly, the roundtable discussion resolutions will inform future efforts and approaches to resource mobilization for iCCM using the CHPCT 2.0 and other related tools.

Guiding questions:

1. What is the context within which the gap analysis and investment case was developed in each country?
    1. Who developed the investment case and what was the composition, background, and preparation of the team for the exercise and stakeholder engagement (who and when)? What are the lessons learned or reflections on the capacity to develop investment cases?
2. What were the lessons learned from the process?
    1. Strengths and the weaknesses of the tool(s) used for gap analysis
    2. Stakeholder engagement
    3. Investment case development
    4. Length of time for the whole process
    5. Dissemination
3. What have been the results of these efforts? How have the gap analyses and investment cases been used?
4. Having gone through this process in multiple countries, please share perspectives on what is needed to facilitate resource mobilization for iCCM. New tools or processes? Improvements to existing tools or processes?

Reference documents

1. The MSH/UNICEF Community Health Planning and Costing Tool (CHPCT 2.0)
2. Scope of work for the consultants in each country
3. Situation analysis, gap analysis and investment case documents (note: depending on the approach, might have separate documents and some may not be complete for sharing).

[1] WHO / UNICEF JOINT STATEMENT Integrated Community Case Management: An equity-focused strategy to improve access to essential treatment services for children," United Nations Child. Fund, no. iCCM, p. 8, 2012, [Online]. Available: http://www.unicef.org/health/files/iCCM_Joint_Statement_2012.pdf.

[2] M. Young, C. Wolfheim, D. R. Marsh, and D. Hammamy, "World health organization/United Nations children's fund joint statement on integrated community case management: An equity-focused strategy to improve access to essential treatment services for children," Am. J. Trop. Med. Hyg., vol. 87, no. SUPPL.5, pp. 6–10, 2012, doi: 10.4269/ajtmh.2012.12-0221.

[3] S. Bennett et al., "Policy challenges facing integrated community case management in Sub-Saharan Africa.," Trop. Med. Int. Health, vol. 19, no. 7, pp. 872–882, 2014, doi: 10.1111/tmi.12319.