Linking Integrated Community Case Management & Nutrition

NEW YORK, NY MEETING REPORT

11-12 DECEMBER 2014

GLOSSARY

CCM	Community Case Management
CHW	Community Health Worker
CMAM	Community-based Management of Acute Malnutrition
iCCM	integrated Community Case Management
IYCF	Infant and Young Child Feeding
MAM	Moderate Acute Malnutrition
MUAC	Mid Upper Arm Circumference
OTP	Outpatient Therapeutic Programme
RUSF/RUTF	Ready-to-Use Supplementary Food/Ready-to-Use Therapeutic Food
SAM	Severe Acute Malnutrition
SBCC	Social and Behaviour Change Communication
TBA	Traditional Birth Attendant

INTRODUCTION

On 11-12 December 2014, a meeting of a broad range of stakeholders with experience in nutrition and/or integrated community case management (iCCM) was convened to explore the linkages between these two domains of health programming. A list of participants is found in Annex A and the agenda is included in Annex B.

The objectives of the meeting were to:

- **develop a common understanding of the iCCM and nutrition landscape and identify key lessons and experiences to date;**
- **explore options for strengthening linkages between iCCM and nutrition activities, and identify and prioritize opportunities to support their implementation.**

This meeting built on two previous meetings. The iCCM Evidence Review Symposium held in Ghana in March 2014 revealed that nutrition was being implemented as part of iCCM, but left unanswered questions about the specific activities this represented, and the practical linkages between the two. A meeting in London in May 2014 of a small group of stakeholders with experience in implementing community-based nutrition programmes identified the need for a comprehensive review of the linkages between iCCM and nutrition, and for dialogue with a wider range of stakeholders.

The meeting in New York began with introductory remarks by David Milliband and Emmanuel d'Harcourt (International Rescue Committee), stressing the importance of and need for linking the two domains. Saul Guerrero (Action Against Hunger UK) then provided the background for the meeting and the proposed objectives.

Participants identified the following expectations for the meeting:

- to learn about what other partners are doing in iCCM and nutrition;
- to initiate/continue dialogue on iCCM and nutrition and to develop consensus on strengthening the relevant linkages;
- to identify what is and is not known about linking iCCM and nutrition, and to plan for next steps.

PRESENTATION OF REVIEW FINDINGS

Lynette Friedman and Cathy Wolfheim presented an overview of the review they had conducted of operational experiences and evidence for linkages/integration of iCCM and nutrition [*Linking nutrition and (integrated) community case management: a review of operational experiences* (see full report **here)**] The presentation began by situating iCCM within the broader framework of community-based infant and child health actions outlined in a three-part package, *Caring for newborns and children in the community, developed by WHO and UNICEF*. This UNICEF/WHO package includes:

Caring for the sick child in the community (iCCM)
http://www.who.int/maternal_child_adolescent/documents/imci_community_care/en/,
Caring for the newborn at home
http://www.who.int/maternal_child_adolescent/documents/caring_for_newborn/en/,
Caring for the child's healthy child growth and development
http://www.who.int/maternal_child_adolescent/documents/care_child_development/en/

iCCM is intended to prevent child deaths in settings where there is poor access to care in health facilities. It provides guidance, training materials, and job aids for Community Health Workers (CHWs) to identify, treat, and/or refer children with diarrhoea, pneumonia, and malaria. Screening and referral of severe acute malnutrition (SAM) is also included, and a red mid upper arm circumference (MUAC) reading is one of the key danger signs. Since iCCM is focused on sick children, the nutrition component in the UNICEF/WHO protocol is limited to: 1) advice on feeding during and after illness and 2) SAM identification and referral. The other two parts of the package, caring for the newborn at home and caring for the child's healthy growth and development, include counselling and promotion related to optimal infant and young child feeding practices.

The review grouped interventions and experiences that linked or integrated iCCM and nutrition into four categories, called Typologies, defined as follows:

Typology 1

Advising on "feeding the sick child" within existing services

Advice on feeding during illness is provided by the CHW to the caregiver of the sick child during the sick child consultation. The standard UNICEF/WHO materials recommend that the CHW advise (not counsel) the caregiver of any sick child treated at home to do the following: give more fluids and continue feeding, return to CHW or go to a health facility immediately if the child has danger signs, sleep under a bed net, and return for follow up in three days.

Typology 2

Linkages with Social and Behaviour Change activities on child nutrition

Many nutrition programmes focus on health education messages or social and behaviour change approaches to improving infant and young child feeding. The linkages between these approaches and iCCM fit into several categories:

- The CHW providing iCCM is part of a larger team that includes volunteers focusing on health education and prevention.
- The same programme that manages iCCM also operates social and behaviour change programmes focused on a larger population.
- Health education messages, including nutrition, are included in the curriculum and responsibilities for the iCCM CHW.

Typology 3

Linkages between iCCM activities and acute malnutrition treatment through assessment and referral

According to the standard UNICEF/WHO protocol, the CHW measures every sick child over six months of age with a MUAC strap and assesses for bilateral pitting oedema. Red MUAC and bilateral pitting oedema are danger signs, and the CHW refers the child to a health facility for immediate care. This process is consistent with Community-based Management of Acute Malnutrition (CMAM) recommendations. The treatment protocol for yellow MUAC is less well-defined. The CHW should refer the child to a feeding programme if one exists nearby; if this is not possible the recommended action is counselling on complementary feeding. In some countries or projects, CHWs use active screening or active case detection through home visits or at growth monitoring activities to assess every child, sick or well.

Typology 4

Treatment of uncomplicated SAM at community level

The iCCM CHW assesses, classifies, treats and follows up cases of uncomplicated severe acute malnutrition at community level or in the home. Complicated SAM cases are referred to an in-patient facility. Adaptations of CMAM protocols to extend acute malnutrition treatment to the community level fall into two categories:

- Assessment, classification, and treatment for acute malnutrition are added onto the existing responsibilities of the iCCM CHW.
- The iCCM CHW is linked to a second community-based cadre with responsibilities and skills for addressing acute malnutrition.

The review noted that the combination of iCCM and nutrition interventions may be linked or integrated. In the generic materials, iCCM is linked to nutrition through the identification of SAM and referral of the child to a feeding programme or rehabilitation centre. iCCM and nutrition are integrated in programmes where the CHW identifies and treats uncomplicated acute malnutrition.

Examples of country and programme experiences with iCCM and nutrition linkage or integration were highlighted in the review. There was a great deal of variability in the types of programmes and linkages, largely dependent on differences in contexts or settings. Available evidence on implementation, effectiveness, and cost of linked/integrated iCCM and nutrition was described and significant gaps were identified.

DISCUSSION OF REVIEW FINDINGS

The plenary discussion on the findings of the review brought up a number of key points:

- The Typologies should be understood as a description of what currently exists, but are not necessarily representative of iCCM and nutrition linkages that could or should exist.
- As iCCM and nutrition programming evolves, additional or revised Typologies may be needed.
- Typologies 1-3 from the review are aspects of nutrition that are already included in the UNICEF/WHO package *(Caring for newborns and children in the community)*, whereas Typology 4 is an addition, which requires more testing and evidence.
- To date, implementation of the UNICEF/WHO CHW package has focused mainly on iCCM. It is crucial to improve what is already being done and to understand the cost and impact of adding activities. There is also a need to emphasize the preventive nutrition aspects (e.g., in the other two parts of the package) as part of the range of what CHWs can do.
- Child survival has to be the overall goal of linked/integrated iCCM and nutrition. The Evidence Review symposium in Ghana found that the impact of iCCM alone on survival seems to be limited; reasons for this should be explored.
- A research agenda is needed to understand how best to operationalize the integration of iCCM and nutrition as well as the impact of integration. This may imply reviewing the iCCM algorithms to find ways to improve the inclusion of nutrition, and the CMAM algorithms to better address the needs of the sick child.

IDENTIFYING AND PRIORITIZING KNOWLEDGE GAPS AND OPERATIONAL OPPORTUNITIES

During two small-group sessions, participants identified, prioritized and then further refined knowledge gaps related to strengthening linkages/integration of iCCM and nutrition. Summaries of the output from these activities are included in **Annexes C, D and E**.

Research priorities focused largely on issues related to implementation of linked/integrated iCCM and nutrition. Participants expressed interest in identifying the best approaches, Typologies or platforms for health promotion and services in communities to achieve better child health outcomes. Specifically, they wanted to understand what is and is not working in current systems through which CHWs provide nutrition social and behaviour change communication (SBCC) or advise on feeding the sick child. They also had questions on how to operationalize the addition of a new component (i.e., SAM treatment) to iCCM and how additional activities affect existing components. Several questions were included related to CHWs' skills, the quality of care they provide, and their ability to take on more activities.

KEY OBJECTIVES FOR INTEGRATING iCCM & NUTRITION

The discussions around the Typologies and knowledge gaps delved into operational details, but also brought out some of the broader issues with implementation and how iCCM or iCCM/nutrition is part of a larger system for promoting child health and treating illnesses. To further explore these issues, five key objectives for integrating iCCM and nutrition were proposed and discussed:

1. Improving coverage and quality of services for the sick child, thereby exploiting the synergy between the health issues and ideally resulting in greater reductions in mortality.
2. Optimizing the preventive aspects of iCCM to maximize its contribution to child nutrition.
3. Improving implementation of the UNICEF/WHO package.
4. Strengthening linkages between community and facility.
5. Linking health and nutrition at the institutional level.

CHALLENGES TO IMPLEMENTING INTEGRATED iCCM AND NUTRITION ACTIVITIES

Discussion of the main challenges to implementing iCCM and nutrition activities resulted in a list of key bottlenecks. These include: poorly functioning supply chains for RUTF, vertical funding streams, lack of standardized nutrition indicators in health information systems and across organisations, inadequate coordination mechanisms for implementation and funding, lack of operational guidelines for implementing iCCM and CMAM, lack of an advocacy plan for the integration of iCCM and nutrition, weak health systems, and low utilization of health services.

THE WAY FORWARD

Participants agreed to identify and set up a governance mechanism for a group that will take forward the work discussed during this meeting. The most feasible option seems to be the creation of a Nutrition subgroup within the iCCM Task Force. Members of the steering committee of this task force agreed to bring this idea before the iCCM Task Force during its December 2014 meeting.

Goals for the Nutrition subgroup within the coming two years are as follows:

- **Getting nutrition-iCCM linkages on the global health and nutrition agenda**
  - Articulating a common agenda, including a business case
  - Developing a plan for strategic advocacy and communication
  - Aim for a special session on nutrition-iCCM in the 2016 iCCM evidence review
- **Supporting implementation and consolidation of information, knowledge, and evidence to inform normative standards/guidance**
  - Optimize nutrition advising in iCCM guidelines
  - Explore ways to expand nutrition in iCCM (potentially including SAM treatment)
  - Explore how to improve care of childhood illness within the CMAM guidelines
- **Develop a platform to move the linkages forward by engaging relevant stakeholders**

CONCLUSIONS

There was consensus that the operational linkages between iCCM and community-based nutrition interventions are feasible and necessary, and are likely to provide benefits to both areas. The review of experiences revealed the limited number and types of experiences, as well as the scarcity of available evidence. A number of research questions need to be explored in order to guide the way forward. There is evidence that CHWs can provide high-quality care for childhood illness and for SAM, as well as high-quality advising on nutrition behaviours. The conditions under which these actions can be carried out remain to be defined, as does the best mix of iCCM and nutrition-related actions and the supports needed to carry them out. It was recognized that although participants embodied a range of organizations, expertise and knowledge, the list of research questions will need to be examined, refined and vetted by a more representative group before being finalized.

ANNEX A

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ANNEX B

PROPOSED AGENDA

THURSDAY DECEMBER 11TH 2014

TIME	TOPIC	SESSION	PRESENTER/FACILITATOR
09:00-09:30		**Registration**	
09:30-09:45	**Welcome**	Plenary Presentation	David Milliband, CEO IRC
09:45-10:00	**Introduction:** Agenda, Who is in the room, Objectives of the Meeting	Plenary Presentation	Emmanuel d'Harcourt, IRC
10:00-10:15	**Background:** How We Got Here, Introduction to the Review	Plenary Presentation	Saul Guerrero, ACF UK
10:15-10:25	**The Basics:** What are the basic elements/processes associated with iCCM?	Plenary Presentation	Cathy Wolfheim & Lynette Friedman, consultants
10:25-11:15	**Presentation of the iCCM & Nutrition Review:** Operational Typologies, Policy Environment, Conclusions & Recommendations	Plenary Presentation	Cathy Wolfheim & Lynette Friedman
11:15-11:30		**Break**	
11:30-12:15	**Q&A**	Plenary Discussion	Valerie Flax, facilitator
12:15-13:00	**Mapping iCCM & Nutrition Typologies:** What "Typologies" for linking Nutrition and iCCM are there? What actions would need to be taken to help strengthen existing/potential linkages?	Plenary Discussion	Valerie Flax
13:00-13:45		**Lunch**	
13:45-14:45	**Identifying Remaining Knowledge Gaps**	Group Work	Valerie Flax
14:45-15:00	**Presentation of Remaining Knowledge Gaps**	Plenary Presentation	Valerie Flax
15:00-15:15		**Break**	
15:15-17:00	**Prioritising Knowledge Gaps and Operational Opportunities:** using different criteria, each working group prioritises knowledge gaps and specific operational opportunities	Group Work	Valerie Flax
17:00-17:15	**Wrap Up**	Plenary Presentation	Valerie Flax

FRIDAY DECEMBER 12TH 2014

TIME	TOPIC	SESSION	PRESENTER/FACILITATOR
09:00-09:30	**Recap from Day One**	Plenary Presentation	Valerie Flax
09:30-10:00	**Presentation of Knowledge Gaps and Operational Opportunities Ranking**	Plenary Presentation	Valerie Flax
09:30-11:00	**Mapping Ongoing Initiatives:** are existing initiatives planned that will address priority knowledge gaps?	Plenary Presentation	Valerie Flax
11:00-11:15		**Break**	
11:15-13:00	**Planning Future Initiatives:** how can we move forward operationally to address some of the knowledge gaps and to build on operational opportunities?		Valerie Flax
13:00-13:45		**Lunch**	
13:45-14:45	**Policy Analysis:** what are the main policy opportunities and challenges facing the further development of successful Typologies? What actions can and should be taken?	Group Work	Valerie Flax
14:45-15:00	**Presentation of Key Actions to influence policy environment**	Plenary Presentation	Diane Holland, UNICEF
15:00-15:15		**Break**	
15:15-16:15	**Future Coordination and Governance:** how will the Working Group connect with key platforms/stakeholders in taking this forward? What are the key objectives of the Working Group in moving forward?	Plenary Discussion	Saul Guerrero, ACF UK
16:15-16:30	**Wrap Up**	Plenary Presentation	Valerie Flax

ANNEX C
OUTPUT OF GROUP WORK ON IDENTIFICATION OF KNOWLEDGE GAPS

Typology 1
Advising on "feeding the sick child" within existing services

- Do CHWs follow the iCCM guidelines and give correct problem solving advice? Why don't CHWs give advice?
- Can the iCCM protocol be enhanced to improve nutritional outcomes?
- Are caregivers able to feed the sick child after having been advised to do so by the CHW?
- Does adding the message on feeding the sick child have an impact on nutritional status?

Discussion:

- If there is no linkage between iCCM and nutrition in a country, Typology 1 is the minimum.
- Typologies 1 and 3 are not mutually exclusive.
- If CHWs are not advising on feeding the sick child, we need to understand why.
- We need to understand whether advising or counseling is more effective in terms of changing feeding practices during illness.

Typology 2
Linkages with Social and Behaviour Change activities on child nutrition

- What has the largest impact – integrated iCCM and social and behaviour change communication (SBCC) or standalone SBCC?
- What skills do CHWs or other health cadres need to combine curative activities with SBCC?
- What are operational Typologies to combine curative and preventive tasks (e.g., single multi-tasking CHWs versus multiple CHWs versus a team approach)?
  - Could existing cadres (curative and preventive) be brought together into one team?
  - What are costs and effectiveness of each option?
- What are effective Typologies for professional development of iCCM workers (including sequencing)?

Discussion:

- We need to define what type of impact should be measured. Nutrition outcomes? Health outcomes?
- What is the range of practices covered in SBCC? In the review, SBCC is focused on infant and young child feeding, but it could include other nutrition topics.
- How much of a burden on CHWs is integration of nutrition interventions? Will adding those activities break the system?

Typology 3

Linkages between iCCM activities and acute malnutrition treatment through assessment and referral

- What is the added value of referral through iCCM? How many "completed referrals" come from iCCM versus usual referral mechanisms?
- What are strategies to improve referral mechanisms? If there is no good referral system, this Typology won't work.
- Are there different Typologies in which the addition of assessment and referral would be easier/more effective (e.g., in some iCCM programmes, CHWs do home visits for screening/referral, not just waiting for the sick child)?
- How do we improve and sustain quality/skills of CHWs to assess and refer?
- Typology of more case finding/home visits versus Typology of waiting for the sick child to come:
  - Does number of SAM cases increase because of that? Increased CMAM coverage. Barriers to access (e.g., social access to coming to that service). Might be a gradual evolution (e.g., might see increase in people coming on their own after the programme has taken root in the community).
- If assessment and referral are already part of the iCCM guidance, why doesn't it happen in every place where iCCM is being implemented?
- Is this Typology cost effective compared to systems/Typologies to assess and refer that are not through iCCM (e.g., non-iCCM CHWs do the assessment and referral)?
- Are the current iCCM guidelines sufficient (e.g., yellow MUAC isn't included)? If we feel that what we have is not enough, where can the iCCM guidelines be strengthened? What work load implications might additions have?

Discussion:

- What about identification and referral of MAM?

Typology 4

Treatment of uncomplicated SAM at community level

Evidence gap:

- Asking the same questions as the Bangladesh paper in terms of coverage of services, quality of care, cost effectiveness, treatment outcomes but in different contexts – including the intervention delivered by the health system, not only NGO supported.
- How can the outpatient therapeutic program (OTP) protocol be simplified for CHWs, including CHWs with low literacy (e.g., medication & RUTF dosages, etc.)?
- What is the impact on the CHW (including risk) on supply chain management of RUTF / RUSF? How does this impact on the CHW community relationship?
- What is the additional workload of the CHW and how does that impact on the quality of service delivery?
- Comparison of Typology 3 and 4 and what are the outcomes, given all of the underlying characteristics of the programme?

Operational Questions:

- What is the impact of the introduction of RUTF to the overall iCCM supply chain management?
- When adding on SAM, what impact does it have on the other iCCM interventions and quality of care, both the existing iCCM components and nutritional components
- What is the minimum capacity (education, literacy, training) of the health worker to treat SAM?
- Is it better to implement all 4 components simultaneously or to sequence them? Is this affected by the maturity of the iCCM intervention?
- What is the increased workload of the health worker when SAM is added and what impact does it have on service provision and motivation?
- How can the addition of SAM treatment be used as an opportunity to evaluate current quality of care and strengthen the platform?
- Should there be a component of active case finding in addition to the passive case finding?
- What is the minimum SAM caseload to ensure that the CHW can maintain quality of care?

General Questions common for iCCM with addition of SAM treatment:

- Variables to consider: different types of CHWs, active versus passive case finding, ratios of population to CHW and CHWs to supervisor, minimal level of supervision (frequency of contact, quality of exchange, supply chain), lessons learned from ICCM, linking to what already exists, country setting, education, SAM prevalence, population density, epidemiological picture affecting malnutrition

Discussion:

- Is there trust from the caregivers for treatment by CHWs?
- If SAM treatment occurs at the community level, how do we avoid turning iCCM into a vertical programme?
- We lack indicators to capture data in relation to all four Typologies in order to monitor trends in outcomes. What are appropriate indicators for each Typology?
- Many of the questions developed during this session are similar to those identified through the iCCM Task Force's CHNRI process. How can these research gaps be addressed? What resources are available to do so?

ANNEX D

OUTPUT OF GROUP WORK ON PRIORITIZATION OF KNOWLEDGE GAPS

Questions are ranked from those that received the most votes to those that received the least.

RESEARCH QUESTION	SCORE
Does integrating SAM treatment into iCCM improve the coverage of one or all services?	15
What is the additional workload of the CHW and how does that impact on the quality of service delivery?	14
What are the outcomes of treating vs. just referring SAM cases?	14
When adding on SAM, what impact does it have on the other iCCM interventions and quality of care of both the existing iCCM components and nutrition components (e.g., breastfeeding promotion)?	13
How can the OTP protocol be simplified for CHWs, including CHWs with low literacy?	12
What are operational Typologies to combine curative and preventive tasks (e.g., single multi-tasking CHWs versus multiple CHWs versus a team approach)?	9
What are strategies to improve referral mechanisms?	8
What is the impact of SAM (or MAM) treatment on the CHW motivation and service uptake?	7
Does adding the message on feeding the sick child have an impact on nutritional status?	6
How do we improve and sustain quality/skills of CHWs to assess and refer?	6
If assessment and referral are already part of the iCCM guidance, why is it not happening in every place where iCCM is being implemented?	6
Is this Typology cost effective compared to systems/Typologies to assess and refer that are not through iCCM (e.g., non-iCCM CHWs do the assessment and referral)?	6
What is the impact on the CHW (including risk) on supply chain management of RUTF/RUSF? How does this impact on the CHW/community relationship?	6
Is it better to implement all 4 components simultaneously or to sequence them? Is this affected by the maturity of the iCCM intervention?	6
Can the iCCM protocol under Typology 1 be enhanced to improve nutrition outcomes?	5
Should there be a component of active case finding in addition to passive case finding for SAM?	5
Do CHWs follow the iCCM guidelines and give correct, problem solving advice?	4.5
Does the follow up visit of a sick/recovering child provide a specific opportunity for SBCC?	4
What is the added value of the referral through iCCM? How many "completed referrals" come from iCCM versus other referral mechanisms?	4
Why is the current protocol not being applied in relation Typology 3?	4
Are the current iCCM guidelines sufficient (e.g. yellow MUAC isn't included)? If we feel what we have is not enough, where can the iCCM guidelines be strengthened? What work load implications might additions have?	4
What is the impact of the introduction of RUTF to the overall iCCM supply chain management?	4
What is the minimum capacity (education, literacy, training) of the health worker to treat SAM?	4
What are the costs and effectiveness for each option?	3
Why don't CHWs give advice?	2.5
What has the largest impact: integrated ICCM - SBCC or standalone SBCC?	2
Are there different Typologies in which the addition of assessment and referral would be easier/more effective (e.g. in some iCCM programmes CHWs do home visits for screening/referral, not just waiting for the sick child)?	2
Can standardized definitions/indicators of performance be developed to start evaluating performance of existing services/Typologies?	2
What skills do CHWs or other health cadres need to combine curative activities with SBCC?	1
Could existing cadres (curative and preventive) be brought together into one team?	1
What are effective Typologies for professional development of iCCM workers (including sequencing)?	1
How does gender impact on appropriateness and effectiveness of SBCC?	1
Typology of more case finding/home visits vs. Typology of waiting for sick child to come. Does number of SAM cases increase because of that?	1
Does Typology 3 differ in relation to referral for SAM only, MAM only or SAM/MAM?	1
What is the minimum SAM caseload to ensure that the CHW can maintain quality of care?	1
Do we know if the caregiver is able to feed the sick child, after having been told to do so by the CHW?	0
How can the addition of SAM treatment be used as an opportunity to evaluate current quality of care and strengthen the platform?	0

Write in candidates:
What is the perception/willingness to access nutrition treatment through CHWs by caretakers/decision makers/community? What factors influence the perception? Comparison between Typology #3 and #4 - cost- effectiveness, coverage (CMAM iCCM), impact
Could iCCM be an effective delivery platform for other nutrition-specific interventions, particularly vitamin A and deworming?

ANNEX E

OUTPUT OF GROUP WORK ON REFINING KNOWLEDGE GAPS IN RELATION TO KEY OBJECTIVES FOR THE INTEGRATION OF iCCM AND NUTRITION

Objective 1

Improving coverage and quality of services for the sick child

- Does the inclusion of SAM improve the coverage of SAM services and the rest of the iCCM services?
- Can you achieve optimal SAM services by linking referral?
- Is passive case finding sufficient to achieve coverage?
- Can the inclusion of SAM treatment be added safely by the same workers delivering the iCCM protocol?
- Does inclusion affect quality of care of SAM treatment and the three-part UNICEF/WHO package?

Objective 2

Optimizing the preventive aspects of iCCM implementation to maximize its contribution to child nutrition

- Is advising on continued feeding being done? Is follow-up on day 3 being done? Indicators on quality of care should be measured and incorporated into performance reviews.
- Is advising on feeding the sick child effective at changing behaviour? Is the timeframe of measurement of performance appropriate? What is the indicator of effectiveness? Do caregivers believe in the CHW's advice? Does confidence in the advice vary by age/gender of the CHW?
- Is advising on feeding the sick child enough? Are parents able to follow the advice? If not, what other options should be suggested? Referrals to integrate into algorithm? Should advising be expanded to IYCF counselling? Should micronutrients and deworming be included through iCCM or another package?
- What are the obstacles to effective advising? (For example, is there a need for a different job aid? Do people not believe in it? Is there capacity to do more than advising? Should someone else be doing it? Is it realistic to do it? Implementation link with other packages? Supervisory or training issues/ options? Minimum criteria for CHW?)
- Who else could provide advice on feeding the sick child? TBA, mothers, other?
- How can performance management be improved?
- Other: Links to other packages? Links to community level SBCC?

Objective 3

Improving implementation of the UNICEF/WHO package

- What lessons can we learn from other integration efforts (e.g., HIV/TB)?
- What are the issues related to the implementation of the existing package?
- How can the design of the existing package be improved?
- What operational platforms exist to deliver the three-part package? What are the differences between operational systems in different locations/countries?
- What is the impact of the 3-part package on the workload of CHWs? Would this compromise quality?
- Which aspects of nutrition are already being integrated into programmes in the field with the package (e.g., exclusive breastfeeding into newborn care, SAM into iCCM)?

Objective 4

Strengthening linkages between community and facility

Coverage

- Does the inclusion of SAM treatment improve (population-based) coverage of SAM services and/or other iCCM packages?
- Does the inclusion of SAM case-finding and referral into iCCM improve coverage of facility-based SAM treatment services?
- Is passive case-finding sufficient to deliver optimal coverage?
- What would be the main factors affecting uptake and utilisation of iCCM and SAM treatment?

Quality of Care

- Can CHWs deliver SAM treatment safely?
  - Can CHWs identify SAM with complications?
  - Is the referral of SAM cases with complications followed?
- Does the integration of SAM treatment into iCCM affect quality of care, for SAM and/or the other packages?
- How does the SAM caseload affect the quality of care, for SAM and/or the other packages?
- How do different ways of integrating SAM treatment into iCCM (after 3 packages, from the start, etc.) affect quality of care, for SAM and/or the other packages?

Objective 5

Linking health and nutrition at the institutional level

- What are the policy and strategy gaps in child health/nutrition that may present opportunities to include integration/linkages between iCCM & nutrition (some policies may be in drafting stages or facing obstacles for implementation depending on country)?
  Learning from country experiences –
- Ethiopia example: health sector transformation plan (HSTP) as overarching policy/strategy that links health and nutrition sectors at national level
- Nepal example: health sector implementation plan and joint financing arrangement for all donors; consolidated nutrition plan with all sectors
- What are the existing platforms for dialogue on child health/nutrition with national and state level institutions and stakeholders?
- Does a champion exist or how can you find a champion within the system to continue to move initiatives forward?
- How can we deliver/communicate effective and succinct messages on the benefits of integration and/or linkages between iCCM & nutrition to foster buy-in and political will (based on benefits to overall child health/survival and evidence)?
- How can we identify, engage and coordinate the major donors of drugs/supplies to advocate and work with the Ministry of Health for a unified and consolidated supply chain system?