Community Health Network ~ Fall Meeting 2012

Call to Action to End Preventable Child Deaths: The INGO Response

October 11-12, 2013. Washington, DC

For more than 10 years, CORE Group meeting agendas (and the gatherings that follow them) have offered a snapshot of community health. What is the state-of-the-art? What are the pressing implementation questions? What approaches, insights and innovations are now established? Abandoned? Emerging?

Representing 86 organizations, 211 people from 10 countries brought their own experiences and ideas to help create that snapshot. Over the course of two days, conference participants built on the theme as they explored the potential and most effective roles for INGOs to play in saving lives of mothers and children. The meeting opened with a lively **World Café plenary,** during which participants dove right into the theme—an examination which continued over the next two days, as the wide range of actors critically examined the ever shifting development landscape. Continued dialogue on how to reach the underserved and the nature of "building capacity" came through in a variety of sessions, as participants shared new tools, best practices and lessons learned.

> *Present at this year's Fall Meeting:*
>
> CORE Group Member Organizations: 42 of 58
>
> CORE Group Associate Organizations: 9 of 15
>
> CORE Group Individual Associates: 9 of 18

CORE Group also had the honor and privilege of presenting the **Dory Storms Award** to two winners this year, Abdullah Baqui and Jane Vella—a fitting personification of the dual need for technical evidence (the "what") and sophisticated processes (the "how"). Dr. Baqui reminded participants of the importance of linking programs, research, and policy. Dr. Vella encouraged the continued use of dialogue, listening and true partnership throughout all of our work. Other special guests included the keynote speaker, Amie Batson of USAID, and David Pelletier of Cornell University.

A variety of **technical sessions** reflected the specific technical roles INGOs play in preventing child deaths, as well as crucial cross-cutting skills that underlie successful programs. Interactive technical sessions focused on Community Case Management of childhood illness, essential nutrition actions, kangaroo mothercare, prevention of prematurity and stillbirth, immunization, nutrition, and agriculture. Other sessions gave participants the opportunity to explore partnership and capacity building, knowledge sharing, equity, Dialogue Education, mhealth, sustainability and mortality measurement.

The meeting also featured the ever popular **Powerbreakfast Roundtables**, which allowed participants to dialogue with a wide world of stakeholders and topics, many from outside the *Community Health Network*—including peacebuilding, biodiversity, child safeguarding, linking factories and community health programming, and creating change through influencing national guidelines (for pediatric TB, and newborn health at home).

Informal **lunchtime discussions** dove into equity, the past summer's HIV/AIDS conference, water and sanitation, care groups, CORE Group's upcoming Practitioner Academy trip to India, and more. CORE Group's eight technical Working Groups spent an afternoon orienting new members, sharing new directions, sharing knowledge and generating ideas, and making plans to move forward with workplan activities for the year.

We are thankful to our three event sponsors this year: Gold Sponsor Otsuka; Silver Sponsor Bayer and Bronze Sponsor Save the Children, and 13 table sponsors.

At the close of this year's Fall Meeting of the *Community Health Network*, Professor David Pelletier provided a meta-level view of what he had witnessed during the course of the event, describing it as as part of a larger evolution within international development. Professor Pelletier described this as a **new learning paradigm**, and offered this vision: "Hopefully this movement will go beyond monitoring and evaluation and an emphasis on evidence, to give attention to the broader set of factors that influence the decisions, policies, procedures and practices of individuals, organizations and governments." He made several recommendations to USAID and to INGOs to support country-owned aspirations; build cross-sectoral partnerships; build strategic capacity for implementation at-scale; strengthen local actors; emphasize a "how" learning agenda; and shape a global and national discourse. His concise yet rich speech and slides can be found here.

The Nitty Gritty: Summaries and key ideas from each session

Note: All slide sets presented throughout the course of the meeting can be accessed online here.

Pre-meeting Events

Essential Nutrition Actions Orientation

Agnes Guyon, *Senior Child Health & Nutrition Advisor*, JSI Research & Training Institute, Inc
Jennifer Nielsen, *Senior Program Manager for Nutrition and Health,* Helen Keller International

 The Essential Nutrition Actions (ENA) framework promotes a "nutrition through the life cycle" approach, addressing women's nutrition during pregnancy and lactation, optimal IYCF (breastfeeding & complementary feeding), nutritional care of sick and malnourished children (including zinc, vitamin A and ready to use therapeutic foods), and control of anemia, vitamin A and iodine deficiencies. The training component for implementation of the ENA framework at both the health facility and community levels consists of a trilogy of materials based on versions that have been tested over time and are ready to be used in new settings and countries.

Kangaroo Mother Care Orientation

Stella Abwao, *Advisor, Newborn Health,* Save the Children/MCHIP

Kangaroo mother care (KMC) is used to care for premature/low birth weight babies and facilitates thermal care through prolonged continuous skin-to-skin contact. For the baby, KMC ensures nutrition by supporting exclusive breastfeeding /feeds with expressed breast milk, promotes infection prevention, continuous weight gain. Increasingly accepted in both high- and low-income countries, KMC has been

proven to substantially reduce neonatal mortality amongst preterm/low birth weight babies (birth weight < 2500 g) in suitable health facility settings and is highly effective in reducing severe newborn infections. The orientation session allowed participants to learn about the KMC practice, positioning technique and discuss challenges to scaling up this life-saving method of care within health facilities and follow up to community settings.

Strengthening the National Malaria Control Efforts through Community-Based Strategies: The President's Malaria Initiative Malaria Communities Program (Grantee Panel, Poster Presentations, and Reception)

PMI and MCHIP highlighted the contributions of seven Malaria Communities Program (MCP) grantees to national malaria control efforts. The Malaria Communities Program was announced December 14, 2006. Through 20 MCP awards to 18 partners in 12 countries, PMI has supported the efforts of communities and non-governmental organizations to combat malaria at the local level. Grantees working in Angola, Ethiopia, Liberia, Kenya, Malawi, Tanzania, and Uganda discussed their strategies, lessons learned, and unique contributions to local, national and global malaria control efforts with representatives from PMI. US Global Malaria Coordinator, Admiral Tim Ziemer, provided opening remarks. The panel discussion can be found at http://www.youtube.com/mchipglobal

Plenary: Amie Batson, Deputy Assistant Administrator, Global Health at USAID, on Ending Preventable Child Deaths

- The June 2012 Call to Action shifted focus from causes of death to "how"/processes: how to scale up, how to increase demand, how to increase access, and how to overcome barriers.
- We need to lean heavily on data and look for new ways of doing business: geography (focusing where most child deaths occur), targeting underserved populations, using data (epidemiological profile), going beyond health programs (women's empowerment, education, economic growth), and mutual accountability and transparency
- Action needs to be in/from countries themselves; players need to align with country plans and programs.
- Both the participants and the speakers raised many questions:
    o How can INGOs adjust to USAID funding shift to countries?
    o As USAID is looking toward the future (post-CSHGP, post MDGs, post-MCHIP), how does partnership with NGOs compare to flagship work, private partnership, and direct government collaboration? What is the INGO comparative advantage? (See "Reinventing the INGO" on DevEx)
    o How can we improve sharing of learning?
    o How can we improve cross-sectoral collaboration?
    o How can we provide services to hard-to-reach populations (equity) and how do we balance localized solutions with need to scale up?
- Next steps for the CORE Group include continued networking and knowledge-sharing; aligning programs with country plans; building country capacity; convening NGOs and CSOs, especially the faith community; facilitating partnerships to build local capacity; and providing feedback to USAID on barriers within the funding system (i.e. short project cycles)

World Café: This noisy, interactive session launched two days of dialogue around the meeting theme, and development of ideas for effective partnering between INGOs, USAID and others. David Pelletier captured the evolving conversations that were started in this session in his closing synthesis.

Abdullah Baqui – Dory Storms Award Winner

Dr. Abdullah Baqui has spent most of his career working to reduce child mortality, particularly in the areas of diarrheal diseases, micronutrients, and vaccines in his native Bangladesh. His groundbreaking work on newborn mortality and stillbirths, published in the Lancet paper of the Year (2008) outlined strategies that are simple but effective in reducing preventable newborn deaths and, importantly, are capable of being replicated widely throughout the world. Since this paper was published, the newborn mortality rate has significantly decreased.

Abdullah is Professor, Department of International Health and Deputy Director, International Center for Maternal and Newborn Health, Johns Hopkins Bloomberg School of Public Health, Johns Hopkins University. He teaches courses on urban health and health information systems and has mentored numerous community health practitioners. His current research to improve child health and survival by enhancing the understanding of the major causes of childhood morbidity and mortality and by designing and/or testing cost-effective public health interventions against them is important to the work of CORE Group colleagues.

His research includes : 1) Development of interventions to improve perinatal and neonatal health and survival; 2) Epidemiology of emerging and re-emerging infectious diseases (e.g., Acute Respiratory Infections, Tuberculosis), 3) Evaluation of diarrhea and ARI vaccines (e.g., shigella vaccine, Hib vaccine), 4) Evaluation of health impact of different formulations of micronutrients, and 5) Evaluation including cost-evaluation of the Integrated management of childhood illness (IMCI) strategy which is part of WHO's multi-country evaluation of IMCI strategy. Additionally, he is interested in research related to urban health care issues and in operations research to improve the management, quality and sustainability of health care delivery systems.

Dory Storms Award Acceptance

- Dory's dreams are yet to be realized; there are still too many deaths
- More than 50% of newborn deaths are preventable
- Successful implementation involves health system strengthening and monitoring and evaluation using real-time data.
- Research and programs need to partner for real progress.
- Dr. Baqui highlighted three programs from his work:
  1. Projahnmo (Bangladesh) is a partnership between the MOH and ICCDR,B, NGOs, and JHU and focuses on feasible, context-specific, cost-effective interventions to reduce newborn mortality. The study involved a package of simple community-based MNH interventions delivered by women CHWs through home visits which resulted in a 34% reduction of NMR and found that postpartum visits needed to be within 1-2 days of birth.

2. RACHNA India is an integrated MCH/N/FP/HIV program with a quasi-experimental design to adjust program strategies through systematic feedback. This study's major finding was that postpartum visits needed to be within three days for NMR reduction.
3. In Tanzania, Jhpiego partnered with the MOH to implement an integrated MNCH program with emphasis on postpartum care. The project found both supply and demand side barriers to care seeking.

Jane Vella – Dory Storms Award Winner

Jane has helped transform how learning events in child survival/health programs are designed and led globally through her work, Dialogue Education ™. Workshops, trainings and conferences changed as organizations acquired training and integrated the adult learning theory for effective learning, transfer and retention of knowledge. The methodology shifted from the traditional monologue, which focuses on what the teacher says, to learners' active participation by considering their knowledge and experience, then designing the events accordingly. To date, 3,500 graduates in 60 countries utilize Dialogue Education in training and development, including those for frontline health workers, staffs and trainers in health programs.

Jane gained her insight on the adult learning principles as educator for 57 years in 35 countries in Africa (27 years in Tanzania where she taught as a Maryknoll Sister), Asia and the Americas (also US). Dr. Vella studied the emerging system of Dialogue Education as her doctoral research at the University of Massachusetts and wrote 7 popular books on this subject. As Director of Training of Save the Children (1984-1989), she and her staff expanded the use of Dialogue Education to the fields in diverse cultural settings, and the resulting reports became the basis of her book *Learning to Listen Learning to Teach*. Jane developed training materials such as: *Learning to Teach for Training of Trainers in Community Development* -1998 (Save the Children) and *Developing Health Journalist (*with Julian Beamish for Family Health International) for journalists reporting on health issues. From then on, Dialogue Education has been adopted by many PVOs doing child survival and development work (Aga Khan University, Catholic Relief Services, CRWRC, CORE Group, Food for the Hungry, Freedom from Hunger, Save the Children, and World Vision etc.) In 1981, Jane founded Global Learning Partners (GLP) to develop a network of certified teachers and practitioners of Dialogue Education.

Dory Storms Award Acceptance

- "A person feels her power when she feels herself being heard."
- Essentials of dialogue education
    - Preparation
    - Principle-driven decision making
    - Process: learning tasks and materials
    - Proof in practice: indicators of learning, transfer, and impact
- Dialogue happens among learners, of whom the teacher is one.
- Preparation is the early dialogue: LNRA, 8 design steps
- It's easy to have too much "what" for your "when."

Office Hours with Jane Vella: Summary

Jane Vella, *Founder,* Global Learning Partners; **Valerie Uccellani**, *Senior Partner*, Global Learning Partners; **Kris Britt**, *Contracts and Customer Relations Manager*, Global Learning Partners

- Dialogue-based learning versus Participatory Affirmation
- Learning, transfer, and impact are all behaviors.
- "Learning Centered" instead of "Learner Centered"
- Dialogue education is moving into new technology and is offering an on-line course.
- It is a challenge- creating learning tasks for certain groups. Global Learning Partners is re-vamping the Learning to Listen course to go more in-depth to help people create learning tasks.

CSHGP Program Learning – a Cross Cutting Review

David Marsh, *Senior Advisor, Child Survival and Global Team Leader, Community Case Management,* Save the Children; **Jim Foreit**, *Consultant;* **Marge Koblinksy**, *Senior Maternal Health Advisor,* USAID; **Nazo Kureshy**, *CSHGP Team Leader*, USAID; **David Pelletier,** *Associate Professor of Nutrition Policy,* Cornell University (Discussant); **Karen LeBan**, *Executive Director,* CORE Group (Moderator)

USAID commissioned three reviews of the CSHGP Portfolio to strengthen program-based learning systems. David Marsh reviewed the iCCM portfolio, Marge Koblinsky reviewed the MNH portfolio, and Jim Foreit reviewed the Operations Research projects. All concluded that while grant recipients provide a huge amount of information, information is not provided in a uniform way that would enable a synthesis of cross project learning. On the other hand, the OR portfolio was a nugget of information though interventions were often too complex. Recommendations to make PVO documentation more useful to global program learning include:

- Having a template executive summary that states the issue, in what context, methods used (study design), intervention packages including inputs and outputs, and endpoints / outcomes.
- Using a project benchmarking system (similar to the one that the iCCM global taskforce developed) to map the specific processes (from global to national to district to local) that the grantee worked on / influenced during the course of the project.
- When designing an OR study, simplify the intervention, reduce the duration of study (under 3 years), focus on 1 dependent variable (distal variables are not under your control).
- CORE could develop trainings on how to write lessons learned.
- Develop incentives for producing papers on negative results
- Be inclusive of all stakeholders especially in country in order to get results used
- Set aside time and money for the learning part of the program
- Develop a common vocabulary for community work, including inputs and outputs, and be rigorous in reporting these contextual details
- Develop a list of competencies needed to make learning a part of the program
- Find outlets for the information.Utilize the new USAID Journal of Science and Practice

David Pelletier summarized the discussions and the program learning theme.

- Clarify WHO needs to know WHAT for WHAT PURPOSE

- Adopt a robust model for understanding HOW learning occurs, HOW it is internalized and how it is applied across partner organizations
- Design strategies for knowledge gathering
- Need for national and global learning / research agendas related to building capacities for collaboration
- Promote learning at all levels – community up to global. Institutionalize the AAA process (Assessment, Analysis, Action).

Community Case Management: A Review of 22 CSHGP Projects since 2000
David Marsh, Senior Advisor, Child Survival and Global Team Leader, CCM, Save the Children

Key Messages

1. The USAID Child Survival and Health Grants Program (CSHGP) has supported numerous projects around the world that currently or previously include community case management components. A review was done of 22 projects since 2000 that had sufficient documentation to highlight patterns of learning related to CCM across CSHGP grantees. The review process used methodological tools including benchmark mapping and a "fill in the blanks" case study template that can be useful for systematically documenting project approaches and achievements. "The benchmark mapping questionnaire and chart are useful tools to facilitate constructive dialogue on how country stakeholders working in different health system component areas are able to introduce, expand and scale up national CCM programs."
2. Since 2000, CSHGP has supported 152 projects of which 123 had some effort controlling pneumonia, diarrhea and/or malaria, but only 22 (10 completed, 12 on-going) had curative intervention delivered in the community at a level of effort $\geq$ 35% and had a "high" level of documentation.
3. Of the 10 completed projects with CCM efforts, all of them significantly increased the percentage of coverage of curative interventions and contributed to thousands of lives saved.

Surprising Twist / New Learning

1. Completed projects contributed to significant yields based on the results framework areas of Access, Quality, Demand, Environment, and Use.
2. Main project results from baseline to endline included:
   - % of children 12-23 months whose last bout of diarrhea was treated with oral rehydration fluids (ORS) increased from < 20% to > 45%
   - % of children < 5 who receive correct first-line treatment for fever within 24 hours increased from 11% to 56%
   - % of children less than five years of age with difficult breathing who receive correct treatment within 24 hours from authorized providers increased from 42% (MTE) to 86%
3. Through group work, the majority of participants felt that the sample benchmark mapping and a case study template were feasible, useful and valid methods to use with some caveats. Many participants were concerned that if these types of unifying methodologies were not supported in donor reporting requirements then the exercise might be redundant, an additional burden or not utilized sufficiently.

Unanswered questions / gaps

Benchmark Mapping:
- Are the benchmarks sequential, such that the completion of one is required for successful completion of the next? For example in the Sierra-Leone case, if CCM Partner Mapping was not conducted and a TAG was not formalized, how could the national program complete a thorough needs assessment?

- The benchmarks need further clarification for some important CCM areas, e.g. the details of a community governance structure that is required for successful CCM implementation. Does this fit in Policy and Coordination, Human Resources or Community and Social Mobilization?

- There was a suggestion that NGOs classify their attribution to the benchmarks in the map, e.g. low, medium or high.

Case Study Template:
- Who is the audience?
- What is the purpose? Can it change over the project life? Can it be used for multiple purposes?
- Is there already too much documentation? Are there already pieces in place for documentation? Utility depends on what the template adds to existing processes/documentation.

The Future – What should be next for CORE Group *Community Health Network* in this topic area?

As methods are refined, help to engage program managers for input to ensure relevancy for learning. Work with CSHGP to further refine program learning methodologies and continue to support platforms that foster the sharing across programs and from groups of projects overall.

For more information about the CCM Benchmarks, Indicators and Results Framework applied in the CCM Program Learning Review, please visit: www.ccmcentral.com*.*

What's Next for Community Case Management of Childhood Illness?

Laban Tsuma, *Senior PVO/NGO Advisor*, MCHIP, ICF; **Sarah Andersson**, *Country Technical Manager*, SC4CCM; **Kathryn Bolles**, *Senior Director, Emergency Health and Nutrition*, Save the Children

Key Messages

1. Over the years we are successfully moving from defining and advocating for CCM; adopting the concept; and implementing programs in countries to monitoring the progress, which means we can begin to see whether we are truly reaching those who need access to services most and better address issues of equity, quality and sustainability.
2. There are three promising, simple solutions to improving CCM product availability:

   - Enhancing Logistics Data Visibility with **cStock** in Malawi

   - Simplifying and **Standardizing Resupply Procedures** in Rwanda

   - A group training approach with **Ready Lessons & Problem Solving** in Ethiopia

3. For example, a simple, SMS-based stock reporting system can have a powerful impact on improving data visibility in the supply chain and factors for success include: a) Good understanding of context and environment; b) Well thought out strategy and focused objectives and c) Constant M&E and improvements.
4. An integrated CCM program that is able to be adjusted and adapted to emergencies could provide a critical service delivery mechanism to reduce excess mortality in the face of an emergency and increase the resilience and ability of communities to cope with emergencies.

Surprising Twist / New Learning

- Across 12 countries over 110,000 CHWs have been trained and are implementing CCM.
- Countries can and do compute indicators on the basis of variables already collected; we have higher density of indicators for Service Delivery and Referral but are very lean on Communication and Social Mobilization; indicators are not making it to national reports and we are collecting important indicators but not segregating by wealth or social class. So even with an equity-focused approach it is still important to examine whether the most vulnerable within those that are vulnerable are being reached.
- A multi-partner working group is looking how CCM can be adapted to emergencies and helping to make communities more resilient.

Unanswered Questions / Gaps

- Are we reaching the most in need with CCM? How can PVOs help? How can equity best be addressed within CCM? How well are we monitoring progress?
- If CCM is so dependent on product availability, can CCM really be adapted to emergency settings where supply chains and transport are usually disrupted?
- As CCM coverage and quality increases, are we helping communities to be more resilient?

The Future – What should be next for CORE Group *Community Health Network* in this topic area?

- Work with PVOs and partners to capture relevant indicators and feed them into national data collection and systems.
- Continue to help disseminate promising, simple solutions to improving CCM product availability.
- Look at how existing equity guidance/checklist could be applied to CCM or explore whether more is needed.

Give Them a Chance: What We Know about Prevention of Prematurity and Stillbirth

James Litch, *Perinatal Interventions Program Director*, Global Alliance for the Prevention of Prematurity and Stillbirth*; **Courtney Gravitt**, *Research Associate II,* Global Alliance for the Prevention of Prematurity and Stillbirth; **Aaron Emmel,** *Senior Policy Advisor,* PATH; **Carolyn Kruger**, *Senior Advisor for Maternal, Newborn and Child Health/Nutrition*, Project Concern International (Facilitator)

Key Messages

- 15 million pre-term births every year and rising
- 1.1. million babies die from preterm birth complications

- 60% of pre-term births occur in sub-Saharan Africa and South Asia
- 75% of deaths of premature babies could be prevented with feasible, cost-effective care
- More than 3.2 million stillbirths occur globally each year
- Stillbirths are largely invisible in global tracking
- Stillbirths are kept hidden due to a lack of data and to social taboos that reduce visibility of stillbirths and the associated family mourning
- Recognition of stillbirths as a public health concern is hampered by confusion and inconsistent application of definitions
- More research needs to be done to determine risk factors in prematurity and stillborn deaths.
- Prevention includes decreasing the risk factors: pregnancy at an early age, mulitparity, short interpregnancy intervals, maternal undernutrition, pre-eclampsia, exposure to harmful substances (tobacco/alcohol/drug use), malaria.
- Program interventions: Good antenatal care, skilled delivery, postnatal care, essential newborn care and access to family planning counseling an d commodities are key areas for intervention which is the standard package for all pregnant women.
- The panel advocated for integration of programs to prevent prematurity and stillbirths into their primary maternal and infant health programs with special emphasis on the antenatal care package, skilled delivery and pregnancy spacing.

Unanswered questions/ gaps

1. More research needs to be done on:
   - Social barriers to visibility of prematurity and especially stillbirths
   - Risk factors for prematurity and still births
2. Continue to promote integration of prevention /prematurity/stillbirths with current MNCH programs and document the experience.

The Future. What should be next for CORE Group *Community Health Network* in this topic area?

The SMRH Working Group will provide the leadership for the newly established Interest Group on Prevention of Prematurity and Stillbirths. The group will determine its agenda for this year and will continue to have web meetings.

MHealth: The Growing INGO Portfolio

Andrea Wilson Cutherell, *Maternal and Child Health and Nutrition Programs Coordinator,* Food for the Hungry; **Michael Frost,** *Director,* JSI Center for mHealth; **Ann Hendrix-Jenkins,** *Director of Partnership Development,* CORE Group; **Gillian Javetski,** *Program Analyst,* Dimagi; **Paul Perrin***, Senior Technical Advisor for Monitoring and Evaluation, Operations Research, and Learning in Health and HIV,* Catholic Relief Services

Public health and medicine are not known for rapid change. (One common statistic is that takes a new, proven medical practice or technology 17 years to saturate the US market.) On the other hand, cell phone technologies represent the epitome of rapid change in today's world.

So it is not surprising that the field of mhealth in low and middle income countries (known for their own issues of inequity) is notable for its extreme disparities. While Rwanda is among the world's leaders in electronic medical record systems development, most community health workers around the world are recording details in notebooks, and report forms arrive by bicycle, weeks later.

The same goes for INGOs—a wide array of mhealth capacity and implementation. This session's presenters represent the leaders within our community. Mike Frost described JSI's extensive, creative mhealth portfolio, which has equipped thousands of health workers around with the world with cell phones that help them do their job better, with a focus on supply chains.

Paul Perrin showed how Catholic Relief Services braved a steep learning curve to set up a system to use cell phones to collect data for a national level malaria survey in Sierra Leone. The audience was convinced of the value of the effort by the time Paul pulled up a live map that marked exactly where, when and by whom each individual questionnaire had been completed. Paul explained how data collection glitches were caught and fixed in real time, how data was backed up in two ways, and more.

Andrea Cutherall of Food for the Hungry (FH) and Gillian Javetski of Dimagi demonstrated the value of a productive relationship between a quality INGO and a saavy technology firm. FH is implementing one of the *CORE Group Commcare Learning Collaborative Grants* to address growth monitoring and promotion in Mozambique. FH is leading the grantees in both implementation and innovation—in just a few months they have worked with Dimagi to create their Commcare "killer app" –and are already adding a new feature that they hadn't planned on including—individual case management.

As our community collectively finds ourselves on different parts of the mhealth learning curve, the most important thing is to keep moving forward. Mhealth is now accepted as a tool that can be useful in terms of quality, scale and equity, with reasonable potential to be cost effective. Not using it at all means lagging behind. Specialized staff are NOT necessary to get started—but as with any global health work, you do need staff with management and implementation skills, and aptitude for figuring out where and when mhealth can make sense. Starting small minimizes risk and enables quick learning.

All four slide sets are worth a look!

Community Health Worker Evidence Review

Henry Perry, *Senior Associate, Health Systems Program*, Department of International Health, Johns Hopkins Bloomberg School of Public Health**; Joe Naimoli**, Public Health Specialist, CDC; **Diana Frymus**, HSS Advisor USAID Office of HIV/AIDS; **Polly Walker**, CHW Program Advisor, World Vision Int.; **Caroline Bishop,** Health Technical Advisor, CRS

- CHWs are here to stay; they are not temporary solutions! There is a global shortage of skilled, motivated and supported health workers at the same time that countries are investing in more equitable approaches, expanding coverage of key interventions, and increasing investments in large-scale programs.
- USAID is working on a CHW logic model based on the finding of the CHW Evidence Summit held in May 2012, will publish the results and case studies, and will have 3 working papers developed from the Summit available in the very near future (stay tuned)

- The Evidence Summit found that CHWs can successfully deliver a range of preventive, promotive and curative services and that technical and social support, and recognition, is critical from the community and health system – context matters. However, there is strong colloquial knowledge but weak evidence about the support – performance relations. Research is needed.
- Globally, there is a lot of fragmentation around CHWs: multiple actors and programs making multiple demands on CHWs that are not well coordinated or based on evidence.
- CRS developed a guide for "working with volunteers" available on their website.
- Do NGOs need a set of principles of practice for working with CHWs? World Vision has a draft set to refine for NGO sign-on. (See Polly Walker.)
- NGOs have so much to contribute to the understanding of community and CHW systems, but must be more rigorous in definition and data capture.
- The CORE Group could promote better understanding and learning about m-health approaches that support CHW performance and continue to share information on CHWs and help standardize terminology so we can compare, contrast, and analyze against similar criteria.

Local Determinants of Malnutrition: Formative Research and Programmatic Implications

Kathryn Reider, *Nutrition Technical Specialist*, World Vision (Facilitator); **Andrea Cutherell,** *Maternal and Child Health and Nutrition Programs Coordinator*, Food for the Hungry; **Sarah Borger**, *Maternal and Child Health Coordinator,* Food for the Hungry; **Carolyn Wetzel,** *Director of Health Programs,* Food for the Hungry; **Justine Kavle,** *Senior Program Officer, Nutrition,* MCHIP and PATH

- LDM tools from FH are evolving and are a work in progress. LDM is "doable" in the field, not too time- or resource-intensive. LDM is a good formative research tool to consider.
- FP and nutrition integration makes sense; there is clear overlap.
- LDM can be used to look at WFA, WFH, and HFA differences through a case/control study
- LDM could be used mid-program, not just at beginning, as it would help to to re-evaluate BCC messages.
- FH is organizing a small working group to discuss LDM.

What's New in Immunization and Where Do PVOs Fit In?

Robert Steinglass, *Project Director*, ARISE Project and Universal Immunization through Improving Family Health Services Project, JSI; **Rebecca Fields,** *Senior Technical Advisor*, MCHIP and ARISE, JSI

- PVOs are often not engaged with immunization activities for a variety of reasons, but they have a very important role to play, particularly surrounding the three key "drivers" of successful routine immunization systems: community-centered health workers; partnership between health system and community; services tailored to community needs (from ARISE project research)
- PVO role includes engaging on global immunization issues, ensuring immunization is a core component of programs, direct immunization, supporting MOH at the district level, mobilizing communities, using birth/service registers to track defaulters, advocacy, and planning and monitoring with the communities.

- Along with new opportunities, PVOs have a role in helping to address challenges: cost, number of vaccines (contacts), cold chain, the integrated approach to disease control.
- How to reach pockets of unimmunized children is a major challenge in immunization.
- Next steps for CORE Group PVOs include:
    - Ensuring immunization is integrated into health activities: whatever the health issue, immunization has a role to play
    - Engaging community in immunization activities
    - Leveraging credibility gained with polio eradication to strengthen routine immunization services

Finding the Sweet Spot – Part 2: Leveraging Agriculture Value Chains to Improve Nutritional Outcomes

Paul Sommers, *TOPS Project* , Mercy Corps

- Key actors within the value chain include producers, assemblers, and processors.
- Solutions should be available on the local market and have local demand.
- Nutritionists/social marketers/BCC people can work together to create demand for nutritious products (any orange flesh sweet potato). Once there is demand the agriculturalists will respond to it and invest their own resources to increase production.
- Remaining questions include: how to integrate agriculture and nutrition programs and how to monitor and evaluate these programs when agriculture and nutrition are managed separately under different bureaucracies.

Understanding the Context that Produces Inequities: An Opportunity to Learn About a Systematic Process Used by Concern Worldwide

Kai Matturi, *Knowledge and Learning Advisor,* Concern Worldwide; **Jennifer Winestock Luna**, *Monitoring and Evaluation Advisor,* ICF (Facilitator); **Jennifer Olson**, *Africa Program Director,* HealthRight International (Facilitator); **Jennifer Weiss**, *Health Advisor*, Concern Worldwide (Facilitator)

- Concern Worldwide recently underwent (in process) a systematic, Contextual Analysis in all country programs to help 1) identify the extreme poor, 2) understand the environment in which they live, 3) design programs to reach them/meet their needs
- Using PRA methods, they explored five key questions: 1) who are the poor, 2) why are they poor, 3) what keeps them in poverty, 4) what opportunities exist for them, 5) what needs to change?
- The analysis explored the three dimensions of poverty from a non-sectoral-specific perspective: inequality, vulnerability, and assets.
- The results are being used in each country to develop 5 year programs as well as country strategic plans to help Concern fulfill its mission of helping people living in extreme poverty to achieve major improvements in their lives.
- Requirements for the process include: initial training for team; facilitator from senior country staff; PRA skills; country-level secondary data collection; constant/continual reflection and analysis; multi-sectoral teams (to avoid sector bias, i.e. always do health programs); triangulation of info; disaggregation of impact groups; comparison of different wealth groups; review of policies;

prioritizing those with worse health coverage; addressing stigma in program design, market analysis for livelihoods

- Concern is planning to fully document the process and results and expects to have a tool to share with other NGOs in 6-8 months.

In*know*vation: Simple Techniques for Tapping into All the Knowledge in the Room

Lani Marquez, *Knowledge Management Director*, USAID Health Care Improvement Project (HCI)-University Research Co., LLC/Center for Human Services (URC/CHS); **Lenette Golding**, *Senior Social and Behavior Change Communication Advisor*, CARE

- People know more than they can say and can say more than they can write down.
- Collecting knowledge is not the optimal knowledge sharing strategy – connecting people to share experience through conversational methods allows for much more efficient knowledge transfer
- While they take a little planning, "connecting" techniques are easy and fun and really worthwhile to enable rich program learning.
- New knowledge is created when people connect and share, integrating their knowledge to produce new synthesized knowledge.
- How can we do more "connecting" in CORE meeting sessions and use techniques to enable deeper knowledge exchange around key implementation questions?
- Next steps include another session at the Spring Meeting or even a half-day workshop to learn and try out other KM techniques.

A Long-term, Integrated Approach to Partnership and Capacity Strengthening

Robert Grabman, *Director, Strength in Solidarity Project*, Catholic Relief Services

- Catholic Relief Services (CRS) believes that articulating partnership principles is important for establishing and maintaining productive, respectful and mutually beneficial partnerships.
- An organization's principles have an impact on the way it carries out partnership and capacity building. In the case of CRS, the principles require CRS to seek and commit to long term relationships (as distinct from grantor-grantee relationships) and therefore to offer capacity strengthening beyond the timeline of a particular project.
- Organizations should be aware that adherence to stated principles is not always easy. They may complicate or slow down decision making. Different partners may interpret principles differently. On the other hand, clearly stated and agreed upon principles provide a basis for dialogue to resolve issues.
- The Consortium Alignment Framework for Excellence (CAFE) tool was presented in an interactive exercise. You may find it useful for forming and working in an effective and efficient consortium. (The CRS partnership principles mentioned above can be found on the inside cover of CAFE.)
- CRS offers a variety of technical resources at www.crsprogramquality.org. For partnership and capacity strengthening materials and tools, including CAFÉ, click on the "Capacity Strengthening" box. Organizations may download and use these at no charge. CRS requests that attribution be made.

- The CRS Strength in Solidarity project was presented using the Pecha Kucha methodology, which might be described as the antithesis to "death by PowerPoint." Participants seemed to enjoy it. In a nutshell, no more than 20 slides are allowed, each slide should contain a single graphic or word, and no more than 20 seconds can be spent presenting any slide. As a result, presentations are fast, dynamic, and devoid of too much information. (See www.pecha-kucha.org for more information.)
- **The CORE Group should continue discussion** on the changing nature of partnerships due to the changing aidscape (the desire of donors to directly fund local NGOs) and the implication for capacity strengthening by INGOs to local NGOs.

Powerbreakfast and Lunch Tables—A "Who's Who" list of Emerging and Intriguing Topics and their Advocates/Experts

1. **Behavior Change: *A Tool for TA*: New Online Case Study Kit on How to Engage Fathers. Ann Jimerson**, *Senior Specialist in Behavior Change*, Alive & Thrive, FHI 360; **Janelle Mackereth**, *Communications Specialist*, Alive & Thrive, FHI 360
2. **Cervical Cancer: Real Opportunities for Addressing a Major Killer of Women in the Communities Where We Work. Janine Schooley**, *Senior Vice President for Programs*, PCI; **Carolyn Kruger**, *Senior Advisor for MNCH*, PCI; **Carol Bristol-Makoane**, *Technical Officer, HIV/AIDS,* PCI
3. **Biodiversity: It's Not Easy Being Green – But Child Health and Survival Depends on It. Kiersten Johnson**, *Senior Researcher*, Center for Design & Research in Sustainability and MEASURE DHS; **Soumya Alva**, *Senior Technical Specialist*, Center for Design & Research in Sustainability; **Anila Jacob**, *Consultant*, USAID E3/Biodiversity and Forestry Team
4. **Child Safeguarding in the Health Sector. Matthew Stephens**, *Child Protection Sector Specialist*, World Vision (representing the Keeping Children Safe Coalition)
5. **Gestational Diabetes: Improved control as an effective approach to reduce childhood deaths. Mychelle Farmer,** *Technical Advisor for Health and HIV,* Catholic Relief Services
6. **Global Health: Science and Practice Journal. Natalie Culbertson**, *Managing Editor*, GHSP Journal
7. **IMCI: Making It Work for More Children: Catching Kids with TB.** Devasena Gnanashanmugam, *Consultant;* Alan Talens, *Health Advisor*, World Renew
8. **Immunization: Why Won't They Take Our Ounce of Prevention? Best Practices in Raising Coverage**. **Lee Losey**, *Deputy Director/Senior Technical Advisor,* CORE Group Polio Project, **Meg Lynch**, *Senior Program Officer,* CORE Group Polio Project
9. **Integrating State of the Art Guidance into National Programming: An Adaptation Case Study (based on the Taking Care of Baby at Home adaptation in Benin). Nancy Newton**, *Senior Advisor, BCC,* University Research Corporation; **Alicia Antayahua**, *Program Officer*, University Research Corporation; **Joan Haffey**, *Consultant*, CORE Group
10. **The Nutrition Program Design Assistant Tool: Let IT help YOU**. **Kathryn Reider**, *Nutrition Technical Specialist*, World Vision; **Kristen Cashin**, *MCHN Specialist*, FANTA/FHI360; **Judiann McNulty**, *Consultant*; **David Shanklin**, *Consultant*
11. **Peacebuilding: Practical Skills for the Field, the Office, and Life in General. Bill Goldberg**, *Co-Director*, Summer Peacebuilding Institute at Eastern Mennonite University

12. **Performance Monitoring and Evaluation: Support to USAID Missions. Virginia Lamprecht**, *Senior Program Analyst,* USAID
13. **Postpartum Hemorrhage and Pre-Eclampsia/Eclampsia: A Global Survey of National Prevention and Management Programs. Khatidja Naithani**, *Program Officer*, MCHIP; **Mandy Hovland**, *Program Officer*, MCHIP
14. **Stillbirths: The Impact of Cultural Secrecy on Measuring Global Burden. Rachel Haws**, *Consultant*
15. **Sustainability—What Do You Mean? (Community-based Family Planning Checklist.) Sharon Arscott-Mills**, *Fellow, International Health*, ICF
16. **Women and Workplace Health Services: The Forgotten Piece in Health System Strengthening. David Wofford**, Meridian Group International and RAISE Health Initiative; **Meira Neggaz,** Marie Stopes International
17. **Care Group Training Manual. Mitzi Hanold**, *Training and Curriculum Specialist*, Food for the Hungry
18. **What to Do About Poo? Lisa Schechtman**, *Head of Policy & Advocacy*, WaterAid in America; **Hope Randall**, *Communications Associate, Child Health*, PATH; **Ashley Latimer**, *Advocacy & Outreach Officer, Child Health*, PATH
19. **What's the Latest and Greatest in HIV/AIDS? Janine Schooley**, *Senior Vice President for Programs*, PCI; **Shannon Senefeld**, *Global Director of Health and HIV,*Catholic Relief Services; **Carol Bristol-Makoane**, *Technical Officer, HIV/AIDS,* PCI
20. **Rapid CATCH Indicators...What does the data say? What has been successful? What has been more difficult? Laban Tsuma**, *Senior PVO/NGO Advisor*, MCHIP, ICF; **Kirsten Unfried**, *Program Analyst,* MCHIP, ICF
21. **Health Equity. Jennifer Winestock Luna***, Monitoring and Evaluation Advisor*, ICF