

**Notes from Technical Meeting on the Role of the C-IMCI Framework
in Today's Child Health Environment
November 20, 2009**

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Meeting Objectives:

1. Gain consensus on the strengths/weaknesses of the C-IMCI Framework as an advocacy tool, planning tool, and/or assessment tool;
2. Inventory tools used for each element and the multi-sectoral platform;
3. Identify preliminary practical recommendations for addressing gaps and weaknesses;
4. Develop draft communication messages to articulate the group's findings regarding the C-IMCI Framework; and
5. Make recommendations and plan next steps to support and advocate for a community child health approach.

Meeting Organization and Resources:

CORE Group/IMCI Working Group and MCHIP co-hosted a technical meeting to analyze the lessons learned from World Relief and Plan case studies and other IMCI experiences and determine the role and positioning of the Framework in the current child health environment. A background document detailing some of the actions and thinking leading up to this meeting is included in Appendix A.

A phone survey was conducted prior to the meeting with invitees unable to attend the meeting and several other key informants in order to provide additional insight to experiences and perceptions related to the framework and the broader child health environment. The results of this survey are included in Appendix D.

The agenda (Appendix B) was organized to start with presentations and then provide the majority of the time for small group work and discussion. Ephraim Toh, Plan/Cameroon presented Plan's experience using the Framework in a C-IMCI project in Cameroon and Lynette Friedman presented a summary of the pre-meeting survey results. Based on these presentations, participants identified the key questions for

discussion and spent the first part of the afternoon in two concurrent small group discussions before coming back together and consolidating recommendations and next steps.

Summary of Discussion:

Current environment: Many things in the global environment have changed since the Framework was developed in 2001, yet some of the same needs remain. While there is more evidence and acceptance of community approaches today than in 2001, community systems are not considered a building block in WHO's Framework for Action¹. While IMCI is accepted in some countries, the Catalytic Initiative is accepted in others, CHIPS is promoted in Ghana, etc. and a broad understanding for community systems programming does not exist. IMCI focused on the child, yet globally, there is now a push for an integrated continuum of care from the pre-pregnant mother through the mother and child dyad. Child deaths have decreased in the past decade, yet newborn and child deaths due to preventable causes remain the largest percentage of those who die. CHWs and their role as community agents have increased in importance in many countries.

The C-IMCI Framework remains a valuable tool (especially as a standardized communication tool) to depict C-IMCI or an integrated approach to community health. In some countries, C-IMCI remains a key entry point for discussions on community health given that IMCI is part of the MoH strategic health plan. In other countries, the framework needs to be rebranded as a broader framework for depicting integrated community approaches to maternal child health. The framework visual remains pertinent given that there is no other similar depiction portraying a community health perspective. If IMCI with its three components (health worker training, health systems, community) is no longer the standard, then another broader framework must be developed to position the portrayal of community systems within a broader health system context. Several alternative broad frameworks were proposed for further discussion.

Given the evidence base and experience that has emerged over the past eight years since the development of the framework, and the new emphasis on an integrated MNCH/FP platform in the Global Health Initiative, the framework should be updated slightly / modified to make it clearer with illustrations that represent other sectoral stakeholders and new directions such as health systems strengthening and community case management. The TAG provided a set of recommendations for updating the framework, noting that all products should be finalized with key stakeholder input including WHO, UNICEF and USAID.

Meeting Results by Output:

1. Gain consensus on the strengths/weaknesses of the C-IMCI Framework as an advocacy tool, planning tool, and/or assessment tool

Appendix D lists the gaps and weaknesses identified by respondents in the pre-meeting survey. These responses were added to the results of a SWOT analysis conducted at the CORE Spring Meeting in April 2009 for a complete listing of strengths/weaknesses (Appendix C). Both documents were included in participant packets and were discussed at the meeting.

¹ http://www.who.int/healthsystems/strategy/everybodys_business.pdf

The Plan/Cameroon experience highlighted the following strengths in using the Framework to package, communicate, and plan program activities. The Framework:

- Helped Plan transition away from programs focused on short term benefits
- Helped rally different groups to quickly consolidate a vision around a healthy child
- Helped identify non-traditional partners who needed to be involved to realize the common vision
- Helped focus partners on “big” picture helping to channel activities towards a shared vision
- Enabled increased accountability of volunteers thereby enabling government to soften in support for community-based treatment of malaria
- Helped pool partners together by providing a standard communication tool
- Presented very clearly the challenges in the program and the fact that not all activities were being visited on the same households
- Became a constant reminder to partners about what was expected of a good community program
- Helped explain the significant confusion that existed at all levels between C-IMCI and CCM

In discussion related to use of the tool for advocacy, planning and assessment, the following consensus emerged:

Advocacy tool: The framework has been used successfully for advocacy purposes at multiple levels: at the national level to legitimize and explicate the role of communicate health in IMCI National Coordination Committee meetings and as an entry point for discussions on CCM; at the district level for discussing decentralized alternative approaches to community health; and at the household level to boost credibility of volunteers, practice of key behaviors, and partnership with women’s groups. It may be necessary to have different versions of the tool to respond to different stakeholders. One schema was to emphasize key advocacy messages by element:

- Element 1 – shifting power to people, need for community empowerment, role of community management committees
- Element 2 – importance of making treatment services availability and culturally accessible
- Element 3 – need for behavior change

Planning tool: Many individuals and organizations are using the Framework as a planning tool to inform program design and prepare proposals. The Framework provided a broad picture for discussing and prioritizing community approaches at the facility level, private / community level, household level and with multiple sectors. Additional tools are needed for in-depth planning for each element and MSP, indicators, and clearer connections with health system items such as supervision, drug logistics, training, etc.

Assessment tool: The Framework can be used to broadly categorize and assess a situation, but indicators for each element are essential to make it useful for this purpose.

2. Inventory tools used for each element and the multi-sectoral platform

Appendix E provides an inventory of tools by elements/MSP. This list reflects materials posted on the CORE IMCI Working Group webpage, pre-meeting survey responses, and meeting participant additions.

Recommendation: Link tools more clearly on website and in new graphic to each element and the multi-sectoral platform.

3. Identify preliminary practical recommendations for addressing gaps and weaknesses

Small group work produced the following discussion and recommendations:

a. Role of the mother and neonate:

The group debated whether the central picture, and therefore focus, should be the child, the mother and child, or the whole family including the father. Concerns were raised about not wanting to broaden the scope of the interventions too widely with the entire family, but also not wanting to exclude the role of the father in the well-being of his children.

Recommendation: Use the family picture from the MSP in the center, but clearly label the title of the Framework to indicate the importance on MNCH. The proposed title for the Framework was: Community Integrated MNCH

b. Role of community mobilization:

The group felt that this should be explained as an underlying component in community child health. Discussion also touched on the word choices related to community mobilization, community ownership, or community empowerment with the felt need to further refine the terms before selecting the appropriate one for inclusion in the Framework. A further issue was raised of how to measure community capacity and the need was identified for a set of tools and resources.

Recommendation: Label the circle around the elements as “community mobilization”.

Recommendation: Link with the CORE M&E Working Group taskforce on community capacity measurement and the Global Fund effort on community competency measurement for malaria.

c. Meaning of arrows:

The group agreed with respondents that the linkages between elements designated by the arrows are not clear. The arrows were seen to represent key building blocks such as supervision and evaluation that are easy to forget in program planning when they are not explicitly stated.

Recommendation: Clarify the meaning of the arrows and the linkages between the elements.

d. Connection to a larger health system:

While the Framework was originally intended to further break out the Community component within the larger construct of IMCI (consisting of training facility-based providers and strengthening health services), respondents expressed that the Framework can be misinterpreted to indicate that community programming can exist as a standalone entity separate from facility-based services. The group felt that it was important to emphasize the connection to a larger health system and clarify that community health programming is not a standing alone effort. They reiterated the importance of positioning community-based programs within a broader health system. They also reiterated that weak clinic-community linkages were a real problem in many places.

Recommendation: Create a thoughtful introduction to any supporting documents describing the Framework to cover this issue.

Recommendation: Link the Framework to a health system graphic so that community systems are not seen as stand-alone.

e. Indicators:

The Plan/Cameroon presentation highlighted the gap in indicators for the Framework beyond behavioral outcome indicators included in the KPC. The group felt that indicators were needed for the process of elements, arrows, and community mobilization. They discussed the need to begin with child health outcomes and work backwards, articulating the centrality of the child health outcomes so that they remain the driver. Discussion revolved around process indicators; system indicators (ex. logistics, supervision, nurse is paid regularly, replacing staff, leading to sustainability framework links); outcome indicators for mothers, infants, children via KPC; and explicit impact indicators for the results. The group also discussed the need to weigh the indicators.

Recommendation: Create one key indicator per element that defines whether the action in that element is at a minimal standard and enables programs to measure changes in actions related to the element over time.

f. Relationship with CCM:

When the Framework was developed, the global and country-level environment was resistant to community case management and the presence of Element 2 served an advocacy function for talking about the importance of community-based treatment. Now, the environment has changed significantly and there is broad support for CCM, however the challenge has shifted to one of needing to demonstrate how the rest of the Framework serves a purpose to support CCM outcomes in order to show relevancy for the other elements of community-based programming in addition to CCM. The group felt that the primary problem related to the positioning of the Framework with CCM was one of branding. Additionally the group decided that both the Framework and CCM were applicable in conflict/fragile states or other settings with weak health systems.

Recommendation: CCM Essentials communications need to emphasize the relationship between CCM and the other elements of community-based programming represented in the Framework.

Recommendation: Design communication materials that are adaptable and can emphasize different elements based on the audience. Since CCM is currently in favor, revise the framework to showcase it more. One thought presented was a web-based version that could be manipulated and would provide the user with the ability to interact with the framework by clicking on various elements.

g. Role of Community Health Workers:

Many governments are now investing in Community Health Workers (CHWs) as the lowest level MOH paid worker. However, the full time duties of these CHWs including the number of households and people served makes it nearly impossible to ensure frequent contact at the household level. Many NGOs continue to form and train a community-selected and based worker who supports these MOH CHWs with household visits and community mobilization and education. While these (often volunteer) workers and/or a paid CHW could be seen in each of the elements, the role of the CHW is not explicitly stated resulting in lack of clarity as to their positioning within the Framework. A recommendation was made to make the CHW an explicit part of the C-IMCI framework, possibly through an illustration of a CHW with the arrows or around the circle.

Conversely, some survey respondents cautioned about the risk in the current environment that is supportive of CHWs of communicating too great of a load on the CHW without factoring in CHW constraints along with the time and effort it takes to make good community-based programs happen. These respondents felt that it was important to somehow communicate implications for policy, financing, supply and supervision within the Framework or supporting text to clarify that the responsibility for child health should not fall solely on the CHW's shoulders.

Recommendation: Continue discussion about the best way to incorporate the CHW in the Framework depiction.

4. Develop draft communication messages to articulate the group's findings regarding the C-IMCI Framework

The following recommendations were made for communication messages based on the current Framework depiction:

- The Framework is part of a larger picture and the link between the framework and the broader health system is essential
- Community mobilization is requisite in addition to the elements
- The multi-sectoral platform is important to emphasize related to understanding the determinants of health
- The Framework now focuses on the healthy family and therefore needs to depict other health issues such as HIV, malaria, and family planning
- Use "IMCI" to open doors as needed, but otherwise articulate a more generic name.

In discussing the role and purpose of the Framework in today's environment, the group identified two distinctly different purposes (and therefore audiences) for the Framework: 1) advocacy to those who make resource allocation decisions and need to know the areas to consider; and 2) program planning for PVO program designers.

Related to advocacy, the group discussed the absence of a "mega-framework" like IMCI upon which to anchor the Framework. They felt that the key question now is the role of the community in the health system. They discussed the role of community-based programming within a "mega-framework" and the need to create better linkages with the health system when it is not working with communities. They discussed the need to better articulate methods for providing community-based services and identified various delivery systems including routine, systematic home visitation; participatory women's groups; and outreach services – all methods that apply to community-based programming beyond child health. They also discussed three dimensions of public health - disease-centered, facility-centered, and community-centered.

The group identified the need for a "mega-framework" to demonstrate what a functioning community health system looks like and recommended that the original C-IMCI Framework and this larger "mega-framework build on each other (framework within a framework). They also suggested focusing advocacy efforts on fitting the community into health system strengthening. The group drafted two potential frameworks – one titled Framework for Maximum Improvement in Community Health (MICH) and the other a Framework for Maximizing Household Production of Health. Both frameworks are included in Appendix F.

Recommendation: Finalize one “mega-framework” demonstrating the position of integrated community-based programming within the larger health system.

5. Make recommendations and plan next steps to support and advocate for a community child health approach.

A major recommendation emerging from the meeting was the need to rework the above objective to now focus more broadly on supporting and advocating for an **integrated MNCH approach** as opposed to solely a child health approach.

The following recommendations were made for next steps:

- Update the current Framework for program planners
 - a. Update the Framework depiction based on the recommendations developed by survey respondents and meeting participants
 - b. Update the principles related to the Framework based on the needs in today’s global health environment
 - c. Update the associated tools such as the facilitator’s guide to represent the changes in the Framework and principles
 - d. Review and update the table on the back of the Framework depiction communicating how the Framework is associated with different health interventions
 - e. Tease out specific tools to support the various elements and MSP and link these on the website and on an electronic Framework depiction
 - f. Develop versions of the Framework targeted for different perspectives and audiences (ex. CCM)

- Develop a “mega-framework” for positioning community health systems and approaches within a broader health systems framework
 - a. Initiate a process to increase the stir, buy-in, etc. on where this is going and why it matters
 - b. Engage other key partners (ex. WHO, UNICEF, Bob Emory) beyond NGOs
 - c. Develop framework for community health systems
 - d. Finalize new acronym
 - e. Pursue TAG led by WHO and UNICEF thinking about who should convene, who is around the table, and the extent of co-ownership/leadership
 - f. Review statements on health systems and current role of communities; challenge conceptualizations
 - g. Legitimize a community health systems approach through various communication channels:
 - i. Write brief journal article to articulate thinking behind framework – need current statement or report card or commentary
 - ii. Develop a statement for the Women Deliver conference

- Seek out opportunities to advocate for the role of community health programming in current planning efforts
 - a. Determine how either framework could fit in with and influence the directions of the Global Health Initiative
 - b. Identify entry points to feed ideas into USAID Global Health working groups (ex. health systems strengthening global health working group, PEPFAR) in order to inform strategic thinking at USAID
 - c. Seek out independent opportunities for discussions with key partners such as WHO and UNICEF through multiple channels

- Meet with UNICEF and WHO to determine their interest to stay involved in the follow through of any or all of these recommendations

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Appendices

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Appendix A: Background Document

Technical Discussion on the Role of the C-IMCI Framework in Today's Child Health Environment

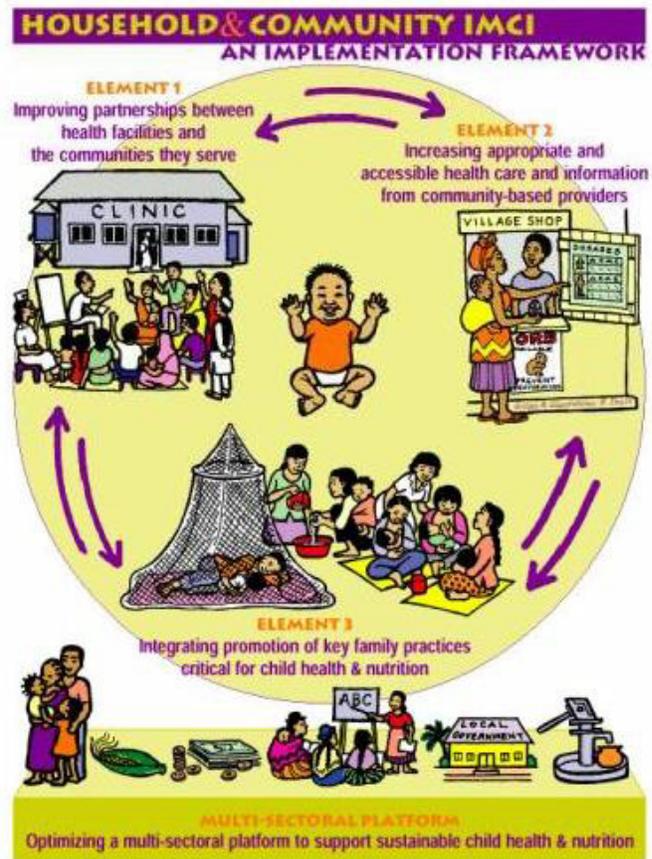
Background Document

The Community IMCI Framework was developed in 2001 as a programming tool highlighting community health and development interventions that could occur at the local facility level (Element 1), in the community (Element 2), at the household (Element 3), and in other sectors and institutions within the community (the Multi-Sectoral Platform including water/sanitation, schools, religious institutions, savings and credit groups, and local government) to improve maternal and child health.

Since the publication of the framework, CORE Group member organizations advocated for community-IMCI with governments, used the framework to plan and communicate program approaches, and represented CORE group experiences with the framework at multi-lateral and regional meetings.

CORE Group promoted communication tools for use with governments, held country C-IMCI workshops, supported development of tools for each of the elements and the multi-sectoral platform and documented case studies of CORE Group members work. In 2009, CORE Group selected PLAN Int. and World Relief through a competitive process to prepare case studies of how their child survival projects incorporated the C-IMCI framework. Initially focusing on several country efforts, the final case studies presented a more in-depth analysis of the use of the C-IMCI framework in Cameroon and Malawi through a four-year project cycle and corresponding lessons learned.

Discussions in the IMCI/Malaria WG during the CORE Group Spring 2009 meeting revealed the following challenges to promotion of C-IMCI Agenda:



- Lack of familiarity with the C-IMCI framework;
- equating C-IMCI with a revised IMCI algorithm for use by lay community workers rather than a set of key family practices;
- prioritization of the Community Case Management strategy as a replacement for a broader C-IMCI strategy;
- feeling that “C-IMCI” represented “everything and nothing” at the same time; having different meanings for different people;
- Feeling that the term C-IMCI limits the focus to child illness rather than focusing on the well mother – child dyad or continuum of care.

In spite of the challenges, NGO community health programs (data collected and recent CORE Group case studies) show that integrated community child health programs can attain high coverage increase in household practices of major health intervention, at low-cost and in a sustainable manner.

Based on the above discussions, CORE Group and MCHIP decided to host one of more technical meetings /discussion to analyze lessons learned from the case studies and other IMCI experience and provide more detailed information to improve the effectiveness and use of the C-IMCI framework or other construct.

Appendix B: Agenda

Technical Meeting on the Role of the C-IMCI Framework in Today's Child Health Environment

Agenda

When: Friday, November 20th from 9:00 – 4:30

Where: MCHIP conference room, 1776 Mass Avenue, Washington D.C.

Meeting objectives:

1. Gain consensus on the strengths/weaknesses of the C-IMCI Framework as an advocacy tool, planning tool, and/or assessment tool;
2. Inventory tools used for each element and the multi-sectoral platform;
3. Identify preliminary practical recommendations for addressing gaps and weaknesses;
4. Develop draft communication messages to articulate the group's findings regarding the C-IMCI Framework; and
5. Make recommendations and plan next steps to support and advocate for a community child health approach.

Time	Activity
8:30 – 9:00	Coffee and pastries
9:00 – 9:15	Welcome and background
9:15 – 9:30	Introductions and review of objectives
9:30 – 10:30	Presentations on C-IMCI Case Studies by World Relief and Plan
10:30 – 10:45	Break
10:45 - 11:15	Presentation on results of pre-meeting surveys
11:15 – 12:30	Plenary discussion and prioritization of key questions for small groups
12:30 – 1:30	Lunch
1:30 – 3:00	Small Group Work
3:00 – 4:00	Presentations, discussions, and conclusions on small group recommendations
4:00 – 4:30	Determine next steps to support and advocate for a community child health approach
4:30	Conclusion

Appendix C: SWOT Analysis

BRIEF SWOT Analysis of C-IMCI Framework – Based on CORE Spring Meeting April 2009 and Interviews November 2009

- **Strengths**
 - Tools now created for each element (Element 1: Partnership Defined Quality; Element 2: CCM; Element 3: Care groups, BEHAVE, PD/Hearth; MSP – Community Capacity Measurement)
 - Powerful tool for political advocacy and communication
 - Strengthens overall health system – promotes health as a social community norm, increases referrals to facility services, increases use of key family practices
 - Need for multi-sectoral platform
 - Partnership building tool between NGO and government MOH
 - Framework helps to show the mother that she is not alone – that there is a network supporting her
 - Useful to see linkages and partnerships – this helps with communications
 - Stating ‘clinic’ is good in that it can be a public or private clinic

- **Weaknesses**
 - Linkages between elements (arrows) not clearly spelled out
 - Linkage between other components of IMCI (improving the skills of health workers and improving the health system) not always clear.
 - Perceived to be in competition rather than supporting the health facility; linkages not clear
 - Categorization within elements not always easy
 - Need for better articulation of relationships between different players / stakeholders within community
 - Need to spell out role of Community Health Workers as “volunteers” different from new cadre of formal ministry paid “health extension agents”
 - Key indicators for elements and MSP not developed
 - Key indicators for integrated community level programming not developed (discussion of frequency and intensity of community contacts; # of community groups for health and development created or strengthened
 - Lack of data to support use of framework in different health scenarios
 - Not clear how the Framework is related to CCM
 - CCM and the maternal-newborn continuum of care needed a formal place in the Framework in both the title and in the content.
 - Include more prescriptive guidance for use
 - MSP too broad and undefined and doesn’t incorporate the subsequent work done by CORE
 - The Framework could better communicate implications for policy, financing, supply and supervision

- The Framework doesn't show the broader picture of health systems development including policies, integration of activities in child health strategies and plans, and service provision
 - Doesn't communicate who is going to do the work in the various elements
 - Not clear how the elements link in with community mobilization
 - Need to add private providers – not visually there right now
 - There is a lot of focus on depiction of malaria with the bednet, not as much with other important diseases like pneumonia. Good inclusion of breastfeeding and nutrition. Perhaps add immunizations, boiling water, smoke going out of house – need better balance of activities
 - The village shop doesn't exist everywhere and people need to see something they can identify as possible in their area.
 - Don't currently see the connection with maternal health – this is all about the child alone
 - The mothers are depicted as recipients right now (of education, of meds, of messages). Their role needs to change to be more action-oriented and focused on individual empowerment.
 - Don't see local government involvement right now – this would help for an advocacy component.
 - Community involvement needs to include the private providers and the private sector and the non-health networks that support child health.
- **Opportunities**
 - Need to provide cost information on community approaches and cost savings information with community-based services for government and individual
 - Framework can be used with other disease and development areas
 - Can be better communicated to describe a broad range of community efforts
 - Provides for engagement between community and health system
 - Can be used as a broader community development tool rather than just a healthy child tool
 - Framework could be used to demonstrate the importance of integration versus vertical programming.
 - The Framework needs to call for action – it should be less about illness and more about encouraging action and enabling the user to see their own role to do something.
- **Challenges**
 - First level (facility) IMCI training often not working or supportive supervision lacking
 - Weak (facility) health systems
 - Funding still flows vertically rather than supports integration
 - Need to communicate benefits to increase broad support to key stakeholders
 - Not being used widely enough
 - There is still a disproportionate focus on facilities (Policy issues)
 - Supervision/mentoring – labor issues
 - Supply chain issues – logistics of supplying pharmaceuticals to community
 - Case load often too large for community workers
 - Referral system – barriers/delays (cost, transportation, social)
 - Frequent Policy Changes

C-IMCI Technical Discussion – Summary from Interviews

1. How have people used the Framework and what is the primary role or purpose of the Framework?

Most people interviewed were familiar with the Framework and many were involved in its development. These individuals all used the Framework for their conceptualization of C-IMCI and community-based programming and had generally used it for program development and proposal writing. Specific examples are included below.

Those individuals not involved with the Framework development were familiar with the depiction, but generally reported using other frameworks or conceptual models. Most tended to feel that the Framework was a useful depiction and that they would accept the concepts included in it, but tended not to see how it could be used in application. One respondent reported having difficulty finding additional information on the Framework on the CORE website. Another reported having difficulty understanding how the Framework applied to her own program work.

Alfonso Rosales, Child Fund (formerly with CRS) reported using the Framework for program design – to identify what already exists and to determine what is missing and needs to be included. He agreed that the Framework might also be helpful for evaluations or assessments, but he has not used it in this way.

Michelle Kouletio reported that Concern Worldwide used the Framework in Rwanda and Bangladesh to inform the development of national policy related to C-IMCI. They used the Framework mainly as a communication tool to share ideas with the rest of the national committee and to help the group organize their thinking in country. In Bangladesh, the second element provided an entry point for advocacy related to training quack doctors and increased the government acceptance of this approach. In Rwanda, she felt the Framework was useful to help others see that C-IMCI was more than just a set of messages and to communicate the connection among CCM, behavior change, and health center partnerships. She saw the primary purpose of the Framework as articulating the critical things needed for prevention and early treatment. In early policy development, it was helpful to ensure that the group was thinking about everything. In Rwanda, when they worked with PSI, the Framework helped to make the case for the importance of interventions other than solely net distribution in order to address malaria. Michelle also reported that she often used the concepts involved in the Framework in conceptualizing what is needed in an intervention without realizing it. She felt the strength of the model was that it demonstrated the importance of the community care component with behavior change and linkages within a package of service delivery and not as a standalone community-based program.

Chris Bessenecker, PCI, reported using the Framework on a regular basis in preparing proposals and constructing programs, ensuring that there are specific strategies by

intervention area for each element. Additionally, he found the Framework useful in countries in conversations with MOH colleagues. While the definition of C-IMCI varies by country, using the Framework in conversations provided a common framework for discussion of interventions and generally elicited a positive response. Chris felt that the Framework needed a more rigid implementation and study of impact. He also mentioned that he would like to see a parallel in the study and expansion of the Care Group model for the Framework.

Cathy Wolfheim, WHO, reported using the Framework in the WHO Briefing Package on C-IMCI and referring to it in various meetings. She felt that it served a useful purpose to help individuals conceptualize community child health programming, but did not help organizations or governments actually operationalize the key family practices of C-IMCI. She reported that she initially was resistant to the Framework because the central focus was not on the key family practices – these were incorporated only in Element 3. However, over time, she has appreciated that more recent WHO training materials fit better with the Framework and the Framework communicates the important aspects of strengthening the link between communities and health services and the role of multi-sectoral groups in good community health planning.

Peter Winch, JHU, reported using the Framework as a checklist in program planning. He felt that the primary purpose of the Framework was to explain IMCI and provide a broader vision. While it did that well, few people are now asking what IMCI or C-IMCI are and in practice, these are no longer salient acronyms in WHO and UNICEF priorities. He felt that the Framework has become less useful in recent years for advocacy, since advocacy is underway separately for malaria, newborn health, etc. and that advocacy presents some of the same arguments but with different language. Finally, he felt that the Framework could serve a useful role in the future in prioritizing NGO research efforts – visually showing what needs to be in place for community approaches and who needs to do research to fill in the gaps in knowledge. Peter suggested looking at the website of the Institute for International Programs at JHU to better understand the work areas they define and see the challenge for CORE in laying it out differently.

2. Critique of the Framework depiction

Respondents provided a variety of critiques to the Framework depiction, identifying what they saw as some of the various gaps and weaknesses in the Framework:

- Clarify how the Framework is related to CCM. One respondent stated that the CCM Guidelines was a wider, more comprehensive tool than the C-IMCI Framework and asked about how the connection was related in CCM Essentials. Another respondent felt that CCM and the maternal-newborn continuum of care needed a formal place in the Framework in both the title and in the content.
- Include more prescriptive guidance for use. One respondent felt that the Framework might need to be more prescriptive to be used in the field. The current Framework doesn't clarify how to use it. That may be why people in the field read it, but don't use it for program design. This individual's experience is that things need to be more prescriptive to be used in the field – their usefulness to

help someone improve their work needs to be demonstrated and steps clearly spelled out. People may be using some parts of it, but the richness comes from use of the entire Framework.

- Essence of the arrows is not clear to those who had not been involved in its creation.
- Clarify Multi-Sectoral Platform. Two respondents felt that the Multi-Sectoral Platform was too broad and undefined and didn't incorporate the subsequent work done by CORE on the definition of the MSP. One respondent was curious how the MSP could be tied better with the social-ecological aspect of the CSSA.
- Connection to the first two components of IMCI not clear.
- The Framework could better communicate implications for policy, financing, supply and supervision. One respondent felt it was important that these be included somehow in supporting text on the Framework to clarify that the responsibility for child health should not fall solely on the CHW's shoulders.
- Another respondent stated that the health systems development is part of the broader picture not depicted in the Framework. This respondent included policies, integration of activities in child health strategies and plans, and service provision in the broader picture.
- There needs to be a balance between the health facility and community investment communicated and it should be clear that community services are not standalone services, but are only part of the picture and that the CHW's role should change as the facilities are strengthened.
- Framework could be used to demonstrate the importance of integration versus vertical programming.
- A missing component in the Framework is who is going to do all of the work involved in the various elements.
- Not clear how the elements link in with community mobilization.
- One respondent had several suggestions related to the Framework depiction:
 - Framework helps to show the mother that she is not alone – that there is a network supporting her
 - Useful to see linkages and partnerships – this helps with communications
 - Need to add private providers – not visually there right now
 - There is a lot of focus on depiction of malaria with the bednet, not as much with other important diseases like pneumonia. Good inclusion of breastfeeding and nutrition. Perhaps add immunizations, boiling water, smoke going out of house – need better balance of activities
 - Stating 'clinic' is good in that it can be a public or private clinic
 - The village shop doesn't exist everywhere and people need to see something they can identify as possible in their area.

- Don't currently see the connection with maternal health – this is all about the child alone – nothing is included on the impact of the mother's health on the child's health. If she is sick or dies, that will have a major impact on the child.
- The Framework needs to call for action – it should be less about illness and more about encouraging action and enabling the user to see their own role to do something.
- The mothers are depicted as recipients right now (of education, of meds, of messages). Their role needs to change to be more action-oriented and focused on individual empowerment.
- Don't see local government involvement right now – this would help for an advocacy component.
- Community involvement needs to include the private providers and the private sector and the non-health networks that support child health.

3. Does the Framework need to be modified to be applicable to all/other interventions (ex. malaria, maternal/newborn health, TB, HIV, etc.)?

Everyone felt that the Framework was equally applicable to other interventions, but that the title was the main barrier to its use. Specific comments included:

- “I recently used the Framework for designing a maternal and newborn health program and just changed the title accordingly.”
- “I encourage you to keep the focus in the Framework on the most common illnesses and highlight these.”
- “Perhaps expand to more comprehensive partnership with community, facility, and environment.”
- “A framework related to the newborn would need to show a stronger health system link with skilled attendants and emergency facility access.”
- “Yes and No. Obviously it makes sense to include these other interventions. But it runs the risk of becoming unwieldy.”

4. Does the title of the Framework help or hinder its use? If hinder, what could it be called?

Most respondents felt that the name needed to change and that the Framework needed to cut its formal links with IMCI. Quotes and an alternate view are included below.

- Too disease focused, illness-oriented - it was stated that this is inappropriate, especially at the community level, and could alienate family planning colleagues.
- Too many different interpretations of IMCI
- “The IMCI in the title is problematic. For many people, IMCI automatically means training courses for facility-based workers. Once they see the acronym

IMCI, they tune out, don't pay any further attention to the document or to the idea. Many people assume IMCI means clinical management.”

- “IMCI has taken hold in many countries and still provides a reference point for people. However, it is often predefined and therefore confusing. I lean towards keeping the name and expanding people's vision of C-IMCI.”

Suggestions included:

- The term community health has a more preventive and promotive connotation
- Needs to send an action message
- Community approaches for case management
- Establishing (or Strengthening) partnerships between community structures and providers
- Community engagement and health care
- Integrated, community-based model vs. management of illness
- Community-based care and services for children

5. How would you describe the current environment related to promoting community-based child health approaches?

Across the board, key respondents felt that the current environment was positive for community-based child health approaches. Quotes included that the environment was “strong right now”, “very positive and exciting”, “very strong globally”, and “quite fertile”. Respondents stressed the importance of capitalizing on this environment.

The MDGs were mentioned by two respondents as part of the global supportive environment with governments trying to meet Millennium Development Goals and identifying the need for some sort of community-based approach.

Two respondents mentioned the Global Health Initiative with Obama. Both stated that there could be opportunities to increase the value of integration and achieve integrated programming, but the sentiment was cautious waiting to see if the Obama health policies will in fact go this direction.

Several respondents discussed the donor and partner interest in CCM and stated that it was important to show how the C-IMCI Framework can enhance CCM. One respondent stated that when the Framework was first developed, there was openness to Elements 1 and 3, but a great deal of resistance to Element 2. This has changed significantly in the last 10 years with the demonstrated value of CCM.

Other comments include:

- Caution that the enthusiasm can also be dangerous if we all don't factor in CHW constraints along with the time and effort it takes to make good community-based programs happen. There is a danger of not being realistic – many of these programs are expensive in terms of dollars, expertise, and time and there is not that much money out there.

- There needs to be a sustainable model with a paid worker supporting volunteers. One respondent talked about the model in Ethiopia with two paid workers at the community level who can train, supervise, and manage community workers and the importance of having geographic spread and learning opportunities for volunteers that are closer to the community level.
- Donors are interested in administrative structures in communities such as mobile phones.

Asha George, UNICEF, described the environment at UNICEF as follows:

- Our Communications for Development (C4D) group is supporting five critical behaviours for child survival at the community level (bed net use, handwashing, exclusive breastfeeding, ORS and one care seeking behavior)
- We are also keen to provide focused support on integrated CCM for the 3 main causes of mortality for children: pneumonia, malaria, diarrhea
- We are beginning to do work that supports the continuum of care for child survival: not just making strengthening linkages from homes/ communities to facilities, but also between child survival and maternal-newborn and HIV. Newborn and HIV is particularly of concern in certain areas.
- We are working more closely with WHO on supporting joint statements and training packages for CHW for care for the sick child, newborn and well child.
- Moving beyond training packages, we are interested in working on program planning guidance, supervision, supplies and logistics issues for community based approaches
- There are a lot of country requests on how to monitor and evaluate C-IMCI and other community based approaches

6. Who do you see as the main audiences for any advocacy efforts related to community-based child health approaches?

There were a variety of answers to this question with respondents mentioning several different groups and purposes for advocacy in addition to some reservations about the overall concept.

- MOH – One respondent felt the barrier here is to support community involvement. NGOs should work more to influence national policy showing how local MOH staff is involved and how it is working. Another respondent felt there were still some MOH staff who were “old school”, but in general MOHs have come a long ways. A third respondent felt that MOH is the main audience to promote the Framework as an overall tool.
- Ministries of Finance – real issues are related to having drugs, supervision, and connections, not just one piece of the picture

- WHO/PAHO and UNICEF – With them on board, we are in a better position to go to MOH. They need to feel that they own any tools or they won't push them.
- USAID – needs to have more demonstration of results, especially tied to cost data. We need to show how we can simplify community-based approaches and make them more efficient per beneficiary. Child Fund did a cost analysis in Honduras to demonstrate the cost savings to MOH and to individual households, thus demonstrating how community-based health services could be promoted in a poverty reduction strategy.
- Congress people and those with purse strings to remind them that pneumonia is the biggest killer. It is also important to advocate for child health in general and not just community-based programs.
- All levels since there is money at all levels.
- Elected officials and traditional leaders at local levels – they need to see health as a visual thing that can help them win elections. It is important to educate them about investments beyond wells, etc. that can be seen in order to get the budget commitment to health. Advocacy should go beyond the health sector.
- I don't know anymore. There has been so much advocacy about so many topics. We need to have a very clear sense of what we want to advocate for, and why, and how it fits with other efforts.
- One respondent asked how we can get enough money and attention worldwide in order to make a change. She wondered if the Framework can do this or if CORE would be better off investing money and energy elsewhere.

7. What existing tools within the various elements need to be better diffused to help implement community-based approaches?

Responses to this question included suggestions of good tools in addition to gaps. Respondents felt that there were a lot of good tools related to Elements 2 and 3, but that the main gaps were in Element 1.

Existing tools mentioned:

Element One:

- PDQ
- Health Center Assessment tools from Bangladesh

Element Two:

- IRC and BASICS CCM tools from Rwanda
- CCM Guidelines
- CRS C-IMCI algorithm
- Traditional birth attendant tools developed by Child Fund

- Recent work on severe acute malnutrition
- Recent work on use of rapid diagnostic tests for malaria
- David Marsh is working on non-literate materials for CCM in Uganda
- WHO training manual on CCM for CHWs

Element Three:

- Designing for Behavior Change
- Family Health Cards created by Peter Goddard in Madagascar, Ethiopia, and Ghana. These are “3rd generation behavior change materials” that are cheaper than counseling cards and can be in every home instead of with CHWs.
- Community training modular materials developed by ESHI/Ethiopia. These were based on TIPS and developed by Mary Stone-Jimenez with AED/Linkages.
- Community Conversations – possibly created by CARE, this is in favor with the MOH in Ethiopia
- Triple C created by Save
- Festivals are good for recognition, celebration, and volunteer motivation.
- WHO/UNICEF training manual on preventive and promotive health should be finalized this year

MSP:

- Sustainability framework could be better connected

General:

- WHO and UNICEF training tools on newborn
- Child Health Program Manager’s Guidelines from WHO/UNICEF
- Costing tools
- Model Families is a strategy used in Ethiopia which sets criteria for recognition and diploma to families adopting healthy practices. In Madagascar, this strategy is used to recognize mayors for model communities based on specific criteria.
- PRA tools
- Helping Health Workers Learn

Gaps/needs mentioned:

- In Element 1, strategies for community management committees need to be better collected along with guidance on fund management and sustainability of community-based funds for community clinics.

- Demonstration of impact on workload at the clinic with IMCI – higher per child (therefore leading to resistance), but when more children don't need to go to the health center, there should be more time per child.
- How to address referral when services are absent.
- Address sustainability related to incentives and workloads.
- What works with partnerships between communities and facilities and negotiating difficult relationships
- Need more on how to promote IMCI in the wider system – ex. district score cards in Rwanda
- Need planning tools
- Community mobilization

Interviews were conducted by Lynette Friedman between November 9 and November 19, 2009. All interviews were conducted by phone or Skype.

Individuals Interviewed:

Peter Winch, JHU

Cathy Wolfheim, WHO

Chris Bessenecker, PCI

Alfonso Rosales, Child Fund

Elena McEwan, CRS

Michelle Kouletio, Concern Worldwide

Mary Carnell, JSI

Bernadette Daelmans, WHO

Connie Gates, JAMKHED

Additional Interviews Requested:

Nazo Kureshy, USAID

Al Bartlett, USAID

Marianna Trias, WHO/WPRO

Samira Aboubaker, WHO

Unable to be interviewed due to travel:

Asha George, UNICEF

David Marsh, Save the Children

C-IMCI Technical Discussion – Interview Questions

1. Are you familiar with the C-IMCI Framework? If so, in what way(s) have you used the Framework? (Probes: Have you used the framework for advocacy? Planning a C-IMCI approach? Assessment of a C-IMCI approach? How did the framework help or hinder your efforts?)
2. What do you see as the primary role or purpose of the Framework? (Follow up probe: Do you see any different roles in the future?)
3. What is missing from or could be better communicated in the Framework to help depict community-based approaches to child health in today's context?
4. Does the Framework need to be modified to be applicable to all/other interventions (ex. malaria, maternal/newborn health, TB, HIV, etc.)?
5. Does the title of the Framework help or hinder its use? If hinder, what could it be called?
6. How would you describe the current environment related to promoting community-based child health approaches?
7. Who do you see as the main audiences for any advocacy efforts related to community-based child health approaches?
8. What existing tools within the various elements need to be better diffused to help implement community-based approaches?

Element 1

Improving partnerships between health facilities and the communities they serve

- Partnership Defined Quality (PDQ), Save the Children
- Client-Oriented, Provide-Efficient (COPE), Engender Health
- Census-Based Impact Oriented Approach (CBIO), Curamericas
- Rapid Health Facility Assessment Tool (RHFA), CSTS+
- Community-Based Health Information Systems
- Health center assessment tools from Bangladesh
- "Health Hut" and "Community health unit" models, ChildFund International
- Community Health Governance Tools, Plan/AKF

Element 2

Increasing appropriate and accessible health care and information from community-based providers

- CCM Essentials, CORE
- C-IMCI Training manual and algorithm, CRS
- Rwanda materials developed by IRC and BASICS
- Siaya District training materials, CARE/Kenya
- Scaling up home-based management of malaria: From research to implementation, WHO/RBM/UNICEF/WB/UNDP
- Community drug management for childhood illness (C-DMCI) manual, MSH/RPM+
- Vendor-to-vendor education to improve malaria treatment in the private sector: A how-to manual for district managers, QAP
- Facing illnesses that attach our children - training manual and facilitator manual, Freedom from Hunger
- Utilizing the potential of formal and informal private practitioners in child survival: Situation analysis and summary of promising interventions, AED
- Working with the private sector for child health, AED
- Diarrhea treatment guidelines for clinic-based health care workers, USAID/WHO/UNICEF/ZNC
- Traditional birth attendant tools, ChildFund International
- Recent work on severe acute malnutrition (CMAM?)
- Recent work on use of rapid diagnostic tests for malaria
- Non-literate CCM materials in development by David Marsh for Uganda
- Training manual for CHWs in CCM, WHO

Element 3

Integrating promotion of key family practices critical for child health and nutrition

- Designing for behavior change, CORE
- Barrier Analysis: A tool for improving behavior change communication in child survival and community development programs, Food for the Hungry
- Positive/Deviance Hearth: Resource guide for sustainably rehabilitating malnourished children, CORE
- Guidelines for developing home-based reminder materials: Helping families save sick children, Project Hope/AED/CHANGE Project
- Participatory community planning for child health: Implementation guidelines, USAID/BASICS
- The Care group difference: A guide to mobilizing community-based volunteer health educators, World Relief
- Family health cards, Madagascar, Ethiopia, Ghana
- Community training modular materials, ESHI/Ethiopia
- Community Conversations, CARE
- Triple C , Save the Children
- Festivals
- Training manual on preventive and promotive health, WHO/UNICEF
- Review of evidence for key family practices, LSHTM
- CB Growth Promotion, (ChildFund interest)

Multi-Sectoral Platform

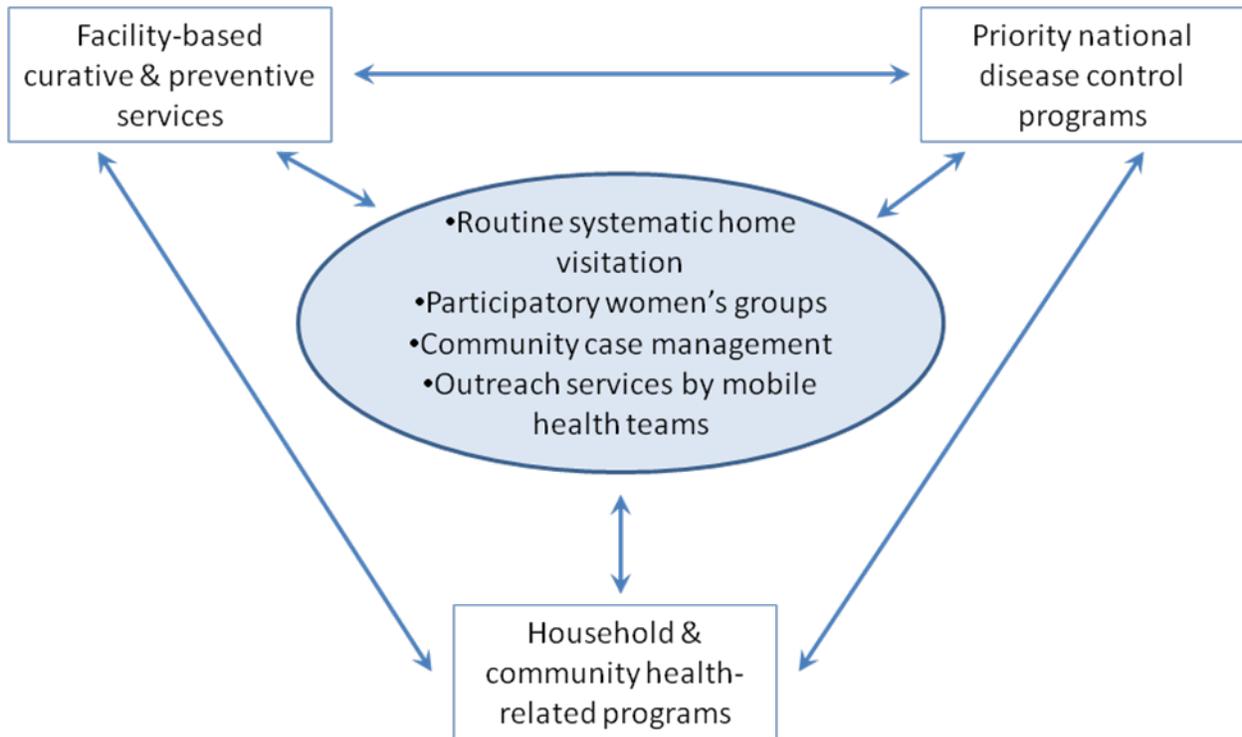
Optimizing a multi-sectoral platform to support sustainable child health and nutrition

- Meeting report and case studies, CORE
- Sustainability framework, CSTS+

General

- Newborn training materials, WHO/UNICEF
- Child Health Program Manager's Guidelines, WHO/UNICEF
- Costing tools, WHO/UNICEF
- Model communities and model families
- PRA tools
- Helping Health Workers Learn
- List Tool (Lives Saved), JHU
- Appreciative Inquiry manual
- IMCI case studies, Plan/Cameroon and WR/Malawi
- Child health in the community reference guide and briefing package, WHO

Framework for Maximum Improvement in Community Health



Framework for Maximizing Household Production of Health

