

Towards a Grand Convergence for child survival and health:

A strategic review of options for the future building on lessons learnt from IMNCI

Global key informant interviews – Synthesis report
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I. Introduction

This report summarizes findings from 20 in-depth, key-informant interviews conducted during April and May of 2016, as part of data collection for the review titled “Towards a Grand Convergence for child survival and health: A strategic review of options for the future building on lessons learnt from IMNCI” (“Strategic Review”). The interviews were semi-structured and focused on respondents’ experience and knowledge of IMCI implementation, program management and coordination, as well as options for improving the delivery and management of global child health in the future. Information from the interviews is designed to illustrate and complement the results from other methods being used for this assessment, including the desk review, the global implementation survey, and the country assessments.

All respondents had a range of expertise in the area of global child health; over half worked in a university and/or research setting and some had dual roles in research and providing care in a health facility. Four respondents had senior roles in non-governmental organizations and three held very senior positions in international organizations. Respondents had a wide range of experience with IMCI, some having worked on IMCI since its inception in the early 1990s. Collectively, respondents had experience with IMCI from countries around the world, including in Eastern and Central Europe, South Asia, Asia Pacific, South America, and across the African continent.

Interviews lasted between 35 and 50 minutes (average duration: 45 minutes), took place over the phone or in person, and were audio recorded. Notes were taken and an aide-memoire was written for each interview. This report summarizes the opinions of key global experts and stakeholders on key questions addressed under the Strategic Review, organized into four sections: Overall impressions of IMCI, broken down by the three components; Lessons learned from implementation and Implications for the future landscape.

II. Overall impressions of IMCI

Respondents highlighted many positive aspects of IMCI’s integrated approach to child health. At the same time, many concerns were raised about roadblocks to full implementation and the capacity of IMCI to reduce preventable child deaths.

A well-designed strategy

“IMCI is remarkable for its simplicity and a lot of brilliance went behind what looks that simple”

Informants were overwhelmingly positive about IMCI as an integrated strategy to improve child

health. The majority said the integrated design made sense from an efficiency and cost-effectiveness perspective, and was important in standardizing practices and knowledge. This approach also helped to improve quality of care and raise standards in how the sick child is treated. One respondent commented that primary case management is the enduring part of IMCI. A few respondents said IMCI training improved clinical capacities and had contributed to improvements in health systems functioning; one respondent noted, “There has been a lot of task shifting to community health workers and this can be attributed to IMCI.”

Roadblocks to implementing IMCI

“IMCI is the right policy but it was never packaged and implemented in the right way”

There was consensus among respondents that IMCI is a challenging program to implement and maintain; many echoed the opinion that, “...it takes a very strong ministry of health to control different donors and say we want an integrated program.” A few respondents voiced concerns that IMCI is not easily kept up over the years and it's hard to push it forward as a single entity and maintain the attention of the ministry of health (MoH) and program managers.

“Governments are often unable to direct money to where it is most needed”

Country stewardship and coordination were also challenged by funding agencies following their own priorities: more often than not, funders set the agenda independent of country need and context and often regardless of what was best for child health. One respondent said, “...funders want to know how many lives have been saved and want to know quickly.” Often funding is allocated without the approval of local authorities and so local priorities are not necessarily addressed. In addition, one respondent referred to IMCI's lack of ‘sex-appeal’ compared to other programs; this is evidenced in the fact that pieces of IMCI attract money, e.g. tuberculosis, malaria, vaccines, but IMCI as a whole did not receive adequate financing.

“...it really depends on who is at the helm of child health”

Multiple respondents said there was need for greater political and economic will to address the social determinants of health in each country. This political will would need to be directed by a narrative or overarching theory of the role of social services and health care in social contracts at national level. One respondent said, “Health services are central in what people want...how do we capture the attention of national leaders to make sure they deliver on this?”

“The [global community's] failure to coordinate the different components was inexcusable”

A majority of those interviewed said IMCI was never fully implemented and that the three components rarely worked in tandem or were not all in place. As one respondent said, “the facility component was going at it alone and left behind health systems strengthening (HSS) and the community component.” Many attributed this lack of coordination to the global community's poor track record in implementing integrated approaches: evidence for this was given in slow progress made in reducing pneumonia and diarrhea—the leading causes of preventable death in children—compared to causes of death that have their own funding stream, i.e. HIV, malaria, TB. Ongoing neglect of child health in conflict zones where health services are not strong is also reflective of the poor coordination cited by respondents, alongside the lack of a WHO-sponsored program or strategy in areas of conflict.

“Now they have a label, but they don't have much in the way of a program”

Multiple interviewees said IMCI was oversold as the only solution to ending preventable under-five deaths and that this emphasis worked in detriment to child health, particularly in terms of ensuring trained health workers. One respondent said many countries have the label IMCI but not much in

the way of an actual program. A few respondents said that, when it came to child health, IMCI should only ever have been a piece of a larger puzzle, and that the focus on IMCI has long been inadequate considering the complexity of child health and how much understandings have evolved over the past 20 years.

i. Health worker performance improvement

WHO and UNICEF developed IMCI guidelines for the management of leading causes of illness and death among children; these guidelines were then developed into a training package to teach integrated case management to health workers who see sick children. There was praise for how the training materials were designed. Many echoed the feeling that IMCI is technically sound and it is what health workers around the world should be practicing and the science behind it is solid. One respondent said, “Its staying power is strong and it is still the way to screen and treat children and the best integrated approach we have.” However, while many respondents said IMCI training was the most robust part of the strategy, concerns around training were raised more than any other topic in interviews.

Issue: The cost and length of pre-service training

“Training is very expensive and clearly there are ways to deliver it more efficiently”

IMCI is delivered via in-service training delivered over 11 days. This design contributes to a culture of absenteeism from the job and is logistically difficult. Once trainees return to their place of work, co-workers often do not know what the training entailed and thus it becomes difficult to implement and often works against what is already in place.

Potential solutions:

- Employ a professional over months or years to supervise and mentor a group. A potential problem is that financiers usually prefer to pay for a short-term training rather than investing in long-term professional development. As one respondent said, “NGOs and donors are like banks and their job is to spend money and they have to do it in a certain time frame. So it is easier to say, let's train 1000 people that will spend all that money in two months and our job is done!”
- “Low-dose” or more frequent training opportunities; this approach might also more widely supported by the private sector. However, potential problems with this approach include increased costs for travel and lodging.

Issue: In-service versus pre-service training

“Forever pulling people out of their job for training”

In-service training, as opposed to making IMCI part of the curriculum in pre-service training, contributes to a number of problems, including contradictory information between guidelines and what is taught in schools, and a lack of applicability to country context. While respondents widely agreed pre-service training for IMCI would be preferable, they offered a variety of explanations for the failure to widely implement it. Many cited poor coordination with heads of pediatric associations, university officials and others involved in setting the curriculum. Others suggested medical professionals in country were not convinced of IMCI’s utility and said it was a dumbed-down version of pediatric care. Another respondent pointed towards funding mechanisms as setting the wrong incentives: “there was a desire to see results in the short run and not after a decade;” others said there was a lack of global prioritization of maternal and child health: “this is seen in the dearth

of post-graduate training courses in child health for pediatric nurses...it has been completely neglected."

Potential solutions:

- Fund colleges and nurse training institutions; training would be applicable to the context and genuinely add to people's knowledge. One respondent said, "...this is particularly important in light of the 'brain-drain' that is occurring all over Africa...we can't lose this opportunity in the future;"
- Obtain buy-in from medical schools and associations to make sure pre-service and in-service training are harmonized.

Issue: Supervision, mentoring, monitoring and evaluation

"Training without supervision is useless."

While the quality of training was generally believed to be very good, nearly all respondents commented on the fact that there has been poor or no supervision and follow-up. Furthermore the number of trainers was small and the proportion of health workers trained in IMCI was never sufficient; for this reason, there was no reinforcement of what had been learned. Because refresher trainings were not built into the IMCI strategy, a loss of skills and knowledge resulted in what one respondent termed a "wash out." Among graduates three or six months out, retention of training was very low and little was done in terms of continuing education or support. If trainees did not have practical experience following the course, with the opportunity to see and treat patients, their retention of skills was even lower. As a result, the lack of mentorship and support were considered by a majority of respondents as a serious blow to the effectiveness of the training—particularly in areas where management and detection are more difficult, such as with pneumonia.

While in the minority, one respondent said poor performance of this component was due to spotty trainers and trainers not doing their jobs. Another individual voiced concern that part of the purpose of IMCI was to reduce the training burden on health workers by providing a single training for everything, and he questioned if this really was achieved.

Potential solutions:

- On-site training on a regular basis (i.e. once per week or every two weeks); you then give people homework and come back in two weeks time;
- A pool of supervisors and teachers to ensure quality of performance (*not* to "control and blame"), understand the health worker's difficulties and provide support on how to do better within limitations of time and resources.
- To improve quality of care, one respondent said remuneration should play a role..."although this is probably too idealistic for many countries."
- A functioning performance review to help keep workers keep abreast of changes in the guidelines and add to peer learning;
- Clinical mentoring to update front-line health workers, i.e. a rolling system that could accommodate different clinical areas: "that is a basic building block - IMCI doesn't have to create such a system but it is necessary before you implement it."
- Monthly supervision, 3 and 6 month follow-up; annual in-service refresher training
- Introducing an information system for case notes and a monitoring form that acts as a treatment form; this allows for data collection and better assessment of program functioning and then transmission of data back to MoH for monitoring and evaluation;
- One respondent described how training in IMCI works well in Kenya at the district level: two senior trainers are vetted carefully; they return to train others with follow-up after 6 weeks

and a strong focus on supervision. No certificates of completion are awarded until supervisors find evidence that the training has indeed been implemented throughout the facility.

Issue: Applicability of IMNCI training materials and target audience

“IMCI must really define its target population of trainees more carefully”

IMCI training must be more applicable to the actual human resources and characteristics of the health system in a particular country. A number of respondents said there cannot be one type of training for everyone. Doctors need a different level of training than a community health care worker or a nurse. In countries where the government has a rotation program, “we have to train everyone, not just one or two nurses” as in reality very few nurses become specialized. Another respondent noted an additional benefit of having more specialized health workers is that it is easier to network them together; they learn from one another and also feel responsible and more accountable for the information they have learned.

Potential solutions:

- Training should use improved technology for challenging diagnoses, such as pneumonia;
- Modify training to reflect the type and quantity of health workers actually present in country; this would be similar to modifying content of the training package to fit most pressing needs in the country, i.e. including or excluding HIV;
- Adapt training and implementation as much as possible to the human resources and characteristics of each country’s health system;

ii. Health Systems Strengthening component

The aim of this component was to promote better treatment and management of the sick child in a facility setting. Feedback on this component was polarized between those who said it should not have been included and those who believed it belonged as part of IMCI but did not work out well in practice. There was nonetheless consensus that the HSS component of IMCI did not work as it was intended and that there were not many positive gains in HSS directly related to IMCI. One respondent said about the idea that IMCI would be the answer to health system strengthening, “I always thought was a little flawed. Everyone has pretty much failed in health systems strengthening; I don’t think anyone got this right with the MDGs.”

Issue: Keeping HSS relevant and functioning as a component of IMCI

“There are not road blocks to health systems strengthening—there are road blocks to strong health systems”

A number of respondents pointed out that IMCI turned out to be a good indicator that health systems were indeed not working in most contexts. The majority said it was naïve to set up IMCI to fix health systems. While IMCI was considered a good case management strategy, functioning health systems are needed for it to work properly, and many respondents said it was not “efficient” for IMCI to tackle HSS. One respondent said IMCI should not get involved in roads and infrastructure and labor, but rather stick to quality primary prevention and treatment for children. Some respondents agreed IMCI added value for health workers, and clarifying the needs of health facilities, but, one noted that “...saying IMCI is going to *do* health systems strengthening, this is not realistic or effective.”

Views on this point were mixed: while one respondent said all aspects of IMCI's HSS component were critical and that nothing could be cut, another said HSS has no place in IMCI. Others said this component was totally ignored, so in many countries its effect was hard to pin down. One respondent said, "IMCI suffered from being integrated where other programs (i.e. TB, Malaria, HIV) bypassed the system and invented their own – and they could afford to." Many respondents echoed the idea that IMCI was one of the few voices trying to integrate health systems but unfortunately was not able to deliver.

Potential solutions:

- IMCI can bring attention to the need to reduce stock outs and promote a well-motivated workforce;
- Better managerial support structures within the health system are essential to rolling out IMCI;
- In contrast to the one-size-fits-all approach, a comprehensive needs assessment can tailor new programs to a country's existing health system;
- Increased donor support will be necessary: "you can't do health systems strengthening alone;"
- Ministries need to sit down and see how programs can be rolled out, identify potential challenges and not pursue interventions in isolation;
- Ministries and partners need to first focus on health system readiness, and then define what program areas need most attention.

iii. Community component of IMCI

The community component of IMCI originally referred to 12 key family and community practices (KFP) related to child health and development. Nearly 10 years after IMCI was implemented, iCCM was introduced as a strategy in part because of a lack of care at the community level from IMCI. iCCM was to provide curative services for major childhood illnesses, (i.e. diarrhea, malaria, pneumonia, etc.) and train community health workers (CHWs).

As part of the interviews, we asked respondents in the first instance to focus on causes of low utilization and coverage of the community component of IMCI and iCCM. Respondents' feedback can be categorized into two main themes: design issues and institutional barriers. We then focused on how demand generation and community participation could be increased in the future and whether or not there are benefits to increasing the range of community interventions.

Design flaws

A number of issues were raised in relation to the design of the community component of IMCI. One senior respondent summarized many of them, stating:

"We were naïve in thinking the community component could do the 12 practices. The laundry list of components and behaviors was not an effective mechanism of communication. While we've we've paid lip service (to community engagement) we haven't addressed it...beyond distributing bed nets."

Multiple respondents said there needs to be a fresh look at the community preventive and promotive behaviors (household production of health) as the most important component of health. Another point raised was that this component shifted treatment away from facilities to the

community; one respondent said: "...we were guilty in bypassing healthcare systems and going straight to the community and this does not help create a community health system."

When it comes to engaging the community and increasing demand, one respondent said "I don't think we've got it right at all." In the design of IMCI, there was no mechanism to create demand for services at the community level; too often, people just don't know that the services are available or they do not have faith in the person in the community that is trained. One respondent said, "We can't get anywhere with IMCI or iCCM without the community buying into it and agreeing to it." Improving the delivery of information so that people do not get several messages from different sources and/or conflicting messages is also important; while such integration is easy to talk about, one respondent pointed out that it is not easy to implement and that, "there are still a lot of gaps in reaching the last household."

Finally, there was agreement from most respondents that it was a mistake to separate IMCI and iCCM: one respondent said these two names, "should never have made it beyond Geneva and New York; they are hopeless names on the ground." However, another respondent voiced concern in changing these acronyms now as that may create even more confusion.

Potential solutions:

- Incorporate evidenced-based community mobilization and support strategies such as women's groups onto existing IMCI community strategies and significantly improve integration with all other areas;
- Utilizing community health contact points, such as antenatal visits, to raise awareness of IMCI among households;
- Conditional cash transfers can be an excellent way to increase care-seeking behaviors though one respondent said "UN agencies have not pushed this;"
- Where IMCI and iCCM are working together, community volunteers were successful in promoting care seeking, "...there is no need to have two components—rather they should be seen as one component with two arms moving together."

Institutional barriers

"WHO is caught in semantics of who is and who is not a health trained provider..."

In addition to design challenges of IMCI, respondents agreed there were a number of institutional barriers that also reduced implementation of this component. There were concerns raised among particularly senior respondents who have worked with IMCI since its inception that WHO was not amenable to working through "non-state actors" to implement this type of program; the result has been that "WHO could not give the necessary support to the community component." In addition, a number of respondents voiced concern that not enough attention was paid to the curative part at the community level. The reason given for this was that "it is a policy barrier: WHO didn't want CHWs to take on a basic curative role."

Multiple respondents said there really needs to be a focus on how we're going to fund, market and train CHWs to make sure services at the primary level are taken care of, particularly with the 'brain drain' in Africa. Likewise, CHWs are becoming increasingly professionalized and the range of tasks they are expected to take on has increased. For this reason, one respondent noted, "we need to think about how we're going to run these systems at scale."

Potential solutions:

- Greater flexibility on who can be a CHW and who is supported in this role;
- National alliances, government buy-in and partnership of like-minded partners to push iCCM to every corner;
- Clarify who is doing what: “Training needs to be targeted at different levels so you don't have clinicians doing what CHWs are doing;”
- Doctors have to be convinced CHWs are not competing with them: “...we can't work only on community case management; the training really has to be targeted at the different levels: community health centers, referral hospitals, etc. so everyone feels they have a value added;”
- A big cadre of CHWs paid by the government and trained in a large package of interventions (WASH, breast feeding, etc.) and a consistent presence of CHWs to increase utilization, such as the army of female health workers in Ethiopia;
- A fuller package for CHWs with a focus on newborn care and the well child and development.

III. Lessons learned from implementation

In addition to those discussed above, the main lessons learned from implementation of IMCI and other child health strategies cited by respondents had to do with country ownership and use of data.

A more flexible framework of assessment and treatment

There should be more openness to “adapting IMCI or (whatever it will be in the future) to the country context.”

Repeatedly, respondents voiced that the one-size-fits-all approach with IMCI prevented proper adaptation and integration of the program. Many respondents pointed out the need to adapt IMCI at country and sometimes even subnational level, not only in content and what should be included in training, but also in how training is delivered and administrative aspects of IMCI. Many respondents echoed the idea that countries need a flexible program they can fit to their needs and setting and that while the main principles would be the same in any context, the agent and support system would be contextualized.

Instead of providing standardized content for IMCI, there is need to engage in separation and priority setting exercises, such as LiST, to find out what the in-country priorities are and then put the coverage and resources in those priorities: “they are hard decisions.” This way, instead of focusing on several dozen illnesses or conditions, policy-makers could focus on those that really pertain to the country's situation. While it is clear there needs to be greater focus on pneumonia and diarrhea, including evidence generation to bring attention to these leading causes of child death, a program where countries (or even at the sub-national level) could mix and match and implement components that they need and that fit their setting would be much more beneficial and effective, respondents said.

Data systems at center stage

“There needs to be a sea change in how we think about and use data if we are really going to get a handle on what is going on and whether practices are changing”

The challenge to identifying clear lessons learned is a lack of data. There was a concern MCE's conclusions about the successes of IMCI implementation were based only on countries where it had been sufficiently scaled up and, therefore, did not capture contexts where implementation was insufficient or even impossible due to under-developed health systems, such as in Niger and Chad.

The whole area of health information has been extremely under-resourced and continues to be. Health workers are often tasked with service delivery as well as health information functions and this leads to a vicious cycle where “they don’t have time to input the data and nobody trust the data so nobody uses them and, in turn, healthcare workers care even less about inputting data.” If health workers are able to input data, the ability to analyze it is often weak.

“Quality assurance should not be set in Geneva with glossy booklets (and boxes) that people tick”

Quality assurance needs to focus on a country’s priorities and is happening at country level. Within a well-functioning M&E environment, there is a need for a rolling quality assurance program to better understand what is and is not working and what is worth the investment. To date, there is a lack of objective evaluations that have been done, including on health worker performance. There is a strong role and need for better assessment of quality; this must be done in a standardized way and need not be complicated. While technology may have a role to play in improving quality assessment, no country can drop their existing health management systems so it is necessary to work with what is already in place.

M&E does not mean a big global program dictating what data need to be collected; such an approach is unhelpful and one respondent said, “...more often than not leads to game playing and data tampering.” However, it was said WHO has an important role to play in getting country offices to track a short list of indicators. It was also suggested that WHO should be doing facility surveys because that is what they are really good at.

“People need to know they own the program”

Any child health strategy must have monitoring and evaluation (M&E) built in alongside it. All respondents agreed M&E is an effective tool to increase motivation and helps clinicians feel empowered. In Malawi, an information system was introduced in the form of a case notes/monitoring form that was turned into a treatment form and this allowed for data collection and better assessment of program functioning. It was then simple to take the collected data back to the MoH. Healthcare workers were taught basic statistics to better understand the data they had collected and they got positive feedback from the MoH. There was no additional remuneration for these efforts but workers said valued and that the program was theirs.

Clarify roles between global, regional and country actors

Respondents highlighted a number of roles for countries, regional and global players in improving implementation of child health strategies.

“WHO should help countries work out for themselves what their priorities are and not define those priorities for them”

Many respondents said that the role of WHO and the global community is to support not prescribe: each country needs to understand its own barriers that influence effective implementation of IMCI and work within those constraints. Governments must see that a program is cost-effective and working and saves lives and can be incorporated into existing health services and not run by external people. The global community can also help countries develop their national child health plans and ensure certain components are present (such as primary case management, hospital care, nutrition, adolescent health, newborn health, etc.) and then support them in making sure these programs are coordinated and functioning in the future.

“There is a need to strengthen country offices”

Respondents said country counterparts in UNICEF and WHO are often not helpful and not

necessarily in line with global guidelines/offices. Likewise, turnover of staff in country and in Geneva means there is inconsistent support for programs.

Mobilizing resources: “...this is the advantage of the global community”

The global community has ready access to governments and ministries of health and so they need to do more to help mobilize domestic and external resources and advocate for child health. Many saw knowledge management as an important role for the global community: helping to generate local evidence and document other places of best practice that can be shared in other contexts. One respondent said that we do not lack guidance or priority at the international level, but rather it is the ability to “roll up our sleeves and work with countries to understand their context and how do we help them in their context...where are the system barriers.”

Financing child health

“A global movement with a huge global investment and global accountability around child health”

The majority of respondents commented on the need for greater financial support for child health. There must be top-level buy in for scaling up child health services and until now, not enough funding has been delivered. A number of respondents said that in order to revitalize child health and IMCI in particular, there must be a movement and actions to lobby foundations with big money to increase investment in child health; such investment is the only way to create an environment for service delivery and to deliver commodities at scale. Echoed by many was the idea that separate financing streams create conflict among different programs for child health. Many felt there is a need instead to focus on child health as a whole.

While financial support is important, valuing IMCI as a program and providing staff and resources is also crucial. However, at the national level, those with the power of budget allocation are not always on board or trained in IMCI. Therefore, multiple respondents said there is a need for better engagement with national politicians and ensuring national accountability; discussions need to be had around social contracts and making sure health services get priority in national budgets.

“We should be improving the ability to implement within the resource constrained environment”

Although in the minority, one respondent said that lack of funding was not the problem, but how the money was used. Another echoed this, stating that a better use of resources is what is needed, and that the focus should be on efficiency gains, not on how much is being spent—but where and how.

Another in the minority, one respondent said shortages in funding are not unique to global health and it is not up to the global community to prioritize health above other needs (i.e. energy, infrastructure, etc). Sustainability is about expanding all resources for a country and not deciding one thing is more important than another: “Earmarked resources, decided out of the country, is a mistake...spending has to be decided within the country.”

Technology: better delivery and case management

Real time data capture could be a “game changer”

A majority of respondents mentioned the role of technology in improving the delivery of child health. Raised repeatedly was the need to update IMCI guidelines electronically: because the guidelines go out of date very quickly, mobile phone technology enables workers to access guidelines that have been updated centrally. Others pointed out that mobile phones also enable real time data capture and can help improve supervision; for example, clinical mentoring and/or quarterly performance reviews at country level could help providers quickly adjust to new recommendations nearly as soon as they were issued. Another respondent said that non-paper

based mechanisms are clearly important for future delivery of care and M&E; for example, the use of scorecards at national and district level to improve social accountability and monitoring.

Algorithms adapted to the consultation process can also improve the quality of time a clinician spends with the patient, instead of feeding an application: this improves care and uptake. Better biomarkers and research can also improve algorithms to identify and refer serious cases. Along the same lines, there are already better mobile health tools available for diagnosing particularly challenging illnesses, including pneumonia.

Newborns

“The newborn piece? It’s the most important thing, that’s where the need is greatest”

A majority of respondents mentioned the need to be looking at newborn care much more aggressively. One respondent raised the concern that it will be difficult to significantly increase utilization of services for newborns in a short time frame; because newborns’ conditions can change very quickly, “the time window where you can do something is short”; as a result, if IMNCI does not quickly improve utilization, “we shouldn’t think it’s a failure...because it will be hard to change.”

There were a number of respondents who felt services need to come as close to the community as possible, but that efforts need to be adapted to each country’s health system. For example, in Tanzania dispensaries already provide community-level services so there is no need to create new ones. On the other hand, one respondent raised concern at the idea of having newborn care in the home because there is evidence many frontline workers do not have the skills to provide appropriate care for newborns.

Two respondents commented on possible severe bacterial infection (PSBI): actors in the field were having trouble understanding the link between PSBI and IMNCI. One respondent said, “I hope it’s obvious these need to be together so as to not confuse people in the field.”

Private sector

“We cannot wish it away or ignore it”

A vast majority of respondents commented on the importance of the private sector in the future of child health delivery and the fact that, until now, it has been completely neglected by IMCI. Respondents raised a number of reasons behind this neglect and all said that engaging with the private sector is paramount to improving child health and cannot be overlooked in the future, because they providers are often so much closer to the community. One respondent said, “If we want to achieve the SDGs, we’ve got to engage the private sector.”

Reasons for the neglect of the private sector were due mostly to institutional barriers and the design of IMCI. In the first instance, respondents said there was a desire by WHO to regulate the private sector whereas this is not a workable solution. Another pointed out IMCI did not engage with the private sector and it took many years before it was even considered. One respondent said “...there wasn’t and still isn’t a strategy for bringing in the private sector with some flexibility.” In improving engagement with the private sector workforce, better registration is needed to know who private providers are.

Another respondent pointed out that public private partnerships can help improve the customer experience and address patient values; for example, having one location where people go for care and treatment. There is also evidence from the MDGs that public-private partnerships helped to improve vaccine coverage and reduce preventable deaths due to AIDS and Malaria. One respondent

said “where we have not seen good results in reducing preventable deaths, i.e. malnutrition, pneumonia, diarrhea, there were no public-private partnerships.”

A key benefit of the private sector is its ability to innovate; one respondent pointed out that, “we need to leverage these talents onto public health goals.” This has not been done to date, one respondent said, because there is a mistrust of the private sector by WHO...so it has “backed itself into a corner and they are missing out on a lot of expertise that could help them achieve their goals.”

IV. Implications for the future landscape of child health

The ultimate goal of the Strategic Review is to produce recommendations to guide the development of approaches to improve access to and quality of childcare services at facility and community levels, and plan how these can be effectively scaled up in the future. Respondents raised a number of issues they said needed to be prioritized when considering the role of IMCI in the future landscape of child health; these are summarized below.

An annual forum to have a common space to share information

While there are a lot of individual bodies, there is no forum at present to align child health initiatives: “We still don’t have a clear lead and common agenda; but it would be useful to have an annual conference to develop a common agenda. We’re getting pushed to do everything with child health and at present there are no common priorities and this is hurting progress in child health.”

“There should not be an effort made to resuscitate (IMCI) in the form it was in”

There was a strong feeling among many respondents that in the process of reviewing IMCI we cannot look to do the same thing and expect a new outcome, hoping “we will be more committed and coordinated this time.” Respondents noted fundamental flaws in the training strategy and in terms of the scale it could achieve; while many respondents said that each of the components of IMCI made sense and had a purpose, the strategy is not possible to fully implement in its current form. One respondent pointed out that IMCI cannot do everything and, until now, “...this has not been recognized.”

In light of the SDGs, respondents said that now is the time for a more holistic, comprehensive approach to child health programs, and helping countries design and implement such programs. There is a need to focus on lessons from other programs in child health, such as country initiatives in Papua New Guinea that are comprehensive and holistic. Others noted that countries will need help “letting go” of IMCI and building on what has worked well. In looking to the future, one respondent stated, “I hope there is as much of an open minded approach as possible and an approach that takes us into the SDG era and not back into the 1990s.”

Coordination of global strategies: “when we allow division it is to the detriment of the child”

A majority of respondents agreed that we need a coordinated response that does not single out individual illnesses but rather promotes a better understanding that symptoms are interrelated and one needs to look at child health in a holistic way. Therefore, we can’t concentrate on one disease and improve child health: “these global management strategies must be working together!”

One respondent gave the example of polio vaccines: workers go into people’s homes as many as 5 to 6 times a year to deliver drops but do nothing else during those visits. This was seen by respondents as a missed opportunity, and also demonstrative of how funding sets the agenda: polio is not one of the leading killers of children under five and yet bundling services together is believed to compromise the goals of polio funders, demonstrating a lack of communication and leading to a creation of parallel supply chains and other actions that do not further the child health agenda.

In the South African context, one respondent said, “We have done so much when it comes to HIV and we kind of almost hitting a ceiling with HIV because it needs to be implemented within an MCH framework and if we don't do that then our ceiling will remain where it is. We won't be able to break through that last barrier.”

“The time has come to move off of the mortality train”

Until now WHO has followed a strategy focused mainly on childhood illness. If this continues in the future, it presents a risk for WHO to be left out as the world's focus shifts to the SDGs. Global policy-makers should not be looking to end child mortality and then move to the next step, rather one respondent said, “they need to be ahead of the game.” While it is easy to be enthusiastic about reductions in child mortality, it is now the time to be looking at the **thrive** portion of the formula (i.e. child development and psychological support, etc.). “WHO has always been resistant to that and they have scoffed at it,” one respondent said. Many agreed that with the Global Strategy and SDGs, global actors need to be looking for more balance and, while keeping our “foot on the pedal” to expand treatment for common illnesses, it is also time to look at improving the lives that are saved, to give children and their families resources to help them fulfill their potential. As one respondent said, “a revised strategy [for IMCI] needs to put things in better perspective.”

Lastly, one respondent highlighted the need for all players to recognize that **“health is not just one of the goals but is both an outcome and a determinant of the other goals and we need to work out this narrative** both at the international scene and increasingly importantly at the national level.”