

CCM Task Force OR Subgroup Meeting

May 2nd from 10:00am – 11:00am EDT

Participants: Dyness Kasungami, Ashley Schmidt, David Hamer, Sarah Lackert, Naoko Kozuki, Rashed Shah, Karin Kallander, Amy Ginsburg

Agenda Item	Notes	Action Items
Background on Shifting Mandate of the CCM TF (Dyness)	<ul style="list-style-type: none">• The Steering Committee has agreed that we should broaden our mandate and are now engaged in the process of thinking through what the CH TF should look like. Following what was laid out in the <i>Mapping Global Leadership in Child Health Report</i> and IMCI Review, we are assuming there will be a higher level advisory group (a high level leadership Steering Committee) providing global overarching leadership in child health in the SDG era. Under the MDGs the primary agenda was survive and reducing under five preventable deaths. But now with the SDGs and the <i>Every Woman and Every Child</i> strategy we are embracing the broader agenda of the child including survive, thrive and transform. It is important to note we are not done with the survive agenda and these related milestones under the SDGs. There is recognition that the survive agenda is still important for many countries, but we cannot wait for all countries to achieve this so we need to discuss what is the new narrative for CH under the SDGs. How do we build on the gains of the MDGs era, and set clear priorities for the next milestones (thrive and transform)?• For OR there is a recognition that we need to invest in implementation research, more data and data analysis to better understand and to better operationalize programs including multisectoral linkages for areas that impact child health and well-being. This includes especially the private sector. Additionally, we need to look at community care, quality, health promotion and integration of services including preventative	

	<p>interventions like immunization and WASH activities.</p> <p>The proposed discussion questions for today’s conversation, as shared in the meeting announcement, are the following:</p> <ol style="list-style-type: none"> 1. How should we re-position ourselves within the technical coordination mandate while the higher leadership level continues to define the new vision and narrative for child health? (We are anticipating a higher level strategic group to lead CH and to come at a later time, but until we have this, we still need to think about technical coordination.) 2. What is the appropriate forum for engagement to continue providing technical direction and implementation support for your chosen priorities to countries? (noting that at country level is where the results and action will be achieved. 3. What are the needs and issues at country level to support effective implementation that should drive the structure of the global group? Because these needs/issues that are critical at country level to support implementation will need to drive our thinking. 	
<p>Group Discussion</p>	<p><i>Should we remain a sub-group in the new CH TF or become part of a larger theme within the broader mandate?</i></p> <ul style="list-style-type: none"> • We have to think about what difference we’ve made thus far and what value we have added in the context of iCCM and think about how we can build on this under the broader mandate. We should identify opportunities that exist for strengthening research including advocacy for operations research (OR) in health programs. We should also think about how we can support building skills for OR at country level. • Evidence for implementation science and 	<p>Summarized notes to be circulated for edits and additional thoughts/comments from the OR Sub Group.</p> <p>Sarah to finalize notes and share.</p> <p>Based on the final notes David/Karin as chairpersons of subgroup the will share a summary with the CCM TF steering</p>

	<p>research help to drive policy, programs and improve quality of implementation. There is a continued role for a research subgroup. We may need to re-consider the type of expertise that participants may need considering the above.</p> <p><i>Specific areas that we should focus on?</i></p> <ul style="list-style-type: none"> • Our group could contribute to maintaining the focus on the community. The recent conferences have shown that the world is moving towards incorporating more of prevention and other conditions (beyond iCCM) into community health service delivery and we should follow suit. • Stunting/under nutrition, neonatal health and childhood development are all important considerations when it comes to community health, but we also need to strengthen links in the community. Referral systems and continued feedback on this process will be important in next steps. • The research agenda is not yet complete. We could review other areas of cross cutting issues (ie: private sector, WASH, livelihoods) to see what's out there. We haven't explored this as much before (ie: the linkages with other sectors at community level that could be beneficial for child health.) • How about linking at higher levels of care? From community to first referral facilities? Particularly for referral and improving outcomes – how do we see the research agenda extending to that? How do we see our role in encouraging national governments to do the research and use the results? • Integration is twofold. It's horizontal at the community level and across other sectors and important to not lose child health as access to care and prevention of disease (ie: survive agenda) is still the main approach. There are also vertical linkages to facilities. We should also consider overall health systems issues. 	<p>committee (send to Dyness) on how OR fits in the CH TF</p> <p>Dyness will keep the subgroup updated on developments regarding the TF shifting mandate.</p>
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	<ul style="list-style-type: none"> • Constituting the research group in terms of iCCM was easier because iCCM was new and it was clear that we needed evidence in design and implementation of iCCM. The package of interventions has generally been standard or limited in most areas. • There are multisectorial approaches that we haven't yet tackled in the community and we are looking at how to integrate better. Survival will still be our main approach, but IRC for example, is currently doing a lot of self-reflection. In terms of humanitarian acute emergency settings and countries such as DRC and South Sudan, the survive agenda still makes the most sense and there is still more research to be done. I think the TF can bring attention to these environments (existing still), where the child mortality burden is high and the potential for research and programming still great. <p><i>Age Brackets?</i></p> <ul style="list-style-type: none"> • Are we considering age limits and new age cut-offs? Do we embrace the child from zero until 18 years of age? • This conversation is continuing and for now all we know is the focus has been on survival- which focuses on children under five. It will be essential for our TF to create boundaries in this regard, to avoid overreach in the future and to create focused priorities with limited resources. <p><i>What do we see our mandate with regards to supporting countries?</i></p> <ul style="list-style-type: none"> • What do we see our mandate to be in supporting countries? From a capacity building perspective, how have we done that and how can we continue doing that? One of the criticisms of the CCM TF is that we have limited impact on country programming because we function at a higher level. Can the <i>TF directly influence countries?</i> <u><i>Is this a realistic expectation? Or do we accept that through TF member organizations we are influencing country programs?</i></u> 	
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	<ul style="list-style-type: none"> • The country level engagement has been for a practice of this group. Research results are shared from the CCM TF with countries. We are directly influencing countries. • Through TF strategies we are working directly with partners in countries to strengthen their capacity to do research. This will be done more readily through individual organizations. • At the global level, it's clear that the TF has been useful to share learning from different projects across countries. • There seems to be an issue of the decreasing numbers of people attending these meetings. We need to be clearer on what we are trying to achieve through this group to increase participation. <p><i>What should our role be given that we are organized at a higher level more removed from countries, but still find a way to engage with programs at the country level?</i></p> <ul style="list-style-type: none"> • Perhaps we take a country where all of our organizations are working and see if there are better ways to organize ourselves at country level that would replicate the CCM TF at country level? Could we seek to replicate the CH TF research thematic group at country level? Is there value in doing that? How would we do it? • In some countries, we working with groups to develop focus research on child health that might be feasible and it's not easy to coordinate For example in Zambia Boston University has tried to pull people together through periodic research, a National Healthcare Conference and this has proved very difficult. • A research sub group of the child health task force within a country could work. But the idea of leadership and resources – limits the ability of a country level task force. • Participation in the CCM TF is voluntary and people come and go depending on how well their interests are being served. Moving forward, when 	
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	<p>we expand the mandate, should we have organizations taking responsibilities for a certain theme? An organization could serve as chair of that theme and be responsible and answerable to the TF for the agreed deliverables. Would organizations be willing to put forward some resources for this?</p> <ul style="list-style-type: none">• This would be hard without specific funding – for universities or companies – unless there is something faculty specific project under which the scope falls. There has to be compensation through service coverage or another grant such as David operates under currently.• Equally, Malaria Consortium doesn't have any funding to support activities like this. <p>Other Questions/Comments</p> <ul style="list-style-type: none">• CH TF should stick to child health and not extend to adolescent health – we should limit ourselves to 0 to 5 years. Perhaps we can consolidate the narrative? But, we will need to make sure we make our case for why we want to limit to 5 years.• What do other subgroups think and what is the guidance from the steering committee on the structure of the CH TF? The CCM TF is constituted by members and decisions are made by consultation –currently the broadening of the mandate and what this means for each subgroup is under discussion. The members' views will determine the objectives and the structure.• We have to be clear about the specific mandate for OR in order to judge our success.• Agreed upon that we will need to broaden beyond iCCM research. <p>Summary</p> <ul style="list-style-type: none">• The role of research and the subgroup remains important.• Where is our comparative advantage? Operational research to inform programs,	
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	<p>(and other types of research should be considered in this next phase).</p> <ul style="list-style-type: none">• We should focus on continuing to be a platform for sharing experiences including research results (given the successes of the past).• We can continue contributing to defining the research agenda as we did under iCCM. We can still advocate to countries as we have already done, as we have built a strong investment case for iCCM.• Developing capacity is best done by individual organizations rather than as a larger group. However, we need to find better ways of linking to the country level technical working groups where we have opportunities. Leadership and resources will constrain how much individuals can contribute to this agenda.	
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