CCM TASK FORCE - NUTRITION WORKING GROUP

1. BACKGROUND

Following the iCCM evidence-review symposium in Ghana in early 2014, organisations from across the nutrition and iCCM spectrum began to review the operational linkages and integration of iCCM and Nutrition, and to explore ways of strengthening those linkages. As part of that process, two inter-agency meetings were convened in London (May 2014) and New York (December 2014) and an independent review of field experiences commissioned and completed (see full report here). As a result of these processes, and as a means of providing a space from which to continue dialogue and collaboration, a Nutrition Working Group was established under the iCCM Task Force. These Terms of Reference (ToR) outline the main focus of the Working Group.

2. OBJECTIVES

2.1. Overall Objective:

To contribute to reducing U5 mortality and morbidity by optimising the role of nutrition within iCCM in policy and practice

2.2. Specific Objectives:

The Working Group will have three main objectives:

1. To consolidate, reinforce and promote the existing nutrition components of iCCM (e.g. nutrition counselling, screening and referral of acute malnutrition cases).
2. To explore options to strengthen the integration of nutrition into iCCM (e.g. acute malnutrition treatment, etc.)
3. To advocate for the development of nutrition within iCCM both in policy and practice including leveraging funding for this work

3. RESULTS

To meet these objectives, the Working Group will aim to achieve a series of results over the next few months. These will be further developed and included as part of an actionable workplan for 2015.

1. Improve representation of the nutrition agenda in future high level iCCM forums, including future evidence-review meetings.
2. Support the dissemination of experiences and lessons learned on iCCM and Nutrition.
3. Develop and/or strengthen technical guidance to optimise the implementation of nutrition components of iCCM interventions through documentation of best practice and development of tools.
4. Coordinate the development of an evidence base on the impact of linking and integrating iCCM and nutrition through operations and implementation research in consort with other CCM TF subgroups (see Annex 1).
5. Strengthen coordination between nutrition and iCCM programmes have common advocacy messages and to leverage funding and resources.

4. MEMBERSHIP

Membership to the Working Group is open to all organisations with a strategic interest and practical experience in the implementation of iCCM and/or nutrition services. This might include national health authorities (e.g. Ministries of Health), UN agencies, Non-Governmental Organisations (NGOs), donors, academics and other technical platforms.

Organisations that have already expressed an interest in a member of this Working Group include WHO, UNICEF, ACF, PSI, Save the Children, IRC and the Children Investment Fund Foundation (CIFF).

Each agency will be responsible for designating representatives to this Task Force subgroup and for covering their participation costs.

5. GOVERNANCE & STRUCTURE

The governance and structure of the Nutrition Working Group will need to be further developed once the membership has been confirmed. This will require consideration of the (co)chairing and the creation of sub-groups to deliver the different strands of the Working Group's agenda and linking with other relevant subgroups of the CCM TF.

5.1. (Co) Chairing

The Working Group will be co-chaired by two (2) members of the Working Group, elected by the whole membership. In order to ensure continuity, the terms of the Chair and the Co-Chair will be 18 and 12 months respectively. As the Working Group is established, all prospective organisations wishing to join will be asked to also confirm their interest in running for the Chair and/or Co-chair roles.

5.2. Subgroups

The co-chairs will be expected to provide oversight and leadership for the implementation of the Working Group workplan. The implementation of the individual components of the workplan might require the creation of individual sub-groups with corresponding sub-group leads. The focus of the sub-groups and the appointment of the sub-group leads will be coordinated as part of the development of the workplan.

6. MODUS OPERANDI

It is envisaged that the working group will convene regular meetings, through video/teleconferences and face to face meetings as decided by the leadership of the group.

The development of meeting agendas will be the responsibility of the Chair and Co-Chair with consultation from the Working Group's membership. The chair and co-chair will coordinate with the CCM TF secretariat.

The co-chairs will be responsible for documenting meeting summaries which will be circulated to the membership for review and comment before they are finalised and posted on CCMcentral.com on the groups' subgroup page.

The group will be represented at and report regularly to the CCM TF.

Annex 1. Preliminary Knowledge Gaps/Research Questions

Identified as part of the iCCM & Nutrition Review and Meeting (December, 2014)

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 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?
    - Does 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 for 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?