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Maternal and Child  
Survival Program



# Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child Workshop Report

October 30 to November 2, 2018  
Accra, Ghana

[www.mcsprogram.org](http://www.mcsprogram.org)

The Maternal and Child Survival Program (MCSP) is a global United States Agency for International Development (USAID) initiative to introduce and support high-impact health interventions in 25 priority countries to help prevent child and maternal deaths. MCSP supports programming in maternal, newborn, and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment. MCSP will tackle these issues through approaches that also focus on household and community mobilization, gender integration, and digital health, among others.

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# Abbreviations

ACF	Action Against Hunger US
BFCI	Baby-Friendly Community Initiative
BFHI	Baby-Friendly Hospital Initiative
CHW	community health worker
CMAM	community management of acute malnutrition
DFID	Department for International Development (UK)
DRC	Democratic Republic of the Congo
ECD	early childhood development
HEW	health extension worker
HRH	Human Resources for Health
iCCM	Integrated Community Case Management
IMCI	Integrated Management of Childhood Illness
KMC	kangaroo mother care
LBW	low birthweight
MCSP	Maternal and Child Survival Program
MOH	Ministry of Health
MUAC	Mid-upper arm circumference
PHC	primary health care
SAM	severe acute malnutrition
SBCC	social and behavior change communication
SDGs	Sustainable Development Goals
SGA	small for gestational age
TAG	technical advisory group
USAID	United States Agency for International Development
WHO	World Health Organization

# Executive Summary

Childhood illness and undernutrition often coexist and lead to a vicious downward spiral for children under five. Addressing child illness without addressing child undernutrition often leads to a higher risk of poor health, infections, failure to thrive, and higher mortality.

From October 30 to November 2, 2018, in Accra, Ghana, the United States Agency for International Development (USAID), in collaboration with the World Health Organization (WHO), UNICEF, and the USAID-funded Maternal and Child Survival Program (MCSP), organized the workshop, “Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child” (see Annex 1 for the workshop agenda). The workshop brought together 115 participants, including representatives from national and subnational ministries of health (MOHs), frontline care providers, and implementing partners, including seven country delegations from the Democratic Republic of the Congo (DRC), Ethiopia, Ghana, Kenya, Mali, Mozambique, and Nigeria (see Annex 2 for the list of participants).

## Workshop Goal and Objectives

The goal of the workshop was to identify key barriers and opportunities for strengthening nutrition services delivered to children under five years of age through routine management of illnesses at the household, community, and primary health care (PHC) facility levels. The specific objectives included:

1. Share successful practices in implementing current policies and guidelines and the associated drivers of those practices.
2. Review persistent barriers to the provision of adequate nutrition interventions during the management of illnesses in under-five children in PHC settings—including the community level—and identify reasons for their persistence.
3. Review nutrition practices for low-birthweight (LBW), small for gestational age (SGA), and/or premature newborns to optimize human milk and breastfeeding.
4. Prioritize the most critical barriers; develop key, country-specific action plans to address these barriers; prioritize actions to implement and adapt them to specific contexts in participating countries.
5. Prioritize actions to implement in the short, mid, and long term; develop short-term country action plans; and agree on the roles and contributions of key partners and other stakeholders after the workshop.
6. Identify and prioritize common themes or barriers that require policy change (including new or modified guidelines) or require further evidence at the global level.

## Consultative Effort to Prepare for the Workshop



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Twenty-nine representatives from WHO, UNICEF, USAID, United Kingdom Department for International Development (DFID), the Gates Foundation, MCSP, and Action Against Hunger US (ACF), formed a technical advisory group (TAG) that regularly met through biweekly calls. The TAG worked to finalize the overall concept note, guide the selection of countries, advise on delegation composition, design the structure and scope of the workshop, identify speakers and resource persons, and support country preparation efforts.

In addition, [a review of current global and country policies and guidelines](#) related to the nutrition of ill and undernourished children at the PHC level was undertaken. The findings served as a foundation for the discussions at the workshop.

## Workshop Structure

To achieve the objectives, the workshop was structured in four steps during four days. Country delegations met at the end of each day to review the information shared during that day and discuss the relevance to their specific context. The country delegates used their preparatory work to build their country action plans and progressively sharpen them by making the interventions more specific, defining the timeline, and sharing roles and responsibilities for implementation. The country action plans were shared on Day 4 (see Annex 3 for the country action plans).

**Day 1:** *Setting the Stage and Defining the Problem*

**Day 2:** *Sharing Successful Practices*

**Day 3:** *Adapting Solutions to Context*

**Day 4:** *Finalize and Share Country Action Plans*



Photo: Kwaku David Photography

## Key Workshop Outputs and Takeaways

1. **Successful practices and drivers for success** shared by country delegations and experts include experiences around creating an enabling environment, supporting service providers, expanding the role of community health workers (CHWs) in nutrition services, integrating early childhood development (ECD), generating demand, as well as using data and research to drive action.
2. **Barriers to implementation** include low service quality and coverage and a weak health system (insufficient workforce, inadequate physical environment, burdensome monitoring and evaluation, and lack of essential commodities and supplies). Added to that is a perceived distinction between “nutrition” and “health,” the lack of clear guidelines on the care and feeding of vulnerable, small, and/or sick newborns or infants, the weakness of community involvement, and the inadequate capacity and resources at the district level.
3. **Key opportunities** discussed include engaging the private sector, as it is an important source for the care of sick children. In addition, the Sustainable Development Goals (SDGs) revived the attention on universal health coverage and triggered tremendous interest in holistic programming in public health.
4. A desk review of guidance on **nutrition practices for LBW, SGA, and/or premature newborns** found that despite gaps in global guidance for managing LBW babies, country guidelines align with current global recommendations when they exist. In addition to the findings of the desk review, countries shared good practices and experiences from the field in meeting the health, nutrition, and developmental needs of small and preterm babies. These included kangaroo mother care (KMC), strengthening community support of breastfeeding, and state-of-the-art techniques for caring for vulnerable, small, and/or sick newborns.
5. **Key actions identified** during the workshop included strengthening existing systems instead of developing narrow-scope interventions and allocating sufficient resources to service delivery points. While **adapting these actions to specific contexts**, country delegations emphasized the integration of sociocultural aspects and other cross-cutting issues into the design of their programs and the importance of working in partnership with all stakeholders.
6. **For the country action plans**, the frontline providers who attended the workshop recommended the following actions to optimize nutrition services in key contexts: strengthen community engagement and ownership, increase resources and workforce, and standardize the package of services. Subnational representatives in charge of planning and implementation recommended focused efforts to improve health workers’ performance and stronger coordination across sectors involved with children and their caregivers. National decision-makers acknowledged the role of the private sector in delivering services and emphasized the need to reinforce public–private partnership and collect information on cost and cost-effectiveness to help mobilize resources.
7. **Priority needs in technical guidance** include prevention and management of moderate wasting, feeding of small and sick newborns, and assessment and treatment of malnutrition in newborns and young children (under six months). **Further evidence and more attention** are needed to address questions around cost-effectiveness of different interventions, simplified measurements and criteria to classify malnutrition, feasibility of integrating nutrition during the sick child encounter, and acceptability of programs involving a breast milk donor (from both recipient and donor’s perspectives) when the biological mother’s milk is not available.



Photo: Kwaku David Photography

## Workshop Recommendations

After four days of intense and lively discussions, workshop participants agreed that childhood illness and undernutrition often coexist and lead to a vicious downward spiral for children under five (including the newborn) and that the focus, during a sick child encounter, is often solely on the treatment of illness rather than the recovery of the whole child. The following are recommendations formulated during the workshop to address these challenges and bring lasting change in nutrition services for the ill and vulnerable newborn and child.

### Health care providers should:

- Optimize existing contacts along the lifecycle (child spacing, pregnancy, birth, newborn period, and childhood) to promote optimal nutrition and quality care for newborns and children.
- Address the concerns expressed by the caregiver by providing targeted nutrition counseling that relates to the immediate symptoms and later recovery.

### Community mobilizers should:

- Strengthen/establish linkages across different services to promote optimal nutrition for all children and promote demand for services in line with local beliefs and cultures.

### Policymakers should:

- Ensure that updated evidence-based policies and guidelines are in place, including clear standard operating procedures, to support optimal growth and development of vulnerable, small, and/or sick infants.
- Facilitate the delivery of integrated services, including nutrition counseling at all levels, maximizing existing opportunities and minimizing missed opportunities (clinic and community, curative, and preventive encounters).
- Strengthen multisectoral collaboration and joint planning.

### Newborn and child health program managers should:

- Promote a systems approach to deliver an integrated package of quality services at scale, strengthen community linkages (beyond CHWs) and invest in human resource development, create an enabling environment, encourage policy dialogue, and ensure accountability at all levels of the health system.
- Ensure that the needs of the sick, small, and vulnerable infant are well addressed in national strategic and implementation plans and that services targeting sick children are delivered efficiently, effectively, comprehensively, and in a timely manner to promote rapid and complete recovery and prevent relapse.
- Promote innovative ways for delivering integrated nutrition and care services, and where there is a gap, support and facilitate implementation research and learning by doing.

### Partners should:

- Support countries in refining and finalizing country action plans and provide technical support for their implementation.
- Advocate and promote integrated nutrition and newborn and child care services at all levels.
- Address guidance gaps identified in improving feeding of the small and vulnerable newborn and child.
- Promote and facilitate the cross-country exchange of experiences and best practices.

## Next Steps

After the workshop, the organizers and a group of key stakeholders reviewed the workshop recommendations, assessed the tasks at hand, and discussed the means to execute them. As a result, the following next steps were outlined.

- **Continue the momentum post-workshop** by leveraging the Child Health Task-Force’s website<sup>1</sup> to facilitate knowledge exchange and dissemination of emerging evidence and guidelines, by encouraging participants to join a Child Health Task Force subgroup, and by creating opportunities for continued and facilitated learning exchange. Country stakeholders particularly expressed this need for increased learning exchange and indicated that emerging knowledge and evidence disseminated at the global level often fail to reach them. MCSP and USAID’s Advancing Nutrition are planning a series of webinars.
- **Transform country plans into action** by supporting countries to align their respective action plans with national strategies and/or sectoral plans, ensure the timing and activities are realistic and integrate them into existing and/or anticipated resources and funding opportunities.
- **Establish continued country support** by ensuring that partners stay engaged beyond the lifetime of specific projects. As an example, USAID’s Advancing Nutrition and MCSP are developing a transition plan to carry forth the country action plans to help support longer-term visions.
- **Harmonize and strengthen the indicators related to nutrition for the ill and vulnerable newborn and child** by addressing the gaps identified during the workshop through the upcoming review of the Demographic and Health Survey questionnaires and tools.



Photo: Kwaku David Photography

<sup>1</sup> [www.childhealthtaskforce.org](http://www.childhealthtaskforce.org)

# Introduction

The “Improving Nutrition Services in the Care of the Ill and Vulnerable Newborn and Child” workshop was held in Accra, Ghana, from October 30 to November 2, 2018. It was organized by USAID, in collaboration with WHO, UNICEF, and the USAID-funded Maternal and Child Survival Program (MCSP). The workshop aimed to identify key barriers and opportunities for strengthening nutrition services delivered to children under five years of age through routine management of illnesses at the household, community, and primary health facility levels. See Annex 1 for the workshop agenda.

## Background and Rationale

Despite a significant reduction in child mortality achieved during the era of the Millennium Development Goals (MDGs), child health, newborn health, and nutrition communities have an unfinished agenda. Globally, evidence of successful interventions and guidance to strengthen the integration of nutrition programming and health services for children are broadly available and known, yet lack of integration and systematic, high-quality implementation persists, particularly at the regional and country level. Efforts to strengthen nutrition programming and implementation as part of routine interventions in broader public health strategies, programs, and policies—not just emergency response—remain inadequate. This lack of integration is partly due to continued fragmentation and suboptimal alignment and harmonization of global and national policies and guidance (guidelines, training, and counseling packages on nutrition practice for sick and/or undernourished children<sup>2</sup>), as well as siloed funding, donor priorities, weak programmatic collaboration, and the complexity of health systems. Some of this guidance is captured in global guidelines for Integrated Management of Childhood Illnesses (IMCI), Integrated Community Case Management (iCCM), the Baby-friendly Hospital Initiative (BFHI), Quality of Care Initiatives, Antenatal, Postnatal and Essential Newborn Care, and Infant and Young Child Feeding (IYCF). However, there is no unified, global technical guidance on the implementation of defined comprehensive packages of interventions aimed at preventing and mitigating the risks and effects of illnesses and malnutrition in children under five.

Some children are at higher risk<sup>3</sup> of becoming malnourished and need attention beyond the capabilities of routine care provided in the outpatient primary health care (PHC) setting. Indeed, the complex nature of their health needs and environment generally require intervention beyond the scope of this workshop. Although neonatal causes and postneonatal causes, including pneumonia, diarrhea, and malaria, remain the leading immediate global causes of child death, the vulnerability to and the severity of these illnesses are exacerbated by undernutrition, which is a contributing factor in 45% of under-five deaths.<sup>4</sup> These children are primarily treated in PHC settings and increasingly at the community level. In addition, recent evidence has shown that increasing breastfeeding worldwide would prevent more than 800,000 child deaths each year, particularly those associated with diarrhea and pneumonia.<sup>5</sup> Therefore, the promotion of breastfeeding deserves additional attention.

Despite this, many PHC providers or community health workers (CHWs) do not address undernutrition in children while diagnosing and treating illnesses, or provide nutritional counseling to parents/caretakers of children with illnesses, thereby increasing the risk of undernutrition and the risk of mortality or increased morbidity from complications associated with childhood illness.

In addition to the increased risk to the child suffering from illness, treatment in the community or facilities also misses an opportunity to include nutritional interventions and support for the family of the sick child.

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<sup>2</sup> For this workshop, the term sick and/or undernourished child(ren) includes small (LBW/SGA), preterm, and sick newborns, malnourished infants and children, and infants and children “at risk” for being undernourished.

<sup>3</sup> At-risk children include those of young mothers, first-time mothers, mothers whose own health or nutrition are compromised, as well as children living with or exposed to HIV and TB, those living in poor and hard-to-reach communities or households, those living in conflict zones, and/or low birthweight/SGA/preterm and sick newborns.

<sup>4</sup> Maternal and Child Nutrition Study Group: Black RE, Alderman H, et al. 2013. Maternal and child nutrition: building momentum for impact. *Lancet*. 382 (9890): 372–375.

<sup>5</sup> The Lancet Breastfeeding Series. 2016. Available at: <http://www.thelancet.com/series/breastfeeding>

While managing the illness of a child, a mother also may require additional information on maintaining her own nutritional status as well as that of other members of the family. Emphasizing the importance of adequate nutrition interventions as part of the continuum of care of vulnerable newborns, infants, and children is an important step toward reducing morbidity and mortality.

The workshop built upon the recent global efforts to support the agenda of the Sustainable Development Goals (SDGs), which drew attention to the importance of nutrition for child survival, health, and development. Recognizing the need for a new way of moving forward—and that siloed funding and implementation lead to poor accountability of stakeholders—technical advisors and donors at all levels have important coordination, advocacy, and technical advisory roles to play in promoting an integrated approach to newborn and child health. The workshop aimed to identify key actions and opportunities to strengthen the nutrition components of existing programs in selected countries.

## Objectives

The workshop objectives were to:

1. Share successful practices in implementing current policies and guidelines and the associated drivers of those practices.
2. Review persistent barriers—identified during the pre-workshop review—to the provision of adequate nutrition interventions during the management of illnesses in children under five in primary health care settings and at the community level, and identify reasons for their persistence.
3. Review nutrition practices for low-birthweight (LBW), small for gestational age (SGA), and/or premature newborns to optimize human milk and breastfeeding.
4. Prioritize the most critical barriers (identified under objective 2); develop key, country-specific action plans to address these barriers; and prioritize actions to implement and adapt them to specific contexts in participating countries.
5. Prioritize actions to implement in the short-, mid-, and long-term; develop short-term country action plans; and agree on the roles and contributions of key partners and other stakeholders following the workshop.
6. Identify and prioritize common themes or barriers that require policy change (including new or modified guidelines) or further evidence at the global level.

## Participants

Criteria for country participation included a government's interest to taking action based on workshop learning, partners' technical and financial commitment to support strengthening of nutrition services for sick children and to translate identified actions into practice, and the relevance of country programs (existing and/or anticipated) to the workshop's overall cross-learning process.

A total of 115 participants attended the workshop, including seven country delegations representing the Democratic Republic of the Congo (DRC), Ethiopia, Ghana, Kenya, Mali, Mozambique, and Nigeria. Country delegations comprised ministry of health (MOH) officials at national and subnational levels, as well as frontline care providers and implementing partner representatives. The workshop also included experts from India, Nepal, UNICEF and WHO country offices, donors, selected nongovernmental organization implementing partners, and experts in newborn, child health, and nutrition. See Annex 2 for a full list of participants.

# Preparatory Work

## Establishment of a Technical Advisory Group

To support the workshop planning, an Organizers Technical Advisory Group (TAG) was established with 29 representatives from the Maternal and Child Survival Program (MCSP), UNICEF, USAID, WHO, the UK Department for International Development (DFID), Action Against Hunger US (ACF), and the Bill & Melinda Gates Foundation. TAG members comprised key persons involved in the workshop germination stage and were initially potential co-hosts and co-funders. Through biweekly calls, under the leadership of MCSP, the TAG organizers accomplished the following:

- Finalized the overall concept note for the workshop, including its rationale, objectives, and expected outcomes.
- Determined country criteria for participation and a participant list for the workshop.
- Designed overall structure and scope of the workshop, topics, and themes, and development of the agenda, including sessions and break-out groups.
- Identified speakers, experts, and resource persons to support the agenda.
- Determined the need for country pre-work, and developed its objectives, scope, and methodologies.

The Organizers TAG first met in January 2018 and continued to meet until the beginning of the workshop in October 2018. An Advisors TAG was formed in February 2018 to include 22 additional stakeholders from organizations such as Save the Children, SPRING, Feed the Future, The SUN Movement, World Vision, the International Rescue Committee, Malaria Consortium, Helen Keller International, the Eleanor Crook Foundation, the London School of Hygiene and Tropical Medicine, and the University of Alberta. The Advisors TAG included recognized technical advisors, field implementers, thought leaders, educators, and advocates in child health, newborn health, and nutrition.

## Review of Policies and Guidelines

Based on TAG decisions, a [review of current global and country policies and guidelines](#) was undertaken. The review included a desk review and some key informant interviews. The review findings were used as a foundation for the workshop discussions.

The desk review<sup>6</sup> scanned existing documents related to the nutrition of ill and undernourished children at the PHC level. Documents were both at the global level and in six participating countries: Ethiopia, Ghana, Kenya, Mali, Mozambique, and Nigeria. The review included policy and strategy documents, technical guidelines on nutrition and management of specific illnesses/conditions, implementation guidelines, and other materials pertaining to the health system. Due to the delayed confirmation of DRC's participation in the workshop, the organizers requested DRC's delegation to include the document review as part of its country pre-work.

Interviews with 28 key informants—13 at the global level and 15 from individual countries—targeted stakeholders who have first-hand knowledge and experience with the nutrition of sick and undernourished children at the PHC level. Key informants represented implementation partners, donors, UN organizations, MOHs, nongovernmental organizations, bilateral agencies, and academia.

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<sup>6</sup> Friedman L, Wolfheim C. 2018. Review of Policies and Guidelines Related to the Nutrition of Ill and Undernourished Children at the Primary Health Care Level. MCSP.

## Country Preparatory Work

Before the workshop, participants were asked to review the status of child health and nutrition services in their countries. A standard template was shared to guide their preparation. One of the key tasks was to review country-specific barriers and to identify potential solutions.

At the workshop, country delegations gathered each day to sharpen their pre-work and convert it into realistic action plans. Building on the experiences, lessons learned, and best practices shared during the workshop, the delegations reviewed and prioritized barriers, identified opportunities, and developed specific actions to be taken in the short, medium, and long term. Facilitators from MCSP, USAID, and other topic experts served as resources for country delegations during these discussions.



Photo: Kwaku David Photography

# Workshop Structure

The workshop agenda (Annex 1) was developed following four themes: (1) setting the stage and defining the problem, (2) sharing successful practices, (3) adapting solutions to context, and (4) planning for action. The workshop comprised plenary presentations, panel discussions, group discussions, as well as country-specific group work. Side meetings and concurrent sessions with experts were also arranged. Each day, country delegations met for several hours in the afternoon to discuss criteria for developing their country action plan addressing barriers to implementation and opportunities for strengthening nutrition services. The country action plans were presented at the culmination of the workshop (see Annex 3). The workshop was facilitated by Dr. Samira Aboubaker.

Details on specific sessions are outlined below.

## Day I, Tuesday, October 30: Setting the Stage and Defining the Problem

### Session One: Workshop Opening and Framing

The session objectives were to provide general context on the current state of global nutrition and child health programming, including the status and contents of global policies and guidelines, flagship interventions, evidence, and future directions of research and implementation. The session covered the global perspectives of nutrition services in the care of the ill and vulnerable newborn and child, the state of global programmatic integration for child and newborn health and nutrition interventions, the evidence on continued feeding of the sick child, and the highlights of the pre-work desk review of global and country policies, guidelines, and barriers to implementation. The presentations and discussions under each topic are described below.



Photo: Kwaku David Photography

**Mr. Steven Hendrix**, Acting Mission Director, USAID Ghana, opened the workshop with a quote from Nelson Mandela, “Our children are the rock on which our future will be built, our greatest asset as a nation. They will be the leaders of our country, the creators of our national wealth, those who care for and protect our people.” He reminded participants that this reality was possible, but could not be realized if children continue to suffer from malnutrition and illness. Mr. Hendrix acknowledged the close partnership between the government of Ghana and the United States, particularly the roles of the First Ladies who demonstrated the commitment to reducing child mortality. He concluded his remarks with a quote from Kofi Annan, “We were all children once. And we all share the desire for the well-being of our children, which has always been and will continue to be the most universally cherished aspiration of humankind.”

**Dr. Emmanuel Odame**, Director of Policy, Planning, and Health, Ghana MOH, speaking on behalf of Ghana’s Minister of Health, welcomed participants and said that the meeting was taking place at the right time in the right place, as Ghana had just completed a three-day conference to deliberate on improving PHC. He said that although Ghana has focused thus far on solving issues related to undernutrition (i.e., wasting, stunting, and underweight), other forms of malnutrition, including overweight, obesity, and diet-related

noncommunicable diseases, are increasingly problematic. He encouraged participants to consider the double burden as they explore approaches to improve nutrition services in their countries. He emphasized that compassion, respect, and dignity must manifest in the provision of health care.

**Ms. Anne Peniston**, Deputy Director, Office of Maternal and Child Health and Nutrition, and Chief, Nutrition and Environmental Health Division, Global Health Bureau, USAID/Washington, highlighted the global burden of malnutrition. With 2 billion people lacking key micronutrients like iron and vitamin A, 155 million children stunted, 52 million wasted, 2 billion overweight or obese, 88% of countries are facing a serious burden of either two or three forms of malnutrition. She emphasized the gaps in linking nutrition services with other service packages such as integrated community case management (iCCM) and requested participants to review and identify ways to address the gaps.

**Dr. Michel Pacqué**, Child Health Team Lead, MCSP, presented the overall workshop goal: to identify key barriers and opportunities for strengthening nutrition services delivered to children under five years of age through routine management of illnesses in the household, community, and PHC facility. He described the six objectives and the process of the workshop to culminate in the presentation of country action plans.

**Dr. Anne Detjen**, Health Specialist, UNICEF, New York, and **Dr. Nigel Rollins**, Senior Technical Officer, WHO Department of Maternal, Newborn, Child and Adolescent Health and Development, Geneva, jointly presented on the current burden of malnutrition, disease, and mortality, the changing environment, and the increased role of the private sector. The presenters spoke on the opportunities for improving nutrition services for the ill and vulnerable newborn and child. These opportunities include the commitments of world leaders and countries to the SDGs, the World Health Assembly Global Nutrition Targets, the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), the Nurturing Care Framework for linking “survive and thrive” to promote health and human potential endorsed by the World Health Assembly, and the revived attention on universal health coverage. The presentations concluded by highlighting the importance of implementing comprehensive packages at community and PHC facilities, optimization of existing opportunities along the lifecycle, and adopting a health systems approach for delivering a package of services with quality and at scale.

**Dr. Nadeem Hasan**, Health and Nutrition Adviser, DFID, presented the global evidence on health systems in the integrated management of childhood illness (IMCI) and iCCM contexts. He used the 2016 WHO review of IMCI and the 2018 extended BMJ series to show that the implementation of global guidelines encounter five major barriers: (1) health workforce challenges, (2) weak community involvement, (3) inequalities in coverage, (4) highly fragmented monitoring and evaluation systems, and (5) district health management teams not adequately resourced. He concluded his presentation by reminding participants that health–nutrition integration is much more than just ensuring that specific nutrition interventions are included in specific health settings: it is about nutrition being treated as an inextricable part of health across the health system.



Photo: Kwaku David Photography

**Ms. Lynette Friedman** presented the highlights of the *Review of Global and Country Policies, Guidelines and Barriers to Implementation*. The review conducted by Ms. Friedman and Ms. Cathy Wolfheim, both independent consultants, was done as part of the workshop preparatory work. The review findings and conclusions were

fed into country work and used as a basis for further discussions at the workshop. A hard copy of the report was shared with workshop participants.

## Session Two: Barriers and Opportunities for Implementation

The session provided an overview of persistent challenges, bottlenecks, and gaps in integrating nutrition services in the care of sick and vulnerable newborns and children and presented opportunities for overcoming the barriers.

**Dr. Mamadou Traoré**, Director of Nutrition Program, MOH Mali, presented a country experience on a multisectoral community approach implemented in the *cercle*<sup>7</sup> of Yorosso that demonstrated the importance of multisectoral platforms and shared vision as a way forward for integrating nutrition services and newborn and child care. A second country experience was shared on the successful integration of curative nutrition services into the existing iCCM program.



Photo: Kwaku David Photography

**Dr. Abraham Tariku**, Child Health Team Lead, Federal MOH, Ethiopia, shared the early experiences in integrating key nutrition indicators into the national health management information system and Unified Nutrition Information System for Ethiopia.

### Panel Discussion

Panel Moderator: **Dr. Michel Pacqué**, MCSP

Panelists: **Dr. Anne Detjen**, UNICEF

**Dr. Smita Kumar**, USAID

**Ms. Grace Funnell**, Action Against Hunger US

**Ms. Lynette Friedman**, independent consultant

Panelists discussed common challenges to the integration of nutrition, child, and newborn health programs and why they persist. They also shared opportunities for overcoming the challenges. The panel moderator concluded the discussion by highlighting the importance of social and behavior change communication (SBCC) and the need to medicalize nutrition as a way to engage families in implementing nutrition interventions that are as important as the provision of antibiotics or antimalarials.

## Day 2, Wednesday, October 31: Sharing Successful Practices

### Session Three: State of the Art Practices by Target Population

The objectives of this session were to review the state-of-the-art guidance available to support countries to improve nutrition services in the care of the ill and vulnerable newborn and child and to share country experiences in implementing the guidance. A country presentation was followed by three concurrent technical sessions that covered support to mothers to optimize breastfeeding, nutrition interventions for ill and vulnerable newborns and infants, and nutrition interventions for ill and convalescent children.

<sup>7</sup> Cercle is an administrative subdivision of a region in Mali.

The concurrent sessions were conducted multiple times to give every country delegate the opportunity to participate in all sessions.

**Ms. Katia Mangujo**, MOH/Nutrition Department, Mozambique, shared experience in integrating nutrition services in the care of ill and vulnerable newborns and children through the Nutrition Rehabilitation Program. Key program highlights included collaboration with the pediatric association in training, mentorship, and development of action plans to improve inpatient management of severe acute malnutrition (SAM); support to communities in strengthening SBCC activities; and assistance to provincial health directorates in implementing child death audits.

**Dr. Nigel Rollins**, WHO, introduced the technical sessions by providing an overview of technical guidance and evidence base for nutrition interventions for ill and vulnerable newborns and children. He shared the WHO global recommendations for appropriate feeding of infants and young children and informed the participants about the forthcoming new guidelines on breastfeeding counseling. He specified that appropriate complementary feeding is: **timely**, meaning that foods are introduced when the need for energy and nutrients exceeds what can be provided through exclusive and frequent breastfeeding; **adequate**, meaning that foods provide sufficient energy, protein, and micronutrients to meet a growing child's nutritional needs; **safe**, meaning that foods are hygienically stored and prepared, and fed with clean hands using clean utensils and not bottles and teats; **properly fed**, meaning that foods are given consistent with a child's signals of appetite and satiety, and that meal frequency and feeding method, (i.e., actively encouraging the child to consume sufficient food using fingers, spoon, or self-feeding) are suitable for age. Finally, he mentioned the need to look at preconception and perinatal health and nutrition because of the clear evidence of their impact on subsequent newborn and child nutrition, health, and development.

### *Technical Session 1: Support to Mothers to Optimize Breastfeeding*

The session was led by **Ms. Patti Welch**, MCSP; **Dr. Veronica Kirogo**, MOH Kenya; and **Dr. Anne Detjen**, UNICEF. They addressed opportunities provided by the Baby-Friendly platforms at the facility and community level to offer ways to improve nutrition services and information on the updated 2018 Baby-Friendly Hospital Initiatives (BFHI) Implementation Guidance and how they compare to the original guidance. The experience shared from Kenya demonstrated the importance of an integrated and comprehensive approach to improving nutrition services and the importance of integration across the continuum of care.



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### *Technical Session 2: Nutrition Interventions for Ill and Vulnerable Newborns and Infants*

The session was led by **Dr. Sushma Nangia**, MOH India; **Dr. Abeba Bekele**, MCSP; and **Dr. Marco Kerac**, London School of Hygiene and Tropical Medicine. The session leaders shared three presentations to start the group discussions: 1) good practices on care for ill and vulnerable newborns and infants from India; 2) a desk review to assess available guidance for feeding the ill and vulnerable newborn and child conducted in seven countries (DRC, Ethiopia, Mozambique, Nepal, Nigeria, Rwanda, and Zambia); and 3) a tool called Community Management of At-Risk Mothers and Infants for health care providers to assess, classify, and manage at-risk mothers and infants under six months old.

### Technical Session 3: Nutrition Interventions for Ill and Recovering Children

The session was led by **Dr. Steve Hodgins**, University of Alberta, and **Dr. Rolf Klemm**, Helen Keller International. The session leaders emphasized that addressing child illness without addressing undernutrition leads to a higher risk of both conditions. Both stunted and wasted children have a higher risk of mortality, thus continued feeding and increased fluid intake during illness remain important recommendations for the management of sick newborns and children. Nutritional counseling is an area in which most health workers receive little formal training, resulting in insufficient quantity and poor quality of counseling during and after illnesses.

### Session Four: Areas for Improvement in Key Program Areas

**Mr. Eric Swedberg**, Senior Director, Child Health & Nutrition, Save the Children, moderated a panel to discuss common challenges to implementation and overcoming them through the strengthening of service delivery. The panelists included **Ms. Jasinta Hyachits Achen**, UNICEF Ethiopia; **Dr. Tewolde Daniel**, UNICEF Kenya; **Dr. Sascha Lamstein**, USAID Advancing Nutrition; and **Dr. Jimmy Anzolo**, MCSP DRC. The participants shared their experiences in using the capacity development framework to systematically assess nutrition-programming capacity in Kenya, the strategies to address low demand for iCCM services in the DRC, and the integration of community management of acute malnutrition (CMAM) into the health extension worker (HEW) strategy in Ethiopia. The panelists agreed on the importance of raising the status and quality of nutrition services within the government system.

## Day 3, Thursday, November 1: Adapting Solutions to Context

### Country Presentations

Delegations from Ghana, Nigeria, and Kenya first presented a wide range of experiences in adapting solutions to context and discussed broader aspects in program implementation. The DRC delegation presented on the Research to Practice Initiative. Both session 5 and 6 speakers discussed the learnings and takeaways from these country presentations.



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**Dr. Isabella Sagoe-Moses**, Deputy Director, Reproductive and Child Health, Ghana Health Service, presented Ghana's experience in integrating early childhood development (ECD) into the Community Health Planning and Services strategy and highlighted that physical stunting had a direct correlation with cognitive stunting. She explained that the Community Health Planning and Services strategy in Ghana brings together

the various stakeholders who are supporting the delivery of health services within their communities. She also shared the positive experience of the ECD program piloted in two regions, Eastern and Upper West Ghana, which resulted in improved knowledge and competencies of caregivers and health personnel in integrating ECD activities into routine child health services.

**Dr. Jocelyn Asibey**, Pediatric Department Head, Regional Hospital, Eastern Region, Ghana, shared Ghana's experiences from the introduction and implementation of KMC in hospitals, that started in 2016 and that has grown into 10 KMC Centers of Excellence established across seven regions. She highlighted the importance of postdischarge follow-up and support to mothers.

**Dr. Olusola Oresanya**, Technical Coordinator, Malaria Consortium, shared the Nigerian experience in equipping CHWs with simplified low-literacy tools to provide SAM treatment in Nigeria. The preliminary result of a feasibility study demonstrated performance that exceeded the international standards and both CHWs and caregivers were satisfied with the services provided.

**Nicholas Konyenya**, Subcountry Nutrition Coordinator, Kenya, shared the added value of the Baby-Friendly Community Initiative (BFCI) as a platform for integration of nutrition services for the ill and vulnerable newborn and child. He shared examples of interventions addressing cultural myths and misconceptions of child illness (the belief that someone observing your infant breastfeeding with “evil eye” causes illness), the establishment of breastfeeding corners, health education to mothers, as well as identification and referrals for affected children.

## DRC Presentation: Identifying Problems and Solutions through Research to Address Challenges in Integration of Nutrition and Child Health

**Prof. Ignace Balowa**, Institut Supérieur de Technique Médicale of Kinshasa, Head, National Nutrition Program, DRC, shared the role of implementation research in identifying and solving challenges to implementation. A qualitative study showed that in some communities, malnutrition is not considered a disease but a shameful condition, often associated with spiritual disturbances. He shared how the MOH and its partners identified key actions based on study findings. Some of the interventions identified as a way forward included regulation of traditional healers, health screening in schools, introduction of protocols on better feeding, counseling, and follow-up home visits.

## Session Five: Cross-Cutting Issues

Panelists discussed cross-cutting issues related to the nutrition services in the care of the ill and vulnerable newborn and child.

Panel Facilitator: **Dr. Alfonso Rosales**, Senior Advisor for Maternal, Newborn & Child Health, World Vision

Panelists: **Ms. Beatrice Eluaka**, SUN Movement, Nigeria

**Dr. Habtamu Fekadu**, Save the Children

**Dr. Veronica Kirogo**, MOH Kenya

**Dr. Tewolde Daniel**, UNICEF Kenya

The panel highlighted the importance of engaging civil society and community organizations; the need to consider the linkages between nutrition and resilience; the need to focus more attention on the poorest, most vulnerable, and food insecure people in the event of shocks; the importance of socio-



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cultural considerations in programming; and finally, the need to consider the gender impact on workloads in the feminization of agriculture.

## Session Six: Solutions and Actions

The objective of this session was to present and highlight experiences in program design and implementation, focusing on overcoming barriers through context-specific solutions.

Participants were assigned to four groups according to their roles and responsibilities to identify common actions by the level of the health system:

1. Frontline care providers addressed issues pertaining to service delivery point.
2. District and regional representatives discussed issues related to planning and implementation.
3. National and state-level actors addressed issues related to resource mobilization and policymaking.
4. Academics and global partners supported by country representatives discussed priority research topics and the need for updates in global guidance.

### *Group 1: Common action at service delivery point*

The group work on service provision was led by **Dr. Isabella Sagoe-Moses** from the Ghana Health Services and included participants represented by frontline health workers and partners supporting service delivery points. The service delivery point is where the “rubber meets the road,” and if nutrition support is to be effective it must be functional at the frontline worker level. Everything comes down to the implementation level. Therefore, support to the service delivery point needs to be prioritized. Major questions raised included ways nutrition services can be effectively integrated into peripheral service delivery points and community activities to improve nutrition services for ill and vulnerable children, and interventions to make it easier to provide services.

### *Group 2: Common action at district and regional level*

The group work on regional and district planning and implementation was led by **Sascha Lamstein** from USAID Advancing Nutrition. The focus was on sharing successful actions that facilitate implementation of integrated programming. The first group of priority actions identified included support to frontline workers to improve and maintain their performance. The second priority action group consisted of ways of engaging with partners and other sectors to leverage support.

### *Group 3: Common action at the national and state level*

The group work on national and state level resource mobilization and policymaking was led by **Beatrice Eluaka** from the SUN Movement Nigeria. To channel the discussion, she shared the Nigerian context (characterized by a high proportion of out-of-pocket health expenditure, little or no safety net for the largely poor informal sector, and high user fees in both public and private facilities). Topics discussed included health financing reform, public-private partnership, costing and cost-effectiveness analysis, alternative funding mechanisms, taxation for earmarked nutrition activities, and timely work-planning and budgeting to proactively align with the national planning cycle. Priority actions identified in all three groups fed into the country discussions and country action plans.

### *Group 4: Priority research topics and needs for an update in global guidance*

Representatives from countries including governments and partners joined the session led by **Dr. Steve Hodgins** from the University of Alberta. As an introduction to the session, Dr. Hodgins referred to existing technical guidance and evidence base for nutrition interventions for ill and vulnerable newborns and children, guidance that is under review and being updated; he also identified areas with gaps in evidence. He then asked participants for additional evidence gaps from their own work or country perspectives. From

the global level, the participants expressed the hope for better documentation of examples of national- and local-level adaptations of global guidelines. Priority areas for guidance were identified and some fed into the country action plans.

## **Day 4, Friday, November 2: Sharing Action Plans**

### **Session Seven: Country Action Plans**

The last day of the workshop began with an open marketplace where country action plans were displayed. Participants were invited to visit country posters while the delegations assigned representatives to present highlights of their action plans developed during the previous days.

**Dr. Samira Aboubaker**, MCSP Facilitator, then led the lively question–answer sessions after each country action plan presentation. After all the countries finished presenting, Dr. Aboubaker provided a workshop review of the objectives and outcomes as well as a summary of the discussions during the four-day process.

**Dr. Smita Kumar**, Senior Newborn Advisor, USAID, provided the closing remarks on behalf of USAID and thanked the organizers, delegates, and participants for their active participation and dedication.

**Dr. Patrick Aboagye**, Director, Family Health Division, Ghana Health Services, closed the workshop on behalf of the Government of Ghana.

# Key Takeaways and Outputs by Workshop Objective

The following section summarizes the takeaways and outputs from different workshop sessions, organized by its six main objectives.

## I. Successful Practices and Drivers for Success

### Creating an Enabling Environment

**Baby-Friendly Community Initiatives:** The experience from **Kenya** demonstrated the effectiveness of BFCI as an integrated and comprehensive approach to promote and protect breastfeeding at the community level with linkages to the health facility. A legal framework and appropriate policies were put in place to support breastfeeding in health facilities, communities, and workplaces (including the private sector) in MCSP-supported areas in Kisumu and Migori, Kenya.

**Engagement of stakeholders:** In **Mali**, the *cercle* of Yorosso, a multisectoral coordination mechanism chaired by the *Préfet*<sup>8</sup>, brought together stakeholders including administrative and political authorities, community and religious leaders, health care providers, and CHWs to address issues related to the delivery of preventive, promotional, and curative services in target villages.

### Supporting Service Providers

**Post-training mentorship:** The **Mozambique** delegation shared their experience in inpatient care for severe acute malnutrition (SAM). In partnership with the Association of Pediatricians, the MOH revised the SAM treatment protocol and, after training the providers in MCSP-supported areas, they focused on continued post-training mentorship to maintain motivation and commitment to change. To foster sustainability, they worked with health providers to develop and implement local solutions and action plans and initiated quality improvement cycles in health facilities.

### Expanding Community Health Workers' Role in Nutrition Services

#### Integration of community management of acute malnutrition into Integrated Community Case

**Management:** Many participating countries shared their experiences in integrating CMAM into an existing iCCM platform. **Ethiopia** increased the availability of CMAM services from 946 to 18,000 health posts between 2008 and 2018. The HEWs demonstrated high performance and contributed to the 58% reduction of stunting in under-fives.

**Integration of severe acute malnutrition into Integrated Community Case Management:** In **Mali**, the first experience of integrating SAM treatment into the iCCM sites reduced families' out-of-pocket payments by one-third, halved the time needed to access treatment, and doubled the treatment coverage (from 42% to 87%). This first phase was conducted with CHWs in seven health center catchment areas in one district. Scale-up in 115 health centers in three districts is being launched as a second phase.

**Training of community health workers on severe acute malnutrition:** **Nigeria** trained community resource persons on simplified protocol. The training included screening for danger signs, conducting an appetite test, and using mid-upper arm circumference (MUAC) with modified color-coding to screen for SAM. Preliminary results of a feasibility study conducted seven months later showed promising results in the overall cure rate. In addition, the community resource persons felt motivated by the children's recovery and by being respected in the community after having acquired the skill to treat children with SAM.

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<sup>8</sup> State's representative at the *cercle*.



captures other nutrition-sensitive indicators from nonhealth sectors. The early experience so far has been promising but will need to be well monitored and documented to facilitate learning.

**Introduction of child health death audits: Mozambique** introduced child death audits, including tracking child deaths due to malnutrition in the MCSP-supported Provincial Health Directorates. A team of 3–5 people led by the national MOH, with representation from the provincial team and partners, reviewed selected hospital records to identify causes of death and draw recommendations to prevent similar deaths. About 80% of the cases discussed were deaths from SAM, and strategies to prevent such deaths have been developed.

**Study on understanding perceptions of malnutrition by providers:** A qualitative study conducted in the MCSP-supported area of Tshopo province in **DRC** shed light on the perception of malnutrition by communities and health care providers. In some communities, malnutrition is considered a shameful condition, often associated with the evil eye or spiritual disturbances. Some of the interventions identified as a way forward include: involving traditional healers to provide advice on nutrition and refer sick children; introducing updated counseling cards for IYCF for healthy and sick infants and children, based on the results of the study; and establishing mother and community support groups.

## Enabling Government Funds to Support Universal Health Coverage

During a group discussion, **Nigerian** national decision-makers shared their experience with the mobilization of 1% from a Consolidated Revenue Fund<sup>9</sup> into the health sector to support the population’s access to basic care and services. The National Health Insurance Scheme would use 50% of this share, the National Primary Health Care Development Agency, 45%, and the Federal MOH, 5%, to strengthen the health system. The next steps will be to advocate for nutrition interventions to be given the attention they deserve in this distribution.

## 2. Persistent Barriers and Reasons for their Persistence

### Barriers and Challenges

The global and country policies and guidelines review, which included desk reviews and key informant interviews, showed that the most pervasive reasons for inadequate nutritional attention during the sick child encounter are **low-quality counseling and low coverage of appropriate interventions**, coupled with health **system constraints**. These constraints included insufficient human resources, inadequate physical environment where a provider has privacy, lack of the right equipment at the right time to carry out a quality conversation and assessment, inadequate indicators with a burdensome and duplicative monitoring and evaluation system for nutrition, and lack of essential commodities and supplies. The key informants found unhelpful the conceptual distinction between “nutrition” and “health” that plays out in funding streams, organizational structures, and implementation.

Specific technical issues reported in the review include the absence of clear, up-to-date guidelines on the care and feeding of vulnerable, small and/or sick newborns or infants in the context of PHC facilities, outpatient, postdischarge, and follow-up care, as well as the management of malnutrition in infants under two months.

Resources are inadequate for the promotion and integration of nutrition services in the care of the ill and vulnerable newborn and child. HIV, TB, and malaria have the Global Fund and other important funding sources to support program implementation, but nutrition and health for children do not benefit from the same level of attention.

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<sup>9</sup> The Consolidated Revenue Fund in Nigeria collects revenue from all national agencies, including the Nigerian National Petroleum Corporation, Nigeria Customs Service, Federal Inland Revenue Service, Nigerian Ports Authority, Nigerian Maritime Administration and Safety Agency, and Nigerian Liquefied Natural Gas.

## Causes of Persistent Barriers

The strategic review of IMCI published by WHO in 2016 and the [expanded 2018 strategic review of child health in the BMJ](#), coupled with other studies, highlighted the following five major factors that prevented the IMCI strategy to perform as expected after 20 years of implementation:

1. Health workforce challenges including inadequate training budgets, staff turnover, retention, motivation issues, weak mentorship and supervisory systems, and insufficient facility readiness.
2. Weak community involvement due to overemphasis of health workers' skills to the exclusion of strengthening health systems, lack of clarity on best approaches, lack of investment in CHWs, and isolated donor-funded initiatives.
3. Inequalities in coverage due to lack of intersectoral action, ongoing medicalized focus on child nutrition and case-management of illnesses, systems strengthening in already strong areas compounding inequities, and inadequate sustainable financing.
4. Fragmented monitoring and evaluation systems due to multiple vertical programs being funded and managed separately, lack of resources for integration, and low priority afforded to information systems.
5. District health management teams suffering from inadequate capacity, authority, and resources to carry out their duties, resulting in coordination challenges and poor program implementation.

Although barriers to improving nutrition services in the care of the ill and vulnerable child are context specific, **weak health systems** remain a major challenge for most countries. Weaknesses in **human resource management** for quantity, quality, remuneration, supervision, mentorship, distribution of tasks and responsibilities, and quality of care are significant barriers that are impeding progress.

## Opportunities

The private sector represents an important source for the care of sick children for both the poor and the wealthy. Two in five caregivers from the poorest households and three in five caregivers from the wealthiest households rely on the private sector for the care of their sick children. Therefore, leveraging resources and addressing the quality and efficiency of the private sector should be part of countries' priorities.

New orientations post-MDG have triggered tremendous interest in more holistic programming in public health and have created excellent opportunities for improving the delivery of nutrition services for the ill and vulnerable newborn and child. These include: the SDG commitments of world leaders and countries; the World Health Assembly Global Nutrition Targets; the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030); the Nurturing Care Framework for linking “survive and thrive” to promote health and human potential endorsed by the World Health Assembly; and the revived attention to universal health coverage.

## Way Forward

**Sustainability** is within the government system and should not be affected by donor withdrawal or end-of-project issues.

**Government ownership and leadership** are key ingredients for sustainability.

**Organizational and donor priorities with siloed funding streams** make integration a challenge. For many countries, these siloed funding streams remain one of the most challenging barriers for integrating nutrition, newborn, and child health services. Donors, country governments, and partners need to work together more closely on determining priorities at the country level.



Photo: Kwaku David Photography

## 3. Nutrition Practices for LBW, SGA, and/or Premature Newborns

### Key Global Technical Guidelines for LBW Babies Are Missing

Global guidelines on feeding and follow-up of small and sick young infants, particularly for LBW infants in low- and middle-income countries, are unclear. More guidance is needed in LBW management in outpatient settings, discharge criteria, and postdischarge follow-up. Nuanced guidance is needed regarding babies who are stunted at birth and those who are SGA, especially if also preterm.

Although LBW and preterm babies are rarely seen in outpatient consultations for sick children, the primary guidelines used are the WHO 2011 *Guidelines on Optimal Feeding of Low Birth-Weight Infants in Low- and Middle-Income Countries*, which will be updated in the next 12–18 months to provide a broader, more holistic set of recommendations about the care and feeding of small babies to support optimal growth and development. WHO, with support from USAID and MCSP, is also in the process of developing a quality standards approach for the care of small and sick newborns, which will include elements of nutrition and feeding for LBW infants.

A desk review conducted by MCSP assessed the guidance for feeding the ill and vulnerable newborn in IMCI materials. Despite the weaknesses of the global guidelines, the report concluded that in the seven countries reviewed—DRC, Ethiopia, Mozambique, Nepal, Nigeria, Rwanda, and Zambia—policies and guidelines are generally in line with the current global recommendations for newborn care when they are available. However, further adaptation may be required to tailor global guidelines to PHC settings in low- and middle-income countries. In addition, the practicality of implementing the guidance in a busy outpatient setting needs to be reviewed, especially when there are discussions on synchronizing or integrating these interventions.



Photo: Kwaku David Photography

Even in the absence of strong data on cost-effectiveness, the following essential actions can be taken while countries wait for the updated guidelines:

- Consider systems for the longer term, more holistic follow-up of vulnerable, small, and/or sick newborns.
- Strengthen postdischarge follow-up of vulnerable, small, and/or sick newborns and support to mothers and caregivers, including exploring community-based approaches, acknowledging that these approaches must be nuanced (e.g., programmatic responses are different for babies who are stunted at birth vs. acutely malnourished).
- Assess and intervene to improve mothers' mental and physical health as part of IYCF and IMCI approaches.
- Find ways to put knowledge and skills into the hands of parents and families to feed their children during and after illnesses.

## Using KMC to Meet the Needs of Small and Preterm Babies

**Ghana** shared its experience in KMC, which first started in 2016 in one region and is now established across seven regions with 10 KMC Centers of Excellence and 50 professionals trained from 2017 to 2018. A retrospective study revealed reduced postdischarge hospital deaths, admissions for postdischarge morbidities, and number of lost to follow-ups. KMC remains an effective way to meet the health, nutrition, and developmental needs of small and preterm babies. Lessons learned include the vital role of postdischarge follow-up at the facility and at home, as well as the importance of counseling spouses and family members to support the mother and enable her to take regular breaks and rest.

## Supporting Breastfeeding at the Community Level

**Kenya** shared its experience on BFCI that expands on the 10th step of the BFHI Ten Steps to Successful Breastfeeding, spearheaded by the MOH with support from MCSP and UNICEF. BFCI has become a prioritized, high-impact intervention for the country. It uses group communication techniques through community mother support group meetings, and individual communication through mother-to-mother support (peer support) during household visits, referral and linkages between community and facility, and baby-friendly community meetings/dialogues to improve IYCF practices, including breastfeeding, through community-level promotion and support. The initiative helped address cultural myths and misconceptions of child illness, helped implement screening of children for acute malnutrition through BFCI, and resulted in significant improvements in IYCF practices according to the data routinely collected.

## Managing Sick and Vulnerable Newborns

Good practices and different techniques for promoting and protecting exclusive breastfeeding, particularly for vulnerable, small, and/or sick newborns, as well as examples of pre-discharge criteria and post-discharge follow-up of these babies and their mothers, were shared through **India's** experiences. These include counseling mothers in maternity wards, the expression of breast milk in neonatal intensive care units, special care in small baby wards, and approaches to involve mothers in the hospital setting. Experiences from India's home-based care for the newborn by Accredited Social Health Activists were also highlighted.

**The London School of Hygiene and Tropical Medicine** developed a comprehensive tool in an attempt to harmonize various newborn, child, and nutrition guidelines. The Community Management of At-Risk Mothers and Infants tool is used to assess, classify, and manage at-risk mothers and infants under six months of age, including breastfeeding assessment and counseling as well as broader maternal and infant health and nutrition.

## 4. Action Plans and Their Adaptation to Contexts

### Developing a “Systems” Approach Instead of Disease-Specific Approach

Interventions are not implemented in a vacuum; they are implemented in the context of a broader health system. Integration has to be rooted in the health system, not just at the service delivery level; it is bigger than ensuring that specific nutrition interventions are included in specific health settings.

One of the challenges of integration is the funding (silos) in which donors and partners operate. Often, deliverables and indicators collected must adhere to project goals dictated by the funding streams instead of integrating into the existing health systems.

### Strengthening Service Delivery Points

Mentoring and supervision of health workers are essential to maintain and strengthen their use of knowledge and skills acquired during training. There is a need to develop and share innovative approaches to address the challenges in sustaining and scaling up effective supportive supervision. In addition, quality assurance with shared responsibility should be introduced and scaled up.

Task shifting should be part of programming; treatment and care should not be restricted to specialized personnel. For example, strengthening the role of CHWs can significantly reduce malnutrition and its impact on growth and development.

SBCC is an extremely important way to engage families in implementing actions that are as important as providing antibiotics or antimalarials. Optimum nutrition counseling includes guidance on the type, quantity, and quality of food, frequency of feeds, and duration of attention and care for infants and young children, as well as emphasizing continued and increased feeding, including breastfeeding, during and after child illness. The “Greet, Ask, Listen, Identify, Discuss, Recommend, Agree, Appointment” approach is an example of a good process to improve counseling.

### Using a Multisectoral Approach to Address Cross-Cutting Issues

Cross-cutting issues discussed at the workshop include the following.

- **The full engagement of civil society and community organizations:** This engagement is essential for improving nutritional services for the sick and vulnerable child. In this process, the health system should work collaboratively with host communities to improve community ownership of health and health programs.
- **Strengthening the resilience of communities:** Nutrition and resilience are intricately linked; good nutrition results in a more resilient person and household, and a resilient person or household results in

good nutrition. It is important to focus on the most vulnerable people and provide a safeguard to the poorest, most vulnerable, and food insecure people in the event of shocks. Intersectoral and intrasectoral collaboration is essential to address nutrition-related issues.

- **Addressing sociocultural barriers:** Sociocultural barriers greatly affect effective coverage. These include cultural misconceptions, poor community awareness, poor health-seeking behavior, maternal workload, poor feeding and caring practices, women’s low literacy and decision-making power, distance, cost of transport, and insecurity.
- **Gender considerations in programming:** With increased participation of women in the agricultural labor force, the imbalance between gender workloads should be considered. Alternative options for childcare might be needed along with the development of pro-women policies. More attention to building the capacity of women through workplace support for mothers in commercial agricultural enterprises is needed.

## Considering the Ongoing Paradigm Shift and Overall Environment

The environment within which programs are implemented is changing. The current major changes discussed at the workshop include:

- An increasing proportion of neonatal deaths;
- A greater contribution of noncommunicable diseases to morbidity;
- Accelerated urbanization;
- The increasing role of the private sector; and
- The unpredictable effects of disasters, emergencies, and fragile states on current and future generations.

Taking into account the overall environment and paradigm shift when setting priorities is important. For example, in response to rapid urbanization, Ethiopia has developed a cadre of urban HEWs along with the existing rural HEWs.

## 5. Country Action Plans

The following common actions were specifically identified by country delegation members, based on their respective roles and responsibilities within the health system (Session 6), then reported to each country team, prioritized, and incorporated into the action plans when relevant and feasible.



Photo: Kwaku David Photography

## Common Actions Prioritized by Frontline Providers

- Integrate nutrition into multiple platforms and optimize services in key contacts such as antenatal care, outpatient consultations, iCCM, immunization activities, health promotion, and community channels (mother-to-mother and father-to-father groups).
- Strengthen community sensitization and engagement, foster community ownership, participation, and engagement from nutrition champions and civil society to increase attendance to facility and community-based nutrition services, and make nutrition (and other health) services more accountable and responsive to community needs.
- Strengthen the interface with and feedback from the community through the development of local action plans with community involvement to serve as benchmarks against which progress can be jointly assessed and reviewed regularly.
- Advocate to policymakers for support and funding for implementing programs.
- Define a clear and standardized package of nutrition services, along with tools to facilitate integration and clarify expectations at each encounter with children at all levels of service delivery.
- Strengthen human resources and staff competency in nutrition, including pre- and in-service training for nutritionists and health facility staff; outreach strategies for communities; engaging volunteers, champions, and civil society in hard-to-reach areas; developing strategies to reach the urban poor; and mentorship opportunities.

## Common Actions Prioritized by Subnational Representatives in Charge of Planning and Implementation

The following actions relate to innovative, sustainable, and scalable ways to address the systems factors affecting health worker performance:

- Clarify performance expectations.
- Address competence as a combination of knowledge, skills, and attributes.
- Provide timely feedback on performance.
- Develop a system of incentives to increase motivation.
- Provide an adequate work environment, including information, tools, and supplies.

The following actions relate to engaging with other sectors to leverage support, such as:

- Support multisectoral nutrition teams at district level such as UNICEF's nutrition cluster model, district nutrition coordination committees, etc.
- Map and engage other sectors and workers that may have contact with children and their caregivers.

## Common Actions Prioritized by National Decision-Makers

- Develop a strong public-private partnership and identify alternative funding mechanisms, outside of the traditional ways. Innovative ways of financing nutrition interventions were discussed, including the creation of trust or endowment funds, philanthropic interventions, corporate social responsibilities, taxes, public-private partnerships, and market-based financial transactions.
- Mobilize government funds, strengthen, or develop health insurance schemes to promote equitable access to health and nutrition services in the context of universal health coverage. Out-of-pocket payments were not considered an alternate domestic funding method because most people are unable to pay the high cost of accessing care.
- Gather information and develop evidence on costing and cost effectiveness to help mobilize resources for implementation.
- Develop specific plans with budgets early, in time to ensure it feeds into the national planning cycle. Once the budget distribution is decided, it becomes very difficult to get additional funding.



Photo: Kwaku David Photography

## 6. Needs for Change in Policies or Guidelines, or for Further Evidence

### The Gap in Technical Guidance

WHO recognizes that the following guidance is lacking:

- The prevention and management of moderate wasting (e.g., yellow mid-upper arm circumference). In particular, on questions related to which children with moderate wasting are at greatest risk of mortality and morbidity, long-term consequences of moderate malnutrition (in addition to early morbidity), what and when are clinical interventions indicated, which children and families should receive broad nutritional support, and which children should specifically receive supplementary foods, and if so, how much and for how long. Additional guidance is needed on what should be done if a child does not respond to treatment or if they relapse. What about cost-effectiveness? What is the relationship between risk factors for wasting and stunting and appropriate management of each? Guidance across the continuum of care, treatment from SAM to moderate acute malnutrition, and optimal nutrition.
- Guidance for low- and middle-income countries on feeding and follow-up of small and sick young infants including LBW infants. Technical guidance should specifically address outpatient settings, discharge criteria, and post-discharge follow-up and management. Guidance should also orient small and sick young infants to the primary levels of the health care system.
- More nuanced guidance regarding babies who are stunted at birth and those who are SGA, especially if also preterm.
- Assessing and treating growth failure in children under six months of age—sometimes referred to as management of acute malnutrition in infants, including identifying infants at greatest risk of serious morbidity and mortality (catching at-risk children early).

## Other Technical Issues Needing More Attention

The three areas above identified for additional guidance are priorities for technical attention and generation of evidence to inform guidance. Other technical issues needing attention include the following:

- Simplifying anthropometric measurements and criteria assessing feeding problems, and providing advice tailored to feeding problems related to increased feeding of foods and fluids during and after illness.
- Evidence on innovative and simpler methods to diagnosing malnutrition.
- Adequately integrating nutrition adequately in the sick child encounter, including the management of acute malnutrition in PHC settings, as well as the feasibility of an effective assessment and counseling at the first contact plus longer term follow-up after discharge.
- Realizing capacity of an overburdened health worker to integrate multiple interventions: what providers can do and cannot do, what are the required skills, and how can they be supported to build and maintain these skills, including the quality of nutrition counseling.
- Increasing acceptability of breast milk banking and giving donor milk to preterm babies as a strategy for the feeding of preterm babies when the biological mother's milk may not be available for any reason.
- Researching to learn how to scale-up and sustain interventions known to improve nutrition support and IYCF behaviors and practices in Africa.
- Although some of the interventions covered during the workshop have cost-effectiveness data, most need further evidence and analysis to help identify and delivery strategies that have the potential to yield the greatest impact and prioritize resource allocation.

## Issues Related to Generating and Processing Evidence to Inform the Development of Program Guidance

In addition to identifying the technical topics summarized above, the participants also discussed the following broader issues related to the process:

- **Defining evidence by using a grade-type approach.** Randomized controlled trials provide “hard evidence,” and are therefore linked with “strong recommendation” verses gray evidence which could potentially be used to generate “practical guidance.”
- **Improving knowledge management** by facilitating access to the most useful and relevant evidence for country-based program actors and building it from the user perspective, using and extending existing platforms [childhealthtaskforce.org, nowastedlives.org, ghspjournal.org, maternal health task force (mhtf.org), healthynewbornnetwork.org, other working groups and communities of practice].
- **Use of Child Health and Nutrition Research Initiative-type processes** can be helpful to engage a broad range of stakeholders in prioritizing areas for further investigation. In addition, there is a need for convergence with agenda prioritized by other groups, including by the Council for Research and Technical Advice on Acute Malnutrition.<sup>10</sup>

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<sup>10</sup> Research areas with high potential impact on the effective management of acute malnutrition at scale but where further research and evidence generation is critically needed. Available online at <https://www.nowastedlives.org/researchagenda/>

## Recommendations

Workshop participants agreed that childhood illness and undernutrition often coexist and lead to a vicious downward spiral. Addressing child illness without addressing child undernutrition often leads to higher risk of poor health, infections, and failure to thrive, including higher mortality in children under five. The focus made during a sick child encounter is often on the treatment of illness rather than the recovery of the whole child. Currently, there is often little or no nutrition counseling that occurs.

The workshop participants made the following recommendations to address these challenges and bring lasting change to improve nutrition services in the care of the ill and vulnerable newborn and child.



Photo: Kwaku David Photography

### Recommendations for Providers of Care

To address the immediate concerns expressed by the caregiver during the sick child encounter, health care providers should first discuss key nutrition messages that clearly connect to the immediate symptoms. Once the caregiver feels more receptive to additional messages, the health care providers should discuss important messages linked to recovery from current illnesses and for the child's long-term nutritional needs.

To promote optimal nutrition and quality care, health care providers should use all contacts with the child and the caregiver, including family planning, contacts during pregnancy, day of birth, newborn visits, and well child encounters to provide specific nutritional messages and interventions. Every opportunity should be optimized to promote a lifecycle approach to nutrition.

### Recommendations for Community Mobilizers

To strengthen and establish linkages across different services, community mobilizers should further strengthen their collaboration with opinion leaders, local organizations, and support groups. By doing so, the health and nutrition services and information they provide will be more efficient and impactful.

To ensure culturally sensitive messaging, community mobilizers should take advantage of their understanding of local beliefs and cultures when promoting demand creation and behavior change.

### Recommendations for Policymakers

To ensure that the needs of the sick, small, and vulnerable infant are well addressed, and to support their optimal growth and development, policymakers should ensure that these needs are included in national strategic plans and that updated evidence-based policies and guidelines are in place with clear standard operational procedures.

To create an enabling environment, policy dialogue, and accountability at all levels of the health system, policymakers should ensure that nutrition is treated as an inextricable part of health across the health system.

### Recommendations for Nutrition, Newborn, and Child Health Technical Experts and Program Managers

To promote a systems approach, program managers should develop an integrated package of services including nutrition counseling at all levels, maximizing existing opportunities, and minimizing missed

opportunities (clinic and community, curative, and preventive encounters), as well as address issues related to strengthening community linkages (beyond CHWs) and human resource development.

To ensure that services effectively promote rapid and complete recovery in sick children and prevent relapse, program managers should develop costed and realistic implementation plans and ensure that they are delivered efficiently, effectively, comprehensively, and in a timely manner.

To facilitate the delivery of integrated services with quality and at scale, program managers should constantly explore innovative ways for implementing programs and facilitate implementation research and learning by doing.

## Recommendations for Partners

To ensure that country action plans are translated into actions, partners should support refining and finalizing them and provide technical support for their implementation. Partners should also promote and facilitate cross-country exchange of experiences and best practices.

In country programs they support, partners should also advocate and promote integrated nutrition, newborn, and child health services at all levels, and include these approaches into the design of these programs.

To address guidance gaps identified in improving feeding of the small and vulnerable newborn and child, partners should provide technical inputs to support WHO's efforts.

## Conclusion

In conclusion, the workshop provided an excellent opportunity to review progress in improving nutrition services in the care of the ill and vulnerable newborn and child. The workshop was held at an opportune time when the world is united behind accelerating progress toward the SDGs, renewed commitment to improve access to health care through universal health coverage, and efforts to revitalize critical child health services.

Participants represented by academia, government, development partners, international organizations, nongovernmental organizations, and civil society were given an opportunity to review the status of nutrition services and care of children, review evidence, available guidance, experiences, and lessons learned. Participants debated the barriers to implementation, prioritized them, and identified actions for addressing the major bottlenecks.

The platform provided the opportunity for South-to-South learning and built a network for future joint learning. Improving nutrition services for all sick and vulnerable newborns and children requires a multi-sectoral approach; leadership and commitment at global, country, and community levels; and innovations to address gaps in knowledge and barriers to implementation.

## Next Steps

As a follow-up to the actions identified during the workshop, the organizers and a group of key stakeholders reviewed the recommendations, continued discussions with country delegations, and assessed the tasks on hand and the means to execute them. As a result, the following next steps were outlined.

## Maintain the Momentum Post-Workshop

The online platform of the Child Health Task Force’s website<sup>11</sup> will be leveraged for hosting and sharing global- and country-level resources and for facilitating knowledge exchange relevant to the workshop themes. Collaboration with other existing knowledge management platforms, as well as global and regional coordination and technical working groups, will also be explored.

Workshop participants are encouraged to join a Child Health Task Force subgroup, particularly the Expansion of the Child Health Package Subgroup and the Nutrition and Child Health Subgroup to continue the dialogue, stay abreast with the latest updates related to child health programming, and participate in ongoing learning exchange.

Opportunities for continued, facilitated learning exchange and cross-fertilization of knowledge beyond the workshop will be created, including webinars, email listserv discussions similar to that of the Child Health Information For All, and exchanges between countries that involve field visits to observe activity implementation. As a first step in responding to this feedback, MCSP and USAID’s Advancing Nutrition are planning to cohost a series of webinars to highlight the gaps and opportunities for strengthening nutrition interventions.

## Transform Country Plans into Action

MOH-led country delegations will continue to consult with their other ministry counterparts and with in-country partners to sharpen and validate their respective plans and seek buy-in, leadership, and resource commitment. The action plans developed during the workshop include key activities to address priority barriers and bottlenecks in implementing quality nutrition interventions in the care of the ill and vulnerable newborn and child. Next steps are to:

- Ensure that the timeline is specific, realistic, and aligned with national strategies and/or sectoral plans;
- Integrate the activities outlined in the country plans with existing and/or anticipated funding and resources; and
- Identify and involve key partners to ensure that follow-on actions and/or specific technical assistance are in place.



Photo: Kwaku David Photography

## Establish Continued Country Support

Partners will stay engaged to promote government leadership and support countries beyond the lifetime of specific projects. As an example, USAID, UNICEF, USAID’s Advancing Nutrition, and MCSP have begun following up with country delegations on engaging other partners and finalizing their country action plans with clear activities, existing funding sources, and partners’ roles defined. In addition, a transition process is ongoing between USAID’s Advancing Nutrition and MCSP to carry out the country action plans and to help support longer-term goals.

## Harmonize and Strengthen the Indicators Related to Nutrition for the Ill and Vulnerable Newborn and Child

Gaps in indicators identified during the workshop will be addressed through the upcoming review of the Demographic and Health Survey questionnaires and tools. The Demographic and Health Survey is among the most important sources of data on mortality, health, and nutrition. In addition, the use of its uniform survey instruments allows detailed comparisons within and across countries.

<sup>11</sup> [www.childhealthtaskforce.org](http://www.childhealthtaskforce.org)

# Annex I. Workshop Agenda

Day One: Tuesday, October 30			
Setting the Stage and Defining the Problem			
Time	Topic	Speakers/Facilitators	Location
<b>Session One: Workshop Opening and Framing</b>			
7:30-9:00	Registration		Pre-Function Area
9:00-9:15	Opening Remarks	Steven Hendrix (Acting Mission Director, USAID Ghana)	Ballroom I
9:15-9:30	Welcoming Remarks	Emmanuel Odame (Director of Policy, Planning and Health, Ghana MOH)	
9:30-9:45	<b>Overview of the Workshop</b> <ul style="list-style-type: none"> <li>Overall goal, objectives, and expected results</li> </ul>	Anne Peniston (Chief, Nutrition and Environmental Health, USAID)  Michel Pacqué (Child Health Team Lead, MCSP)	
9:45-10:15	<b>Introduction</b> <ul style="list-style-type: none"> <li>Process, agenda, norms, and expectations</li> </ul>	Samira Aboubaker (MCSP Facilitator)	
10:15-10:45	Tea/Coffee Break		Pre-Function Area
10:45-11:15	<b>Context and Background</b> <ul style="list-style-type: none"> <li>Global perspectives of nutrition and child health within the paradigm shift</li> <li>Global and regional data, statistics, and tendencies</li> </ul>	Nigel Rollins (Senior Nutrition Expert, WHO)  Anne Detjen (Health Specialist, iCCM/IMCI, UNICEF)	Ballroom I
11:15-11:45	<ul style="list-style-type: none"> <li>Summary of recent publications</li> </ul>	Nadeem Hasan (Nutrition Advisor, DFID)	
11:45-12:30	<b>Results of the Pre-Work</b> <ul style="list-style-type: none"> <li>Highlights of review of global and country policies, guidelines and key barriers for implementation</li> </ul>	Lynette Friedman (MCSP Research Consultant)	
12:30-13:30	Lunch		Sankofa Terrace

## Day One: Tuesday, October 30

*Setting the Stage and Defining the Problem*

Time	Topic	Speakers/Facilitators	Location
<b>Session Two: Barriers and Opportunities for Implementation</b>			
13:30-14:00	<b>Country Presentations – Barriers and Opportunities</b> <ul style="list-style-type: none"> <li>• Mali</li> <li>• Ethiopia</li> </ul>	Mali Delegation  Ethiopia Delegation	Ballroom I
14:00-15:00	<b>Review of Key Bottlenecks and Lessons Learned</b> <ul style="list-style-type: none"> <li>• Barriers found during pre-work, reasons for their persistence, and how they can be overcome</li> </ul>	Facilitator: Michel Pacqué (MCSP)  Panel members: <ul style="list-style-type: none"> <li>• Anne Detjen (UNICEF)</li> <li>• Lynette Friedman (MCSP Research Consultant)</li> <li>• Smita Kumar (USAID)</li> <li>• Grace Funnell (Action Against Hunger US)</li> </ul>	
15:00-15:15	Tea/Coffee Break		Pre-Function Area
15:15-17:15	<b>Country Work</b> <ul style="list-style-type: none"> <li>• Delegations meet together to review country-specific barriers and gaps and identify opportunities to resolve them</li> </ul>		Country delegations assigned rooms as follows: <ul style="list-style-type: none"> <li>• Meeting room 1: Nigeria</li> <li>• Meeting room 2: Mozambique</li> <li>• Meeting room 3: Mali</li> <li>• Meeting room 4: Ghana</li> <li>• Ballroom I: Ethiopia, Kenya</li> <li>• Foyer roundtable: DRC</li> </ul>

## Day Two: Wednesday, October 31

### Sharing Successful Practices

Time	Topic	Speakers/Facilitators	Location
9:00-9:15	<b>Barriers to Implementation: Recap and Review</b>	Serge Raharison (MCSP)	Ballroom I
<b>Session Three: Current State-of-the-Art Practices by Target Population</b>			
9:15-9:30	<b>Country Presentation – Successful Country Practices</b> <ul style="list-style-type: none"> <li>Mozambique</li> </ul>	Mozambique Delegation	Ballroom I
9:30- 9:45	<b>Introduction to Technical Session</b> <ul style="list-style-type: none"> <li>Overview of technical guidance and evidence base for Nutrition Interventions for ill and vulnerable newborns and children</li> </ul>	Nigel Rollins (WHO)	
9:45-10:45	<b>Technical Sessions with Rotating <u>Presenters</u> to Cover Nutrition Interventions for Ill Children and Newborns in IMCI and iCCM Settings:</b> <ul style="list-style-type: none"> <li>Topic 1: Support to Mothers</li> <li>Topic 2: Ill and Vulnerable Newborns and Infants</li> <li>Topic 3: Ill and Convalescent Children</li> </ul>	Topic 1: Patti Welch (MCSP), Veronica Kirogo (Kenya MOH), Anne Detjen (UNICEF)  Topic 2: Sushma Nangia (India MOH), Marko Kerac (London School of Hygiene and Tropical Medicine), Abeba Bekele (MCSP Ethiopia)  Topic 3: Steve Hodgins (University of Alberta), Rolf Klemm (Helen Keller International)	Country delegations have been assigned rooms as follows. Only facilitators move during concurrent sessions. <ul style="list-style-type: none"> <li>Meeting room 1: Nigeria, Kenya</li> <li>Meeting room 4: Ethiopia, Ghana</li> <li>Ballroom I: DRC, Mali, Mozambique</li> </ul>
10:45-11:15	Tea/Coffee Break		Pre-Function Area
11:15-12:15	<b>Continuation of Prior Technical Sessions</b> with Rotating <u>Presenters</u> to Cover Nutrition Interventions for Ill Children and Newborns in IMCI and iCCM Settings		
12:15-13:15	<b>Continuation of Prior Technical Sessions</b> with Rotating <u>Presenters</u> to Cover Nutrition Interventions for Ill Children and Newborns in IMCI and iCCM Settings		
13:15-14:15	Lunch		Sankofa Terrace
14:15-14:45	<b>Management of Acute Malnutrition: Integration, Primary Health Care and Future Direction</b> <ul style="list-style-type: none"> <li>Current practice and innovation of severe and moderate acute malnutrition</li> </ul>	Grace Funnell (Action Against Hunger US)	Ballroom I

## Day Two: Wednesday, October 31

*Sharing Successful Practices*

Time	Topic	Speakers/Facilitators	Location
<b>Session Four: Areas for Improvement in Key Program Areas</b>			
14:45-15:45	<b>Practices in Program Management and Service Provision</b> <ul style="list-style-type: none"> <li>• Training, supervision, collection, and use of data, drugs and supplies, continuum of care, and referral</li> </ul>	Facilitator: Eric Swedberg (Save the Children)  Panel members: <ul style="list-style-type: none"> <li>• Jasinta Hyachits Achen (UNICEF Ethiopia)</li> <li>• Tewolde Daniel (UNICEF Kenya)</li> <li>• Sascha Lamstein (USAID Advancing Nutrition/JSI)</li> <li>• Jimmy Anzolo (MCSP DRC)</li> </ul>	Ballroom I
15:45-16:00	Tea/Coffee Break		Pre-Function Area
16:00-17:30	<b>Country Work</b> <ul style="list-style-type: none"> <li>• Country delegations meet together to review program implementation and system strengthening strategies</li> </ul>		Country delegations have been assigned rooms as follows: <ul style="list-style-type: none"> <li>• Meeting room 1: Nigeria</li> <li>• Meeting room 2: Mozambique</li> <li>• Meeting room 3: Mali</li> <li>• Meeting room 4: Ghana</li> <li>• Ballroom I: Ethiopia, Kenya</li> <li>• Foyer roundtable: DRC</li> </ul>
19:00	Workshop Dinner		Outdoor Patio

## Day Three: Thursday, November 1

### *Adapting Solutions to Context*

Time	Topic	Speakers/Facilitators	Location
9:00-9:15	<b>Review of Gaps and Best Practices</b>	Serge Raharison (MCSP)	Ballroom I
9:15-10:00	<b>Country Presentations – Adapting Solutions to Context</b> <ul style="list-style-type: none"> <li>• Ghana</li> <li>• Nigeria</li> <li>• Kenya</li> </ul>	Ghana Delegation Nigeria Delegation Kenya Delegation	Ballroom I
10:00-10:30	<b>Identifying Problems and Solutions Through Research to Address Challenges in Integration of Nutrition and Child Health: The DRC Experience</b>	DRC Delegation	
10:30-11:00	Tea/Coffee Break		Pre-Function Area
<b>Session Five: Cross-Cutting Issues</b>			
11:00-12:00	<b>Cross-Cutting Issues</b> General relevant issues not thoroughly addressed during this workshop such as building country resilience, CSO engagement, gender considerations, and socio-cultural issues	Facilitator: Alfonso Rosales (World Vision)  Panel members: <ul style="list-style-type: none"> <li>• Beatrice Eluaka (SUN Movement, Nigeria)</li> <li>• Habtamu Fekadu (Save the Children)</li> <li>• Veronica Kirogo (Kenya MOH)</li> <li>• Tewolde Daniel (UNICEF Kenya)</li> </ul>	Ballroom I
12:00-13:00	Lunch		Sankofa Terrace

## Day Three: Thursday, November 1

### *Adapting Solutions to Context*

Time	Topic	Speakers/Facilitators	Location
<b>Session Six: Solutions and Actions</b>			
<b>13:00-14:30</b>	<b>Identification of Common Actions by Level of Health System</b> <ul style="list-style-type: none"> <li>Participants review and discuss successful actions that facilitate implementation of integrated programming by level of health system.</li> </ul>		Participants should attend the session that represents their current position.
	Group 1: Service Delivery Point - Service Provision	Isabella Sagoe-Moses (Ghana Health Service)	Ballroom 1
	Group 2: District/Regional Level - Planning and Implementation	Sascha Lamstein (USAID Advancing Nutrition)	Ballroom 2
	Group 3: National/State Level - Resource Mobilization and Policy-Making	Beatrice Eluaka (SUN Movement, Nigeria)	Meeting room 1
	Group 4: Academics and Global Partners – Priority Research Topics and Needs for Updates in Global Guidance	Steve Hodgins (University of Alberta)	Meeting room 4
14:30-14:45	Tea/Coffee Break		Pre-Function Area
<b>14:45-17:30</b>	<b>Country Work</b> <ul style="list-style-type: none"> <li>Country delegations meet together to complete action plans and prepare for their presentation</li> </ul>		Country delegations have been assigned rooms as follows: <ul style="list-style-type: none"> <li>Meeting room 1: Nigeria</li> <li>Meeting room 2: Mozambique</li> <li>Meeting room 3: Mali</li> <li>Meeting room 4: Ghana</li> <li>Ballroom 1: Ethiopia, Kenya</li> <li>Foyer roundtable: DRC</li> </ul>

## Day Four: Friday, November 2

### *Planning for Action*

Time	Topic	Speakers/Facilitators	Location
<b>Session Seven: Action Plans</b>			
9:00-10:00	<b>Country Action Plan Marketplace</b>	Country Delegations Samira Aboubaker (MCSP Facilitator)	Ballroom I
10:00-11:00	<b>Facilitated Discussion of Country Action Plans</b>		
11:00-11:30	Tea/Coffee Break		Pre-Function Area
11:30-12:30	<b>Summary and Next Steps</b> <ul style="list-style-type: none"> <li>• Summary of workshop findings and discussion and clarify follow-up actions.</li> </ul>	Samira Aboubaker (MCSP Facilitator)	Ballroom I
12:30-13:00	<b>Closing Remarks</b>	Patrick Aboagye (Director, Family Health Division, Ghana Health Services) Smita Kumar (Senior Newborn Advisor, USAID)	
13:00-13:30	Boxed lunches available for all participants upon exiting the ballroom		

## Annex 2. Participant List

### DRC Delegation (4)

Evariste Mbombeshayi, MCSP, Nutrition Advisor  
Ignace Balowa, MOH, Associate Director, Programme National de Nutrition (PRONANUT)  
Jean Fidèle Ilunga, MOH, National IMNCI Coordinator, Programme Nationale de Lutte contre les Infections Respiratoires Aiguës (PNIRA)  
Jimmy Anzolo, MCSP, Provincial Program Team Leader

### Ethiopia Delegation (7)

Abeba Bekele Ayele, Save the Children, Newborn Health Advisor  
Abraham Tariku, Federal MOH, Child and Newborn Coordinator  
Jasinta Hyachits Achen, UNICEF, Nutrition Specialist  
Medina Mohammed, Primary Health Care, Nurse  
Taye Wondimu, Oromia Regional Health Bureau, Nutrition Program Coordinator  
Yared Abebe Fantaye, USAID Transform: Primary Health Care/JSI, Senior Nutrition Advisor  
Yunis Mussema Abdella, USAID, Child Health Advisor/Program Development Specialist

### Ghana Delegation (31)

Aimee Ogunro, USAID, Health Development Monitoring and Outreach Specialist  
Akosua Kwakye, WHO, National Programme Officer  
Alice Adams, Ghana School of Public Health, MPH Candidate  
Amos Asiedu, MCSP, Monitoring, Evaluation & Research Specialist  
Augustine Simon Kab, Ghana Health Service, Nutrition Officer  
Comfort Yankson, USAID Systems for Health, Performance Base Grants Advisor  
Daniel Degbotse, MOH, Head of Monitoring and Evaluation Unit  
Emmanuel Attramah, MCSP, Communications Specialist  
Emmanuel Ankrah Odame, MOH, Director of Policy, Planning, Monitoring & Evaluation  
Gifty Ampah, Ghana Health Service, Program Manager  
Henry Nagai, USAID Strengthening the Care Continuum Project/JSI, Chief of Party  
Isabella Sagoe-Moses, Ghana Health Service, Deputy Director of Family Health  
Jacqueline Bony, USAID, Health Development Officer  
Janean Davis, USAID, Director of Health Office  
Jennifer Larri, Ghana School of Public Health, MPH Candidate  
Jocelyn Asibey, Eastern Regional Hospital, Specialist Pediatrician  
Joseph Ashong, USAID, Nutrition Specialist  
Julie Pwamang, USAID, Nutrition Program Specialist  
Karen Caldwell, MCSP/Jhpiego, Country Director  
Kyoko Sakurai, JICA, Expert in Nutrition for MCHRB Project  
Lilian Selenje, UNICEF, Nutrition Specialist  
Mame Yaa Nyarko, Princess Marie Louise Hospital/Pediatric Society of Ghana, Pediatrician  
Oluwatosin Kuti, Ghana Health Service, Health Specialist  
Patrick Aboagye, Ghana Health Service, Director of Family Health Division  
Priscilla Wobil, UNICEF, Health and Nutrition Specialist  
Rebecca Fertziger, USAID, Deputy Director of Health Office  
Sodey Akoto, Ghana School of Public Health, PhD Candidate  
Steven Hendrix, USAID, Acting Mission Director  
Shaibu Osman, USAID RING Project/JSI, Senior Nutrition Officer  
Veronica Quartey, Ghana Health Service, Nutrition Officer  
Zulaiha Yahaya, Ghana Health Service, Community Health Nurse

**Kenya Delegation (9)**

Brenda Ahoya, AFYA HALISI, Senior Service Delivery Officer, Nutrition  
Chabi Joseph Martin, WHO, NPO Child Adolescent Health and Nutrition  
James Njiru, Action Against Hunger, Research and Learning and Grants Coordinator  
Joyce Maringa, Waita Health Center, Nursing Officer  
Nicholas Konyenya, MOH, Nutritionist  
Ruth Tiampati, USAID, Program Management Specialist - HBC and Nutrition  
Silas Agutu, MOH, Program Manager  
Tewelde Daniel Woldegiorgis, UNICEF, Nutrition Specialist  
Veronica Kirogo, MOH, Deputy Director of Nutrition and Dietetics Services

**Mali Delegation (7)**

Aissatou Dioum, UNICEF, Nutrition Specialist  
Cheick Amadou Tidiane Traoré, MOH, Regional Director of Health in Kayes Region  
Jean Kamate, USAID, Health Services Development Specialist  
Mamadou Traoré, MOH, Nutrition Division  
Mohamed Ibrahim Mahmoud, MOH, Nutrition Officer, Direction Nationale de la Santé  
Moustapha Coulibaly, MOH, Medical Chief of Selingué Health District  
Shanda Steimer, USAID, Director of the Health Office

**Mozambique Delegation (9)**

Carlos Mafigo, UNICEF, Health and Nutrition Specialist  
Dulce Nhassico, USAID, Child Survival Program Management Specialist  
Gizela Azambuja, Nampula Central Hospital, Child Health Focal Point at MOH  
Katia Mangujo, MISAU Focal Point for Nutritional Rehabilitation Program at MOH  
Leonor Matias, Nampula DPS, Pediatrician at the Inhambane Provincial Hospital  
Marta Chemane, MCSP, Child Health Adviser  
Matias Langa, International Baby Food Action Network (IBFAN), Former Executive Coordinator  
Melanie Picolo, MCSP, Senior Nutrition Advisor  
Sulaimana Isidoro, MISAU, Medical Chief at DPS Nampula Province

**Nigeria Delegation (16)**

Alaa El-Bashir, USAID, Health Officer  
Beatrice Eluaka, Civil Society–SUNN, Executive Secretary  
Beatrice Kwere, Kebbi State MOH, State Nutrition Officer  
Chris Isokpunwu, Federal MOH, Head of Nutrition  
Emmanuel Adung, MCSP, Newborn Health Advisor  
Dahiru Mahmoud, Bauchi State Primary Health Care Development Agency, EU-UNICEF, Desk Officer  
Hamza Yakubu Sade, Bauchi State Primary Health Care Development Agency, State Nutrition Officer  
Linda Ethel Nsahtime-Akondeng, UNICEF, Health Manager  
Mariya Saleh, Integrated Health Program, Deputy Chief of Party  
Nkeiru Onuekwusi, MCSP, Child Health Team Lead  
Ogechi Akalonu, National Primary Health Care Development Agency, Public Health Nutritionist  
Olatunde Adesoro, Malaria Consortium, Senior Project Manager  
Olusola Oresanya, Malaria Consortium, Country Technical Coordinator  
Oluyinka Olutunde, Breakthrough Action Nigeria, Senior Technical Advisor: MNCH+N  
Tinuola Taylor, Federal MOH, Deputy Director of Child Survival  
Zakaria Fusheini, UNICEF, Nutrition Specialist

### **International Presenters and Partners (17)**

Alfonso Rosales, World Vision US, Senior Advisor for Maternal and Child Health  
Bethany Marron, International Rescue Committee, Nutrition Advisor  
Deepak Paudel, Save the Children, Deputy Chief of Party, Strengthening Systems for Better Health  
Emily Keane, Save the Children, Nutrition Advisor  
Eric Swedberg, Save the Children, Senior Director  
Grace Funnell, Action Against Hunger US, Associate Director, Nutrition and Health  
Habtamu Fekadu Lashtew, Save the Children, Senior Director, Nutrition  
Nicki Connell, Eleanor Crook Foundation, Nutrition Technical Director  
Lynette Friedman, MCSP, Research Consultant  
Marko Kerac, London School of Hygiene and Tropical Medicine, Assistant Professor  
Nadeem Hasan, UK Department for International Development, Nutrition Advisor  
Prudence Hamade, Malaria Consortium, Senior Technical Advisor  
Rolf Klemm, Helen Keller International, Vice President for Nutrition  
Samira Aboubaker Mohammed, MCSP Facilitator  
Sascha Lamstein, USAID Advancing Nutrition, Senior Technical Advisor  
Stephen Hodgins, School of Public Health - University of Alberta, Professor  
Sushma Nangia, India MOH, Director Professor and Head, Neonatology, LHMC, New Delhi

### **UNICEF and WHO (3)**

Anne Detjen, UNICEF, Health Specialist - iCCM/IMCI  
Anne-Sophie Le Dain, UNICEF, Nutrition Specialist  
Nigel Rollins, WHO, Senior Nutrition Expert

### **USAID (4)**

Anne Peniston, USAID, Deputy Director, Maternal and Child Health and Nutrition and Chief, Nutrition and Environmental Health Division  
Fartun Yussuf, USAID, Program Analyst  
Nefra Faltas, USAID, Child Health Advisor  
Smita Kumar, USAID, Senior Newborn Advisor

### **MCSP Headquarters (8)**

Ashley Schmidt, MCSP Child Health, Senior Program Officer  
Corinne Mazzeo, MCSP Newborn Health, Senior Specialist  
Elizabeth Hourani, MCSP Child Health, Program Coordinator  
Maryalice Yakutchik, MCSP Communications, Manager  
Michel Pacqué, MCSP Child Health, Team Leader  
Patti Welch, MCSP Nutrition, Technical Officer  
Serge Raharison, MCSP Child Health, Senior Technical Advisor  
Stella Abwao, MCSP Newborn Health, Technical Advisor

### **Total (115)**

# Annex 3. Country Action Plans

## Country Action Plan: Democratic Republic of the Congo

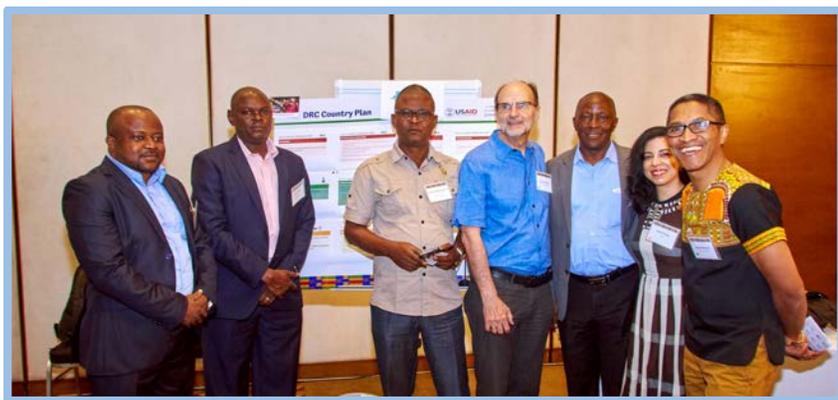


Photo: Kwaku David Photography



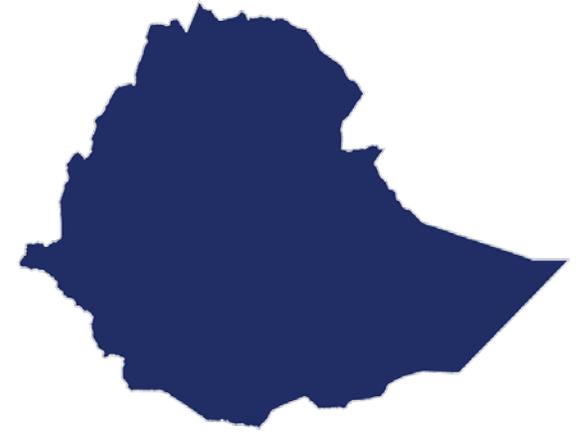
DRC			
Priority Gap	Priority interventions	Priority Inputs	Timeline
<ul style="list-style-type: none"> <li>• Low community involvement in the fight against</li> <li>• Malnutrition (in general)</li> </ul>	<ul style="list-style-type: none"> <li>• Strengthen the capacity of CHW's capacities.</li> <li>• Support the implementation of the NAC approach (NAC: "nutrition à assise communautaire" or "nutrition at community level").</li> <li>• Strengthen awareness in the community (including in terms of the Community Champion approach).</li> <li>• Strengthen the capacities of CAC (CAC: cellule d'animation communautaire, this means "community animation unit").</li> <li>• Establishment of economic self-sufficiency approaches (AGR: "Activités génératrices de revenu" or "Income generating activities," AVEC: "Associations Villagoises pour l'Épargne et le Crédit" or "Villages Associations for Savings and Credit").</li> <li>• Setting up committees of traditional healers.</li> </ul>	<ul style="list-style-type: none"> <li>• Standards, guidelines, and harmonized tools</li> <li>• Execution fund (financial resources)</li> <li>• Trainers</li> <li>• Printed materials (e.g., pedagogical support: IYCF advice cards, identification sheet, invitations ...)</li> <li>• Mid-upper arm circumference (MUAC) ribbons</li> <li>• Health Zones Framework Team (to identify traditional healers)</li> <li>• Fuel and lubricant</li> </ul>	<p>1st quarter 2019 and 2nd quarter 2019</p>

DRC			
Priority Gap	Priority interventions	Priority Inputs	Timeline
<ul style="list-style-type: none"> <li>• Inadequate competent and motivated CHWs (e.g., iCCM, nutrition)</li> <li>• Insufficient equipment and materials</li> </ul>	<ul style="list-style-type: none"> <li>• Capacity building of CHWs on nutrition and child health.</li> <li>• Improve the basic training program, integrating new nutrition approaches.</li> <li>• Capacity building of nutrition providers and integrated approaches.</li> <li>• Strengthening supervision.</li> <li>• Develop/implement approaches to improve the quality of services (mentoring, EAQ: “Equipe d’Amélioration de la Qualité” or “Quality Improvement Team”).</li> <li>• Advocacy at provincial government level for the institutionalization of CHWs, with a budgetary line.</li> <li>• Advocacy to the Ministry of Health for capacity building of nutrition and nutrition staff.</li> <li>• Nutrition enhancement in IMCI (guidelines, tools, training, inputs, supervision, and monitoring and evaluation).</li> <li>• Supply of nutrition materials and equipment.</li> <li>• Develop/implement approaches to improve the quality of services (mentoring, quality assurance review [QAR]).</li> </ul>	<ul style="list-style-type: none"> <li>• Trainers</li> <li>• Printed matter (data sheets, supervisory framework, collection tools, and data reporting)</li> <li>• Educational support: Maps, tips, IYCF</li> <li>• Execution Fund</li> <li>• Multisectoral Nutrition Committee</li> <li>• Advocacy document</li> <li>• Means of transport</li> </ul>	1st quarter 2019 and 2nd quarter 2019
<ul style="list-style-type: none"> <li>• Insufficient Integration of nutrition into iCCM</li> <li>• Verticality of standards and guidelines</li> <li>• Insufficient budget lines for nutrition and child health at provincial level</li> </ul>	<ul style="list-style-type: none"> <li>• Consolidate the process of integrating nutrition into IMCI.</li> <li>• Explore the adaptation of the simplified use of MUAC in iCCM.</li> <li>• Plan contextualized activities.</li> <li>• Harmonize and integrate standards.</li> <li>• Nutrition guidelines and tools and IMCI.</li> <li>• Advocacy at the provincial level, with support from the central level, for the institutionalization of CHWs, with a budget line.</li> </ul>	<ul style="list-style-type: none"> <li>• Standards and guidelines</li> <li>• Advocacy documents</li> <li>• National supervision</li> <li>• Provincial executive teams and health zone teams</li> <li>• Pedagogical support (e.g., IYCF counseling cards, MUAC ribbons)</li> <li>• Printed materials (e.g., data collection and management tools)</li> <li>• Execution Fund</li> </ul>	2nd quarter 2019 - ongoing

## Country Action Plan: Ethiopia



Photo: Kwaku David Photography



Ethiopia			
Priority Gap	Priority Interventions	Timeline	Priority Inputs
<ul style="list-style-type: none"> <li>Suboptimal utilization of primary health care</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen Kebele Command Post as in Quality Improvement Transformation Plan.</li> </ul>	Ongoing	<ul style="list-style-type: none"> <li>Sensitization workshops</li> <li>Targeted, topic-specific technical assistance through Government of Ethiopia, relevant implementing partners, and civil society</li> <li>Finance</li> <li>Human resources</li> <li>Consumables (flip charts, notebooks, pens, stationery)</li> </ul>
	<ul style="list-style-type: none"> <li>Support geographic expansion of community-based health insurance.</li> </ul>	Ongoing	
	<ul style="list-style-type: none"> <li>Improve stock management at health center (HC) level.</li> </ul>	Ongoing and short term (6–12 months)	
	<ul style="list-style-type: none"> <li>Support cross-training of staff on nutrition and child health at HC level.</li> </ul>	Ongoing	
	<ul style="list-style-type: none"> <li>Increase geographic coverage of open house strategy.</li> </ul>	Quarterly (starting in 6 months)	
	<ul style="list-style-type: none"> <li>Systematically improve Health Development Army (HDA) capacity and effectiveness.</li> </ul>	Short term (12 months)	

**Ethiopia**

Priority Gap	Priority Interventions	Timeline	Priority Inputs
<ul style="list-style-type: none"> <li>Lack of evidence for effective delivery strategies to inform health programming in pastoral /semipastoral populations</li> </ul>	<ul style="list-style-type: none"> <li>Prepare draft zero concept paper (1 to 2 pages) for sensitization.</li> <li>Key nutrition and child health focal people should sensitize heads of Health System Special Support Directorate and Maternal Child Health and Nutrition Directorate to ensure buy-in and engagement.</li> <li>The MOH should organize meetings with case teams from Maternal Child Health and Nutrition Directorate, the Research Advisory Council, the Health System Special Support Directorate, and the Deliverology Unit for sensitization.</li> <li>Ensure availability of appropriate funding to conduct high-quality implementation research (IR) on ongoing and new programmatic activities.</li> <li>Engage the Regional Health Bureau and other regional stakeholders to inform the strategic implementation approach.</li> </ul>	Short term (6–12 months)	<ul style="list-style-type: none"> <li>Government commitment and partner support</li> <li>Key focal people to lead and support coordination</li> <li>Community support</li> <li>Human resources</li> <li>Funding</li> <li>Participation of academic/research institutions</li> </ul>
	<ul style="list-style-type: none"> <li>Incorporate IR into existing programming platforms employed by partners and government.</li> </ul>	Long term (2 years)	
<ul style="list-style-type: none"> <li>Weak primary health care unit (PHCU) linkage</li> </ul>	<ul style="list-style-type: none"> <li>Form a technical working group to refine plan with involvement of key stakeholders and relevant directorates.</li> </ul>	Short term (6 months)	<ul style="list-style-type: none"> <li>Workshop and regular meetings</li> <li>Implementation of agreed initiatives in select woredas (districts)</li> <li>Documentation of lessons learned</li> </ul>
	<ul style="list-style-type: none"> <li>Test agreed approaches with iterative learning to support scale-up.</li> </ul>	Short term (12 months)	

## Country Action Plan: Ghana



Photo: Kwaku David Photography



Ghana			
Priority Gap	Priority Interventions	Timeline	Priority Inputs
Inadequate nutrition commodities, supplies, and equipment: <ul style="list-style-type: none"> <li>• Equipment (e.g., weighing scales, length boards)</li> <li>• Supplies (e.g., counseling cards, food models)</li> <li>• Commodities (e.g., ready-to-use therapeutic food, ReSoMal, F-75, F-100)</li> </ul>	<ul style="list-style-type: none"> <li>• Advocate for essential nutrition commodities to be included in the essential medicines list.</li> </ul>	Last quarter 2019	<ul style="list-style-type: none"> <li>• Technical assistance</li> <li>• Funding</li> <li>• Training</li> </ul>
	<ul style="list-style-type: none"> <li>• Enhance logistics management for essential nutrition commodities.</li> </ul>	2019 to 2020	
	<ul style="list-style-type: none"> <li>• Explore alternative funding sources, e.g., the private sector and the district assembly common fund, to procure equipment and supplies.</li> </ul>	2019 to 2020	

**Ghana**

Priority Gap	Priority Interventions	Timeline	Priority Inputs
Limited staff capacity, knowledge, and numbers: <ul style="list-style-type: none"> <li>• Inadequate supervision and accountability</li> <li>• Workload</li> </ul>	<ul style="list-style-type: none"> <li>• Improve accountability and quality of supportive supervision (both health staff and community health volunteers), harmonizing process indicators to be reported regularly.</li> </ul>	2019 to 2021	<ul style="list-style-type: none"> <li>• On-the-job training and strengthening of the performance appraisal management system</li> <li>• Funding</li> <li>• Technical assistance</li> </ul>
	<ul style="list-style-type: none"> <li>• Clearly define roles and responsibilities for all staff and task shifting/sharing.</li> </ul>	End of 2019	
	<ul style="list-style-type: none"> <li>• Revitalize Integrated Management of Newborn and Childhood Illnesses/integrated Community Case Management at all levels.</li> </ul>	2019	
Weak linkage between facility and community: <ul style="list-style-type: none"> <li>• Cultural beliefs and practices that negatively affect children’s health</li> <li>• Poor attitude of health workers</li> </ul>	<ul style="list-style-type: none"> <li>• Step up sustained social and behavior change communication activities (increase frequency and diversify channels of communication).</li> </ul>	2019	<ul style="list-style-type: none"> <li>• Funding</li> <li>• Technical assistance (development of information, education, and communication materials)</li> </ul>
	<ul style="list-style-type: none"> <li>• Strengthen community groups.</li> </ul>	2019	
	<ul style="list-style-type: none"> <li>• Provide nonmonetary rewards for performing staff.</li> </ul>	2019	
	<ul style="list-style-type: none"> <li>• Use a quality improvement approach at the facility and community levels.</li> </ul>	2019	

## Country Action Plan: Kenya



Photo: Kwaku David Photography



Kenya					
Priority Gap	Priority Interventions	Activities	Timeline	Source of Funds	Remarks
<ul style="list-style-type: none"> <li>Policy does not allow for treatment of pneumonia and acute malnutrition at community level</li> </ul>	<ul style="list-style-type: none"> <li>Develop/adopt policy to allow use of amoxicillin, ready-to-use therapeutic food, and ready-to-use supplementary food at community level by community health volunteers to treat pneumonia, SAM, and moderate acute malnutrition, respectively.</li> </ul>	<ul style="list-style-type: none"> <li>Hold evidence review meeting with panel of experts.</li> </ul>	Quarter I 2019/20	<ul style="list-style-type: none"> <li>Living Goods,</li> <li>UNICEF</li> </ul>	<ul style="list-style-type: none"> <li>Inaugural meeting held in December 2018.</li> </ul>
		<ul style="list-style-type: none"> <li>Draft the policy brief.</li> </ul>	Quarter I 2019/20	<ul style="list-style-type: none"> <li>UNICEF</li> </ul>	
		<ul style="list-style-type: none"> <li>Finalize the iCCM SAM and moderate acute malnutrition study.</li> </ul>	Quarter I 2019/20	<ul style="list-style-type: none"> <li>ACF, Save the Children, UNICEF</li> </ul>	<ul style="list-style-type: none"> <li>Fieldwork to be completed in May; data analysis to commence in August 2019.</li> </ul>
		<ul style="list-style-type: none"> <li>Disseminate study findings.</li> </ul>	Quarter 2 2019/20		
		<ul style="list-style-type: none"> <li>Harmonize and update all guidelines and tools/manuals.</li> </ul>	Quarter III 2019/20		

**Kenya**

Priority Gap	Priority Interventions	Activities	Timeline	Source of Funds	Remarks
<ul style="list-style-type: none"> <li>• Inadequate dissemination of key policies, strategies, guidelines to frontline health workers, including:</li> <li>• National Maternal, Infant, and Young Child Nutrition Policy</li> <li>• Policy guidelines for preventive vitamin A supplementation for children 6–59 months</li> <li>• Newborn, Child, and Adolescent Health Policy</li> <li>• Basic Paediatric Protocols</li> <li>• BFCI trainers guide, 2018</li> <li>• The First 1,000 Days: Ensuring good health of mother and baby, 2018</li> <li>• Mother &amp; Child Handbook</li> </ul>	<ul style="list-style-type: none"> <li>• Ensure dissemination of policies up to frontline health workers.</li> </ul>	<ul style="list-style-type: none"> <li>• Develop MOH dissemination guide to provide minimum standards for dissemination of policies, strategies, and guidelines to the lowest level of service delivery, including other relevant users.</li> </ul>	Quarter III 2018/19	<ul style="list-style-type: none"> <li>• MOH, mobilize additional resources from partners</li> </ul>	<ul style="list-style-type: none"> <li>• Started discussions with the Division of Standards and Quality Assurance.</li> </ul>
		<ul style="list-style-type: none"> <li>• Prioritize/map policies for dissemination.</li> </ul>	Quarter III 2018/19		
		<ul style="list-style-type: none"> <li>• Utilize existing opportunities to distribute dissemination guide as it is developed.</li> </ul>	Quarter II 2018/19	<ul style="list-style-type: none"> <li>• UNICEF, Food and Agriculture Organization of the United Nations, Nutrition International, Clinton Health Access Initiative</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing</li> </ul>
		<ul style="list-style-type: none"> <li>• Use different cadres' professional associations' conference meetings to disseminate policies.</li> </ul>	Quarter IV 2018/19	<ul style="list-style-type: none"> <li>• External resource mobilization</li> </ul>	<ul style="list-style-type: none"> <li>• Kenya Paediatric Association conference in April 2019; Midwives Association of Kenya conference in June 2019</li> </ul>

Kenya					
Priority Gap	Priority Interventions	Activities	Timeline	Source of Funds	Remarks
<ul style="list-style-type: none"> <li>Inadequate integration of nutrition in health service delivery</li> </ul>	<ul style="list-style-type: none"> <li>Strengthen integration of nutrition into routine services (e.g., emergency triage assessment and treatment plus care, integrated management of newborn and childhood illness [IMNCI], iCCM, commodity supply).</li> <li>Utilize health systems approach to integration (to explore how to include nutrition in performance appraisal of health system staff).</li> <li>Hold joint review meetings.</li> <li>Orient nutrition personnel on IMNCI.</li> </ul>	<ul style="list-style-type: none"> <li>Scale up trainings on revised guidelines (emergency triage assessment and treatment plus care, IMNCI, iCCM).</li> </ul>	Ongoing, through Quarter I 2019 (March)	<ul style="list-style-type: none"> <li>UNICEF, Amref, Clinton Health Access Initiative, Nutrition International (NI)</li> </ul>	<ul style="list-style-type: none"> <li>Three trainings on IMNCI held in January 2019; 40 of 47 counties trained, yet the MOH would like critical mass of health workers trained.</li> </ul>
		<ul style="list-style-type: none"> <li>Provide supervision and mentorship.</li> </ul>	Ongoing, through Quarter I 2019 (March)	<ul style="list-style-type: none"> <li>UNICEF, Amref, Clinton Health Access Initiative, NI</li> </ul>	
		<ul style="list-style-type: none"> <li>Scale up BFCI implementation.</li> </ul>	Quarter II 2018/19	<ul style="list-style-type: none"> <li>UNICEF, NI, ACF</li> </ul>	<ul style="list-style-type: none"> <li>Disseminated BFCI training manual to the 47 counties in November/ December 2018.</li> </ul>
<ul style="list-style-type: none"> <li>Inadequate number of staff nutritionists, nurses, and clinicians, and inadequate competencies in nutrition in terms of providing nutrition counseling and services</li> </ul>	<ul style="list-style-type: none"> <li>Nutrition should be included in the review of the human resources for health (HRH) strategy.</li> </ul>	<ul style="list-style-type: none"> <li>Advocate for representation of nutrition unit in the review and development of HRH strategy.</li> </ul>	Quarter III 2018/19	<ul style="list-style-type: none"> <li>MOH</li> </ul>	<ul style="list-style-type: none"> <li>Nutritionists from over half of the counties may not have adequate competencies. Focus has been on arid and semiarid counties (for partner support). Capacity building is more concentrated in these areas.</li> </ul>
		<ul style="list-style-type: none"> <li>Hold planning meetings to harmonize nutrition package to be included in HRH strategy.</li> </ul>	Quarter II 2018/19		
		<ul style="list-style-type: none"> <li>Advocate for inclusion of nutrition within the performance appraisal of clinical staff.</li> </ul>	Quarter IV 2018/19		
		<ul style="list-style-type: none"> <li>Strengthen nutrition content in pre-service training.</li> </ul>	Quarter IV 2018/19		

## Country Action Plan: Mali



Photo: Kwaku David Photography



Mali								
Priority Gap	Priority Interventions	2019		2020		2021		Priority Inputs
• Weak community mobilization	• Scale up multisectoral community platforms (district/towns/villages).	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• Financing</li> <li>• Technical assistance</li> <li>• Training</li> <li>• Tools</li> <li>• Kits for nutritional demonstrations</li> <li>• Material and equipment for anthropometric measurements</li> </ul>
	• Scale up the mid-upper arm circumference performed by mothers, the traditional healers initiative, and treatment for SAM without complications performed by CHWs.	X	X	X	X	X	X	
	• Strengthen community ownership by local governments and community health center committees.		X	X	X	X	X	
• Insufficient implementation of comprehensive care of the child	• Relaunch the implementation of clinical IMCI, child growth monitoring, and promotion of the child, and take into account the missing aspects (e.g., early childhood development).	X	X	X	X	X	X	<ul style="list-style-type: none"> <li>• Financing</li> <li>• Technical assistance</li> <li>• Training</li> <li>• Tools</li> <li>• Kits for nutritional demonstrations</li> <li>• Material and equipment for anthropometric measurements</li> <li>• Units for KMC</li> </ul>
	• Strengthen communication and counseling in health facilities.	X	X	X	X	X	X	
	• Scale up the KMC strategy for health/nutrition activities.		X	X	X	X	X	

Mali

Priority Gap	Priority Interventions	2019		2020		2021		Priority Inputs
<ul style="list-style-type: none"> <li>Insufficient monitoring of activities</li> </ul>	<ul style="list-style-type: none"> <li>Perform a qualitative study for a better understanding of providers' and households' behavior.</li> </ul>	X						<ul style="list-style-type: none"> <li>Financing</li> <li>Training</li> <li>Tools</li> <li>Integrated supervision</li> <li>Monitoring and evaluation</li> </ul>
	<ul style="list-style-type: none"> <li>Complete analysis of bottlenecks related to the supply of nutrition services.</li> </ul>	X	X	X	X			
	<ul style="list-style-type: none"> <li>Strengthen coaching at all levels and improve the health information system for community data.</li> </ul>	X	X	X	X	X	X	

## Country Action Plan: Mozambique



Photo: Kwaku David Photography



The Mozambique delegation developed a country action plan during the workshop that is currently under review with the Government of Mozambique. It was not finalized for public distribution at the time of this report's publication.

## Country Action Plan: Nigeria



Photo: Kwaku David Photography



Nigeria			
Priority Gap	Priority Interventions	Timeline	Priority Inputs
<ul style="list-style-type: none"> <li>Inadequate coverage and implementation of Nigeria's Integrated Management of Childhood Illness (IMCI) package, which includes treatment of severe acute malnutrition</li> </ul>	<ul style="list-style-type: none"> <li>Map coverage of "One PHC per Ward" initiative.</li> </ul>	<ul style="list-style-type: none"> <li>Short term</li> </ul>	<ul style="list-style-type: none"> <li>Training resources (materials, venue, food, etc.)</li> <li>Equipment (bowls for food demonstrations, mid-upper arm circumference [MUAC] tapes, etc.)</li> <li>Supplies (medicine, ready-to-use therapeutic food [RUTF], job aids, reporting forms)</li> <li>Human resources (adequate number and timely payment)</li> <li>Venue and supplies for coordination meetings</li> <li>Transport allowance (for supervision)</li> </ul>
	<ul style="list-style-type: none"> <li>Map implementation of IMCI package (people trained, supervision conducted, etc.).</li> </ul>	<ul style="list-style-type: none"> <li>Short term</li> </ul>	
	<ul style="list-style-type: none"> <li>Strengthen coordinated planning at local government area (LGA) and state levels to determine roles and responsibilities.</li> </ul>	<ul style="list-style-type: none"> <li>Medium term (already ongoing)</li> </ul>	
	<ul style="list-style-type: none"> <li>Advocate for funding from government.</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Coordinate donor/partner action (insist on alignment).</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Identify champions for Child Survive, Thrive, and Transform.</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Develop plan for engaging private sector health care providers.</li> </ul>	<ul style="list-style-type: none"> <li>Medium term</li> </ul>	

**Nigeria**

Priority Gap	Priority Interventions	Timeline	Priority Inputs
	<ul style="list-style-type: none"> <li>Roll out Nigeria’s IMCI package—improve health services, strengthen health system (including integrated supervision), and mobilize the family and community.</li> </ul>	<ul style="list-style-type: none"> <li>Short term (already ongoing)</li> </ul>	
	<ul style="list-style-type: none"> <li>Engage the commercial sector (manufacturers of RUTF, pharmaceuticals, employers).</li> </ul>	<ul style="list-style-type: none"> <li>Short term (already ongoing by Scaling Up Nutrition Business Network)</li> </ul>	
<ul style="list-style-type: none"> <li>Low political commitment, at all levels, to translate policy into action</li> </ul>	<ul style="list-style-type: none"> <li>Actively engage nutrition and child health professionals with the Child Health Technical Working Group (to bridge divide in the Federal Ministry of Health/State Ministry of Health and Nigeria Primary Health Care Development Agency [NPHCDA]/State Primary Health Care Development Board [SPHCDB] and other sectors).</li> </ul>	<ul style="list-style-type: none"> <li>Short term</li> </ul>	<ul style="list-style-type: none"> <li>Human resources</li> <li>Targeted evidence-based advocacy materials (develop and print)</li> <li>Workshop/meeting resources (print materials, venue, food, etc.)</li> </ul>
	<ul style="list-style-type: none"> <li>Identify champions for Child Survive, Thrive, and Transform.</li> </ul>	<ul style="list-style-type: none"> <li>Short term</li> </ul>	
	<ul style="list-style-type: none"> <li>Advocate at all levels and among a range of actors (e.g., Governors’ Forum, Committee on Health of the National Assembly, National Council on Nutrition) to raise awareness of the importance of fetal and child growth and development.</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Assess and strengthen state and LGA committees on multisectoral food and nutrition.</li> </ul>	<ul style="list-style-type: none"> <li>Medium term</li> </ul>	

**Nigeria**

Priority Gap	Priority Interventions	Timeline	Priority Inputs
<ul style="list-style-type: none"> <li>Limited community nutrition services (community health extension workers work in facilities; they don't go to communities)</li> </ul>	<ul style="list-style-type: none"> <li>Build and track cadre of trained community volunteers on integrated community case management/community infant and young child feeding counseling platforms.</li> </ul>	<ul style="list-style-type: none"> <li>Medium to long term</li> </ul>	<ul style="list-style-type: none"> <li>Human resources</li> <li>Equipment (bowls for food demonstrations, MUAC tapes, etc.)</li> </ul>
	<ul style="list-style-type: none"> <li>Promote food-based demonstrations (by positive deviants) as part of existing platforms, such as an NPHCDA/SPHCDB activity, to optimize routine immunization services (outreach).</li> </ul>	<ul style="list-style-type: none"> <li>Medium term</li> </ul>	
	<ul style="list-style-type: none"> <li>Coordinate with nutrition-sensitive interventions (water, sanitation, and hygiene; agriculture; food preservation).</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Advocate for funding from government for community nutrition services.</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Revitalize meetings between community members and PHC staff (Facility Development Committee/Ward Development Committee).</li> </ul>	<ul style="list-style-type: none"> <li>Short term and continuous</li> </ul>	
	<ul style="list-style-type: none"> <li>Use existing data regarding fetal and child growth and development for decision-making at the community level.</li> </ul>	<ul style="list-style-type: none"> <li>Medium term and continuous</li> </ul>	