Findings of the Child Health Task Force Survey

November 2017

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Abbreviations

CHTF   Child Health Task Force

iCCM   Integrated Community Case Management

iCCM TF   Integrated Community Case Management Task Force

IMNCI   Integrated Management of Neonatal and Childhood Illnesses

KM   knowledge management

MCHIP   Maternal Child Integrated Program

MCSP   Maternal and Child Survival Program

SDG   Sustainable Development Goals

USAID   United States Agency for International Development

WHO   World Health Organization

Preamble

The purpose of this report is to inform the next steps in the consultation process for the development of terms of reference for the proposed Child Health Task Force (CHTF). The primary audience for the report is the Integrated Community Case Management of Childhood Illness Task Force (iCCM TF) Steering Committee, and the secondary audience is the iCCM TF membership. The findings from the CHTF survey were interpreted in the context of recent reports and ongoing discussions among global child health stakeholders about what the vision and scope of child health should be in view of the UN Secretary General's Global Strategy on Women's, Every Woman Every Child (EWEC strategy), which is intended to achieve the child health Sustainable Development Goals (SDGs). It is important to align the CHTF mandate with the global strategies for child health because these strategies will ultimately shape the child health landscape, inform policymakers, and determine the resources available for global health generally and child health specifically.

Summary of Survey Process, Findings, and Recommendations

Survey Process

The iCCM TF Steering Committee made the decision to broaden the mandate of the task force from iCCM to child health at the 2017 Institutionalizing Community Health Conference meeting (Johannesburg, South Africa, March 28, 2017). The decision was made in light of recommendations from the Maternal and Child Survival Program's "Mapping Global Leadership in Child Health" study, the World Health Organization's "Towards a Grand Convergence for Child Survival and Health: A Strategic Review of Options for the Future Building on Lessons Learnt from IMNCI" report, and the "Child Health Moment of Reflection" report from a meeting of key child health stakeholders in Florence, Italy, and in view of the changing global landscape in the SDG era. The steering committee sought feedback from iCCM TF members during a teleconference meeting on April 13, 2017. Participants in this meeting unanimously supported the decision to expand the mandate of the task force to include child health in addition to childhood illness. However, the steering committee and task force members agreed that more discussion was needed to build consensus on the mandate of the proposed Child Health Task Force and how it would operate. During the teleconference, the task force decided to start a consultation process with two steps: (1) each of the seven task force subgroups would hold a teleconference to discuss the mandate; and (2) the task force would conduct a survey of all of its members to build consensus on the outcomes of the subgroup discussions.

The task force subgroups held teleconferences in April and May 2017 to discuss the mandate of the proposed CHTF. The themes that emerged from the subgroup discussions broadly addressed the core mandate and the operational structure of the proposed CHTF and informed the questions for the survey. The five themes identified by task force members for the core mandate of the task force were (1) advocacy, (2) technical coordination, (3) creating a platform for learning and sharing, with a focus on implementation approaches[1] and research, (4) support for countries, and (5) knowledge management. Discussion of the operational structure focused on how the steering committee would provide leadership to the CHTF and how members would participate in subgroups to fulfill the objectives of the CHTF.

The questionnaire, administered through Survey Monkey®, solicited feedback on:

- The target age group for the CHTF;
- What the CHTF's mandate should be (addressing the five themes synthesized from the subgroup discussions);

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[1] Implementation approaches in this context refers to how evidence-based interventions are put into practice in real life, including operations research and/or program implementation with systematic process documentation to inform an iterative learning process.

- How to organize the CHTF;
- Representation of its members;
- How to improve participation in and increase the effectiveness of the new task force; and
- Partnership principles.

The complete survey is included as an annex to this report.

The 19-question survey was sent to all 300 iCCM TF members on the list-serve. Responses were anonymous and the survey collected no background or demographic data on respondents. The initial response period was June 5–14, 2017. After the initial response period, there were 48 responses. To increase the number of responses, a reminder email was sent to the list-serve, and the response time was extended for 5 days. At the end of the 5 additional days, four more people had completed the questionnaire, and the survey was closed.

Key Findings

Fifty-two of the 300 task force members who were registered on the iCCM list-serve responded to the survey. This response rate was lower than anticipated. Participation in the iCCM TF and subgroup teleconferences in 2016 ranged between 10 and 26 people, depending on the topic under discussion, indicating that the number of active members of the task force is much lower than the number of registered members.

There was no clear consensus on the target age group for the CHTF. However, more respondents (47/51) were in favor of including newborns under the CHTF mandate than including school age children (30/51). Respondents commented that whereas newborn interventions can be delivered on the same platform as child survival interventions, interventions for school age children need a multi-sectoral approach. This observation could explain in part why fewer respondents want school age children to be included in the scope of the CHTF. Regarding priorities for the CHTF under the EWEC Survive, Thrive, and Transform agenda, one respondent proposed coordination, leadership, technical support, and resource mobilization. Respondents proposed that further consultation with groups involved in implementing interventions for newborn and school age interventions would contribute to a better understanding of opportunities for delivering interventions on the same platform.

One of the objectives of the survey was to get feedback on whether or not members wanted the five themes that emerged from the subgroup discussions to form the core mandate of the CHTF. Almost all respondents (over 90 percent for each theme) agreed on all five themes. In response to a question about the task force's research mandate, only half of the respondents said they wanted the task force to expand its research agenda from operations research to other types of research.

When asked to rate the relative importance of the five themes for the CHTF in order to contribute to the child health targets under the Sustainable Development Goals, the majority of respondents rated all themes, except expanded research, as a either *very important* or *important*.

Respondents suggested a wide range of issues for coordination, including policy, program design and implementation approaches, monitoring tools, and resource mobilization. Coordination of advocacy efforts was also mentioned a number of times.

Regarding learning and sharing of implementation approaches and research, suggested topics included community-based approaches to increase equitable access to quality assessment and treatment of childhood illness, integration of prevention, nutrition, WASH, financing community approaches, and strengthening supply chains.

Respondents' suggestions for improving knowledge management included developing a deliberate focus on dissemination and using knowledge generated from programs by encouraging south-to-south learning exchanges among developing countries and creating a versatile and up-to-date website. At least three respondents mentioned addressing the needs of the different language groups among task force members in order to increase participation and use of materials produced by the task force.

While there was strong interest in providing support to countries, there was no consensus on the best way to engage country-level child health stakeholders to ensure their active participation in the task force. More respondents preferred integrating support to countries in all subgroups than establishing a country support subgroup.

It is important to note that the survey focused on themes that should be included in the mandate of the CHTF but did not address how to achieve the mandate. Further discussion should focus on defining specific objectives and outcomes under each of the suggested themes as well as how to achieve them. Addressing the "how" should result in prioritizing a few actions under each theme that will contribute to achieving the desired CHTF outcomes and are feasible given time and resource limits.

Concerning leadership of the task force, respondents wanted the steering committee to continue to lead the CHTF. They suggested that the steering committee should expand its current membership (i.e., UNICEF, USAID, Save the Children, and WHO) to include representatives from ministries of health, more donor agencies/ governments, academic institutions, professional associations, and the CORE Group.

On member participation in subgroups, a majority of respondents wanted to keep the iCCM TF subgroups. Respondents proposed mechanisms for improving accountability, including making the subgroups time-bound and disbanding those that are not active. Many respondents also supported appointing organizations to lead subgroups or thematic areas for specified terms to increase the effectiveness of subgroups.

Finally, respondents supported developing CHTF partnership principles for the member organizations.

Recommendations

1. The steering committee should ensure that discussions about the age group(s) for the CHTF involve stakeholders from:

    a. Newborn groups, in order to agree on what elements of newborn health can be included in the CHTF; and

    b. Groups that understand programming for school age children, in order to identify opportunities or synergies with the child survival interventions for under-5 children.

2. The steering committee should define the outcomes that the CHTF expects to achieve and set criteria for further refining and prioritizing the actions (under the themes proposed by task force members) that will be necessary to achieve the outcomes.

3. The steering committee should consult further both at the global level and, more importantly, at the country level to learn what the country level finds to be useful inputs from the global level and how to engender mutual accountability.

4. The steering committee should consider the immediate needs in the area of child health and seek to build momentum to reach consensus on those needs.

5. The steering committee should review the comments, questions, and suggestions that respondents submitted on strengthening the steering committee to ensure broader representation and ownership of the committee by task force members.

6. The number, types, and composition of subgroups should be decided through a transparent mechanism, taking into account the challenges of keeping subgroups active under the iCCM TF.

7. The steering committee should explore the proposal to have organizations lead a particular theme or subgroup for a specified term.

8. To inform the design of CHTF principles that promote inclusiveness, the steering committee should explore how other organizations use partnership principles.

Background

The iCCM Task Force and the Changing Child Health Landscape

The Integrated Community Case Management of Childhood Illness Task Force (iCCM TF) was established to advance the state of community-based treatment for three major childhood killers—diarrhea, pneumonia, and malaria.

As iCCM programs expanded, the task force provided a coordination mechanism for global experts and a forum to build consensus on tools and materials created to support implementation of iCCM across countries.[2]

Since its inception in 2009/2010, the iCCM TF has advocated for favorable iCCM policies and promoted harmonized iCCM tools and approaches to increase access to high-quality services for sick children who are underserved by facility-based care. The iCCM TF has more than 300 registered members from more than 70 organizations and has been a successful mechanism for coordination and reduction of duplication of efforts (e.g., by creating tools for planning and monitoring and evaluation). It has made state-of-the-art tools for iCCM implementation available to its members and the child health community and has enabled stakeholders to have a unified voice when advocating for evidence-based iCCM policies and practices.

The iCCM TF steering committee, which includes representatives from WHO, UNICEF, USAID, and Save the Children, provides strategic leadership and direction to the task force. The membership of the steering committee dates back to the creation of the task force and reflects the organizations that were involved in iCCM policy formulation, funding, and implementation of early iCCM programs. The iCCM TF has seven subgroups that focus on (1) Monitoring and Evaluation, (2) Demand Generation, (3) Supply Chain Management, (4) Workforce Issues, (5) Operations Research, (6) Nutrition Integration, and (7) Costing and Financing of iCCM.[3] Formation of subgroups is determined by the degree of importance of the given topic to effective iCCM implementation, and membership in subgroups is by self-selection based on members' expertise and interest in contributing to the agenda of a subgroup. USAID's global technical assistance programs, the Maternal Child Integrated Program (MCHIP) and the Maternal and Child Survival Program (MCSP), have served as the iCCM TF's secretariat since 2010, and staff members from these programs have been active participants in most of the task force subgroups.

On June 22, 2016, the steering committee issued a memo to the iCCM TF membership about the status of child health and funding for global health.[4] In the memo, the steering committee noted the changing landscape of child health and iCCM since the task force began. These changes include expanded iCCM programs at the country level, availability of tools that countries can use to implement iCCM successfully, the start of the Sustainable Development Goals (SDGs), and the rollout of the Global Financing Facility. Moving forward, the steering committee wanted to focus on how the iCCM TF could and should engage with this evolving landscape to ensure that iCCM is integrated with broader child health programs and not implemented as a standalone strategy. After the steering committee issued the memo, other important reports and conversations emerged to inform the steering committee's decision-making. Those reports and conversations included: (1) USAID/MCSP's "Mapping Global Leadership in Child Health" study, (2) WHO/UNICEF's "Towards a Grand Convergence for Child Survival and Health: A Strategic Review of Options for the Future Building on Lessons Learnt from IMNCI," and (3) the "Child Health Moment of Reflection" report from a meeting of key child health stakeholders in Florence, Italy, in January 2017. These reports and meetings informed the steering committee's decision to broaden the mandate of the task force from iCCM of childhood illness to child health. The broader mandate is in line with the UN Secretary General's Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), which promotes a more integrated approach to child health and ensures a continuum of care from the household/community to

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[2] See iCCM Task Force Fact Sheet: http://ccmcentral.com/wp-content/uploads/2016/05/iCCM-Task-Force_Fact-Sheet.pdf
[3] The subgroup on iCCM in Emergencies is not a formal subgroup, but it operates like one and it was involved in the consultation process.
[4] Memo to iCCM Task Force Members, June 22, 2016 (MCSP communication, available on request).

the hospital level. Whereas the iCCM TF focused only on advancing the iCCM strategy to reach children underserved by facility-based case, the Child Health Task Force (CHTF) would be a technical body designed to advocate for child health and to contribute to strong and integrated child health programs at the country level. The CHTF will promote appropriate household behaviors, preventive services, and access to timely and effective case management of childhood illnesses. In addition, the CHTF will promote linking of child survival interventions with interventions for children to thrive and to transform communities. The broader CHTF approach is in line with the Global Strategy's emphasis on accelerating progress toward the child health SDGs: reducing neonatal mortality to less than 12 per 1,000 live births and under-5 mortality to less than 25 per 1,000 live births by 2030.

Consultation Process

After making the decision on March 28, 2017, to expand the mandate of the task force from iCCM to child health, the steering committee held discussions with iCCM TF members on April 13, 2017. The task force members unanimously supported the decision to expand the mandate of the task force. However, the steering committee and task force members agreed to facilitate more discussions in the task force subgroups about issues such as:

1. The scope of child health and the structure of the CHTF given the ongoing discussion among child health stakeholders about the definition of "child" (refer to "Moment of Reflection" report);

2. The needs (as perceived by iCCM TF members) in the area of child health at the country level and how the Child Health Task Force global group should address country needs for child health programming;

3. The structure of the Child Health Task Force (e.g., what subgroups are needed; re-organizing/redefining the mandate; abolishing some of the existing subgroups and adding others, etc.); and

4. How to engage child health stakeholders, including country-based folks, and whom to engage.

The iCCM TF secretariat requested the subgroup chairpersons to convene their subgroups to discuss these issues. In April and May 2017, facilitated by the secretariat, the Operations Research, Nutrition, Workforce Issues, Supply Chain Management, and iCCM in Emergencies subgroups each held at least one teleconference. The secretariat participated in all of the teleconferences, took minutes, and circulated the minutes to subgroup members for correction to ensure that all points of view were taken into account. Attendance at these teleconferences ranged between five and 12. The secretariat also had informal one-on-one discussions with the chairpersons of the Monitoring and Evaluation, Demand Generation and Social Mobilization, and Costing and Financing subgroups, because they could not convene enough subgroup members to hold a teleconference.

From the subgroup teleconferences and discussions with chairpersons, the secretariat distilled five themes that could define the core mandate of the TF: (1) advocacy, (2) technical coordination, (3) creating a platform for learning and sharing (ultimately split into two themes—[3a] implementation approaches and [3b] research), (4) managing knowledge, and (5) supporting countries.

Survey Methods

To validate the five themes and solicit further feedback from task force members, the secretariat designed a survey. To ensure that respondents had the same understanding of the five themes, each theme was explained and/or defined in the questionnaire and the explanation was followed by a specific question (see annex). The questionnaire also solicited feedback on issues related to the operational structures of the task force—specifically, leadership through the steering committee, member participation through subgroups, how to improve representation and participation in the steering committee and subgroups, and how to improve the task force's effectiveness. The steering committee reviewed the 19 questions before the questionnaire was finalized, and the survey was administered through Survey Monkey, a web-based survey platform.

The questionnaire went to all 300 iCCM TF members on the task force list-serve. Responses to the questionnaire were anonymous. The initial response period was June 5–14, 2017. After the initial response period, there were 48 respondents. A reminder email was sent to the list-serve, and the response time was extended for 5 days. At the end of the 5 additional days, four more people had completed the questionnaire, and the survey was closed. In total, 52 people answered the questions.

Analysis

We ran frequency tables for the quantitative data in Excel. Comments and suggestions from the open-entry comment boxes were coded and synthesized under emerging themes. Respondents also raised questions and issues in the comment boxes, and these are included in the findings. We retained the wording of questions raised by the respondents in most cases, except where more than one respondent raised the same issue. In the latter case, the comment/question is consolidated and rephrased to avoid repetition.

Findings

To make the results easy to understand, we present quantitative results by thematic area and include key messages from the qualitative feedback and issues/questions raised by respondents in the open-entry sections of the survey. For each question, the explanatory note given in the questionnaire is included first and is followed by the findings.

Age Group Focus for the Child Health Task Force

The Millennium Development Goals focused on child survival and ending preventable deaths of children under 5 years of age. The SDGs broadened the child health agenda to Survive, Thrive, and Transform. Moving from child survival to child health calls for a new narrative and definition of both "child" and "child health."
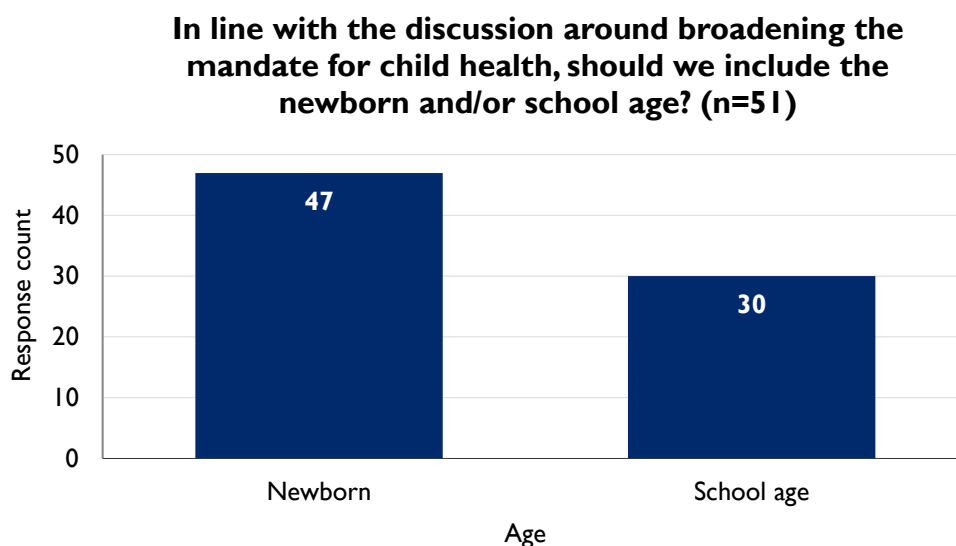
Respondents were asked the following question: *In line with the discussion around broadening the mandate for child health, should we include the following: (a) newborn (b) school age?*[5] In addition, respondents were asked to comment on priorities for the Child Health Task Force for the Survive, Thrive, and Transform agenda.

Figure 1 shows the respondents' preferences. (47/51) and (30/51) responded that they wanted newborns and school age children included, respectively. (Note that these responses were not mutually exclusive.) One respondent did not answer the question. Respondents' comments provided more insight. Although respondents were asked to suggest priorities for the Child Health Task Force for the Survive, Thrive, and Transform agenda, they provided comments on the decision to include newborn and/or school age groups. There were comments in favor of both newborns and school age children. Some respondents highlighted the fact that the needs of the newborn are divided into needs associated with or arising during labor and delivery (terms used included "day of birth" and "events around birth") and needs associated with the day after birth, beyond the immediate postpartum, or after the day of birth. Overall, more respondents argued in favor of including newborns, saying that newborns are more vulnerable to illness and death than school age children. From a program perspective, comments addressed the fact that interventions for newborns (terms used included "newborn illness" and "newborn infections") can be delivered on the same platform as case management of childhood illness. One respondent said, "We could include school age but there is not a lot of information on which to base interventions." One respondent commented that the task force should focus only on the 0–5 age group.

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[5] "Newborn" and "school age" were not defined in the questionnaire, but were assumed to represent the age groups not addressed under iCCM (0–28 days and above 5 years through pre-adolescence) in line with discussions leading to the survey and the Every Woman Every Child movement, which defines children and adolescents as distinct age groups. The specific age range included under child health is a continuing discussion among child health stakeholders and the CHTF is expected to contribute to reaching consensus.

Regarding priorities for the CHTF under the Survive, Thrive, and Transform agenda, one respondent advocated for "coordination and linkages, leadership, technical support, and resource mobilization." Another said that the task force "should include early childhood development" and all phases of child growth. Overall, the comments suggest that there is no simple answer to priorities for the task force, and respondents have divergent views on what to emphasize.

Figure 1: Age groups to be included in the mandate of the Child Health Task Force

In line with the discussion around broadening the
mandate for child health, should we include the
newborn and/or school age? (n=51)

Synthesis of issues raised in the comments section

- Most respondents recognized that the inclusion of newborns and school age children is integral to a comprehensive child health agenda, and would be well aligned with the move by the global community from a focus on survival of children under 5 to the Survive, Thrive, and Transform agenda.

- Some respondents noted that both newborns and school age children need attention, but that addressing the needs of school age children requires a multi-sectoral approach and includes addressing sexual and reproductive health needs, requiring multiple delivery platforms.

  - Respondents noted that inclusion of school age children offers the opportunity for influencing the next generation.

  - Respondents noted that focus on survival alone would be increasingly hard to sell.

Questions raised by respondents for further discussion

- A broadened age group requires a multi-sectoral approach; to what extent will the CHTF engage other/multiple relevant sectors?

- How should the CHTF limit its mandate in order to be effective and still be able to sell its agenda as a technical coordination body to donors and stakeholders?

- Does the CHTF need to address all age groups? Are there ways of ensuring that both newborns and school age children (outside the under-5 age range) are not neglected, while keeping the focus on the under-5 age group?

Mandates of the Child Health Task Force

We asked respondents to indicate whether four of the themes from the subgroup discussions—(1) advocacy, (2) coordination of partners, (3a) implementation science, (3b) research, and (4) knowledge management—
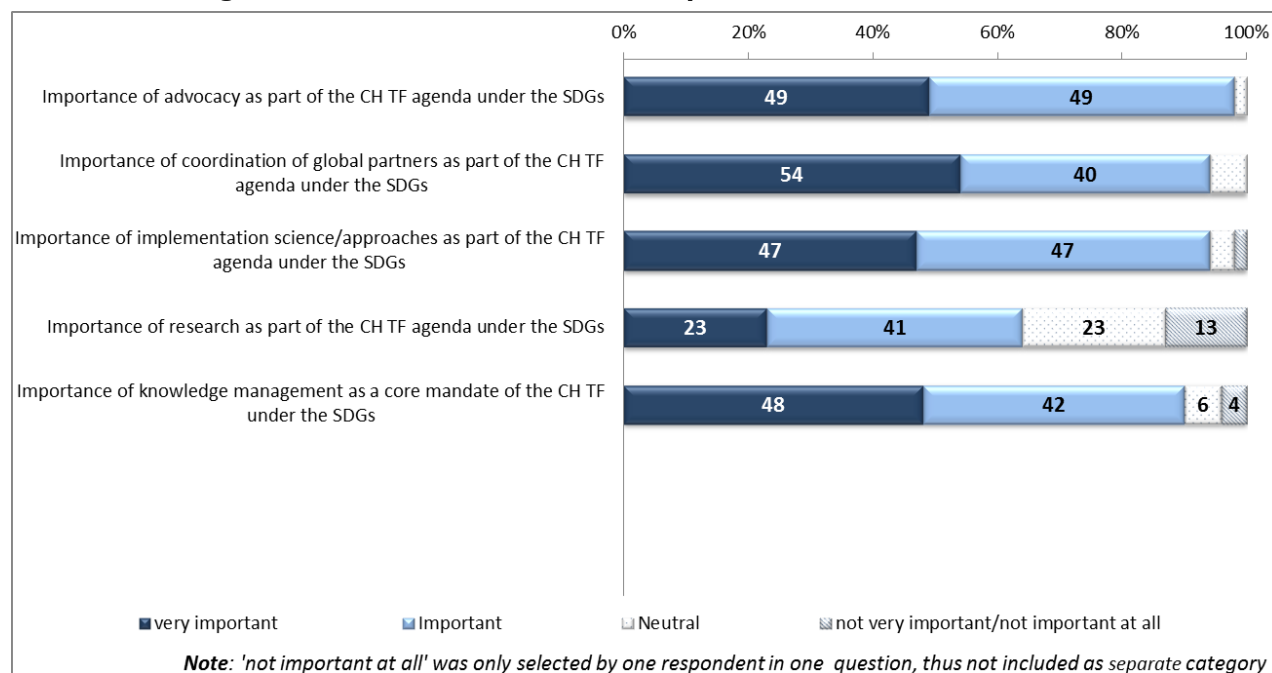
should be a core mandate of the TF. (Questions about the fifth theme—support to countries—were slightly different, so this theme is addressed separately below.) Each theme was explained, and then the respondents were asked, **Should x be a core mandate of the global CHTF? Y/N.**

Respondents were also asked to rate the relative importance of the themes to achieving the child health targets under the SDGs. Table 1 below presents the respondents' answers to the question on the task force mandates. Figure 2 shows the respondents' rating of the relative importance of each mandate to achieving the child health targets under the SDGs.

Table 1: Respondents' answers to the question about task force mandates

Should the following be a core mandate of the Child Health Task Force? (n=52)		
Mandate	Yes % (#)	No % (#)
Advocate	96 (50)	4 (2)
Coordination	96 (50)	4 (2)
Implementation science/approaches	94 (49)	6 (3)
Research	54 (28)	46 (24)
Knowledge management	94 (49)	6 (3)

Figure 2: Respondents' ratings of the importance of each mandate to achieving child health targets under the Sustainable Development Goals

Note: 'not important at all' was only selected by one respondent in one question, thus not included as separate category

Theme 1: Advocacy

Programs and approaches that address the health needs of children are currently fragmented by age group, disease, and strategy, to name a few. Advocacy includes arguing for a comprehensive and integrated approach and resources to address the needs of children to survive, thrive, and contribute to transforming their communities.

Respondents answered the question, **Should advocacy of child health stakeholders be a core mandate of the global CHTF?** Ninety-six percent of respondents said advocating for child health should be a core mandate of the CHTF (see Table 1). Forty-nine percent of respondents said advocating for child health is *very*

important, and 49 percent said it is *important* to achieving child health targets under the SDGs. One respondent was neutral and one skipped the question (see Figure 2). Overall, respondents wanted to include advocating for child health as a mandate of the CHTF.

Theme 2: Coordination

The global health community, and more specifically the community of child health stakeholders, includes diverse individuals and organizations at the global and country levels. A global technical coordination mechanism enables these stakeholders to work together effectively. A coordination body can create a common purpose and share information, tools, and resources to move the child health agenda forward.

Respondents were asked, **Should coordination of child health stakeholders be a core mandate of the global CHTF?** Ninety-six percent of respondents said that coordination should be a core mandate of the CHTF (Table 1). Fifty-four percent of respondents said coordination is *very important* and 40 percent said coordination is *important* to achieving the child health targets under the SDGs. Only three out of 50 respondents rated coordination as neutral (Figure 2).

Respondents were asked for their opinion about specific issues/areas that need coordination (see annex, question 4 comment box). Suggestions covered a wide range of issues, including policy, program design and implementation approaches, monitoring tools, research priorities, resource mobilization, and so on. Respondents highlighted the need for coordination in relation to the workforce for child health programs—specifically, community health workers and their training, supervision, and salaries. Coordination of advocacy efforts was mentioned a number of times. For example, one respondent noted, *"On advocacy, need to speak with a common voice and agenda in order to be most impactful. One challenge I foresee with this, though, is that because different stakeholders define the child differently, for ex., in the new terms of reference there should be some articulation of how to have a common mandate and voice despite different stakeholders having different priorities and areas of focus."*

Synthesis of issues raised by respondents in the comments section

- Respondents recognized that advocating for child health will only be effective if stakeholders agree on the issues that need to be addressed.
- Respondents saw coordination as important to creating a common platform for resource mobilization; sharing technical tools, evidence, and common standards of practice; and avoiding duplication and increasing effectiveness.
- Respondents proposed that the following areas be included in the task force coordination agenda: conducting a needs analysis, setting research agendas, and developing common standards for program implementation.

Questions raised by respondents for further discussion

- Should there be a moratorium on the formation of new coordination bodies to avoid duplication of efforts?
- Who should issue and enforce the moratorium?

Theme 3: Learn, share

We subdivided learning and sharing into two subthemes—learning and sharing **implementation science/approaches** and learning and sharing **basic research**—and provided the following definitions:

- **Implementation science** is how evidence-informed interventions are put into practice (or not) in real world settings. Implementation science includes operations research, but it may also be program

implementation with systematic documentation and program adjustment based on active learning. Learning and sharing also includes innovation and the diffusion of innovations to implement programs.

- **Basic Research** is research that is exploratory, fills in the knowledge we do not have, and seeks to identify/explain relationships between variables; as part of a broadened mandate for the iCCM TF, basic research would include clinical trials.

Implementation science or approaches

Respondents were asked to answer the question, **Should implementation science/approaches be a core mandate of the CHTF?** They were also asked to rate the importance of implementation science/approaches to achieving the child health targets under the SDGs. Lastly, respondents were asked their opinion about key issues for learning and sharing in implementation science/approaches (see annex, questions 6 and 7).

Ninety-four percent of respondents wanted learning and sharing of implementation science/ approaches to be a core mandate of the CHTF. Forty-seven percent of the respondents rated implementation science as *very important* and 47 percent rated it as *important* to achieving child health targets under the SDGs (see Figure 2). On key issues for learning and sharing implementation/science approaches, some respondents gave a single suggestion while others gave several. For example, one respondent said, *"What are sustainable and cost-effective interventions that communities find acceptable?"* while another listed "*adequate data collection and processing, use of data for decision making and improve health, technical support.*" Other topics suggested by respondents include the following:

- Understand what solutions for child health work in different contexts
- Knowledge of the service provider
- The changing technologies to be taken into consideration
- Adequate data collection and processing
- Use of data for decision-making and to improve health
- Technical support and innovations (to be explored further)
- Community-based approaches to increase equitable access to quality assessment and treatment of childhood illness
- Integration of prevention (nutrition, WASH, early childhood development, accident prevention) with case management at the facility, community, and household levels
- Financing community approaches and strengthening supply chains

Research

During the iCCM TF Operations Research subgroup discussions, some members proposed expanding from operations research to a broader research agenda for child health, including clinical trials. This proposal was used to inform the subsequent survey questions on the theme of learning and sharing. In the survey, respondents were to comment on whether the task force research agenda (under the learning and sharing theme) should be expanded beyond operations research to include basic research.

Respondents also were asked to rate the importance of a broadened research mandate to achieving child health targets under the SDGs. Finally, respondents were asked to comment on the appropriateness of a broadened research agenda under the Child Health Task Force.

Only 54 percent of respondents said yes to expanding the research mandate beyond operations research. Forty-six percent said the task force should continue with operations research only. Similarly, fewer respondents rated a broader research mandate as being important to achieving child health targets under the SDGs (Figure 2). Some respondents said that broader research—including clinical trials, for example—is not the mandate of most of the organizations involved in the iCCM and the CHTF. "*We are implementers and donors,*

not bench researchers," one respondent noted. However, some respondents argued for research that would broaden our understanding of child health and how child health needs should be addressed.

Topics suggested for research included (1) Integrated Management of Childhood Illnesses and related necessary referral mechanisms, (2) expanding the focus beyond the community in both directions to facility-level and household-level care, and (3) humanitarian and emergency settings. Topics suggested for an expanded research mandate to generate evidence included clinical trials, drugs and vaccine potencies, diagnostics/prognostics, treatment, nutrition, WASH, and reduction of household air pollution.

Moving forward, one respondent said, there is a need to build consensus on what operations research is and how to make it responsive to program needs.[6] "*Operations research is becoming an antiquated term. We need to think about implementation science and research on a range of topics from the community to public health sector health facilities to the private sector,*" commented another respondent.

Questions and issues raised by respondents for further discussion

1. How can the CHTF continue pushing issues that are outside the mandate of the task force, but relevant to achieving the SDGs related to child health?

2. There is a need for the CHTF to create a process for clarifying that the task force cannot address everything, but that members should/can belong to other networks (e.g., basic research groups) and contribute, as well as inform, the child health operations research agenda.

3. There is a need to continue discussions and adjust the CHTF agenda to address emerging needs.

Theme 4: Knowledge management

Knowledge management (KM) includes generating and disseminating knowledge and disseminating documents that result from the work of the task force. Under the iCCM TF, knowledge management also included hosting the website, ccmcentral.com. Respondents were asked to say whether knowledge management should be a core mandate of the CHTF. They were also asked to rate the importance of knowledge management to achieving the child health targets under the SDGs, and to provide ideas for managing knowledge under the CHTF.

Ninety-four percent of respondents said knowledge management should be a core mandate of the CHTF. Forty-eight percent of respondents rated KM as *very important* and 42 percent said it was *important* to achieving the child health targets under the SDGs. Respondents provided comments on KM and suggestions for how to do KM under the CHTF. One respondent commented on the host organization and the quality of the website. Specific suggestions given included the following:

- Consolidate KM to avoid duplication and the re-creation of tools and approaches.
- Focus on dissemination and the use of knowledge generated from programs by encouraging south-to-south learning exchanges among developing countries.
- Create a more versatile and up-to-date website.

At least three comments referred to language barriers in the context of improving knowledge management at the global level and building the capacity of country-level officers to access and use the knowledge. Respondents suggested that KM should address the diverse language groups of the membership in order to make knowledge more accessible and usable. They also suggested the use of technology/mHealth as well as centers of excellence and communities of practice to increase reach. Others suggested approaches included

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[6] Operations research was not explained in the questionnaire. The authors assumed a common understanding of operations research as focusing on identifying operational issues faced by program managers during program implementation and applying scientific methods to test solutions. It therefore follows that operations research always happens in the context of program implementation, which is not the case with basic research studies (e.g., clinical trials or drug efficacy studies) that happen under more controlled, "laboratory-like" conditions.

the use of case histories, success stories, photos, and videos in multiple languages to disseminate knowledge and learning from the task force members.

## *Questions and issues raised by respondents for further discussion*

1. Knowledge management will still have to be "housed" somewhere/with someone, I'm guessing via the Secretariat. And who would this management function get transitioned to after MCSP ends?

2. How can we ensure transmission of knowledge and monitor its application beyond dissemination meetings?

3. Provide field capacity-building on knowledge management (in English and French language); promote standard guideline for child health knowledge management.

Theme 5: Support to countries

During the initial meetings, iCCM TF members suggested that the overall goal of the CHTF should be to enable countries to implement stronger child health programs. The CHTF could provide countries with direct support for strategic planning and costing, resource mobilization, program reviews, and so on, including providing tools for these processes. Participants in the survey answered the question, ***How should the CHTF engage with countries and/or country programs?*** Respondents could choose from the following three options for their response: (a) Establish a country-specific subgroup; (b) Integrate support to countries in all of the task force subgroups; and (c) Other (specify).

Figure 3 shows respondents' answers to the question of how the task force should engage with countries and/or country programs. Although the answers were intended to be mutually exclusive, some respondents selected between the first two options and then gave suggestions for the "other" option. Therefore, the total number of responses is greater than 52.

Figure 3: Respondents views on how the task force should support countries

How should TF engage with countries/county child health programs (n=52)
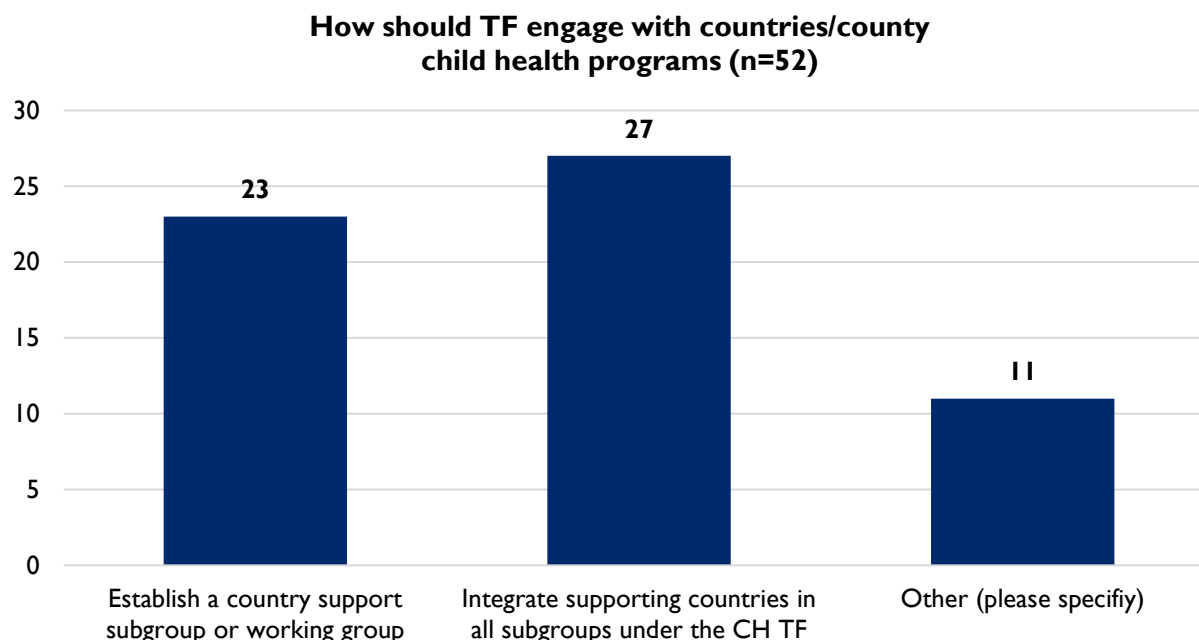
Twenty-three respondents said the task force should establish a country support subgroup, while half (27) of the respondents favored integrating support to countries with the other subgroups. Eleven respondents selected "other" and suggested specific approaches, including the following: (1) Establish regional groups

[authors' note: no details were given]. (2) Get out to countries to find out what they need/want; increase their numbers as members of the task force; initiate activities through the task force that directly benefit and involve countries. (3) Ensure that communication to country offices and sub-country offices of member organizations is shared with the entire group. (4) Categorize the support-to-countries subgroup to avoid language barriers (French-speaking countries, English, Spanish...). Some suggestions were more general—for example, "Coordinate with others to create a practice-oriented research type of network and community of practice"; and "Best to look at what works at country level." One respondent specifically questioned the capacity of the task force to support countries, saying, *"If enabling countries to implement stronger programs is a goal, why are they not represented? The task force has no capacity and is not positioned to provide country support."*

Overall, respondents' comments highlight the problem of having a task force that to date has existed to serve country needs as per iCCM TF goals and objectives[7] and a membership made up primarily of global members because country-level members are inactive. *"Integrating country work may be a bit difficult and likely requires more thought about how best to do this. As a Child Health TF, it may depend less on the funding streams, as there should be funding/implementation for some child health activities in all countries,"* a respondent observed.

Respondents highlighted some issues that need to be addressed to ensure effective support to countries, including the participation of country-level child health stakeholders in the task force. Some respondents said they would like to see task force members travel to countries, mass communication to all members, and so on. Finally, the respondents urged the CHTF to address the language barrier and provide for regional groupings along language lines during task force meetings to ensure effective engagement.

Questions and issues raised by respondents for further discussion

1. If enabling countries to implement stronger programs is a goal, how can the task force ensure that countries are represented in the task force?

2. There is a need to define "country" people. Is being geographically based in a country sufficient to quality as country person? Will expatriate/NGO staff based in countries count?

3. How should the task force engage country folks? Are there successful models to learn from?

Operational Structure

Respondents were asked to indicate whether the task force should maintain the steering committee as the primary leadership structure and subgroups as the means of participation for task force members. Respondents were asked to provide additional feedback on how to strengthen both the leadership and the participation of members to achieve the goals and objectives of the task force.

Steering committee

Under the current iCCM TF, the steering committee comprises representatives from WHO, UNICEF, USAID, and Save the Children, and provides leadership and direction to the overall task force. MCHIP and MCSP, funded by USAID, have provided secretariat support to the iCCM TF and steering committee.

Most respondents (81 percent; 42/52) want the steering committee to continue leading the CHTF. Respondents said the steering committee is a mechanism for building ownership across agencies. Some respondents also commended the steering committee of the iCCM TF for providing leadership to date while noting the potential for improvement. One respondent noted, *"[W]ithout such kind of leadership, nothing gets done."* Among the negative sentiments expressed by respondents was the fact that the steering committee is *"too US based and donor heavy."* Suggested changes included adjusting the civil society representation, with the CORE Group as the appropriate private voluntary/civil society representative. Respondents also suggested a more transparent approach to determining members of the steering committee, and noted that members should serve time-limited or rotational terms, informed by periodic stocktaking of their contributions.

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7 ccmcentral.com/wp-content/.../iCCM-Task-Force_Fact-Sheet.pdf

Respondents who answered yes to having the steering committee continue to lead the task force were asked whether the membership of the steering committee should be expanded or remain the same. They were also asked to suggest additional members for the steering committee, if they supported expansion. Seventy-seven percent (of the 42 who responded in favor of expansion) wanted the steering committee membership to expand, while 16 percent (7/42) wanted the current size to be maintained. One person did not respond. Suggestions for additional members from countries/governments (ministries of health) and organizations included the Canadian government, the United Kingdom, and the Bill and Melinda Gates Foundation. Five respondents mentioned country-specific representation from the following: national child health program implementing partners, ministries of health, directors of national drug stores, organizations working in health systems and other sectors, some of the recent and past chairs of the subgroups of the iCCM TF, the private sector, the Global Fund, the World Bank Group, academic institutions, and professional associations, including community health worker associations. Suggested functions of the steering committee beyond leadership and vision included providing guidance, validating technical documents and tools, and advocating and mobilizing resources while ensuring that non-steering committee members are fully involved in actions and decision-making. A few respondents were less specific, suggesting that the steering committee membership be defined by the new mandate and the terms of reference for the task force.

Establishing and participating in subgroups

Respondents were asked to indicate (1) whether the task force should maintain subgroups as a structure for member participation in achieving its goals and objectives, and (2) their level of interest in participating in at least three thematic areas (or subgroups).[8] Members of the task force are free to join any number of thematic areas or subgroups of interest. Respondents were asked the following question: ***Please indicate your interest (from most to least interest) in participating in the following thematic areas: Advocacy, Coordination, Implementation Sciences/Approaches, Research, Support to Countries, and Knowledge Management.***

Most respondents (83 percent; 43/52) said they wanted the task force to maintain subgroups as a primary structure for member participation. Respondents were asked to indicate which three of the thematic groups they would be likely to join. This question was included to determine whether respondents planned to participate in the subgroups and contribute to achieving the goals of a given mandate or theme.

Respondents selected all thematic areas nearly evenly, with the exception of basic research. The implementation science/approaches theme ranked first, followed by support to countries. Knowledge management, coordination, and advocacy closely followed, while basic research ranked lowest among members' interests.

Regarding approaches to improving participation, respondents indicated that they want subgroups to be time-bound and/or to disband if considered ineffective. They also want to have defined deliverables and ensure that every member has a responsibility. Respondents want less frequent teleconferences and a variety of communication forums, including webinars, online forums, regional activities, and annual face-to-face meetings to share best practices and challenges. Some respondents also said the five thematic areas or mandates should become the subgroups. Respondents think subgroup members should develop terms of reference and deliverables, but also noted that subgroups need an accountability mechanism in order to be effective.

Leadership of subgroups

Respondents were asked to indicate whether subgroups or thematic areas should be led by individuals who were elected by the members of the thematic group (i.e., chair/co-chairs), as is the case under the iCCM TF, or whether the subgroups should be led/chaired by organizations that designate individuals to lead them. They were asked to comment on either choice. In addition, the respondents were asked to give suggestions for who should be responsible for developing terms of reference, recruiting members, and/or defining deliverables for the subgroups or thematic areas.

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[8] For the purpose of this questionnaire, thematic groups or mandates were treated as subgroups, with the understanding that this will evolve based on outcomes of the consultation process.
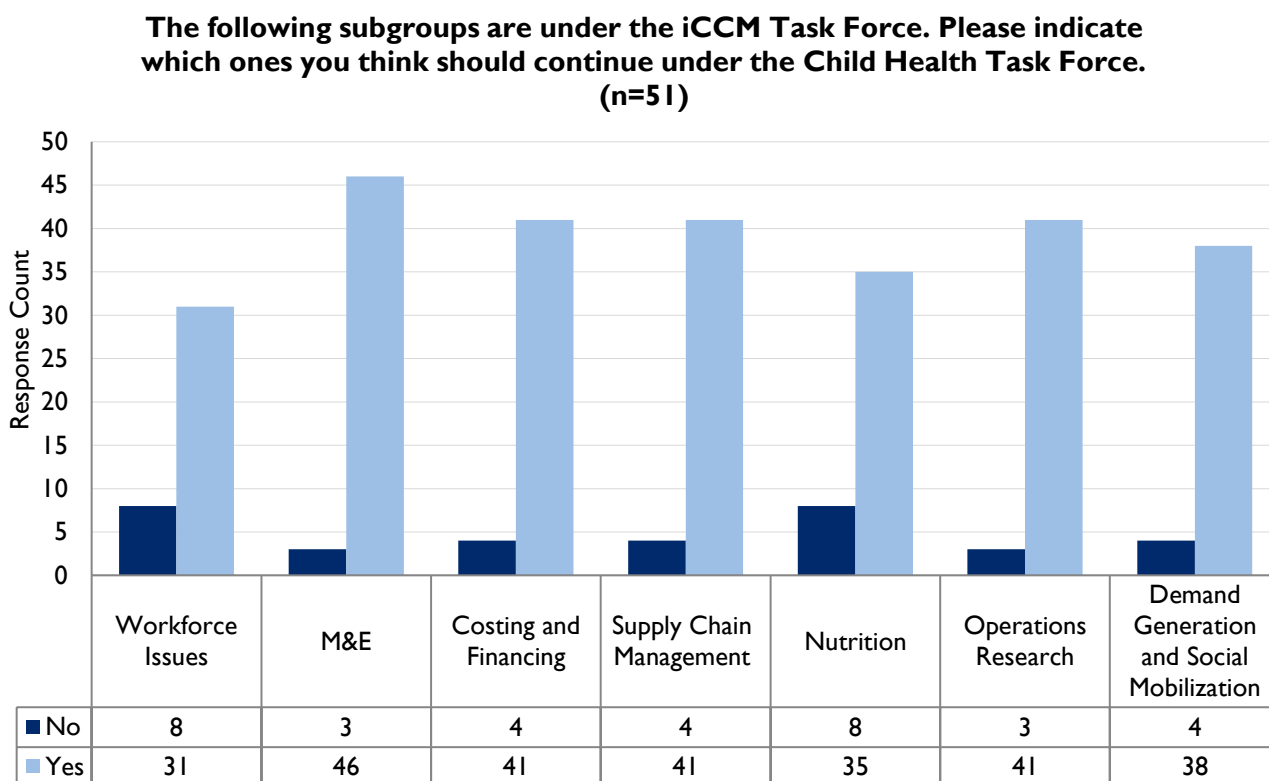
Ten respondents skipped this question. Among the 42 who responded, 52 percent (22) were in favor of organizations appointing leaders and 48 percent (20) preferred elected individuals to lead. Comments were submitted only by those who preferred leaders to be appointed by organizations. The reason offered was to ensure that individuals have the backing of the organization. Such organizations can allocate time to lead and to show commitment and accountability for agreed-upon results. However, the respondents noted that individuals nominated by their organizations to lead subgroups should be screened both by the steering committee and by members of the respective subgroup. They also proposed a flexible mechanism to support leadership by qualified individuals who might not belong to an organization (e.g., independent consultants). Others observed that some organizations, whose funding is based on specific projects, might not have resources to commit to the CHTF, despite their interest in its work. This would be true in cases where the task force work is not included in the organization's project proposal and does not directly contribute to the project's deliverables.

iCCM Task Force Subgroups

The steering committee also wanted to get feedback on how best to proceed with existing subgroups under the iCCM TF. Respondents were asked whether iCCM TF subgroups should be maintained.

Figure 4 shows that most respondents want the subgroups under the iCCM TF to be maintained. Respondents suggested that the subgroups should be transformed to broaden their mandates from iCCM to include broader child health. A few respondents suggested that the thematic groups or mandate of the CHTF should inform/translate into subgroups under which some of the current subgroups of the iCCM TF could exist as sub-task groups. Some respondents also said they want fewer subgroups than the seven that exist under the iCCM TF.

Figure 4: Subgroups under the Child Health Task Force

The following subgroups are under the iCCM Task Force. Please indicate which ones you think should continue under the Child Health Task Force. (n=51)

	Workforce Issues	M&E	Costing and Financing	Supply Chain Management	Nutrition	Operations Research	Demand Generation and Social Mobilization
No	8	3	4	4	8	3	4
Yes	31	46	41	41	35	41	38

Partnership Principles

Member organizations are expected to contribute to the effective functioning of the task force, including allocating time and effort. Sometimes individual and/or organizational interests can get in the way of working together effectively. Partnership principles can help to manage expectations and strengthen partnerships by, for example, recognizing and allocating staff time to perform task force responsibilities. Respondents answered the question, **Should the CHTF develop partnership principles that members agree to?** Seventy-one percent (37/52) of respondents were in favor of the CHTF having partnership principles, four percent (2/52) said no to developing partnership principles, and 25 percent (13/52) were neutral. Respondents in favor of partnership principles observed that every organization or group must have rules/terms of engagement for better coordination and expected conduct such as declaring conflicts of interest, respecting country and community ownership, committing to information sharing, pool funding, transparency, acting on agreements, and committing to contractual deliverables. However, respondents cautioned that such principles should be flexible enough to change over time.

Discussion and Recommendations

This survey marks a critical milestone in the consultation process to inform the development of terms of reference for the CHTF. The low response rate not withstanding, the findings are important enough to inform the steering committee's decisions on the mandate of the CHTF. The findings should be intepreted in the broader context of all discussions among task force members and global child health stakeholders on the scope of child health, the reports and strategies mentioned above—"Mapping Global Leadership in Child Health," "Towards a Grand Convergence for Child Survival and Health: A Strategic Review of Options for the Future Building on Lessons Learnt from IMNCI," and "Child Health Moment of Reflection"—and the changing global landscape in the SDG era.

The Scope of Child Health (Age Groups)

The task force members are supportive of the decision to broaden the mandate of the task force from iCCM of childhood illness to child health. The task force members' response to the June 22, 2016, memo from the steering committee, the subsequent task force teleconferences, and the subgroup discussions showed that members agreed that the decision to expand beyond iCCM is not only inevitable, but also strategic. While this decision itself is straightforward, the details of the broader mandate and how to achieve it are not.

Overall, survey respondents support the inclusion of newborns more than school age children in the scope of the CHTF. However, respondents also indicated that the decision is not without consequence. It mirrors the ongoing effort among global child health stakeholders to define the child in a way that unites them while also being responsive to programming and funding realities. Task force members recognize the health needs of children of all ages, while program design, implementation, and financing often favor programs with a narrow mandate because they are easier to implement and results can be more easily quantified.

The iCCM strategy focused on children ages 2 months to 5 years and community-level case management. Some respondents (and other commentators) ascribe the success of the iCCM TF to iCCM's narrow scope. In practice, children under 2 months old were seen and in many cases treated by community health workers providing iCCM. In some countries/areas the iCCM package includes home visits to all newborns and referral of sick newborns. Ongoing pilot programs and the scale-up in some countries (such as Nigeria) of the management of possible severe bacterial infections at the community level, in which many members of the iCCM TF are involved, may have contributed to the greater support for including newborns than for including school age children.

The continuing discussion of the age group(s) of focus for the CHTF should involve stakeholders who understand programming for school age children in order to identify opportunities and synergies with child survival interventions for the under-5s.

Beyond the age groups included in child health, respondents commented on early childhood development as an important component of child health to include in the CHTF. The task force could create guidance on how to add early childhood development to existing platforms for delivering child survival interventions and develop indicators to measure progress.

The Mandate of the Child Health Task Force

The survey results show that respondents support the five broad themes—advocacy, coordination, learning and sharing in implementation approaches (including operations research), knowledge management, and support to countries—that should define the mandate of the CHTF. These themes were identified by the secretariat through discussions with subgroups. Respondents rated all themes, except expanded research, as either *very important* or *important* but also expressed concern about the task force taking on too much. Discussions to date, including the survey, have not addressed the specific outcomes desired for each theme or how to achieve them. It follows that the steering committee should now focus on defining expected outcomes for the CHTF and how they can be achieved. This will help both the steering committee and task force members determine what can feasibly be achieved under the task force, considering available resources and time.

Tasks suggested by respondents for coordination included conducting a needs analysis (for child health), setting research agendas, and developing common standards for program implementation. An example of setting a common standard for program implementation is the iCCM implementation framework. The effort to develop an implementation framework and identify indicators for select Survive and Thrive interventions—similar to iCCM—might encourage stakeholders to belong to the task force. Stakeholders would have an opportunity to learn and contribute their expertise to the process, which could have the benefit of reducing fragmentation in efforts to develop implementation standards. The standards are likely to be used by more stakeholders and to increase the value of available resources.

Some issues that might be important to child health, but that might not fit easily within the immediate sphere of influence of the task force or might fit better in a longer-term strategy, should be acknowledged as issues for the task force to address as the child health landscape evolves. The task force could also identify strategic liaisons to address those issues deemed outside its immediate mandate. Issues raised by respondents related to learning under implementation approaches and research included: integration of prevention (nutrition, WASH, early childhood development, accident prevention) with case management at the facility and community levels, and community-based approaches to increase equitable access to quality assessment and treatment of childhood illness. The steering committee should include learning about what already exists at the country level in these areas in the short term. The knowledge versus practice gaps can then inform a long-term strategy for the CHTF.

Respondents unanimously favored including support to countries in the mandate of the task force, but did not address the challenge of how to implement and achieve this. The steering committee should consult further at both the global level and, more importantly, the country level to learn what countries find to be useful inputs from the global level and how to engender mutual accountability.

The steering committee should consider the immediate needs in the area of child health and seek to build momentum toward reaching consensus on those.

As a next step, the steering committee should define the outcomes that the CHTF expects to achieve and set criteria for further refining and prioritizing the actions under each theme that will be necessary to achieve these outcomes.

Leadership of the Task Force and Participation of Members

Respondents support the role of the steering committee in setting the overall agenda of the CHTF. They noted areas that can be improved and provided suggestions for strengthening the oversight role of the steering committee.

One of the recommendations for the steering committee was to improve accountability. While acknowledging that the steering committee cannot include everyone, respondents said that, as much as possible, the steering committee should be transparent and should create a mechanism for obtaining member feedback on its role and performance on an ongoing basis. The steering committee should review the comments, questions, and suggestions on strengthening the steering committee to ensure broader representation and ownership by task force members.

An encouraging finding is the willingness of some task force members to have time-bound subgroups and leadership of the subgroups, and to disband those subgroups that do not deliver on their objectives. The number, types, and composition of subgroups should be decided through a transparent mechanism.

The finding that members want to keep all the current subgroups under the iCCM was surprising because some subgroups, such as Demand Generation and Social Mobilization and Costing and Financing, have struggled to maintain an active membership and have not been actively engaging the issues in their objectives. In some cases it seems that members are driven by the "face value" of the theme—for example, the need to address costing and financing of iCCM—even though the subgroup has limited membership and is relatively inactive. This reality should be taken into account when deciding which subgroups to establish so that the task force does not end up with a lot of subgroups that require secretariat support to keep moving but have limited outputs. Some subgroups should be considered as task teams that convene around a specific deliverable and disband afterward. For example, the costing and financing subgroup was useful for supporting countries to develop costed concept notes for iCCM under the Global Fund New Funding Model, but needs to define a new agenda.

In addition, the steering committee should explore the proposal to have organizations lead particular themes or subgroups for an agreed-upon term. In this way, the lead organization would be responsible for ensuring achievement of objectives. This mechanism was tried under the Diarrhea and Pneumonia Working Group with mixed although promising results (personal communication with the Diarrhea and Pneumonia Working Group Secretariat).

Members support the development of partnership principles. However, they encouraged an approach to using partnership principles that is flexible and can change over time. The principles will explain what can be expected of organizations or individuals joining the task force—for example, the need to explicitly sign up for task force membership, the need to indicate which task force objectives they will contribute to, the requirement to update membership or affiliation information, and so on. The steering committee can use the list of signed-up members and organizations to determine its strength and review member participation on an ongoing basis.

To inform the design of the CHTF principles that promote a commitment to a common agenda and inclusiveness, the steering committee should explore how other organizations use partnership principles.

Recommendations

1. The steering committee should ensure that discussion about the age group(s) of focus for the CHTF involves stakeholders from:

   - Groups that focus on newborns—in order to agree on elements of newborn that can be included in the CHTF; and

- Groups that understand programming for school age children—in order to identify opportunities and synergies with the child survival interventions for the under-5s.

2. The steering committee should define the outcomes that the CHTF expects to achieve and set criteria for further refining and prioritizing the actions (under the themes proposed by task force members) that will be necessary to achieve these outcomes.

3. The steering committee should consult further both at the global level and, more importantly, at the country level to learn what the countries find to be useful inputs from the global level and how to engender mutual accountability.

4. The steering committee should consider the immediate needs in the area of child health and seek to build momentum to reach consensus on those needs.

5. The steering committee should review the comments, questions, and suggestions related to strengthening the steering committee to ensure broader representation on and ownership of the committee by task force members.

6. The number, types, and composition of subgroups should be decided through a transparent mechanism taking into account the challenges of keeping subgroups active under the iCCM TF.

7. The steering committee should explore the proposal to have organizations lead a particular theme or subgroup for an agreed-upon term.

8. The steering committee should explore how other organizations use partnership principles to inform the design of the CHTF principles that promote commitment to a common agenda.

Next Steps

1. Share the final report with the Steering Committee.

2. Hold a meeting of the steering committee to address issues/questions raised by respondents and recommendations of the report to inform the development of the task force terms of reference.

3. Develop terms of rerence for the Child Health Task Force.

Annex

Child Health Task Force Questionnaire: June 2017

The purpose of this questionnaire is to get your feedback on how the iCCM Task Force (iCCM TF) Steering Committee should broaden the mandate and focus of the iCCM Task Force to include child health. This questionnaire builds on the discussions of the iCCM TF subgroups and the Steering Committee. The findings will inform next steps for developing terms of reference for the Child Health Task Force.

The iCCM TF primarily focused on advancing favorable policies for iCCM, and harmonized and provided tools and approaches for introducing and scaling up integrated community case management of childhood illness. The task force contributed to increasing access to effective and timely case management, thereby reducing under-5 mortality in populations underserved by facility-based care. Under the new global architecture for child health, the current iCCM TF proposes to broaden its mandate to become the Child Health Task Force (CHTF). The CHTF will be a technical body designed to contribute to strong child health programs in line with the Sustainable Development Goals. Resources for global health and child health are shrinking; therefore, there is a need to sharpen the vision and move toward an integrated platform to maximize efficiency and reduce costs. We invite you to respond to the questions below as candidly as you can. Please use the comment boxes to add your thoughts on issues that are not addressed by specific questions and suggested answers.

Question 1:
Age. The Millennium Development Goals focused on child survival and ending preventable deaths of children under 5 years of age. The SDGs broaden the child health agenda to Survive, Thrive and Transform. Moving from child survival to child health calls for a new narrative and definition of both "child health" and "child." In line with the discussion around broadening the mandate for child health, should we include the following:

a.   Newborn Y/N

b.   School age Y/N

Comment Box: Please comment about priorities for the Child Health Task Force for the Survive, Thrive, and Transform Agenda.

Question 2:
Mandate 1:
Advocate Programs and approaches that address the health needs of a child are currently fragmented by age group, by disease, and by strategy, to name a few. Advocacy includes arguing for a comprehensive and integrated approach and resources to address the needs of children to survive, thrive, and contribute to transforming their communities. Should advocacy be a core mandate of the global CHTF?

a.   Yes

b.   No

Question 3:
Mandate 1: Advocate
If you answered yes to question 2, rate the importance of advocacy as part of the CHTF agenda under the SDGs.

a. Note important at all

b. Not very important

c. Neutral

d. Important

e. Very Important

Question 4:
Mandate 2. Coordinate
The global health community and, more specifically, child health stakeholders include diverse individuals and organizations at the global and country levels. A technical coordination mechanism enables these stakeholders to work together effectively. A coordination body can create a common purpose and share information, tools, and resources to move the child health agenda forward. Should coordination of child health stakeholders be a core mandate of the global CHTF?

a. Yes

b. No

Comment Box: in your opinion, what specific issues/areas need coordination?

Question 5:
Mandate: Coordinate
If you answered yes to question 4, rate the importance of coordination of global partners as part of the CHTF agenda under the SDGs.

a. Note important at all

b. Not very important

c. Neutral

d. Important

e. Very Important

Question 6:
Mandate 3. Learn, Share
We subdivided learning and sharing into two subthemes: implementation science/approaches and research. Implementation science is how evidence-informed interventions are put into practice (or not) in real-world settings. Implementation science includes operations research, but it may also be program implementation with systematic documentation and program adjustment based on active learning. Learning and sharing also includes innovations and diffusion of the innovations to implement programs.

Mandate 3a. Implementation Science
Should implementation science/approaches be a core mandate of the CHTF?

a. Yes

b. No

Question 7:

Mandate 3a. Implementation Science

If you answered yes to question 6, rate the importance of implementation science/approaches as part of the CHTF agenda under the SDGs.

a. Note important at all

b. Not very important

c. Neutral

d. Important

e. Very Important

Comment Box: In your opinion, what are the key issues for implementation science?

Question 8:

Mandate 3b. Research

Should the research agenda be expanded beyond operations research?

a. Yes

b. No

Question 9:

Mandate 3b. Research

If you responded yes to question 8, rate the importance of research as a core mandate of the CHTF under the SDGs.

a. Note important at all

b. Not very important

c. Neutral

d. Important

e. Very Important

Comment Box: Comment on the appropriateness of broadening beyond operations research under the Child Health Task Force.

Question 10:

Mandate 4. Knowledge Management

Knowledge management includes generating, packaging, and using appropriate forums for disseminating knowledge and documents resulting from the work of the task force. Under the iCCM Task Force, this included hosting the website. Should knowledge management be a core mandate of the CHTF?

a. Yes

b. No

Question 11:
Mandate: Knowledge Management
If you responded yes to question 11, rate the importance of knowledge management as a core mandate of the CHTF under the SDGs.

a. Note important at all

b. Not very important

c. Neutral

d. Important

e. Very Important

Comment Box: provide new ideas for managing knowledge under the child health task force.

Question 12:
Mandate 5. Support to Countries
The overall goal of the CHTF is to enable countries to implement stronger child health programs. Areas of direct support to countries by the CHTF could include strategic planning and costing, resource mobilization, program reviews, etc., including providing tools to use for these processes. How should the task force engage with countries and/or country programs?

a. Establish a country support subgroup or working group Y/N

b. Integrate supporting countries in all subgroups under the child health task force Y/N

Comment Box: other (please specify)

Question 13: Participation
Members of the task force are free to join any number of thematic or subgroups of interest. Please indicate your interest in participating in the following thematic areas: Advocacy, Coordination, Implementation Sciences/Approaches, Research, Support to Countries, and Knowledge Management.

Comment Box: List your top three, starting with the area you are most interested in.
Comment Box: Add comments about how to improve participation in thematic or subgroups.

Question 14: Operational Structure: Steering Committee
Under the iCCM TF, the Steering Committee (SC) comprised representatives from WHO, UNICEF, USAID, and Save the Children, and provided leadership and direction. MCHIP and MCSP, funded by USAID, provided secretariat support to the iCCM TF. The iCCM TF operated under subgroups relevant to iCCM implementation. Should the steering committee continue to lead the CHTF?

a. Yes

b. No

Comment Box: Comment on the role of the Steering Committee.

Question 15: Operational Structure: Steering Committee
If you responded yes to question 14, should the membership be expanded for the SC?

a. Yes

b. No

Comment Box: Suggest potential members of the SC.

Question 16: Operational Structure: Subgroups
Should the CHTF continue with subgroups as the primary operating mechanism?

a. Yes

b. No

Comment Box: Make suggestions for who should be responsible for developing terms of reference, recruiting members, and/or defining deliverables for the subgroups or thematic areas.

Question 17: Operational Structure: Subgroups
Should the subgroups or thematic areas be led by individuals elected by the membership of the thematic group (i.e., chair/co-chairs) as is the case under the iCCM TF? Or should the subgroups be led/chaired by organizations who then designate individuals to lead?

a. Individuals Y/N

b. Organizations Y/N

Comment Box: Or should the subgroups be led/chaired by organizations who then designate individuals to lead?

Question 18:
The following subgroups are under the iCCM Task Force. Please indicate which ones you think should continue under the Child Health Task Force.

a. Workforce Issues Y/N

b. Monitoring and Evaluation Y/N

c. Costing and Financing Y/N

d. Supply Chain Management Y/N

e. Nutrition Y/N

f. Operations Research Y/N

g. Demand Generation and Social Mobilization Y/N

Question 19: Partnership Principles
Member organizations are expected to contribute to the effective functioning of the TF, which should include allocating time and effort. Sometimes individual and/or organizational interests can get into the way of working together effectively. Partnership principles can help to manage expectations and strengthen the partnership—for example, by recognizing and allocating staff time to perform task force responsibilities. Should the CHTF develop partnership principles that members agree to?

a. Yes

b. No

c. Neutral

Comment Box: If yes, what additional issues should the principles address?