


# First Global Review and Coordination Meeting on Integrated Management of Childhood Illness (IMCI)

Santo Domingo, Dominican Republic  
9-12 September 1997

**IMCI**  
brings it all  
together

**INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS**

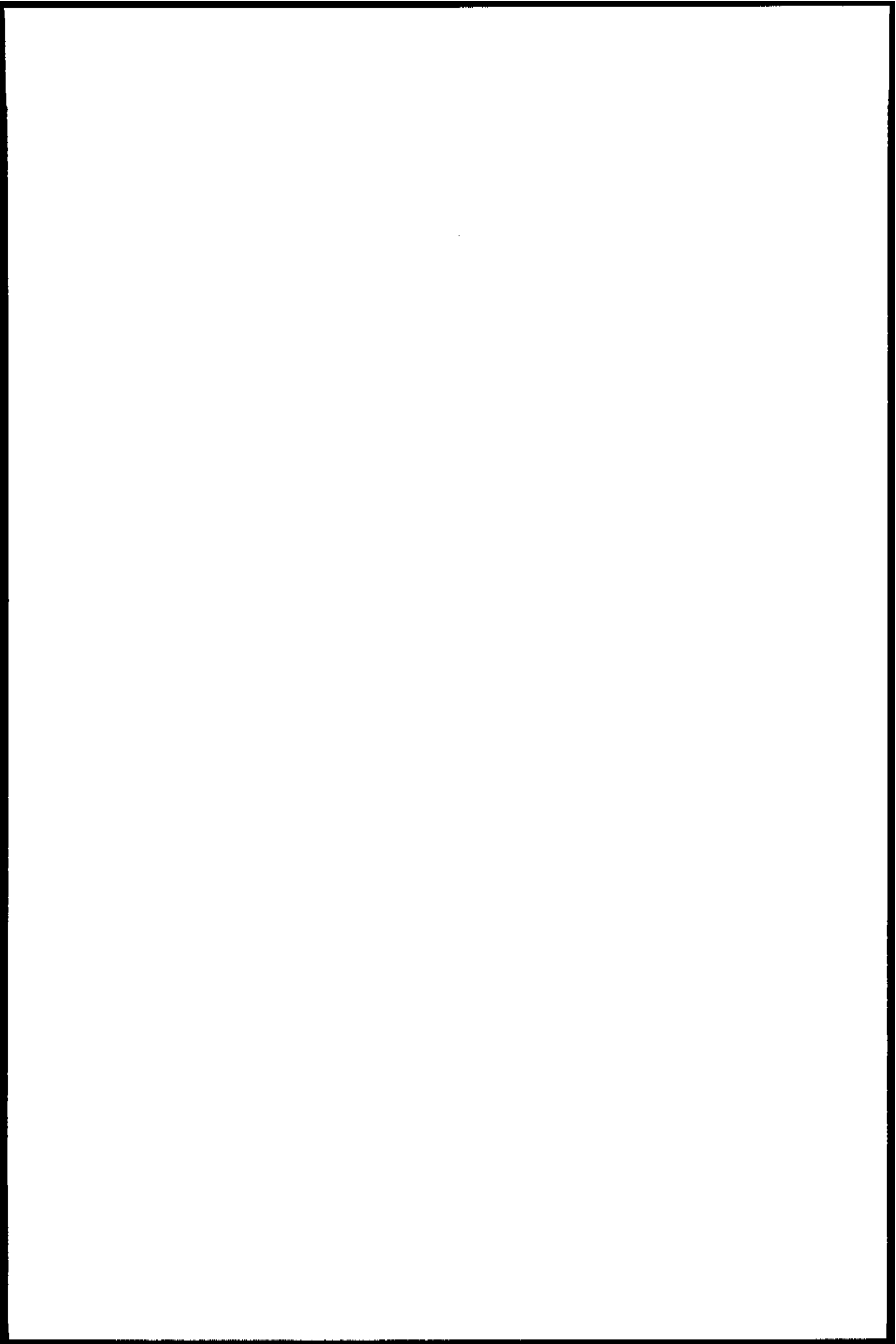
tackles the major killers of children



through prevention and treatment

by improving skills of health staff,  
health systems and  
family and community practices





**FIRST GLOBAL REVIEW  
AND COORDINATION MEETING ON  
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS  
(IMCI)**

**Santo Domingo  
Dominican Republic**

**9 to 12 September 1997**

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## **The Santo Domingo Call for Action on Integrated Management of Childhood Illness**

The **First Global Review and Coordination Meeting on Integrated Management of Childhood Illness** was held in Santo Domingo, 9 - 12 September 1997. One hundred and thirty public health programme managers, paediatricians, epidemiologists and other health authorities from 26 countries, along with representatives of non-governmental organizations, multilateral and bilateral agencies met to review progress with, and make recommendations for, research, development and implementation related to the Strategy known as **Integrated Management of Childhood Illness (IMCI)**.

### **Call for Action**

We, the participants of the **First Global Review and Coordination Meeting on Integrated Management of Childhood Illness**, held in Santo Domingo, 9 - 12 September 1997.

#### **Recognizing that:**

- each year, worldwide, more than 11 million children die before they reach the age of 5 years;
- 70% of these childhood deaths are caused by five common, preventable or easily treatable childhood conditions: pneumonia, diarrhoea, measles, malaria and malnutrition;
- throughout much of the developing world families do not have access to the basic means to prevent these conditions nor to the simple treatments needed to stop them from being fatal;
- in some countries and globally, achievement of the World Summit for Children goals for childhood mortality and morbidity reduction by the year 2000 will require a massive and immediate renewal of commitment and effort;
- this situation represents a failure to guarantee the fundamental rights of children as embodied in the Convention on the Rights of the Child,

#### **Welcome:**

- the development by WHO and UNICEF of **Integrated Management of Childhood Illness (IMCI)** as a strategy to respond to this situation, combining proven, simple and affordable preventive and treatment interventions;
- the support provided by other international, multi- and bilateral governmental agencies and non-governmental organizations to the development and implementation of the IMCI Strategy,

**Congratulate** the countries in all regions of the world that have pioneered the use of this new Strategy, have enabled its early assessment and improvement, and have maintained their commitment to its effective implementation,

**Conclude:**

- based on the early experience in these countries, that implementation of the IMCI Strategy is feasible, has advantages over a series of disease-specific approaches and can result in cost savings;
- that correctly followed, the Strategy has the potential to significantly improve the quality of child health care, to reduce unnecessary hospitalization and to substantially reduce childhood mortality;
- that the IMCI Strategy could contribute to the implementation of health system reforms as part of a basic package of cost-effective health services,

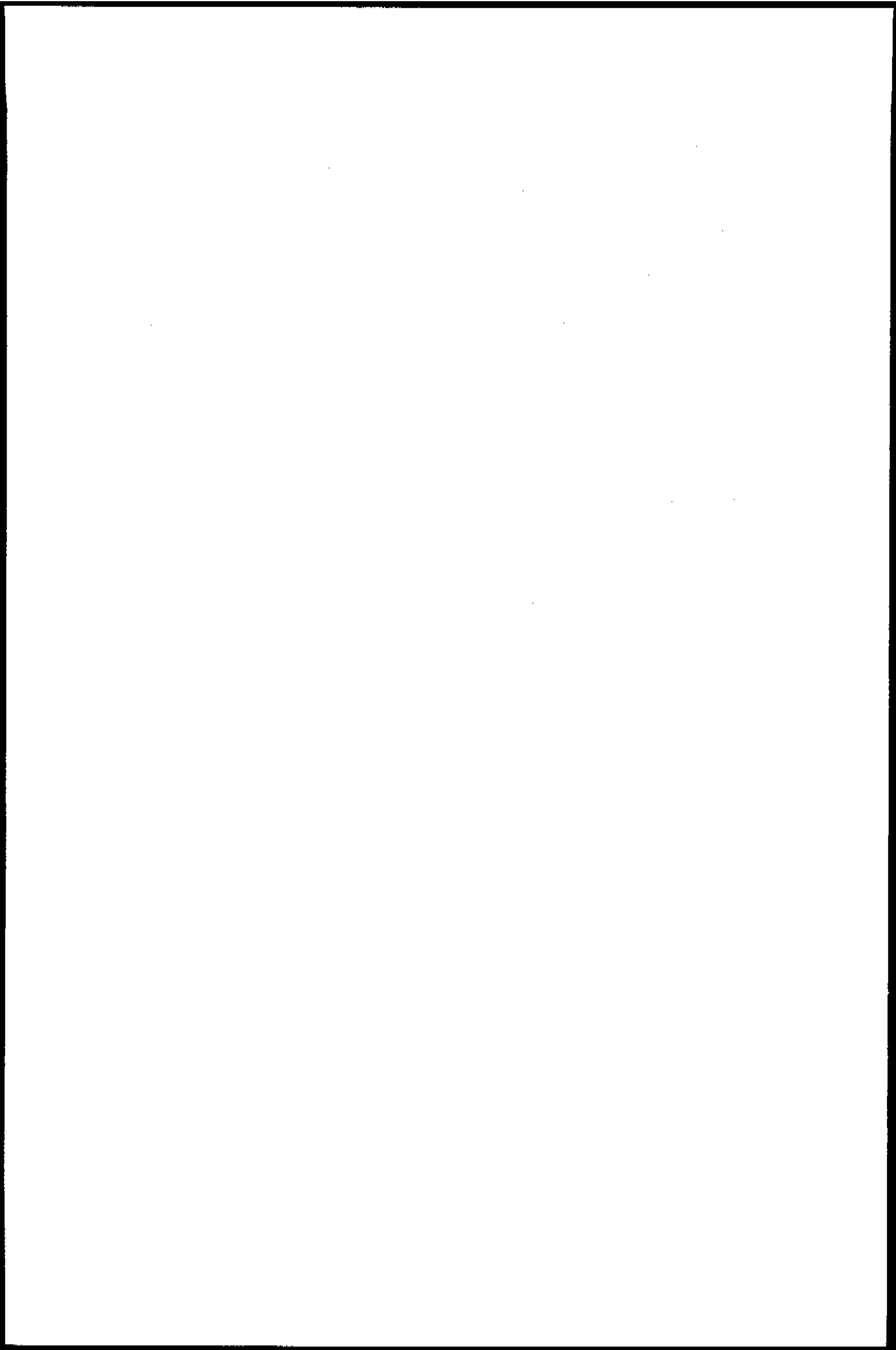
**Emphasize:**

- that better coordination of existing health actions and resources is an important step towards more integrated services;
- the importance of giving equal attention to all three components of the IMCI Strategy, as outlined in the joint WHO/UNICEF Statement on IMCI, namely:
  - improving the skills of health personnel in the prevention and treatment of childhood illnesses,
  - improving health systems to deliver quality care,
  - improving family and community practices in relation to child health;
- in this regard, the need to accelerate the development of methodologies and tools for the last two of these components;
- that in seeking affordable ways to include all health personnel in the implementation of the Strategy, every effort must be made to maintain the quality of training and ensure supportive follow-up;
- that IMCI must be accompanied by efforts to improve maternal health and to address the causes of perinatal mortality;
- that the attention given to nutrition, including breastfeeding, in the IMCI Strategy is an important complement to, but not a substitute for, the development and promotion of other effective interventions in these areas;
- the need for further development of the IMCI Strategy to be based on evidence of efficacy and effectiveness and, therefore, the importance of a well defined and prioritized research agenda;
- the importance of defining sensitive and reliable indicators of progress and of setting realistic targets and measuring progress towards their achievement,

**Pledge** our commitment to promoting the IMCI Strategy, and other efforts to reduce mortality and morbidity and to promote healthy growth and development of children,

**Call upon** international, multi- and bilateral governmental agencies, national and local leaders, governmental and non-governmental organizations concerned with health and development, members of the health community at all levels (including private health practitioners), community organizations and members, in summary, all those with an interest in improving child health:

- *to acknowledge the major contribution that can be made by the IMCI Strategy to improving child health and to promote its application;*
  - *to provide the political commitment, financial and other support necessary for the full potential of the Strategy to be realized;*
  - *to take advantage of the potential contribution of different partners, taking into account their respective expertise and experience, in order to support the implementation of IMCI with the greatest possible efficiency;*
  - *to work actively towards the implementation of the full recommendations of this First Global Review and Coordination Meeting on Integrated Management of Childhood Illness.*
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## 1. Introduction

The First Global Review and Coordination Meeting on Integrated Management of Childhood Illness (IMCI) was held in Santo Domingo, 9 to 12 September 1997. Around 130 public health practitioners, paediatricians and researchers from 26 countries and a number of international and non-governmental organizations met to review progress and to make recommendations for research, development and implementation related to IMCI.

The meeting was opened by His Excellency Mr J. David Fernandez, Vice President of the Dominican Republic, who welcomed the participants and expressed his Government's commitment to the introduction of IMCI as an important step towards meeting national goals in child health.

The aims of the Review and Coordination Meeting were to:

- *create a forum where those who are working on IMCI could examine the accumulated experience and share the lessons that have been learned*
- *offer orientation and up-to-date information to the key partners involved in research and development activities related to IMCI*
- *provide a base for coordinating activities and come to agreement on possible areas of collaboration.*

### 1.1 Background - The IMCI Strategy

Every year more than 11 million children in developing countries, about 20,000 a day, die before they reach their fifth birthday, many during the first year of life. Seven in ten of these deaths are caused by pneumonia, diarrhoea, malaria, measles or malnutrition - and often by a combination of these conditions. In addition, at least three quarters of all episodes of childhood illness are caused by one or more of these five conditions, and treatment is often complicated by the need to combine therapy for several conditions. An integrated approach to managing sick children is therefore needed, as a way of taking child health programmes beyond single diseases to address the overall health needs of the child.

Projections made in 1996 indicate that these five conditions will continue to be the major cause of child mortality in the year 2020, unless significantly greater efforts are made to control them.

Much has been learned from disease-specific control programmes in the past 15 years. Today's challenge is to apply the lessons of these programmes to strategies that bring together activities so as to improve the prevention and management of childhood illness. The WHO Division of Child Health and Development (WHO/CHD), with UNICEF, has responded by developing the Strategy known as Integrated Management of Childhood Illness.

The Strategy brings together improved case management with aspects of nutrition, immunization and several other important influences on child health, including maternal health. Using integrated interventions both in the health facility and at home for the

treatment and prevention of major childhood illnesses, the IMCI Strategy aims to not only reduce death and the frequency and severity of illness and disability but also to contribute to improved growth and development. This set of interventions aims to improve practices both in health facilities and at home.

In individual countries the combination of interventions that makes up IMCI may be modified to take account of other conditions for which there exist effective methods of treatment or prevention. The main interventions of the IMCI Strategy are likely to evolve as new findings from analysis of the global burden of childhood disease become available.

The IMCI Strategy has three major components:

- Improvements in the skills of health workers through the provision of locally-adapted guidelines on integrated management of childhood illness and training and other activities to promote their use
- Improvements in the health system required for effective management of childhood illness
- Improvements in family and community practices in relation to child health.

The Strategy was developed on the basis of a broad platform of practical experience and research. WHO and others are pursuing a continuous programme of research and development to meet the needs for information and operational methodology arising from the experience of the countries that are implementing IMCI.

The first countries started the process of introduction of IMCI in 1995. To date, early implementation is under way in 20 countries in all the WHO regions. At least another 20 are starting the process of introducing IMCI. A growing number of multilateral and bilateral agencies and non-governmental organizations are supporting implementation, and the present Review and Coordination Meeting comes at an opportune moment to help give a common direction to this support.

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## 2. IMCI in the Dominican Republic

Dr Rafael Schiffino, Vice Minister of Health and National Director of Health of the Dominican Republic, described the introduction of IMCI in his country.

The Dominican Republic was one of the first countries to begin IMCI implementation in the Region. Activities started in 1996. Since then, a national adaptation workshop and three regional courses have been held in the country, creating a critical mass of course facilitators and training 83 first-line health workers.

IMCI has gained political support as a component of the National Mortality Reduction Project currently being implemented in the country, and as an integral strategy to reduce mortality and morbidity rates in line with the goals established by the World Summit for Children in September 1990.

An operational plan has been developed for the IMCI Strategy, which includes:

- Close collaboration with the national essential drug programme (PROMESE) to ensure adequate supply of drugs at the local level
- The designation of the Robert Reid Hospital in Santo Domingo as the main teaching hospital for IMCI
- An inter-country IMCI project between the Dominican Republic and Haiti with the Ministries of Health and the Societies of Pediatrics to implement jointly IMCI activities in border towns.

The MOH considers community involvement to be of fundamental importance to achieving lasting results and looks forward to using the community health worker training modules that are being developed by PAHO.

The country will slowly expand activities to other subregions and begin monitoring and evaluation activities. The plans for the immediate future call for closer involvement of the NGO community and put emphasis on developing IMCI teaching in medical and nursing schools.



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### 3. Global partnerships for IMCI

IMCI is not only a strategy which brings together many aspects of the health care of children but also a platform for the collaboration between those organizations that are supporting national health authorities in their efforts. This collaboration and the roles of the various partners were addressed specifically by UNICEF, the BASICS project, the World Bank and the group of NGOs present.

#### 3.1 UNICEF

UNICEF's overall approach to the welfare of children is centred on the International Convention on the Rights of the Child. The Convention guarantees the rights of the child to, *inter alia*, access to good quality health care, and it is in this context that UNICEF has developed its strategies for the support of child health care.

The focus of the UNICEF Health Strategy and Implementation Plan is on advocacy and policy dialogue, good quality services, and health promotion with an emphasis at the household and community level. Monitoring and evaluation are essential to all of these. IMCI fits well within this framework, and UNICEF is expanding its involvement in both the development of IMCI, with a priority on the development of the community component, and on support to national IMCI activities, emphasizing building the capacity at the district and local levels of the health system to improve the quality of health care.

In August 1997, UNICEF and WHO issued a joint statement on their commitment to IMCI. This will provide a useful stimulus particularly to collaboration between the organizations in countries, where WHO and UNICEF are already working closely.

UNICEF has a comparative advantage in the area of community mobilization, and it will take the lead, in full collaboration with WHO, in developing the IMCI component of improving family and community practices.

#### 3.2 BASICS

The USAID-funded BASICS project is in the fourth of five years of implementation. It stresses strong operational partnership with countries and organizations to help them improve access to health care for children. BASICS is active in over 30 countries in one or more of three closely-linked main areas: IMCI, immunization, and nutrition. In order to reduce childhood mortality these should be seen through two lenses: the first is a magnifying lens which represents expansion of services through involvement of the private sector. The second is a lens which focuses on behavioural change. Monitoring and evaluation and the dissemination of information are essential components.

Children die not only because of infection with micro-organisms but also because of the ways that human beings behave and health systems work. BASICS uses the Pathway to Survival to identify the opportunities for interventions, which are all potentially included in IMCI: improving skills of health workers, improving the health system to support effective management of childhood illness and extending the reach of the health services into the community. BASICS sees the most pressing challenges as:

- lowering the costs of training
- organizing the health system to make IMCI possible, for example by making essential drugs available
- finding the best ways to support and monitor IMCI-trained health workers
- developing effective and practical community interventions for IMCI.

### **3.3 The World Bank**

The World Bank sees IMCI as one of the essential interventions within its Health, Nutrition and Population (HNP) sector, and has been collaborating with WHO on its development and implementation since 1995.

The objectives of the World Bank's involvement in HNP are to :

- improve HNP outcomes for the poor
- enhance performance of HNP services
- secure sustainable financing.

Common public sector reforms in service delivery, to which IMCI can contribute, are improving efficiency in the use of resources as well as the effectiveness of interventions. The expected outcomes are better quality of care and increased consumer satisfaction.

The World Bank seeks to achieve these objectives by:

- sharpening strategic directions to improve child health globally
- achieving greater impact by building the countries' capacity
- empowering their own staff
- strengthening partnerships with international and national organizations and NGOs.

In the countries where IMCI implementation is being supported by the World Bank, it is being used as:

- an opportunity to enhance the existing child health activities as a part of PHC or a child development project
- a stimulus to improving the capacity of district health services
- a strategy within the health sector reform.

The World Bank considers the following points crucial for the implementation of IMCI:

- emphasis on the human dimension
- response to the clients' needs, in which clients are both the local stakeholders in the countries who should take ownership of IMCI, but also the child and its family, whose needs should be assessed
- indicators and targets to monitor the outcome and impact of IMCI implementation.

### **3.4 Non-Governmental Organizations (NGOs)**

All the partners represented in the Meeting recognized that the national and international NGOs had an important role in IMCI. There are roles at different levels and in different areas of concern:

**In the introductory phase**, NGOs, in addition to assisting in general mobilization of interest and consensus building, can play an important part in planning at different levels. Their experience at the community level could make an important contribution to adaptation of feeding advice and community strategies.

**In the early implementation phase**, NGOs have an important role in training, supervision, community mobilization and quality assurance.

**In the expansion phase**, the NGOs have an important role in disseminating the experience of IMCI in the health care system.

NGOs work in many different settings, but many focus their attention on the peripheral health system, where they have a role in supporting decentralized services. At this level they can assist with planning, implementation, monitoring and evaluation of the services and the activities in the community.

The flexibility of many NGOs gives them a particular role in innovation and operations research at different levels. Some have skills in improving the quality of care, testing which approaches are effective and bringing the perspective of caretakers and the community.

NGOs are already working with national health authorities and other major partners in countries that are introducing IMCI. This involvement will be expanded, and appropriate NGOs will be asked to participate widely in the development, testing and implementation of new methodology and approaches.



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## 4. The implementation of IMCI in countries

### 4.1 An overview

From the experience of the first group of countries has emerged a practical process for the introduction and implementation of IMCI. This allows for countries first to build up the coordination and consensus that they need to implement the Strategy effectively, then to gain experience gradually by focusing initially on a limited area, and eventually to use that experience to expand activities in a controlled fashion.

The process may be considered as falling into three phases.

- introduction
- early implementation in a limited area
- expansion of coverage and activities.

**The introduction phase includes:**

- orientation to IMCI, including discussions of the implications for the country
- the establishment of an IMCI management structure, usually a working group, to manage the process of introduction and early implementation
- building national capacity to undertake the early phases by training key staff in the working group in IMCI
- obtaining the practical commitment of the Ministry of Health.

**The early implementation phase includes:**

- development of a national strategy/plan for IMCI, including a training plan
- selection of initial districts
- adaptation of IMCI guidelines and materials as described in the Adaptation Guide
- building and maintaining a consensus on the guidelines
- preparation and planning at district level, including ensuring the availability of drugs, planning for training and follow-up, strengthening the focus on community actions and ensuring consistency in IEC messages
- training of health workers and follow-up of trainees
- community actions to improve health and care-seeking behaviour
- monitoring of process and outcome focusing on creation of district capacity, coordination/management, the quality of training and the performance of health workers
- review of the implementation of IMCI in the country since the beginning to give a base for decisions on expansion.

**The expansion phase includes:**

- increase of coverage of all three components of IMCI
- initiation of IMCI in additional districts
- broadening the range of IMCI activities (e.g. referral care, preservice training)
- monitoring and evaluation

As of August 1997, 17 countries were in the introduction phase, 20 countries in the early implementation phase and two countries in the expansion phase.

## **4.2 Implementation in Uganda**

Uganda was the first country to go through all the steps described above. The National IMCI focal point described the experience:

### **4.2.1 General achievements**

- IMCI has been accepted by all concerned programmes and bodies
- IMCI has proved to be a valuable stimulus to programmes to review and disseminate policies and treatment guidelines
- Central and district capacity has been built for training, monitoring and follow-up of IMCI
- A strategy for implementation and expansion of IMCI is in place.

### **4.2.2 Adaptation**

External technical help was needed initially, but not for subsequent local adaptations of feeding recommendations and local terms.

### **4.2.3 Training**

A total of 194 health workers have been trained in courses of 11 days' duration with an average of 17 participants who saw a mean of 22 cases each. Although there were some shortages of patients, training at district hospitals was feasible. The performance of the trainees at the end of the course was satisfactory. The training course was felt to be intensive but practicable in the Uganda setting.

### **4.2.4 Post-training follow-up**

Findings on follow-up visits of health workers 4 to 6 weeks after training showed that 80% were implementing IMCI in their health facility. Observing 78 trained health workers managing cases it was found that:

- 22 out of 27 severe cases were correctly referred
- 44 out of 49 cases needing antibiotics received an antibiotic
- 28 out of 31 cases needing an antimalarial received an antimalarial
- 8 out of 11 cases needing ORT received ORT

### **4.2.5 The main conclusions**

- IMCI is appropriate for use in Uganda
- IMCI has advantages over existing disease-specific programmes
- a main challenge will be to maintain the commitment and consensus of all concerned programmes and bodies
- there is a pressure from donors and the MOH to expand faster than initially planned. Although a plan was made for phasing out CDD/ARI training gradually while IMCI was being introduced, no CDD/ARI courses have been conducted since the introduction of IMCI

- in order to ensure sustainability, it is important to incorporate IMCI into the existing health system and to include IMCI activities in the district health plans. This may also make IMCI less dependent on external funding
- even if health workers have been trained in CDD/ARI previously, the integrated nature of IMCI demands that they go through the whole course
- the IMCI course was not considered suitable for Nurse Aides and CHWs, who have limited educational background. However, IMCI concepts and messages should be included in their training.

### **4.3 Challenges**

From the lessons learned so far from Uganda and elsewhere, among the challenges to the success of IMCI in a country are:

- Identifying sustainable management solutions
- Allowing time needed to build consensus
- Sustaining consensus and a broad base of support for IMCI
- Developing effective links with health reform efforts
- Determining the correct pace for expansion
- Achieving full involvement of all partners in health, including NGOs.



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## 5. Improving and maintaining health worker skills and practices

Continuing the examination of practical issues arising from implementation, the experience of four countries in different aspects of IMCI was presented and discussed.

### 5.1 Sudan: building consensus on clinical guidelines

Consensus building began with the involvement of key players in the adaptation process. Adaptation was a joint effort of the Ministry of Health, WHO, UNICEF, NGOs, and the Paediatric Association of Sudan. The Adaptation group was led by the Director of the Education Development Centre, and paediatricians were actively involved in the subgroup activities. The adaptation process followed the recommended WHO process of:

- review of existing clinical guidelines, local terms and feeding recommendations
- subgroup meetings to effect changes in the modules
- distribution of the revised materials for review
- group meetings to obtain consensus on changes made
- consensus building meetings
- field testing of the mother's card.

The process took 10 months. It was concluded that even though the adaptation process takes time, it is an essential step for consensus building and ownership of IMCI. Involvement of a wide range of institutions and authorities, including particularly paediatricians and medical schools, can facilitate consensus.

### 5.2 Indonesia: experience with inservice training

Indonesia is one of the early-use countries for IMCI implementation. The decision was taken early in the implementation to have only one set of national guidelines which would be translated into Indonesian. The adaptation process enjoyed the cooperation of the National Paediatric Society.

The 11-day training course may not be sustainable in Indonesia for various budgetary and administrative reasons. Possible alternatives are therefore being tried out, including a five-day course with extensive follow-up by the medical faculty of the Gadjah Mada University and the supervisors of the health workers. The preliminary results are promising and the World Bank is contemplating funding a research study to compare the performance of health workers trained using this course with that of their 11-day-trained colleagues.

In addition, Indonesia has had good experience with distance-learning methods and looks forward to the possibility of applying this to IMCI.

*Preservice training.* The Ministry of Health is in the process of developing guidelines and methodology for incorporating IMCI into preservice medical and nursing training in collaboration with the Paediatric Society.

*Training of other health workers.* Consideration is being given to the training of community health workers and of staff in referral hospitals, in order to involve the full range of health workers managing sick children.

The following are important issues that have emerged from the implementation of IMCI training in Indonesia:

- the greater benefit of integrated training, follow-up and supervision compared with single disease approaches
- opportunities to try out innovative approaches and training methods may prove useful for the training of all cadres of health workers
- there should be only one national generic set of IMCI guidelines, which can then be adapted to suit local conditions.

### **5.3 Bolivia: experience with inservice training**

Bolivia began training in December 1996 with a course for facilitators. To date, 54 facilitators and 46 health workers have been trained. The 11-day course has been used exclusively, with an average of 15 participants, each of whom saw about 35 cases. In general the training has gone well, although some participants have had difficulty with reading the materials and some changes have been made to accommodate this. Clinical exposure has been good, with participants seeing almost all important signs and classifications.

The particularly good points in the training are seen as:

- the systematic approach, reinforced by the use of the chart booklet
- the opportunity for plenty of hands-on practice
- the training on counselling skills, which is something new for most participants
- the general satisfaction felt by the trainees about the completeness of the experience.

The not-so-good points noted were:

- too much reading for many participants
- some difficulties with the language and terminology
- difficulty in assessing some of the danger signs
- specific problems of urban mothers, which were not so well addressed by the course.

The Ministry of Health has concluded that the course is appropriate for Bolivia, that there is a need to review some of the materials, that the role of the facilitator is crucial and must be recognized in thorough training, and that a follow-up visit will be essential to reinforce the training given in the course.

#### **5.4 Tanzania: experience with follow-up of trained health workers. Plans for preservice training**

Follow-up after training is necessary because IMCI is complex and past experience shows that health workers are unlikely to implement their newly acquired skills if they are not followed up. The objectives of follow-up include to:

- support and reinforce transfer of IMCI skills to clinical work in facilities
- identify and solve problems faced by the health worker when applying IMCI guidelines
- identify health facility support/constraints in IMCI implementation, and
- use information collected to monitor and improve IMCI implementation in the country

The follow-up in Tanzania is carried out 4 to 6 weeks after the health workers complete the IMCI course. It is done jointly by specially-trained IMCI trainers from central and district levels and the district supervisors. The tasks include:

- case management observation
- review of facility conditions
- caretaker interview
- collection of data for monitoring purposes
- debriefing and problem solving with facility staff and the District Health Management Team (DHMT).

Thirteen courses have been conducted and 206 front-line health workers trained. To date, 116 have been followed up once. The remaining 90 are yet to be followed up.

The following are looked for as signs suggesting that IMCI is being implemented in the health facility:

- use of IMCI chart booklet and other materials supplied during training
- introduction of IMCI to other health workers in the facility
- ORT corners opened or re-opened
- more rational use of drugs
- administration of first doses of drugs at facility
- innovative efforts to assist cases needing referral, e.g. provision of transport, or home monitoring of cases by Village Health Workers where referral is not possible
- greater client satisfaction.

The findings of the follow-up visits so far include:

- 82 and 84% of the trained health workers were found to be managing children correctly at the first and second visits respectively. The two visits were two to four months apart.
- 79% of caretakers showed good understanding of how to administer drugs at home
- 51% of health facilities not giving immunizations daily
- in 72% of health facilities, referral care was not available within two hours travel, making referral very difficult or impossible
- some of the basic IMCI drugs were missing in 15% of health facilities. The percentage was more than 50% if chloramphenicol was included in the list.

Important lessons have been learned by the Ministry of Health which will improve the IMCI process. The data from the follow-up will be included in the review of the IMCI implementation which will be undertaken before plans are made for expansion.

Tanzania is experimenting with the use of the IMCI training course as a block in the preservice training of paramedical staff. Only the resources normally available in the preservice schools will be used to support the training, in order to test the sustainability of the exercise. The first training will start in November 1997.

## **5.5 Summary and conclusions**

Building consensus on the clinical guidelines in-country and adapting them to suit the local situation and policies is a long but necessary process. It usually involves the formation of Working Group(s) with representation of various departments and institutions. The widest possible representation of institutions and authorities is important if consensus and a sense of ownership are to be achieved. Paediatricians are a particularly important group to be considered for involvement in the process.

Health worker skills are developed during training, but a one-time training is not enough to ensure maintenance or sustainability of improved performance by the health worker. Hence the need to look for ways of continuously reinforcing these skills.

The intensive 11-day training course is targeted at first-level health workers. The factors which need particularly to be considered in order to ensure the quality of training include careful selection of appropriate training sites, facilitators and participants, a generous facilitator:participant ratio and the availability of a good number and range of clinical cases.

The problems encountered in the use of the course include particularly reading and language difficulties and a shortage of suitable cases. The 11-day duration of the inservice training course is contentious. Some countries feel that 11 days is necessary to cover the course content adequately. Others feel the need to look at possible options which may be operationally easier without reducing the efficacy of the training.

Practical options for preservice training need to be developed as soon as possible, since it is likely to be more sustainable and cost-effective. Several countries are exploring this, using different approaches.

Follow-up after training appears to be a feasible and important activity in the IMCI Strategy. Trained health workers require support to initiate and implement IMCI at facility level, reinforce their skills, identify and solve problems. Those doing the follow-up must be very familiar with IMCI and should be specially trained. National and district trainers should be among the supervisors.

Experience so far indicates that fully-trained health workers perform IMCI case management well. Caretaker knowledge and satisfaction also appear to have been enhanced.

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## 6. Regional perspectives on IMCI

The two regions of the world in which IMCI implementation has made most progress are Africa and Latin America. The activities of the major partners supporting the regional efforts were presented and discussed.

### 6.1 IMCI In Africa

WHO/AFRO, with the collaboration of the United Kingdom Department for International Development (DFID) and USAID has established a Task Force for planning, coordination, support and resource mobilization for IMCI implementation in the Region. The Task Force has developed a framework for IMCI implementation in the Region up to the year 2001 with clear goals, objectives, strategies, indicators and expected results. To date, 16 countries in the Region are at various stages of implementation of IMCI.

The regional strategy is to:

- focus initially on first-level health facilities
- support IEC activities that contribute to improvement of home care
- strengthen national capacity for sustainable implementation
- strengthen monitoring and evaluation
- strengthen WHO's regional capacity to provide technical support
- ensure effective collaboration among the partners.

The main difficulties which are being faced relate to the lack of experience in the region in the development of the IMCI Strategy and the harmonization of the efforts of the various organizations which are supporting aspects of the Strategy in the countries of the region. Another important concern is the uncertainty about the future of the existing programmes for the control of ARI and diarrhoeal disease.

DFID supported implementation of ARI and CDD in eight countries in Africa through WHO/AFRO in 1995-96. This provided a platform for the future implementation of integrated child care, and two of these countries were also supported in taking the first steps towards IMCI. Starting in 1997 DFID is funding a project to strengthen the capacity of WHO/AFRO to support national IMCI activities. This will include some funds for IMCI in specific countries. In addition, IMCI is being supported through bilateral funds in a number of countries. A second project is providing support to IMCI and malaria control activities in the Region.

IMCI fits well within DFID priorities in that it promises to increase the efficiency and effectiveness of health care at peripheral levels, gives attention to the health of women and children and improves access to good quality health care.

USAID's strategy for support to IMCI in Africa focuses particularly on four areas:

- direct funding of IMCI implementation in four countries
- collaboration with AFRO to build regional capacity and to launch IMCI activities in five countries
- operations research
- development and testing of IMCI tools.

The overall aims of USAID support to IMCI in Africa are to improve the quality of care, to strengthen the critical components of the health system, to develop the community and home management of children and to ensure both ownership of IMCI by national health authorities and its sustainability within the health system.

All partners recognize that success in implementation of IMCI will depend not only on the level of technical and financial support that can be given to countries but also on the speed with which countries take ownership of the Strategy.

## 6.2 IMCI in the Americas

The Regional IMCI Unit of WHO/AMRO has supported the progressive implementation of two phases of the introduction of IMCI into the countries of the Americas.

First, country CDD and ARI national programmes were strengthened and combined. Secondly, the other components of IMCI were gradually introduced into the child health programmes. Ten countries with an infant mortality rate greater than 40/1000 were selected to begin implementation (Bolivia, Northeast Brazil, Ecuador, Peru, Dominican Republic, Guatemala, El Salvador, Honduras, Haiti and Nicaragua). Other countries will gradually begin activities in 1998.

Two major preparatory steps were taken:

*Forming a structure of general support.* This included particularly agreement among the major partners, PAHO, USAID/BASICS and UNICEF, on the strategies for supporting countries.

*Strengthening the Region's capacity to provide technical support to countries.*

Considerable care has been taken to ensure the acceptance of and commitment to IMCI at all levels of the health system, including the academic institutions, in countries. The process of introduction was tailored to the needs of individual countries but basically followed the lines suggested in the global presentation.

IMCI has been presented to all ten of the target countries. Adaptation has been completed in nine, training has started in five, and to date four of these have started implementation at district level. Enthusiasm in these countries is generally high. The most important problems encountered are that planning at the central level is weak, that there is a lack of practical tools to guide integration, that there is a high level of separate programme activities, and that there remain some difficulties with both internal and external coordination. The Regional strategy is designed to help overcome precisely these problems.

The BASICS Project has developed a five-year Regional IMCI Initiative with PAHO to promote and implement IMCI in eight USAID Child Survival countries, with funding from the Regional Bureau for Latin America and the Caribbean. Joint work plans have been developed in Bolivia, Ecuador, Peru, El Salvador, Guatemala, Honduras, Nicaragua and Haiti. The objective of the initiative is to promote the *more effective delivery of child health services in response to CDD, ARI and malnutrition*. Regional and country level Interagency Coordinating Committees will be strengthened to provide political and technical support.

UNICEF's focus of support for the IMCI initiative arises from the right of every child to access to health care. Child's rights, social mobilization, including the creation of private alliances and working with NGOs, will be continued and strengthened under the IMCI initiative.



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## 7. Regional partnerships and strategies

In order to focus on issues that were of general interest in the countries in individual regions, four regional discussion groups were formed. All the groups were asked to:

- identify the five most important challenges over the coming two years, and
- define promising approaches to addressing these challenges.

The deliberations of the four groups were discussed and synthesized in a plenary session.

Seven major areas of challenge appeared to be universal. These, with a summary of the suggested solutions, are listed below:

### *Availability of national resources*

- encourage Ministries of Health to include IMCI in the budget, on the basis, as demonstrated in the Dominican Republic (see section 2), that it provides a means to address important national health and social priorities
- include IMCI in planning for health sector reform as an essential component of the basic package of health care
- in this context, mobilize donors to support IMCI activities and include IMCI in activities planned for support by the World Bank
- involve non-governmental organizations in support for IMCI implementation.

### *Difficulty in building capacity to increase coverage of services without losing quality*

- ensure that inservice training of health workers is focused, well planned and adequately monitored
- introduce IMCI into preservice training institutions.

### *Sustainability of IMCI at national level*

- integrate IMCI into the health sector reforms
- include IMCI training in the continuing education programmes and preservice training.

### *Community involvement and ownership*

- review existing CDD/ARI, nutrition, malaria and other relevant programme experiences and build on their success
- develop guidance tools for the community component of IMCI and make them available to countries for building into their community health programmes
- document successful community initiatives relevant to IMCI and use them for advocacy
- Involve non-governmental organizations (NGOs) and community groups.

### *Political commitment*

- collect and provide data to convince decision-makers that IMCI is cost-effective
- conduct operational research to obtain convincing information on the local need for and practicability of IMCI.

### *Monitoring and Quality Assurance*

- develop clear indicators
- develop integrated monitoring and supervisory tools
- conduct periodic evaluation of IMCI activities as the basis for planning continuing activities and expansion.

### *The relationship of IMCI to health sector reforms*

- incorporate IMCI as early as possible in the planning for health sector reforms
- use potential entry points such as quality assurance, capacity building, decentralization
- ensure health information systems (HIS) take account of IMCI.

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## 8. IMCI Tools under Development

The IMCI Strategy still requires a number of tools to be developed and this calls for the collaboration of different agencies and partners.

### 8.1 WHO/CHD is undertaking work relating to all three components of the Strategy:

#### *Tools to improve health workers' skills*

- completion of the IMCI Adaptation Guide. CHD recognizes that although the Guide can be finalized, there will always be scope for updating
- materials to support different IMCI inservice training schedules while maintaining the 80 hours' duration of the course
- guidelines for follow-up after training
- methods and materials for improving care at the first referral level.

#### *Tools to improve the health system*

- drug supply management training course for first-level health workers, with BASICS
- planning and management guidelines.

#### *Tools to improve family and community practices related to child health*

- a guide for interventions to change behaviour
- a guide for interventions to improve careseeking.

### 8.2 BASICS has an active programme of development of tools

#### *Tools to strengthen skills of health workers*

- a community health worker training course
- a manual for training of facilitators of the 11-day inservice course
- a complementary course to teach IMCI case management to health workers with limited reading proficiency.

#### *Tools to strengthen health services*

- a health facility assessment and planning tool. Intended to collect information on the case management of the most important causes of childhood mortality and morbidity and to strengthen the capacity of managers to plan an integrated system of health care delivery
- a drug management assessment manual.

**8.3 UNICEF's** programme of development of tools will address the components of improving child health at household and community level and improving quality of care at the health facility level.

- a methodological base for supporting behaviour change, and promoting active participation and involvement of communities, drawing on the experience of existing programmes
- tools to adapt counselling cards and nutrition counselling guidelines
- an advocacy kit for promoting public health policies
- guidelines for working with household and communities
- tools for better supervision, including a self-assessment questionnaire
- advocating for the development of a common methodology for improvement of the quality of health care
- an Electronic Toolbox for quality improvement; a network for supporting sharing of information and systematization of experiences.

Once again it is critically important that the development efforts remain relevant and coordinated.

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## 9. Update on IMCI Research and Development

### *IMCI research priorities*

The research agenda on IMCI is coordinated by WHO/CHD and carried out in collaboration with a number of institutions, including particularly those in the USAID-funded Child Health Research Project - Applied Research in Child Health (ARCH) of Harvard University, ICDDR,B and Johns Hopkins School of Public Health.

**9.1** The priorities of the **Child Health Research Project - USAID** include acute respiratory infections, control of diarrhoeal diseases, micronutrients and antimicrobial resistance. The Project also has an important focus on operations research related to IMCI, in particular:

#### *Improving case management*

- training and training outcomes
- referral care

#### *Improving health systems to deliver IMCI*

- support to health worker performance
- availability, management and use of drugs
- district management and evaluation
- cost and impact studies

#### *Community and household care and careseeking.*

**9.2** WHO/CHD supports research with the focus on the development and evaluation of new or improved methods for preventing and managing childhood illness. The priority areas for research are:

#### *Research aimed at the development of clinical tools and guidelines*

- alternative antibiotics for treatment of dysentery
- ARI diagnosis and treatment
- management of bacterial meningitis
- malaria diagnosis in low-risk areas
- management of the severely malnourished child.

#### *Operational research on IMCI implementation*

- performance of IMCI guidelines in the hands of health workers in various settings
- alternatives in the organization of IMCI training
- performance of training follow-up and IMCI job aids in improving health worker performance
- patient responses to follow-up and referral recommendation
- the costs of providing IMCI.

### *Research on family and community behaviour*

- care seeking
- compliance with advice from health workers on treatment
- response to counselling on feeding
- evaluation of community-based nutrition interventions

### *Research on prevention interventions*

- vitamin A supplementation
- zinc supplementation
- the effects of reducing indoor air pollution.

**9.3 The ARCH project** is using applied research to improve existing child survival approaches and technologies. It aims to identify, develop and test new, cost-effective interventions to improve child health and to help countries to incorporate them into policy. It also aims at strengthening and sustaining global and national capacities to conduct applied research relevant to policies.

The priority research themes for ARCH are:

- improving ARI case management
- addressing antimicrobial resistance
- improving professional practices, particularly the use of medicines
- improving household behaviours
- the role of zinc in child health
- country case studies on the use of research to improve health policies.

**9.4** Various sections in the **US Centers for Disease Control and Prevention** carry out research work relevant to IMCI. The operational research programme touches on:

- assessment of methods of maintaining and improving health worker performance
- the time needed/available to follow IMCI guidelines
- compliance with counselling messages and advice on referral
- deviations from the "Pathway to Survival"
- outpatient morbidity reporting categories in relation to IMCI classifications
- IMCI indicators.

The research agenda presented and discussed was comprehensive and to a large extent relevant to the needs of IMCI. A high degree of coordination was shown by the complementarity of the research agenda supported by the various partners. It is essential that results from the research are made available to those developing and implementing IMCI activities in country, and that the research community is kept aware of the needs arising from implementation.

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## 10. IMCI Implementation Issues at Country Level

The meeting split into three subgroups to discuss different facets of IMCI implementation. The subgroups discussed the issues on the basis of information from a wide range of short presentations describing country experience, research results and planned development activities.

The topics addressed by the groups were:

1. The contribution of IMCI to the strengthening the health system
2. Improving family and community practices
3. Expanding IMCI coverage - what is feasible?

The conclusions and recommendations of each subgroup are presented below:

### 10.1 The contribution of IMCI to the strengthening of the health system

#### *IMCI and drug management*

- Evidence suggests that the lack of essential drugs is the "killer constraint" for IMCI at first-level health facilities.
- IMCI promotes the rational use of drugs, and in the long run may help with drug availability and forecasting of drug requirements.
- For several reasons, individual organizations supporting IMCI are not likely to be successful in improving drug availability on their own. It requires a coordinated approach by all partners.
- Organizations/agencies supporting IMCI should learn to seize local opportunities to advocate for improved drug availability.

#### *IMCI and the organization of work at health facilities*

- In busy, particularly urban, health facilities, time constraints, long waiting times, congestion and sub-optimal assignment of responsibilities to staff can compromise the practice of IMCI. Rural health facilities may have problems with shortage of trained staff and intermittent lack of auxiliary services (weighing, ORT corner, immunization).
- There is enough universality of problems between settings and countries to justify hopes that operations research on clinic organization may produce useful generic tools for assessment and intervention. However, solutions to problems of clinic organization must be sought and implemented by local decision-makers, including the workers in the health facilities. Suitable generic tools could help this process.
- New methods are needed to enable local decision-making. A team approach to problem resolution - "quality management" - can lead to revised roles and responsibilities, improved clinic organization and the ownership of solutions. Although most important solutions can be developed by the health facility staff, some problems require action at district level or higher.

### *IMCI and quality improvement*

- Achieving and sustaining acceptable levels of health worker performance of IMCI requires district-based supervision/support that is routine and regular, is broadly integrated and includes supervision of case management by IMCI-trained supervisors.
- The cost-effectiveness and sustainability of such supervision (as opposed to approaches which shift the burden for quality maintenance to the facility staff after a few visits) must be documented through research.
- "Supportive supervision" can be defined as supervision which reinforces the team problem-solving process. Efforts to develop supportive supervision should build upon past experience with quality improvement.

### *Monitoring IMCI*

- There is a need for new mechanisms to monitor the quality of IMCI training and the results from initial follow-up.
- The national systems for monitoring and evaluation, including the national HMIS, should be adapted to take account of the needs of IMCI implementation. This is a matter of some urgency, and advantage should be taken of action to modify the HMIS in the course of health system reform.
- The monitoring process should consider first the information needs of the district managers and the staff of the health facilities.
- Routine supervision can be a major source of information for monitoring the quality of IMCI, but routine, district-based supervision will not offer the continuity and consistency among districts that vertical programmes have obtained from conventional top-down monitoring.

### *Outstanding research and development issues*

- Can routine supervision ensure satisfactory quality? Is observation of case management sufficient? Is validation by a well-trained physician necessary?
- How can the quality of practice in the private sector, where supervision is rarely possible, be achieved?
- Can a consumer demand for quality be promoted?
- What are the constraints to better internal supervision?
- Methodology for monitoring IMCI coverage, access and demand.

## **10.2 Improving family and community practices**

The group addressed two broad questions:

*What is "IMCI in the Community"?*

*What approaches and processes can be proposed?*

Presentations were made on interventions to promote a safe environment and on promoting growth and development and increased resistance to infection. Experiences from

Madagascar on social mobilization and counselling skills, and from Bolivia and Kazakhstan on social autopsy were also presented and discussed.

*The group concluded as follows:*

- "IMCI in the Community" is action with and in the community to keep children healthy and to prevent them from dying. It should take account of the major causes of child mortality but should not be limited to them. It should be stimulated by the introduction of IMCI in the health system and benefit from and be adapted to the range of interventions that IMCI promotes.
- Actions to promote good nutrition and health are a more suitable starting point for community interventions than the direct causes of mortality.
- The concept of the "quality of care" in the household is useful to guide the development of community actions. This would include the care of the well child as much as home care and care-seeking for the ill child. The community's view of the quality of care available from the health service would be an important measure of the success of IMCI and an indication for directions of development.
- Although there will be a need for some new approaches to strengthen behaviour change, IMCI-related community interventions should build on existing community-based actions.
- Community channels and networks of communication, rather than only individual contacts, should be exploited.
- The linkage between the health facility and the community is crucial, not only for the care of the sick child but also to provide support to the community in health prevention and promotion. In this context the expansion of the role and deployment of community health workers will be important for the success of IMCI.
- The variability of communities demands that actions be developed to meet their specific circumstances and needs. This means that "going to scale" must be considered not as replicating a common package but as applying widely guidelines for community action which define a process for developing community-specific actions.
- It is very important that health authorities consider the community component of IMCI as being of equal importance to the other components. There is a risk that this component will be left behind, which would be damaging to the impact of IMCI.
- The development of a strategy for community action for IMCI requires a manual that outlines possible approaches and options to working with communities to ensure child health, with the focus on process rather than implementation guidelines. The manual should include case studies of successful programmes.
- Partnership between communities and other key players is essential. The MOH should collaborate closely with NGOs and other community-based associations.

*The next steps could be:*

- document relevant existing experience
- organize a consultation between agencies and bodies with suitable skills, including NGOs

- identify and adapt existing tools
- implement field trials with appropriate partners
- ensure long term commitment to the community component of IMCI from the start of IMCI implementation.

#### *Operations research questions*

- Does an integrated approach mean that the beneficial results of separate programme (such as immunization) suffer?
- Can an integrated approach be cost-effective at community level?
- What factors determine care-seeking behaviours at the household and community levels?
- What is there in the IMCI approach than can strengthen on-going community-based initiatives?

### **10.3 Expanding IMCI coverage - what is possible?**

The group drew on experience from Tanzania on district capacity building, from Uganda on the process for planning for expansion and from Peru on monitoring of the quality of care after training. The issues surrounding health system reform were summarized by a representative of the World Bank, and a presentation was made on measuring impact and cost-effectiveness.

The conclusions of the group discussion on these presentations were as follows:

- There is very little experience so far in this phase of implementation. It is clear that any plans for expansion must be based on a thorough review and appreciation of the experience in the earlier phases. The collection and analysis of the data required for this must be planned for from the beginning of the process.
- Plans for expansion should:
  - be district-focused and gradual
  - build as much as possible on existing structures, including inservice training systems, health information and monitoring, and district development plans
  - place emphasis on quality
  - emphasize sustainability, through use of existing structures and developing preservice training to reduce the burden of new skills acquisition.
- The main constraints to expansion have been:
  - shortage of suitable manpower for training, supervision etc.
  - lack of drugs and other health facility resources
  - the districts may be slow in accepting ownership, thereby increasing the load on the central level
  - pressure from Governments and/or donors for unrealistically rapid expansion.
- Most of the constraints to implementation and expansion are inherent in the system and are not specific to IMCI. The challenge is to use IMCI to overcome these chronic problems.
- It will be important to measure the cost and assess the effectiveness of IMCI.

- although IMCI is clearly a qualitatively better way of approaching child mortality than the present separated programmes, there is a real need, from the point of view of both national health authorities and partner agencies, to measure the cost and to demonstrate the effectiveness of the Strategy. There is as yet limited information on these. Methods are being developed as a part of the IMCI research effort and will be applied as soon as possible.
- it is unlikely that the impact on mortality will be demonstrable either soon or on a large scale. Some demonstration of this will be necessary, but in the meanwhile the emphasis should be placed on improving the measurement of quality of care and client satisfaction.

*The group recommended:*

- the development of a tool to guide countries in expanding their IMCI implementation
- that Governments should include IMCI in sector-wide health plans
- including IMCI in district plans to ensure both ownership and resources
- the selection of simple indicators to monitor implementation and expansion - for example, client satisfaction, improved health worker performance
- including IMCI in preservice training to ensure sustainability and improve coverage
- arranging to collect and use data on potential efficiency savings; for example, drug-use studies
- developing standard methodology for assessing and attributing costs for IMCI-related activities
- developing tools to assess effectiveness
- using the system of reporting for the Convention on the Rights of the Child to promote IMCI as an essential component of health care.



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## 11. Monitoring Global Progress

A joint presentation by WHO and UNICEF provided an overview of work that has been done to date in IMCI monitoring and evaluation. A working group has been established, the overall strategy has been agreed upon, development priorities have been set, and milestones have been identified for tracking progress in IMCI implementation at regional and global levels. The Strategy includes the definition of methods and measures for monitoring and evaluation of process, outcomes, impact, and costs of IMCI. Realistic targets will be set for both milestones and indicators.

The discussion highlighted the need to draw on the experiences of other programmes, for example the Expanded Programme on Immunization, to define a limited set of indicators that can be understood and used at all levels, including at facilities and districts. The difficulties inherent in defining simple indicators for IMCI case management were emphasized. Suggestions included involving NGOs in the monitoring of indicator levels.

There was some concern that the proposed targets for milestones related to IMCI implementation were too low, and would therefore not be useful in advocacy efforts. One suggestion was that the criteria for milestones could be loosened to include integrated approaches in other health programmes such as maternal or reproductive health, to increase the number of countries defined as progressing with integration. It was agreed that innovative approaches for increasing IMCI coverage should be actively pursued, but that these approaches should be carefully evaluated to ensure that health workers achieve competence in IMCI.



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## 12. Concluding session

An important focus of the Meeting was the role of IMCI in health system reform. This perspective and its significance to the reform process supported by the **World Bank** in the Dominican Republic and other countries was reviewed. The emphasis of IMCI on the importance of the peripheral levels of the health system, on the quality of care and on strengthening of district management makes it a natural component of health sector reform, both stimulating and providing a focus for essential change.

The future of the Strategy is to an extent dependent on how it is seen by national health authorities and those that support them. **UNICEF** presented a strategy for ensuring the visibility of IMCI. A concerted effort should be made to bring the advantages of IMCI to the attention of policy-makers, providers, professional associations, NGOs, the private sector, the donor community and the public at large. An energetic approach is needed to establish partnerships in support of the Strategy, using all available networks and information channels. The Convention on the Rights of the Child offers a common platform for all partners in the holistic approach to child health and development that is represented by IMCI.

From the perspective of the **bilateral development agencies**, IMCI brings together many of the prevailing priorities. The emphasis on quality of care and the role of the community is well matched with the stimulus that IMCI gives to the development of the district health system. The attention that is being given to monitoring and evaluation will be much welcomed, but it is important to the donor community to be able to see the cost and the effectiveness of the Strategy. Workable methods for doing this should be given priority in the development programme. IMCI is a practical approach which has a solid scientific base. Research will continue to be important, but it will be essential to keep it focused on the needs of implementation.

### **The Santo Domingo Call for Action on Integrated Management of Childhood Illness**

Dr Rafael Schiffino, Vice Minister of Health and National Director of Health of the Dominican Republic, congratulated the participants on the success of the Meeting. IMCI holds an important place in the future of the health system of the country, and to mark this, the President of the Republic had decreed that "IMCI Day" would be observed every year on September 9.

Dr Schiffino read the *Call for Action on Integrated Management of Childhood Illness* that had been agreed by the Meeting.



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### 13. Summary of the main conclusions and recommendations

The meeting concluded that:

- based on the early experience in countries, implementation of the IMCI Strategy is feasible, has advantages over a series of disease specific approaches and can result in cost savings
- correctly followed, the Strategy has the potential to improve significantly the quality of child health care, reduce unnecessary hospitalization and reduce substantially childhood mortality
- the IMCI Strategy could contribute to the reform of health systems as part of a basic package of cost-effective health services.

It recommended:

#### 1. General issues

- that health authorities and their partners give equal attention to all three components of the IMCI Strategy, as outlined in the joint WHO/UNICEF Statement on IMCI, namely:
  - improving the skills of health personnel in the treatment and prevention of childhood illnesses
  - improving health systems to deliver quality care
  - improving family and community practices in relation to child health.

In this regard there is a need to accelerate the development of methods, guidelines and tools for the last two of these components

- in seeking affordable ways to include all health personnel in the implementation of the Strategy, every effort must be made to maintain the quality of training and ensure supportive follow-up
- the attention given to nutrition, including breastfeeding, in the IMCI Strategy is an important complement to but not a substitute for the development and promotion of other effective interventions in the area of nutrition
- further development of the IMCI Strategy should be based on evidence of efficacy and effectiveness. It is therefore important to sustain a well-defined and prioritized research agenda
- It is increasingly important to define sensitive and reliable indicators of progress for IMCI, to set realistic targets and to measure progress towards their achievement.

## 2. Specific issues

### *IMCI and health sector reforms*

In planning health sector reforms, health authorities and their partners should:

- incorporate IMCI as early as possible into the planning process
- use potential entry points such as quality assurance, capacity building and decentralization
- ensure health information system development takes account of IMCI.

### *IMCI and drug management*

Because evidence suggests that the lack of essential drugs is a crucial factor determining the success of IMCI:

- IMCI should be used to promote the rational use of drugs
- the various organizations concerned with the introduction of IMCI in a country should coordinate closely in ensuring drugs supplies
- organizations supporting IMCI should seize local opportunities to advocate for improved drug availability.

### *IMCI and improving the quality of care*

- Achieving and sustaining acceptable levels of health worker performance of IMCI requires regular district-based supervision and support. It should be broadly integrated and include supervision of case management by IMCI-trained supervisors
- The cost-effectiveness and sustainability of such supervision (as opposed to approaches which shift the burden for quality maintenance to the facility staff after a few visits) must be documented by research
- "Supportive supervision" can be defined as supervision which reinforces the team problem-solving process. Efforts to develop supportive supervision should build upon past experience with quality improvement.

### *IMCI and improving family and community practices*

"IMCI in the Community" is action with and in the community to keep children healthy and to prevent them from dying.

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available from the health service would be an important measure of the success of IMCI and an indication for directions of development

- Although there will be a need for some new approaches to strengthen behaviour change, IMCI-related community interventions should be built on existing community-based actions in relation to diarrhoeal diseases, ARI, nutrition, malaria and other health problems
- Community channels and networks of communication, rather than only individual contacts, should be exploited
- The linkage between the health facility and the community is crucial, not only for the care of the sick child but also to provide support to the community in health prevention and promotion. In this context the expansion of the role and deployment of community health workers will be important for the success of IMCI
- The variability of communities demands that actions be developed to meet their specific circumstances and needs. This means that "going to scale" must be considered not as replicating a common package but as applying widely guidelines for community action which define a process for developing community-specific actions
- It is very important that health authorities consider the community component of IMCI as being of equal importance to the other components. There is a risk that this component will be left behind, which would be damaging to the impact of IMCI
- The development of a strategy for community action for IMCI requires a manual that outlines possible approaches and options to working with communities to ensure child health, with the focus on process rather than implementation guidelines. The manual should include case studies of successful programmes
- In planning for community action, health authorities and their partners should involve non-governmental organizations and community groups.

The next steps in developing the family and community practices component of IMCI could be:

- document relevant existing experience
- organize a consultation between agencies and bodies with suitable skills, including NGOs
- identify and adapt existing tools
- implement field trials with appropriate partners
- ensure long term commitment to the community component of IMCI from the start of IMCI implementation.





**SESSION 3: GLOBAL PARTNER PERSPECTIVES AND PRIORITIES FOR IMCI**

Moderators: E. Dayrit, Philippines  
J. Tulloch (WHO/HQ)  
Rapporteur: S. Verver (WHO/AFRO)

2.00 Presentations: V. Orinda (UNICEF)  
R. Waldman (BASICS)  
I. Pathmanathan (World Bank)

3.00 Commentaries and plenary discussion

3.30 TEA

**SESSION 4: IMCI IMPLEMENTATION AT COUNTRY LEVEL**

Moderators: E. Chomba, Zambia  
B. Sadrizadeh (WHO/EMRO)  
Rapporteur: M. Östergren (WHO/EURO)

4.00 **Overview of IMCI implementation:** G. Hirschall (WHO/HQ)

4.30 **Country case study:** N. Kenya Mugisha, Uganda

5.00 Discussion

6.00 Adjourn

**Day 2 - Wednesday, 10 September 1997**

**SESSION 5: HOW TO IMPROVE AND MAINTAIN HEALTH WORKER SKILLS AND PRACTICES -  
OPTIONS FOR TRAINING AND FOLLOW-UP**

Moderators: A. Bartlett (USAID)  
G. Mukasa (WHO/CHD Technical Advisory Group)  
Rapporteur: D. Oluwole (WHO/Tanzania)

9:00 **Country presentations:**

**Sudan:** Building consensus on clinical guidelines (A. Shadoul)

**Bolivia:** Experience with in-service training (J. Telleria)

**Indonesia:** Experience with in-service training (I. Hernawati)

**Tanzania:** Experience with follow-up of trained health workers.

Plans for pre-service training (P. Mongi)

10.15 Discussion

10.30 COFFEE

**SESSION 6: REGIONAL PERSPECTIVES ON IMCI: SIMILARITIES AND CONTRASTS**

Moderators: B. Höjer (SIDA)  
D. Newberry (CARE International)

Rapporteurs: N. Kenya Mugisha, Uganda  
C. Drasbek, WHO/AMRO

11.00 **IMCI in Africa**

Presentations: A. Kabore (WHO/AFRO)  
A. Robb (DFID, UK)  
H. Sukin (USAID)

12.00 **IMCI in the Americas**

Presentations: Y. Benguigui (WHO/AMRO)  
S. Lutjens (USAID)  
S. Slater (on behalf of UNICEF/TACRO)

1.00 LUNCH

**SESSION 7: REGIONAL PARTNERSHIPS AND STRATEGIES**

2.00 **Regional working groups:**

Sub-Saharan Africa

Moderators: A. Kone (BASICS)  
D. Oluwole (WHO/AFRO)  
V. Orinda, UNICEF

Rapporteur: J. Nsungwa-Sabiiti, CDD/ARI/IMCI,  
Ministry of Health, Uganda

North Africa, the Middle East and Europe

Moderators: B. Sadrizadeh (WHO/EMRO)  
V. Mangiaterra (WHO/EURO)  
Rapporteur: M. Östergren (WHO/EURO)

Asia

Moderators: W. Aldis (WHO/SEARO)  
S. Atwood, (UNICEF)  
Rapporteur: J.M. Virtanen (WHO/WPRO)

Latin America and the Caribbean

Moderators: B. Smith (BASICS)  
Y. Benguigui (WHO/AMRO)  
K. Vanormelingen (UNICEF)  
Rapporteur: O. Suriel (WHO/AMRO)

*Participants will break into regional groups. Each group will be moderated by a team and will undertake three tasks:*

- 1. Identify the five most important challenges for IMCI implementation in the region over the coming two years.*
- 2. Define promising approaches to address these challenges.*
- 3. Describe a minimum of three concrete ways in which collaboration within the region can be strengthened.*

*Group reports on Tasks 1 and 2 will be presented at the close of the session; reports on Task 3 will be collected and combined into a single report for presentation in Session 12.*

4.30 **Report back on regional group work for Tasks 1 and 2**

Moderators: D. Oluwole (WHO/AFRO)  
L. Casazza (World Vision)  
Rapporteur: S. Egwaga, CDD/ARI/IMCI, Ministry of Health, Tanzania

6.00 Adjourn

**Day 3 - Thursday, 11 September 1997**

**SESSION 8: UPDATE ON IMCI RESEARCH AND DEVELOPMENT**

Moderators: R. Frischer (USAID)  
J. Martines (WHO/HQ)  
Rapporteur: F. Bustreo (WHO/Sudan)

9.00 **IMCI tools under development**

Presentations: J. Bryce (WHO/HQ)  
P. Desrosiers (BASICS)  
V. Orinda (UNICEF)  
K. Vanormelingen (UNICEF)

10.00 Discussion

10.30 COFFEE

11.00 **IMCI research priorities**

Presentations: J. Martines (WHO/HQ)  
R. Frischer (USAID)  
J. Simon (Applied Research in Child Health, Harvard University)  
M. Deming (US Centers for Disease Control and Prevention)

12.15 Discussion

1.00 LUNCH

**SESSION 9: IMCI IMPLEMENTATION ISSUES AT COUNTRY LEVEL:  
GROUP WORK**

*Participants will break into three groups to address the following topics and issues. Each group will be guided by a team including moderators, rapporteur, and presenters. Each session will include country presentations where appropriate.*

*Work in groups will continue throughout the afternoon. Each group will be asked to prepare a brief written report and a set of recommendations. These will be presented to the plenary in Session 10.*

**SESSION 9A: IMCI CONTRIBUTIONS TO STRENGTHENING THE HEALTH SYSTEM**

Team Leader: BASICS

**Objectives:**

1. To review country experience to date with health system issues related to IMCI, as well as results of related health system research
2. To develop recommendations for how to improve health system support for IMCI, including strategies for collaboration
3. To identify priority research and development activities needed to improve health system supports for IMCI

**Agenda:**

*This will be a combination of presentations (country experience, research results where available, and planned development activities) and focused discussion to identify needs and priorities.*

2.00 **Overview of health system issues related to IMCI**

Improving drug distribution and other system issues - Madagascar

- 2.15 **Availability of drugs**  
Overview of issues/country experience to date  
Cost implications of improved drug usage - Central Asian Republics  
Identification of needs and priorities
- 3.00 **Organization of work at health facilities**  
Overview of issues/country experience to date  
Organization of work at first-level facilities - Morocco  
Identification of needs and priorities
- 3.45 COFFEE
- 4.00 **Quality improvement strategies, including supervision**  
Overview of issues/country experience to date  
Quality assurance approaches - Zambia  
Maintaining health worker performance - Kenya  
Identification of needs and priorities
- 4.45 **Monitoring and use of information for IMCI management**  
Overview of issues/country experience to date  
Routine monitoring of IMCI - Uganda  
Experience with use of monitoring results- El Salvador  
Identification of needs and priorities
- 5.30 **Review and prioritization of research and development needs**
- 6.00 Adjourn  
Team leader and selected team members prepare report for presentation 12 September

#### **SESSION 9B: IMPROVING FAMILY AND COMMUNITY PRACTICES**

Team leader: UNICEF

#### **Objectives:**

1. To describe existing interventions to promote improved family and community practices and their potential contribution to reducing child morbidity and mortality.
2. To review ongoing and planned research and development work and identify priorities.
3. To make recommendations on how the process of moving from research and development to implementation of interventions can be accelerated.

## **Agenda:**

*The introduction will highlight the importance of the component and present the objectives of the group work. Four sessions will follow. The first three sessions will consist of (i) presentations, addressing objective 1 above, followed by (ii) discussions with the group to elicit ongoing and planned research and (iii) review of the lists by the group to identify gaps and priorities. The last section is a discussion to address objective 3.*

### **2.00 Introduction: family and community practices and IMCI**

#### **2.10 Promoting a safe environment**

- Interventions and their likely contributions
- Inventory of ongoing research and development activities
- Selection of priorities

#### **2.50 Promoting growth and development and increased resistance to infection**

- Interventions and their likely contributions
- Inventory of ongoing R&D work
- Selection of priorities

#### **3.30 COFFEE**

#### **4.00 Promoting appropriate family responses to illness**

- Interventions and their likely contributions
- Inventory of ongoing R&D work
- Selection of priorities

#### **4.40 Moving from research and development to implementation: how can the process be accelerated?**

#### **5.30 Adjourn**

Team leader and selected team members prepare report for presentation 12 September

## **SESSION 9C: EXPANDING IMCI COVERAGE - WHAT IS FEASIBLE?**

Team Leader: WHO

### **Objectives:**

1. To review current experience and discuss possible constraints to expansion of IMCI to achieve wide coverage and significant impact .
2. To identify priority research and development activities needed to answer questions related to IMCI in the context of health system reforms, affordability, cost-effectiveness, and impact measurement.
3. To develop recommendations for IMCI expansion at country level, and strategies of collaboration.

**Agenda:**

*This session will address a number of issues and constraints to IMCI for which there may be limited experience to date. Four particular issues will be highlighted through presentations followed by discussion and identification of needs and priorities.*

- 2.00 **Introduction:** G. Hirschall (WHO/HQ)
- 2.15 **Expanding IMCI coverage/maintaining quality**  
District capacity building - Tanzania  
Planning for expansion - Uganda  
Monitoring quality - Peru
- 4.00 **Health system reform - a constraint or an opportunity for IMCI?**  
Health sector reforms (World Bank)  
Experience with decentralisation - Zambia
- 4.45 **Is IMCI affordable/cost-effective ?**  
Results from study conducted in Central Asian Republics  
Assessing cost effectiveness
- 5.15 **Can we show impact early to maintain support to IMCI?**  
Measuring mortality (WHO/HQ)
- 6.00 **Adjourn**  
Team leaders and selected team members prepare report for presentation 12 September

**Day 4 - Friday, 12 September 1997**

**SESSION 10: REPORTS FROM SMALL GROUPS WORKING ON IMPLEMENTATION ISSUES**

Moderators: S. Bashar, Sudan  
R. Salgado (BASICS)  
Rapporteurs: T. Lambrechts (WHO/HQ) and Team leaders

9.00 **IMCI contributions to strengthening the health system**  
Presentation: Team leader of session 9A

Discussion

9.45 **Improving family and community practices**  
Presentation: Team leader of session 9B

Discussion

10.30 COFFEE

11.00 **Expanding IMCI coverage - what is feasible?**

Presentation: Team leader of session 9C

Discussion

**SESSION 11: MONITORING GLOBAL PROGRESS**

Moderators: R. Waldman (BASICS)

Y. Garnatie, Niger

Rapporteur: J. Bryce (WHO/HQ)

11.45 Presentations: UNICEF/WHO

Discussion

12.30 Lunch

**SESSION 12: STRENGTHENING GLOBAL SUPPORT FOR IMCI**

Moderators: J. Tulloch (WHO/HQ)

J. Torres-Goitia (WHO/CHD Technical Advisory Group)

Rapporteur: G. Hirschall (WHO/HQ)

2.00 **Panel Discussion:**

IMCI and health sector reform: P. Marquez (World Bank)

The role of non-governmental organizations in IMCI  
implementation: D. Marsh (Save the Children Fund, USA)

Enhancing the visibility of IMCI: V. Orinda (UNICEF)

Mobilising support and collaboration for IMCI: B.M. Eggen, Norway

Improving collaboration: Dr Elvira Dayrit, Philippines

3.30 **Reading of the Santo Domingo Call for Action on Integrated Management  
of Childhood Illness:**

Dr R. Schiffino, Vice Minister of Health and National Director of Health,  
Dominican Republic

4.00 Adjourn



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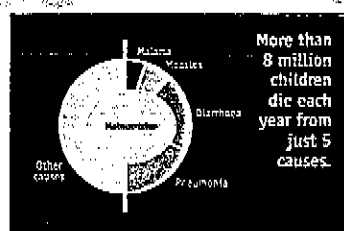
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