CCM TF Costing and Financing Subgroup- Teleconference: December 8, 2014 at 9:00 a.m.

Participants: Frida Kasteng (London School of Hygiene and Tropical Medicine), Dyness Kasungami (JSI/MCSP), Eduard Tschan (American Red Cross / Columbia Earth Institute – 1MCHWs), Uzaib Saya (MSH), Colin Gilmartin (MSH), David Collins (MSH), Ivy Mushamiri (1MCHWs).

Topic	Main points	Decision, next steps
Individual and organizational updates	• Dyness (MCSP): There is a need to assist global fund recipients with more robust planning and costing. The iCCM community should urge countries to develop and cost their iCCM plans (e.g. 5 years). This inventory can be useful to comprehensively cost iCCM program.	• Brainstorm – how can iCCM subgroup communicate and provide resources to global fund recipient countries to help with costing and planning?
Update on MCSP consultancy on iCCM/malaria integration (Dyness)	• Dyness (MCSP): Reportedly, the malaria community has expressed concern over malaria / iCCM integration under the GFATM new funding model. Therefore, the CCM Task Force commissioned a small piece of work to solicit feedback from the malaria community. Seven individuals were interviewed across multiple entities/ organizations (PMI, PSI, PCAP Africa, Malaria No more, Clinton Health Access Initiative, and national malaria control programs). The feedback received was very interesting. • Summary of findings: 1) *Evidence* – iCCM is an effective strategy however there are doubts of the strength of evidence around integration and benefits. There is a feeling that evidence is weak; 2) *Advantages* – integration makes sense and is good in many cases, improves efficiency, has positive multiplier effect, leverages resources. *Disadvantages* – adds complexity in weak health systems (sort of a paradox). 3) Malaria has strategic plans and defined M+E systems. Capacity is limited for integration; monitoring systems are often parallel. When you combine systems, disadvantages outweigh advantages. 4) *Barriers perceived* – adding additional demand on existing resources, particularly for malaria. Resources are already not sufficient and there is limited appreciation for targeting more than one illness for improving child survival. 5) *New GF model* – colleagues have not understood new funding model completely. The rules governing disbursement are not shared broadly. No assured funding for non-malaria commodities. Malaria program might get pulled down.	• The CCM Task Force and sub-group will need to think through how we might communicate and put together evidence or a learning agenda on the benefits of integration as well as a plan for collecting more information/evidence.

	Group discussion: • David Collins (MSH) – It's difficult hard to see what would be the additional cost for providing integrated services. Separate programs (e.g. malaria and iCCM) require separate supervisors, implementation, training, etc. Integrated supervision would save resources. It is important to dispel the myth that adding pneumonia/diarrhea increases the platform cost. Training would slightly increase with additional modules but there would be minimal or no increase in management and supervision. • Eduard Tschan (American Red Cross) – Consider the cost of integration and the fixed costs around management and supervision. Delivery costs could be integrated. Ending preventable mother and child deaths requires providing services to everyone (full access and equity) and therefore we need to effectively integrate packages. Where is the advocacy platform for making this point more effectively to reach these goals in the years to come? Can we really scale up normal delivery channels? How can we "arm" CHWs better in future? Are channels sufficient and how can we build capacity around them? How can we jointly advocate for analysis → delivery? Could we use the CHW Central website platform for advocacy? • David – key words "remote areas." How many supervisors can you send to remote areas? It is not efficient to send one supervisor to a remote area looking at only one malaria program as opposed to an integrated program. • Ivy Mushamiri (1MCHWs): 1MCHWs campaign can bring government, stakeholders, donors, and partners together. We could use these opportunities to issue strategy documents.	
Supporting country-level planning and costing for Global Fund recipients	There is a need to build capacity for country level planning and costing, particularly for 18 countries submitting Global Fund malaria/iCCM concept notes. • Dyness: A 1 page flier to communicate key messages. Opportunity – create folders with fliers that are easily accessible for policy documents and target 18 countries doing Global Fund applications. Now that you received funding, what help do you need with capacity building for planning and costing? This would also serve as an opportunity to strengthen collaboration between country-level malaria and child health programs. • David: What do Global Fund people think? Would this be valuable? Where	

	was the pressure initially to include iCCM in concept notes? • Dyness: UNICEF was active in advocating for integration. Additionally, groups lobbied USAID for integration. The general view is that the Global Fund has concerns about how well this approach will work and therefore keeps coming back to UNICEF and the Financing Task Team to ensure it will work. What support can be given to countries for operationalizing concept notes? • Uzaib Saya (MSH): Is there an example where countries have received non-malaria commodity funding? • Dynes: Uganda was the first country to be approved and is doing operational planning. Zambia is another country that is beginning discussions on operational planning. There are no cases for lessons learned. We are learning as we go.	
Review and reactions to iCCM tool comparison matrix Attachment:  iCCM Tool Comparisons_9 Decer	A comparison matrix (draft) of the iCCM costing tool has been circulated for review and feedback. • Eduard: How different are the MSH tools? • David: Community Health Services Costing Tool was developed in Liberia (hospitals, health centers, community); most of services were provided by NGOs and negotiating contracts with donors for funding and they wanted to know cost of services at all levels. The tool was used for the basis of the development of the 1MCHWs simplified tool. It can cover all community health services (10-20 services; mix of preventive and treatment services). iCCM is a small subset focused on three diseases/child survival and really on treatment services. MSH tools are both "bottom up" calculating normative cost of 1 service multiplied by the number of services. The advantages are that it can be used for scaling up / unit and shared costs. • David: The Futures Institute One Health Tool appears to be a linked package of vertical programs - the advantage is to use it at the national level using comparisons of different program interventions (malaria vs. HIV/AIDS vs. TB). There are differences with scale, methodology and issue of integration vs. vertical program. iCCM is a bit of a hybrid because it is a set of integrated services and some programs cover a limited number of other services including red eye, malnutrition, etc.).	• Provide edits/feedback on tools matrix to Colin Gilmartin (cgilmartin@msh.org)

	• Eduard: How can we use this matrix and tools to apply them as implementers? Let's look for opportunities arising (i.e. how can we integrate programs better?) We have to demonstrate that services are as cost-effective as can be. • David: MSH iCCM Costing and Financing Tool has financing and planning aspects for which people can use it to scale up / introduce and make decisions and options for supervision/management/locating CHWs in remote areas and modelling the cost per impact.	

Proposed agenda items for next meeting:

- Concrete ideas on how can iCCM subgroup communicate and provide resources to Global Fund recipient countries to help with costing and planning.
- Finalize iCCM tool matrix and decide on avenues for dissemination.