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**INTEGRATED MANAGEMENT
OF CHILDHOOD ILLNESS
ACTIVITIES IN FRANCOPHONE AFRICA**

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ACRONYMS

AFRO	WHO African Regional Office
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CDD	Control of Diarrheal Diseases
CS	Cercle de Santé
CHD	Child Health and Development
CHU	Centre Hospitalo-Universitaire
DD	Diarrheal Disease
DHMT	District Health Management Team
DRS	Direction Regional de la Santé
DPM	Deputy Prime Minister
EPI	Expanded Program on Immunization
FD	Febrile Diseases
HQ	Headquarters
HRN	Human Resources Nursing program
IEC	Information, Education and Communication
IMCI	Integrated Management Childhood Illness
IRA	Infection Respiratoire Aigüe
LMD	Lutte contre les Maladies Diarrhéiques
LOE	Level of Effort
MAL	Malaria
MCH	Maternal and Child Health
MOH	Ministry of Health
NUT	Nutrition
ORT	Oral Rehydration Therapy
SFC	Santé Familiale et Communautaire
TAACS	Technical Advisor for AIDS and Child Survival
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

Purpose of the Trip

1. Meet with BASICS regional staff in Dakar, Senegal, and discuss joint BASICS/AFRO child survival activities in the region.
2. Participate along with other BASICS staff in the Second Regional Meeting on the Implementation of IMCI in Brazzaville, Congo from February 25 - 28, 1997.
3. Assess the degree of commitment and understanding of all key decisionmakers to IMCI implementation in Togo, and plan for the IMCI orientation workshop.
4. Collaborate with WHO/AFRO in the organization of the second IMCI orientation workshop in Bamako, Mali.

Activities and Accomplishments

1. Meetings

Briefing were held in—

- Senegal, with Dr. Adama Koné, BASICS regional director, and Dr. Serigne Diène, nutrition advisor.
- Togo, with the MOH directeur general, the directeur general adjoint, the chef de la Division Santé Familiale, the Directeur du Programme Paludisme, the chef du Service des Maladies Transmissibles, the chef du Service de Pédiatrie, the directeur du Programme IRA, the directeur du Programme LMD, and the directeur de l'Hopital Secondaire de Bè. The directeur général de la Santé formally agreed to the organization of the orientation workshop, which is scheduled to be held on the 10, 11 and 12 of April, 1997.
- Mali with Dr. Tony Musinde, WHO/AFRO; Dr. S. M. Diakite-Diallo, Division SFC; and Ms. Karen Hawkins Reed, TAACS.

Dr. Paultre P. Desrosiers participated in the Second Regional Meeting on the Implementation of the Integrated Management of Childhood Illness (IMCI) that was held at the regional office in Brazzaville, from 25-28 February, 1997. Various organizations such as UNICEF; representatives from Mali, Togo, Niger, Tanzania, Uganda, and Zambia; and other relevant units in WHO/AFRO and WHO/CHD/HQ attended the meeting.

Lessons learned at the regional level during the meeting—

- The introduction of IMCI in any given country needs to be based on concrete and relevant information.
- It is essential for sustainability's sake that countries take ownership of this approach.
- The use of existing support structures of the country is a key factor.
- The incorporation of the approach in pre-service training should be encouraged.
- Joint involvement at an early stage of the MOH and pediatric department of a University Teaching Hospital is a must.
- The availability and use of competent national and international consultants is highly desirable.

A number of pre-service and in-service activities have been suggested to WHO/AFRO by its partners which could, in a way, strengthen the countries' capacity to implement IMCI. They range from working within the decentralized district by empowering the DHMT to better plan for IMCI and the use of the health facility survey tool, to community-level health programs and IEC/behavior change.

Desrosiers met with Ms. A. Kondé, WHO/AFRO HRN regional advisor, to talk about a pre-service education program for nurses/midwives and other health professionals in the African region. AFRO solicited BASICS support and collaboration in the development of regional Francophone training course to strengthen teaching methodology in pre-service education programs for nurses/midwives in the African region.

2. Second IMCI Orientation Workshop in Bamako, Mali

Desrosiers participated in the planning meeting for the preparation, and facilitated in collaboration with WHO/AFRO, the second IMCI orientation workshop in Mali. This workshop served as an opportunity to involve key players at the MOH in the decision to introduce IMCI, to review and discuss factors influencing the decision, and to propose solutions and plan the first year's training activities. During the workshop, participants selected three districts that were prepared for the implementation of IMCI and developed a one year plan of activities for these districts.

Participation in all these activities provided an opportunity to meet and establish rapport with the different players, from the BASICS regional office advisors and the WHO experts to MOH officials and other partners. In addition, the trip provided useful insights into the degree of planning necessary for successful implementation of IMCI, as well as an understanding of the

level of complexity of the implementation process. It also resulted in renew acquaintance with key IMCI players from Uganda, Tanzania, Zambia, Mali, Niger, and Togo, and time to explore their individual experiences with this new approach.

I. PURPOSE OF THE TRIP

1. Meet with BASICS regional staff in Dakar, Senegal, and discuss joint BASICS/AFRO child survival activities in the region.
2. Participate along with other BASICS staff in the Second Regional Meeting on the Implementation of IMCI in Brazzaville, Congo, from February 25-28, 1997.
3. Assess the degree of commitment and understanding of all key decisionmakers to IMCI implementation in Togo and plan for the IMCI orientation workshop.
4. Collaborate with WHO/AFRO in the organization of the second IMCI orientation workshop in Bamako, Mali.

II. BACKGROUND

BASICS and WHO/AFRO have developed very good collaboration in the coordination and implementation of child survival activities, especially in West Africa. Through its regional office in Dakar, Senegal, BASICS provides both technical leadership and practical field programs for reducing infant and childhood mortality in the region.

BASICS' priorities in West Africa have three overlapping agendas:

1. Developing and servicing country programs.
2. Developing the capacity of African institutions in the region to provide leadership and technical assistance.
3. Leveraging and complementing the resources of multilateral partners in the region.

BASICS also collaborates with other international and nongovernmental organizations according to each partner's technical and organizational strengths in the following six programmatic areas:

- Sustaining immunization programs
- **Integrating effective case management of childhood illnesses**
- Strengthening the link between nutrition and health
- Promoting and sustaining healthy behaviors
- Improving techniques for monitoring and evaluation
- Establishing public/private partnerships

III. TRIP ACTIVITIES

A. Meetings in Dakar, Senegal

The first meeting in Dakar was on February 21, with Dr. Adama Koné, BASICS regional director for Francophone Africa. The discussion focused on the many activities that were planned during the last meeting in December with WHO/AFRO, the Second Regional Meeting on the Implementation of IMCI in Africa, the preliminary visit in Togo, and BASICS' participation in the second orientation workshop in Mali. Dr. Koné gave an update of his meeting with Dr. Musinde, WHO/AFRO CDD/ARI/IMCI advisor for West Africa, and suggested to Desrosiers, BASICS IMCI technical and training coordinator, that he discuss the plan further with the staff at AFRO.

The meeting with Dr. Serine Mbaye Diène, BASICS regional nutrition advisor, was rather brief. The discussion with Diène was about the upcoming regional workshop on the food box adaptation process. He gave an overview of the workshop goal and objectives, the curriculum development process, the criteria for the selection of the participants and the countries that will be selected to participate in the workshop.

Dr. Mutombo wa Mutombo and Mr. Mamadou Sène were not available to talk about their recent experience with the IMCI orientation workshop that was held in Dakar from January 27 to 29, 1997.

B. Meetings in Brazzaville, Congo

Second Regional Meeting on the Implementation of IMCI in Africa (25 - 28 February)

The Second Regional Meeting on the Implementation of the Integrated Management of Childhood Illness (IMCI) was held at the regional office in Brazzaville, Congo, from 25-28 February, 1997. Various organizations such as UNICEF; representatives from Mali, Togo, Niger, Tanzania, Uganda, and Zambia; and other relevant units from WHO/AFRO and WHO/CHD/HQ attended the meeting.

The General Objective of the Meeting Was—

To strengthen the implementation of integrated management of childhood illness (IMCI) in the African region.

Specific Objectives Were—

1. Adopt, based on reports to the meeting, relevant recommendations for improvement of IMCI implementation in the region.

2. Revise the common approach adopted in February 1996 for IMCI implementation.
3. Adopt the provisional 5-year plan of action (1997-2001) for support to countries on IMCI implementation in the region.

The meeting was officially opened by the DPM, then Dr. Antoine Kaboré, WHO/AFRO CDD/IMCI regional advisor, made a presentation on "IMCI Implementation in the African Region and Lessons Learned," where he emphasized the fact that because of the difficulties and the conditions of the health care systems in many of the African countries, the introduction of the IMCI approach would certainly be justified. In addition, he stressed that IMCI is an approach and not a program; it is aimed at promoting collaboration among existing programs.

Dr. Kaboré added that the IMCI implementation strategy developed by AFRO provides for a progressive introduction of IMCI in countries in the following manner:

- * 10 percent of the countries will implement IMCI by the end of 1996
- * 20 percent by the end of 1997
- * 50 percent by the end of 2001

He elaborated on the important steps that have to be followed in implementing IMCI: *advocacy, orientation workshop, first year planning activities, adaptation of the generic training materials, training, monitoring and evaluation, and replanning*. Based on the experience of the past year, one additional step has been added to facilitate the process: *the preliminary visit*.

To ensure the sustainability of the IMCI process, three key elements have been identified—

1. The preliminary visit
2. The forum for national consensus (which should happen at the end or as part of the adaptation process).
3. A budgetary line to support IMCI implementation.

Kaboré also put emphasis on the lessons learned at the regional level, such as:

- The introduction of IMCI in any given country needs to be based on concrete and relevant information.
- It is essential for sustainability's sake that countries take ownership of this approach.
- The use of existing support structures of the country is a key factor.
- The incorporation of the approach in pre-service training should be encouraged.

- Joint involvement at an early stage of the MOH and the Pediatric Department of a University Teaching Hospital is a must.
- The availability and use of competent national and international consultants is highly desirable.

He ended by speaking of the many constraints that AFRO is facing to efficiently implement this approach in many countries and recapitulated the key points predisposing the effective implementation of IMCI in the African region.

Dr. Jim Tulloch, director of WHO/CHD/HQ, spoke on the role that the IMCI approach will be playing as it incorporates five major diseases and the natural overlapping of responsibilities of many programs. He insisted on the need to involve other IMCI-related programs. He added that WHO/CHD has decided to make this new initiative a worldwide effort with a scope beyond simple demonstration in a limited number of countries. Dr. Tulloch noted that his division at HQ was engaged in the development of other materials to complement the existing IMCI training course. He commended WHO/AFRO staff for their leadership and dedication in the development of the first IMCI implementation strategy.

UNICEF was represented in the meeting by Dr. Vincent Orinda, senior advisor, Health Section. Dr. Orinda noted that there was currently no official agreement between WHO and UNICEF on IMCI. A draft memorandum was actually formulated during the meeting which then went for review by both organizations.

Country Experiences

One of the important aspects of the meeting was the presentation by respective representatives of the three early users: Uganda, Tanzania, and Zambia. Lessons learned from these countries have enabled WHO/AFRO and the other partners to better grasp the scope and the implication of such an approach in the African region.

Uganda

According to Dr. Kenya Mungisha, national CDD/ARI/IMCI program manager, and Dr. Jesca Nsungwa, national IMCI focal person, the Ugandan experience started in 1994 with the formation of an ad hoc working group to establish a common understanding of the IMCI approach and to identify factors that could influence efficient and effective implementation of IMCI. In June 1995, the orientation workshop was launched to share information and to build consensus. Training strategies were developed following an 18-month adaptation process. Although general interest in IMCI was widespread, there was a lack of commitment of high-level decisionmakers and severe infrastructure problems which limited the benefits of IMCI. To date Uganda has conducted 8 IMCI training courses and trained 159 health workers (94 nurses, 30

clinical officers, 24 medical officers, and 11 pediatricians). Training costs were estimated at \$15,000 per course.

Many participants had great difficulty with the reading assignments during the training and were not able to internalize the new concept. In certain instances, the *Assess and Classify the Young Infant* module and the associated clinical sessions were omitted due to time constraints.

Recommendations

- Better planning and coordination of the IMCI training course.
- Develop better selection criteria of initial candidates to be trained as national facilitators or master trainers.
- Facilitators should be trained in IMCI skills development.
- Develop better selection criteria for the training of first-line health workers.
- District health teams should be dedicated and trained to conduct quality training and follow-up interventions.

Tanzania

Tanzania was the country to carry out the first IMCI field test: Arusha, February-March 1995. During this field test, it was observed that maternal and child health assistants (MCHAs) could not finish the last two modules of the training course. In November 1995, an IMCI action plan was developed, and six districts were selected as potential sites for the implementation of IMCI. The adaptation process started in February 1996, with the technical assistance from both WHO/CHD and WHO/AFRO; the material was translated from English to Kiswahili in November 1996 and finalized in August 1996. The first master training was conducted in September 1996; 3 regions and 4 districts were selected and a total of 91 health workers were trained. Sixty-seven percent of the participants did very well in the course. Like Uganda, Tanzania was plagued with severe coordination and infrastructural problems: not all facilities provide EPI services; some facilities have timing devices; poor communication with the districts; very expensive audio-visual materials; availability of facilitators; difficulty in providing adequate follow-up supervision; etc.

Tanzania has pretty much followed the WHO-recommended steps of implementation and made progress in their consideration for the introduction of the IMCI approach in pre-service training.

Recommendations

- Better preparation for IMCI implementation.

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- Encourage better multi-sectoral and inter-program collaboration.
- Greater governmental involvement and commitment.
- Develop better selection criteria of initial candidates to be trained as national facilitators or master trainers.
- Facilitators should be trained in IMCI skills development.
- Introduce the IMCI approach in the basic training institutions.

Zambia

The process used in the implementation of IMCI in Zambia was quite different from the other two countries. During the design phase of the **Zambian Child Health Project** in 1995, several donor partners, i.e., UNICEF and WHO, along with BASICS/USAID discussed with senior officials from the MOH the importance of the IMCI approach and how it could be an asset to the government Health Sector Reforms Project. After several rounds of active negotiations, a consensus building meeting was organized with 30 senior officials from MOH and partner organizations to seek a common understanding of the IMCI approach as it applied to the country. An IMCI advisory committee was created to help coordinate and conduct the adaptation of the training materials.

At this date, Zambia has conducted three facilitator trainings and five health worker training courses. More than 120 health workers have been trained in 3 provinces. However, the follow up and monitoring of these health workers is still considered to be lacking. Drug availability, a key requirement for health worker performance, and the motivation of caretakers to seek care appropriately still remain dilemmas. Zambia also faces similar infrastructural problems as those reported by the Tanzanian representatives.

Recommendations

- Involve key decision-makers at central, regional, and district levels in the planning process.
- Pre-train supervisors of participants.
- Build into organizational policies, practices, and procedures recognition for meeting the goals of educational programs.
- Use participant self-assessments for what has been learned and what participants believe they can apply.

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- Develop self-monitoring instruments and techniques in areas where supervision are scarce.
- Involve key players at all levels (supervisors a/o facilitators) in follow-up activities.
- Schedule, if possible, district refresher sessions.

Meeting on the Pre-Service Education Program for Nurses/Midwives and Other Health Professionals in the African Region

Kondé is involved in the development of pre-service training programs for nursing/midwifery and other related health personnel. One of the recommendations for the implementation of WHO resolutions is that provisions should be made to re-orient the nursing/midwifery pre-service curricula towards a primary health care approach to improve the quality of care that is provided to the community.

To support the member states in implementing the strategies for basic training of nurses/midwives, WHO/AFRO has developed a plan of action.

The specific objectives are—

- Train at least 25 Francophone regional facilitators and master trainers in curriculum development and teaching methodology.
- Train 25 facilitators and master trainers in the adaptation and utilization of generic training materials in educational institutions and technical programs.
- Network with regional WHO collaborating centers, universities, and educational institutions to accelerate activities for pre-service curriculum development.

One of the major activity areas proposed was to hold an intercountry Francophone workshop with teachers from educational institutions, EPI trainers, and members of the WHO national country teams.

AFRO solicited BASICS support and collaboration in the development of regional Francophone training course to strengthen the teaching methodology in pre-service education programs for nurses/midwives in the African region.

Key Issues

- WHO/AFRO is taking the leadership role in the coordination and implementation of a regional Francophone training course.

- AFRO will initiate administrative and logistics planning for the regional Francophone training course.
- BASICS will give technical support to AFRO in the development of the curriculum for the regional Francophone training course.
- BASICS is awaiting a formal invitation from AFRO requesting its technical support.

Meeting with WHO/AFRO, WHO/HQ, UNICEF, SARA/USAID, and BASICS to Review AFRO's IMCI Regional Implementation Strategy (March 1-4)

WHO/AFRO has scheduled a 3-day meeting with its partners to review the provisional 5-year plan of operation and to discuss the many issues that individual partner organizations may have with the plan. At the beginning of the meeting, Dr. Deogracias Barakamfitiyé, WHO/AFRO/DDC director, stressed the fact that the strategy document was essentially a WHO/AFRO document.

Kaboré presented once again the WHO/AFRO regional implementation strategy and asked the group to wait and pose their questions at the end to facilitate discussion. Many group members were concerned about the inadequacy of the IEC portion of the IMCI materials and suggested that AFRO try to incorporate an IEC strategy in the document. In addition, many other suggestions were made to AFRO by different partners, such as the inclusion of the expected results to the narrative, the omittance of the words “*at the first-level facility*” in the general objectives, etc.

AFRO agreed to make some changes but will stick with the essence of the content of the document. We will await the final WHO/AFRO document to assess the degree to which the recommendations of the partner organizations were taken into consideration.

C. Meetings in Lome, Togo

Planning of the Visit with the IMCI Focal Persons

The first meeting was with Professor Assimadi, head of the Pediatric Department of the University Hospital; Professor Tatagan, ARI coordinator; and Dr. Agbobli, CDD coordinator to review the plan for the three day visit.

Visit to the Pediatric Department, the DTU, and Nutrition Ward at University Hospital of Lomé-Tokoin

The Department of Pediatrics was created in 1972 when National Hospital was converted to a teaching hospital (CHU). It is a 150-bed department with four distinct units, hospital care, teaching, and research. The department has 14 physicians, 2 physician assistants, 36 nurses, 3 dieticians and puericulturists, 1 social worker, 1 instructor, 18 nurse aides, and 3 housekeepers.

The department provides services such as general and emergency pediatrics, infectious diseases, nutrition, hemoglobinopathy and other genetic ailments, neonatology, cardiology, neurology, etc. The services are provided around the clock, with 10,000 to 12,000 patients seen a year at the ambulatory clinics and 6,000 to 7,000 patients hospitalized annually. Malaria is the number one disease treated or cases seen at the department (41.82 percent), followed by ARI (9.23 percent), and DD (7.45 percent). The department's Diarrheal Training Unit was built by USAID (CCCD), and can be used by participants during the IMCI training course. The facilities are adequate for inpatient clinical practice, and the inpatient clinical instructor is trained in IMCI.

Constraints

- Lack of adequate supplies and equipment for efficient case management.
- Lack of adequate financial and human resources.

Solutions Proposed

- Continuing medical training for health personnel.
- Rehabilitation or/and construction of facilities (Emergency Unit, neonatology).
- Organization of a case management pilot zone in rural area (for research and training).

Visit to the Secondary Hospital of Bé

This former maternity clinic was recently converted to a specialized mother and child hospital to facilitate the case management of these two vulnerable groups. This integrated mother and child services approach was initiated for the first time in Benin, and was recently introduced to Togo. We met with Dr. Togma-Bakélé Barandao, the director of the hospital, and the *surveillant général*, who is a medical assistant equivalent to a physician assistant in the United States. The hospital is well maintained and serves a large population of under-5 aged children. There is adequate space for training and well organized triage of children with general danger signs. This hospital is suitable for IMCI training.

Visit to Rural Health Center

Assimadi accompanied Desrosiers to a health center which was about six kilometers from the City of Lome. The health center is headed by a medical doctor who is assisted by other categories of health workers. It has specified maternity and children under-5 services. On the day and time of our visit, the health center was not busy and we did not see too many cases of ARI, DD, or FD. We were told that the patients were already gone and that it was not the right season for cases of diarrhea and acute respiratory infections. Although we did not see the ORT room, the space is adequate for screening of patients.

Meetings with the MOH Directeur General de la Santé, the Directeur General Adjoint, the Chef de la Division Santé Familiale, the Directeur du Programme Paludisme, and the Chef du Service des Maladies Transmissibles

Agbobi, Tatagan, and Desrosiers paid a courtesy call to many key decisionmakers at the MOH to inform them once again about IMCI and to advocate support for its implementation in Togo. They all expressed their interest and commitment at improving the case management of childhood illnesses and recognized that the implementation of this approach may involve some major changes in health policies and regulations. In addition, the directeur général de la Santé formally agreed to the organization of the orientation workshop that is scheduled to be held on the 10, 11, and 12 of April, 1997.

Key issues

- There is general interest in IMCI and the MOH high-level decisionmakers seem to be committed to the introduction of IMCI in Togo, but they still need to formalize the IMCI coordinating body.
- The country has a network of well organized first-line health facilities. Eighty percent of the latter are using the Bamako Initiative with an efficient essential drugs distribution system.
- The IMCI drugs are available in 80 percent of the first-line health facilities.
- The head of the Pediatric Department is trained in IMCI and is fully engaged in the implementation process.
- The CDD and ARI coordinators are, for now, playing the leadership role.
- Regular supervisory visits to health facilities will be essential in order to monitor and ensure that case management of childhood illnesses is done correctly.
- The dates for the orientation workshop are set for April 10, 11, 12. Musinde, WHO/AFRO, will participate along with Koné, BASICS regional director.
- GTZ is assisting the Hospital Secondaire de Bé in the implementation of integrated case management of the mother and child (ICMMC) or (consultation intégrée mère et enfant CIME).
- GTZ is willing to collaborate in the implementation of IMCI in the first-line health facilities.
- WHO and UNICEF will support IMCI or any IMCI-related activities.

D. IMCI Planning and Orientation Workshop in Bamako, Mali

Purpose of Visit

1. Participate in the planning meeting for the preparation of the second IMCI orientation workshop in Mali.
2. Facilitate in collaboration with WHO/AFRO the second IMCI orientation workshop in Mali.
3. Participate in the planning of the first-year IMCI training activities in Mali.
4. Participate in a consensus meeting between WHO/AFRO, the MOH, and USAID.

Background

Following the joint WHO/AFRO, BASICS, and UNICEF meeting in Dakar, Senegal in December 1996, it was agreed that BASICS would collaborate with WHO/AFRO in the implementation of the IMCI approach in Niger, Togo, Côte d'Ivoire, and Mali. To accommodate the gradual phase-in of participating countries, AFRO will be the lead partner in the first phase design, planning, training, monitoring, and evaluation in Niger, Mali, and Côte d'Ivoire. All IMCI-related activities will foster joint AFRO/BASICS participation to the degree that enough funds are made available to both partners.

Planning Meeting for the Preparation of the Second IMCI Orientation Workshop in Mali

The purpose of the planning meeting was to get a firm commitment from all the key decisionmakers, identify the factors that could influence efficient and effective implementation of IMCI, and plan for the second IMCI orientation workshop.

IMCI Orientation Workshop

This workshop served as an opportunity to involve key players at the MOH in the decision to introduce IMCI, to review and discuss factors influencing the decision, to propose solutions, and to plan the first year training activities. Following the formulation and acceptance by the participants of the district selection criteria, participants have identified three districts—one urban (commune V of Bamako), one semi-urban (Koulikoro), and one rural (Djenné)—as potential target areas for integrated case management training.

Planning of the First Year IMCI Training Activities in Mali

This involves the formalization of the advisory committee, the adaptation of the generic training materials which will comprise of an introductory workshop to seek input from key staff of

vertical programs (DD, ARI, MAL, DRUGS, NUT, etc.) (duration one to two weeks), a mid-term workshop to assess the progress of the adaptation process (one week), and a final consensus workshop to facilitate analysis and decisionmaking on key issues relating to the training materials (duration one week). The adaptation of generic training materials to the local situation involve a review of national policies and guidelines, food and fluid recommendations, and local terminology for common complaints, e.g., fever, difficult breathing, etc. The training of master trainers will take 11 days and be followed by a 5-day facilitator training and the actual training of the first-line health workers by the newly trained facilitators for 11 days (total duration of activities: 5 weeks). A follow-up visit will take place four to six weeks after the training course to reassess health worker performance and to identify possible needs for organizational changes to improve quality of care. At the end of the first year, an evaluation will be conducted to assess the impact of IMCI approach.

BASICS will collaborate with the WHO/AFRO technical support to the degree that enough funds are available or budgeted in the new delivery order.

Recommendations

1. The MOH has to formalize, as quickly as possible, the IMCI advisory group.
2. WHO/AFRO has to make available, as soon as possible, the necessary funds to implement this first year plan of action.

Consensus Meeting Between WHO/AFRO, MOH, USAID

Briefing with Dr. Tony Musinde, WHO/AFRO; Dr. S. M. Diakite-Diallo, Division SFC; Ms. Karen Hawkins Reed, TAACS; and Dr. P.P.Desrosiers of BASICS/HQ

The purpose of this meeting was to revisit the joint WHO/AFRO/BASICS plan and to identify areas where the Mali Mission could fund IMCI activities in Mali as part of the proposed BASICS 18-month workplan.

Key issues

- WHO/AFRO is taking the leadership role in the implementation of IMCI in Mali, but would welcome the technical support of BASICS in the process.
- Hawkins Reed, USAID/TAACS, is considering BASICS' proposal to collaborate with AFRO and the MOH in the implementation of IMCI in Mali.
- BASICS must urgently deliver the operational budget for the one-year IMCI activities in Mali to the TAACS.

- There is a need for a computer specialist to train local technicians so that they can support the adaptation of training materials.
- Hawkins Reed noted the importance of the development of IMCI-related community interventions in collaboration with the Groupe Pivot.

BASICS Proposed IMCI-related Activities in Mali

Adaptation Introduction Workshop (Atelier d'introduction du processus d'adaptation) LOE: 33 person days for regional staff (nutrition specialist, IEC specialist, ARI/CDD/EPI specialist), and 9 person days for one HQ staff training coordinator. Proposed dates May 12-25, 1997.

Midterm Workshop (Atelier a mi-parcours) To assess the progress of the adaptation committee. LOE: 9 days for one regional staff and 12 days for one computer specialist from HQ (August). This computer specialist will train the two (2) computer technicians from the MOH in the use of the software program.

Consensus Workshop (Atelier de consensus) LOE: 9 days for one regional staff and 12 days for one HQ staff training coordinator. (November)

Training of Master trainers and Training of First-line Health Workers LOE: 30 person days one staff from the regional office or training coordinator from HQ. (January-February 1998, 5 weeks)

Monitoring (Supervision) LOE: 17 person days for one regional staff.

Evaluation LOE: 17 person days for one regional staff and 21 person days for one staff from HQ. (June 98) (80 person days for preparation, collection, analysis, and dissemination of results)

Working with Groupe PIVOT to help develop mechanism to improved care at home and community levels. LOE: 60 person days.

E. WHO/AFRO and BASICS Joint IMCI and Other Related Activities Plan

WHO/AFRO has formally agreed to collaborate with BASICS in most of the major child survival activities that were proposed during the joint meeting in Dakar in December 1996.

IV. CONCLUSION

The development of a new and improved system for providing quality child health care through the implementation of IMCI is going to be a long and complex task for all interested partners.

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While there seems to be a common understanding of the specific approach described in the WHO/UNICEF training materials, perceptions still differ on many aspects of the implementation of this initiative. And despite the widespread interest in IMCI and the commitment of high-level decisionmakers in the MOHs of many countries in the African region, health infrastructure systems (organization of health facilities, referral systems, drugs and supplies, recurrent costs) is still lacking and does not show any signs of improvement in the near future. Nevertheless, IMCI remains one of the most cost-effective public health interventions that can be undertaken by most developing countries. While the potential benefits and cost-effectiveness of this approach are important and promising, it should be carefully accomplished in a staged fashion to allow countries to slowly absorb the changes and take full ownership of the initiative.

Participation in all these activities provided an opportunity to meet and establish rapport with the different players, from the BASICS regional office advisors and the WHO experts to MOH officials and other partners. In addition, the trip provided useful insights into the degree of planning necessary for successful implementation of IMCI, as well as an understanding of the levels of complexity of the implementation process. It also resulted in renew acquaintance with key IMCI players from Uganda, Tanzania, Zambia, Mali, Niger, and Togo, and time to explore their individual experiences with this new approach.

V. RECOMMENDATIONS/FOLLOW UP

1. BASICS should support the development of an agenda and topics for operations research studies in the African region.
2. BASICS/HQ needs to send a current operational budget to the USAID Mission in Mali.
3. BASICS, in collaboration with its partners, should encourage the development of an effective follow-up mechanism to ensure the transfer of training in the health facilities.
4. BASICS should collaborate with AFRO in the development of an user friendly IMCI reporting system that can help participating countries monitor their IMCI activities, evaluate feedback, and strengthen implementation.
5. BASICS should collaborate with other partners in the development of community-level health materials to complement the IMCI effort in the first-line health facilities.
6. BASICS should play a major role in improving drug management and logistics capacity in countries that plan to introduce IMCI.
7. BASICS is awaiting a formal invitation from AFRO requesting its technical support in the development of the curriculum regional Francophone training course to strengthen the

teaching methodology in pre-service education programs for nurses/midwives in the African region.

APPENDIXES

APPENDIX A
LIST OF PERSONS MET

List of Persons Met

Senegal

Dr. Adama Koné, BASICS Regional Director
Dr. Serigne Diene, Nutrition Advisor

Congo

Dr. D. Barakamfitiye, WHO/AFRO DDC, Director
Dr. Antoine Kaboré, WHO/AFRO CDD, Regional Advisor
Dr. Lazare Loco, WHO/AFRO ARI, Regional Advisor
Dr. Doyin Oluwole, WHO/AFRO STP/CDR Medical Officer
Dr. T.S. Musinde, WHO/AFRO CDR, Medical Officer
Dr. J.Tulloch, WHO/HQ CHD, Director
Dr. G. Hirschall, WHO/HQ, Programme Manager
Dr. Vincent Orinda, UNICEF, Senior Advisor, Child Health
Dr. Suzanne Prysor-Jones, SARA Project, Director
Dr. A. Robb, ODA
Dr. Bob Pond, BASICS Technical Officer

Togo

Dr. Essosolem Batchassi, Directeur Général de la Santé
The Directeur Général Adjoint de la Santé
Prof. J.K. Assimadi, Head of the Department of Pediatrics
Prof. Komlan Tatagan-Agri, Directeur Programme IRA
Dr. Elise Apétsianyi Agbobli, Directeur Programme LMD
Dr. N.F. Kambatibe, Chef de la Division Santé Familiale
Dr. A.H. Gayibor, Responsable du Programme National de lutte contre le Paludisme
Dr. A.D.T. Kpinsaga, Chef du Service des Maladies Transmissibles
Dr. Togma-Bakélé Barandao, Directeur de l'Hôpital de Bé

Mali

Dr. Zaccharia Maiga, Secrétaire Général MOH
Dr. Lasséni Konaté, Directeur National de la Santé
Dr. Aïssata Ba Sidibé, UNICEF
Dr. Sarmoye Cisse, MPN/WHO
Dr. Madina Ba/Sangare, Head of the SFC Division
Dr. S.M. Diakite-Diallo, CDD/ARI/Nutrition Coordinator, SFC Division
Dr. Fanta Diallo Touré, Groupe PIVOT
Dr. Sidi Diallo, Responsable, Programme Elargi de Vaccination
Dr. Fousseyni Sidibé, Responsable, du Programme National de lutte contre le Paludisme
Prof. Toumani Sidibé, CHU Gabriel Touré
Prof. Alhousséini Ag Mohamed, CHU Gabriel Touré

APPENDIX B

**REPORT OF THE SECOND REGIONAL MEETING ON THE
IMPLEMENTATION OF IMCI IN THE AFRICAN REGION**

WHO AFRICAN REGIONAL OFFICE

DIVISION OF INTEGRATED DISEASE CONTROL

**SECOND REGIONAL MEETING ON THE IMPLEMENTATION OF THE
INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)
BRAZZAVILLE
25 - 28 FEBRUARY 1997**

MEETING REPORT

1. Introduction

The major killers of African children under 5 years of age such as pneumonia, diarrhoea, malaria, measles and malnutrition can be prevented or treated by the use of simple and affordable techniques and medications. Most children often present with one or more of these diseases to health facilities that provide sub-optimal care.

In an attempt to improve the quality of care provided to under-fives at the first level health facility using simple affordable techniques and medications, WHO and UNICEF developed the package for the Integrated Management of Childhood Illness (IMCI). This package integrates curative, preventive and promotional services in order to provide a comprehensive and more effective delivery of child health services.

Many countries in the African Region regard IMCI as a response to the needs of the masses and expect its implementation to cause a drastic reduction in childhood mortality. Consequently, the WHO African Regional Office has adopted this approach as a way of supporting its Member States in their struggle for improved child survival and health.

In 1995, WHO/AFRO began the implementation of this approach. Major steps taken by the Regional Office of WHO in 1996 towards the implementation included a series of orientation meetings for the Division of Integrated Disease Control and other relevant Units in AFRO; WHO/AFRO Units and partners interested in IMCI implementation in the Region; WHO Country Representatives; and National Managers for the Control of Diarrhoeal Diseases and Acute Respiratory Infections.

To date, seven countries namely: Eritrea, Ethiopia, Mali, Niger, Tanzania, Uganda and Zambia have begun implementation and many more have indicated interest.

One of the outcomes of the orientation meetings was a resolution to periodically review and evaluate implementation in the Region. As part of the implementation of the recommendations, the second Regional meeting on the implementation of the Integrated Management of Childhood Illness (IMCI) was held at the Regional Office of the World Health Organization in Brazzaville from the 25 - 28 February 1997.

2. Objectives and Expected Outcomes

2.1 General Objective

To strengthen the implementation of the Integrated Management of childhood Illness (IMCI) in the African Region.

2.2 Specific Objectives

To:

- * adopt, based on reports to the meeting, relevant recommendations for improvement of IMCI implementation in the Region;

- * revise the common approach adopted in February 1996 for IMCI implementation;
- * adopt the provisional five-year plan of action (1997-2001) for support to countries on IMCI implementation in the Region.

2.3 Expected Outcomes

- * appropriate recommendations adopted for improved IMCI implementation in the Region;
- * common IMCI implementation approach adopted in February 1996 revised;
- * provisional 5-year Plan of Operation to support countries in IMCI implementation in the Region adopted.

3. Method of Work

This consisted essentially of presentations in plenary followed by discussions. There were also joint meetings of WHO AFRO and HQ with individual participating countries and partners.

4. Meeting Proceedings

4.1. *IMCI: Regional and Global situation*

This session had two presentations:

4.1.1. The first, titled "IMCI implementation in the region and lessons learned" was presented by Dr. Antoine Kabore, CDD/WHO/AFRO.

The presenter gave a general background on the health situation in Africa, stressing the difficulties encountered in case management, the scarcity of resources, the high cost of drugs, lack of confidence in the health care system, all of the many conditions that would justify the introduction of the Integrated Management of Childhood Illness (IMCI) Approach.

IMCI is an approach and not a programme; it is aimed at promoting collaboration among existing programmes. It is expected to be implemented within the framework of existing structures and therefore does not necessarily require the development of specific new ones.

A regional implementation strategy has been developed with the following objective: to improve the quality of care provided to children under five years of age at the first level health facilities.

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The strategy provides for a progressive introduction of IMCI in the countries of the region in the following manner:

- * 10% of the countries will be implementing IMCI by the end of 1996
- * 20% by the end of 1997
- * 50% by the end of 2001

In addition, the presenter elaborated on the implementation steps of IMCI as adopted in 1996, namely: advocacy, orientation workshop, first year planning activities, adaptation of generic materials, training, monitoring and evaluation, replanning.

To date, eight countries of the region have started with the implementation process: Ethiopia, Eritrea, Mali and Niger have already held their orientation workshop, Madagascar is in the process of adapting the generic materials; Uganda, Tanzania and Zambia are preparing for the evaluation of the first year of IMCI implementation.

However, based on the experience in the last 12 months, one additional step was added to facilitate the process, that is the preliminary visit. The objective of this initial visit is to assess the health care delivery system of the intending country and to determine the feasibility of the existing health system to support the introduction of IMCI. Botswana, Cote d'Ivoire, South Africa and Zimbabwe have all benefited from this preliminary visit.

Three key elements have been identified to ensure the sustainability of the IMCI process:

- * the preliminary visit
- * the forum for national consensus
- * a budgetary line to support IMCI implementation

4.1.1.2. Lessons learned at Regional level

- The decision of the country to introduce IMCI should be based on concrete and relevant information
- The ownership of the approach by the countries is a key factor of sustainability.
- The existing support structures at country level, such as training facilities, drugs distribution, monitoring and evaluation systems must be utilized.
- The incorporation of the approach in pre-service training must be encouraged.
- Collaboration of the MOH with Universities should be strengthened through the early involvement of the Paediatricians.

- The availability of competent national and international consultants is paramount.

4.1.1.3. Constraints

- Inadequate number of well trained IMCI experts in the region to support countries for implementation
- The increasing demand and pressure from countries and partners to accelerate the implementation process
- The complexity and the duration of the implementation process
- The difficulty in obtaining consensus of all partners involved.

4.1.1.4. Prospects

- The preliminary visit will be an integral part of the implementation process
- The development of a core of trained national experts
- The ownership of the approach by countries is of high priority
- The incorporation of this approach in the curricula of the pre-service medical and paramedical schools is necessary
- The strengthening of CDD/ARI programmes to continue in countries or districts not yet implementing IMCI
- A five year plan of action to be developed and implemented by WHO/AFRO and partners

4.1.2. The second presentation was by Dr Jim Tulloch titled "Place of IMCI in relation to other programmes"

4.1.2.1. IMCI includes 5 major diseases and, therefore, 5 natural partners among WHO programmes, those dealing with ARI, diarrhoea, measles, malaria and malnutrition. In addition, a number of other WHO Programmes (eg prevention of blindness or oral health) were involved in the development of IMCI.

4.1.2.2. There are many reasons why an integrated approach is needed, for example: overlap of clinical presentations of ARI and malaria, the importance of nutrition in the management of diarrhoea, the need to treat diarrhoea, ARI and nutrition problems associated with measles. This means programmes must work together.

4.1.2.3. For some programmes IMCI is only one part of their work, eg malaria control or nutrition, but it is an important part and requires their support. IMCI can be an entry point for nutrition programmes.

4.1.2.4. In addition IMCI needs to involve the essential drugs programme, those dealing with health systems improvement and health manpower development. University medical departments, and especially paediatricians, should also be fully involved.

4.1.2.5. UNICEF, ODA, USAID (BASICS and SARA) GTZ are already important partners. It will be important also to continue to seek World Bank and African Development Bank support.

4.1.2.6. At Global level WHO/CHD has decided to make IMCI a worldwide effort not just demonstration in a limited number of countries. This means taking a long term perspective. WHO will not be able to provide technical cooperation with all countries immediately. Most countries should continue active support to CDD and ARI activities, where possible combining them as a step towards integration.

4.1.2.7. Although IMCI activities have started in all WHO regions, AFRO is leading the way. This review meeting is the first of its kind globally.

4.1.2.8. The commitment and dedication of AFRO staff and their counterparts in countries in early implementation of IMCI must be recognized.

4.2. COUNTRY EXPERIENCES

4.2.1. UGANDA

4.2.1.1. **Introduction**

The steps of implementation of IMCI in Uganda, and lessons learned, were discussed elaborately, by Dr. Kenya Mungisha, National Programme Manager and Dr. Jesca Nsungwa, National IMCI Focal Person, Uganda.

The presentation discussed the process of initial planning, orientation for acceptance of IMCI, adaptation, progress made, lessons learned and future plans for Uganda.

4.2.1.2. **Objectives**

To share the experience acquired by Uganda, during the implementation, training and follow up in IMCI in order to enable other countries plan better for the introduction of IMCI.

4.2.1.3. **Key Issues Discussed**

a) **Introduction of IMCI**

In the Initial planning and Orientation, it is extremely important to obtain consensus among key programmes (CDD/ARI, Nutrition, Malaria, Paediatricians, Essential Drugs Programme and Health Worker training schools, etc.) and major

partners.

Strategies are necessary for the acceptance of IMCI among stakeholders, e.g. "working group", in order to facilitate the process of adaptation and plan for training.

Commitment is required from all programmes, to support the adaptation of modules consistent with the country's policies, on issues such as breastfeeding, vitamin A supplementation, immunization prior to training.

b) Training

The main objective of Uganda's training was to increase district capacity within a decentralised system.

The following criteria were applied to select a central training site:

- * Proximity of District to the Centre
- * Experience in CDD/ARI training
- * Adequate health facility, accommodation
- * Availability of drugs
- * Cooperative DMO

Uganda has a "case control" training situation, with one district following selection criteria closely and another with poor compliance.

The results of health worker performance were not too different. All together, 159 health workers including 11 paediatricians, 24 medical officers were trained during 8 courses.

c) Difficulties encountered:

- * selection of the wrong participants
- * low patient load at the district
- * lack of transport and drugs
- * the regular transfer of trained staff

d) Follow-up after training

The objective of follow-up was to reinforce skills of trained workers, monitor performance and solve problems, in order to maintain the quality of training.

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Follow-up visits showed that essential drugs and supplies were inadequate, but health workers performed well in immediate problem solving and use of IMCI chart booklets.

Follow up visits also showed that referral was difficult due to lack of transport.

4.2.1.4. Recommendations

- In the initial planning phase and for every step of the IMCI process, consensus of all programmes and key partners, is essential.
- There is need to close the gap between the legal provision and practice, to enable health workers who work with children to prescribe appropriate drugs.
- Policy guidelines are to be clarified in order to better support disease specific training courses in IMCI.
- It is recommended from the Uganda experience, that Course Directors undergo a 2 day orientation.
- Follow-up to be conducted within the framework already existing systems.

4.2.1.5. Conclusion

The main objective of the introduction of IMCI is to reduce infant and child mortality through improved quality of care.

The complexity of the process of the introduction of IMCI was demonstrated in the Uganda experience.

4.2.2. TANZANIA

IMCI implementation in Tanzania followed different steps namely:

4.2.2.1. Initial Preparation

- meeting to introduce the process
- field testing of the WHO/UNICEF materials
- training of clinical facilitators and MCH staff

4.2.2.2. Development of a plan of action

Identification of the districts based on set criteria: existing resources, performance in CDD/ARI, accessibility.

4.2.2.3. **Adaptation of generic materials**

In collaboration with the relevant programmes: EPI, Malaria, and the University, the materials were adapted and later translated into Kiswahili.

4.2.2.4. **Preparation for training**

Identification of training sites and participants: national, regional and local.

4.2.2.5. **Training and Follow-up of Health Workers**

Training of senior paediatricians, zonal coordinators, and of health workers in 4 districts, with a total of 91 health workers trained.

Introduction of IMCI into preservice training (plan of action developed).

Training of supervisors: National supervisors were trained in two groups.

The IMCI team identified some facilitating factors as well as lessons learned:

4.2.2.6. **Facilitating Factors:**

- * government interest in IMCI
- * availability of human and financial resources
- * presence of partners to support the introduction of the approach (TEHIP), HMIS)

4.2.2.7. **Constraints:**

- * poor communication with the districts
- * high cost of implementation of the approach
- * long absence from work of the few facilitators
- * new approach requiring frequent replanning
- * very expensive audio-visual materials for renting
- * supervision requiring means of transport

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4.2.2.8. **Lessons learned:**

- * good preparation necessary
- * inter and multisectorial support required
- * needs government commitment
- * needs to train all health workers
- * introduce IMCI into preservice training for sustainability
- * ensure quality of training
- * pay attention to selection criteria

4.2.2.9. **Key Issues discussed**

The following were discussed in plenary:

- * provision of essential drugs
- * the competence of trainers on nutrition
- * the planning aspect of IMCI in the context of Health Sector Reforms

4.2.2.10. **Recommendations**

- * To incorporate IMCI in Health Sector Reforms for institutionalization
- * Include Health Sector Reformers in IMCI Orientation Workshop

4.2.3. **ZAMBIA EXPERIENCE (financed by BASICS, WHO, UNICEF)**

Zambia organized a series of meetings to obtain consensus for IMCI. Following this, an Adaptation Workshop was conducted prior to the adaptation of the generic materials.

4.2.3.1. The following steps were followed:

- * planning of implementation
- * adaptation of the materials
- * replanning of activities

- * workshop on planning of training and follow-up strategies

A certain number of documents were elaborated for Health Information System which are currently being tested.

4.2.3.2. Difficulties

Zambia mentioned similar difficulties on implementation as those of Tanzania:

- * transport difficulties (for patients and participants)
- * pressure from National Board of Health to reduce Infant Mortality

4.2.3.3. Lessons learned:

- * training courses have been conducted centrally and therefore there are not enough facilitators
- * since supervisors were not trained in IMCI, it has been difficult to conduct quality supervision

4.2.3.4. Critical Analysis of Tanzania and Zambia Experiences:

Tanzania and Zambia reflect two scenarios of early use countries in the Region. Whereas Tanzania has put a lot of effort in sticking to the WHO recommended steps of implementation, Zambia offers another possible picture of what could happen with a different approach to these steps. It also reflects the role of other bilateral donors and stakeholders in supporting this approach.

Tanzania has had some unique experiences unlike other countries: they had the benefit of field-testing the IMCI materials. They have also had an experience of translating the training materials into Kiswahili in the shortest possible period. They have exemplified innovations in the use of enlarged photocopies of the chart booklets as wall charts, a process which may not be acceptable in most countries. They have also been able to run a 5-day course for facilitation techniques using the WHO facilitator guide as it is. Tanzania has also made progress in their consideration of the introduction of IMCI in preservice training.

Zambia on the other hand exemplifies a country where the process used for implementation has revealed a lot of information, in particular the need to involve local experts in the introduction of this approach from the very beginning. BASICS has played an important role in IMCI implementation in this country and a lot of negotiations have taken place at country and regional level amongst experts from Zambia, BASICS and WHO. It is important that an agreement was reached to replan, and include some of the steps previously not given adequate attention in the preparatory phase.

Zambia's historical background and level of project in Health Sector Reforms (HSR) provides a first learning experience. The role of HSR in IMCI needs to be clearly

spelt out and intensively advocacy for. It is high time that HSR is brought on board and the role of WHO in this advocacy will be very instrumental.

The cost effectiveness of IMCI as a strategy for reduction of mortality through improved care is better understood through the shared experiences.

4.3.3.5. Key Issues:

- Consensus building, a strong framework for the success and sustainability of IMCI will remain a continuous process.
- Obtaining commitment at all levels of implementation is a prerequisite.
- Supervision and follow-up will remain a strong tool in the strengthening and improvement of IMCI implementation.
- The balance between quality of care and pressure to expand needs to be placed in focus and not be lost along the way.

A lot of problems and lessons have been identified from this experience and should be utilised. Funding and support services needs for IMCI implementation were clearly articulated.

Drugs availability, a key requirement for health worker performance, and motivation of caretaker to seek care appropriately still remains a dilemma. As attempts are made to ensure drugs availability at the first level health facilities, there is need for a parallel need to ascertain that these drugs will be rationally used at this level.

Key in this meeting is the fact that experiences from countries still continue to assist countries intending to implement this approach, and indeed WHO as they seek to provide guidelines to countries. Further experience is required for us to make major changes and conclusions at a technical level.

4.2.3.6. Recommendations:

- * Need to obtain consensus for IMCI implementation
- * WHO should support countries to implement IMCI. The process will take time because it is a holistic health care delivery.
- * Careful documentation of all these issues is recommended.

4.3. Experiences of partners

4.3.1. Support for IMCI Implementation: BASICS

BASICS come from Reach, Health Com. and Pritech projects.

It is a USAID-funded project.

It has been awarded a 5-year contract starting 1993 as a major technical agency at USAID child survival programme in different countries.

BASICS Project's support to IMCI in African countries:

4.3.1.1. BASICS has several country level projects which can provide major support to IMCI:

- Zambia
- Madagascar
- Eritrea

4.3.1.2. BASICS is in several countries to support IMCI operational research and demonstration activities in the following countries:

- Niger
- South Africa
- Nigeria (only in the private sector)
- Kenya (CDC for supervision activities)

4.3.1.3. Potential countries for future IMCI support:

- Ethiopia
- South Africa
- Mali
- Togo
- Benin
- Kenya
- Senegal

4.3.1.4. BASICS Regional Support in IMCI

Regional office in Dakar (Senegal).

- There are 2 IMCI trained consultants.

BASICS HQ in Washington

- There are 8 IMCI-trained consultants.
- There are 2 IMCI adaptation consultants
- Contract with management group that has several nutrition adaptation consultant

BASICS plans to expand the pool of their consultant for clinical adaptation strengthening of supervision and nutrition adaptation. Also they will have consultancy available to support drugs management, malaria, IEC, Monitoring and Evaluation aspects of IMCI. These consultants will be available to support country specific and Regional IMCI efforts.

4.3.1.5. BASICS Global support

BASICS has developed several materials for IMCI training:

- The complementary course - targeted to health workers with little literacy and capability to read.
- Course for training IMCI facilitators (still in draft).
- The preparatory guide - guide to help managers prepare introduction of implementation in the country.
- Drugs supply management course.

BASICS has also made available IMCI course materials in French and Spanish.

4.3.1.6. Support for NGOs

BASICS will support NGOs in implementing IMCI. The identified NGOs are Care, Hope, World Vision, Save the Children, Africa, ADRA and Project Concern.

In addition, two BASICS technical officers, Drs. Desrosiers and Mutombo gave their comments on activities and plans for IMCI implementation in 5 West African countries namely: Ivory Coast, Mali, Niger, Senegal and Togo.

4.3.1.7. Discussion

Dr J. Tulloch, Director CHD/HQ pointed out that among the materials developed by BASICS, there was collaboration with WHO in 2 of them namely: the complimentary course and drugs supply management course). WHO is still looking into the development of the course for training on IMCI facilitation techniques. WHO does not recommend to countries the use of the IMCI preparatory guide.

WHO/AFRO medical officers (Brazzaville and Cote d'Ivoire) expressed appreciation of the collaboration between WHO and BASICS in Zambia and the West African countries.

They urged for continuing collaboration for better implementation of IMCI in the African Region.

4.3.2. SUPPORT FOR IMCI IMPLEMENTATION: TANZANIA ESSENTIAL HEALTH INTERVENTION (TEHIP)

4.3.2.1. Introduction

The Essential Health Intervention Project (EHIP) originated from the 1993 World development report "Investing in Health" and the subsequent 1993 conference in Ottawa "Future Partnership for the Acceleration of Health Development.

Tanzania is the first partnership country for EHIP, the project in Tanzania is therefore called "Tanzania Essential Health Intervention Project (TEHIP). The Government of Tanzania is implementing TEHIP in collaboration with IDRC (International Development Research Centre) and WHO.

4.3.2.2. The broad objectives of TEHIP are :

To:

- increase and strengthen the capacity of district health management teams (DHMTs) and authorities in the two participating districts to effectively plan and deliver essential health interventions based on burden of diseases and cost effectiveness analysis and;
- measure, assess and document the overall impact and lessons learned in delivering selected health interventions at the district level

Currently TEHIP is operating in two districts Rufiji and Morogoro.

4.3.2.3. Characteristics of TEHIP

- TEHIP is a four-year research and development project beginning in 1996, with the goal of testing the feasibility of institutionalizing an evidence-based approach to planning, using local estimates of burden of diseases and cost-effective analysis as tools for priority setting and allocating health resources. The approach will involve the selection of essential health intervention packages at the district level.

4.3.2.4. TEHIP Support for IMCI implementation in Tanzania:

- TEHIP has identified IMCI as one of the most cost-effective interventions in provision of health services.
- TEHIP is supporting the 2 districts in IMCI implementation in the following areas:
 - * In the development of annual health plans according to district health profiles (HMIS).

- * 694 000 USD has been secured for IMCI implementation in the 2 districts (USD 326 000 for Morogoro - USD 358 000 for Rufiji. The money is allocated for training, support supervision, drug supply and equipment.

4.3.2.5. Discussions

TEHIP was congratulated for the support provided for IMCI implementation. It was emphasised that the Tanzanian IMCI team is working in close collaboration with TEHIP for the implementation of this approach in the TEHIP-assisted districts.

4.3.2.6. Recommendation

It was recommended that TEHIP should work in collaboration with the Government of Tanzania to develop a strategy for the sustainability of the approach following the discontinuation of TEHIP assistance.

4.4. Prospects

The presentations can be grouped under two themes:

- the WHO 5-year plan of action of support for IMCI implementation in the African Region
- Statements by partners (UNICEF, USAID/SARA, ODA)

4.4.1. The WHO/AFRO 5-Year Plan of Action For IMCI implementation in the African Region

4.4.1.1. The development of a 5-year plan of action was considered necessary in the context of a poor understanding and inadequate knowledge of IMCI, poor quality of care delivered by health workers at the first level health facilities.

The main objective of the 5-year plan of action is to improve the quality of care provided to children under 5 years of age at the first level health facilities.

The IMCI implementation at country-level will be progressive, from 20% in 1997, to 60% in Y2001. In the selected districts in countries implementing IMCI, the training of frontline health workers will be increased progressively from 15% of facilities training 100% of personnel managing children under 5 years in the first year of implementation, to 100% of health facilities by the year 2001.

The following strategies will be employed: the promotion of sustainable activities; national and sub-regional capacity building and their judicious utilization; strengthening of WHO/Regional capacity, improvement of collaboration with partners, and promotion of operational research activities.

The implementation of IMCI requires countries to take certain measures and steps of which the key ones are: the ownership of the approach, adaptation of the generic materials, national capacity building, the development of facility support services such as essential drugs, provision of a budget line for IMCI in the country budget, and the introduction of IMCI into preservice medical and paramedical institutions.

4.4.1.2. Very good discussions followed this presentation emphasising the following points:

- priority research topics on IMCI
- the level of introduction of IMCI in training schools
- the necessity for a previsit to assess the important aspects necessary for IMCI implementation

4.4.2 Prospects

Several presentations were made on prospects.

4.4.2.1. WHO/AFRO

For WHO/AFRO, CDD/ARI activities to be continued and promoted until IMCI implementation covers all countries, in order to continue to reduce childhood mortality.

4.4.2.2. Partners

The various partners - UNICEF, USAID/SARA, ODA - expressed their support and solidarity for IMCI implementation at regional and country level having clearly defined their goals and objectives.

4.4.3. Plenary Discussions

The plenary discussions were devoted to two concerns raised by participants namely: the quality of training and follow-up, and the quality of the training of trainers and facilitators.

4.4.3.1. The follow-up of trained health workers is critical for the improvement of the quality of training. This visit strengthens the quality of training, it bridges the gap between the training and the routine supervision. It should be planned, budgeted for and implemented 4 to 6 weeks after the training preferably along with the trainers, and using simple and relevant tool.

4.4.3.2. The Training of Trainers and Facilitators

Several models of training of facilitators drawn from the experiences of Zambia, Tanzania were presented and discussed during the session.

Some pertinent recommendations were made in the light of the discussions and concrete proposals concerning the duration of training were made: WHO will provide further guidance to countries on this issue.

5. Recommendations

5.1. Improvement of IMCI Implementation

5.1.1. Actions by countries:

- Countries should take ownership of IMCI through the provision of a budget line by the government as well as the WHO country office.
- Health Sector Reforms process going on in many countries should be seen as an opportunity to introduce IMCI in the Minimum Package to be implemented at the district-level

5.1.2. Action by countries, WHO and Partners:

- Ensure the strengthening of facility support services in order to obtain optimal IMCI implementation (organization of patient flow at health facilities, improvement of referral services, supervision, provision and distribution of drugs including the pre-referral drugs for IMCI, and improvement of IEC in IMCI).
- National managers of programmes related to IMCI implementation should be invited to various national, intercountry and regional IMCI meetings, subject to the availability of funds.

5.1.3. Action by countries and partners:

- Partners should continue to support activities for the control of diarrhoeal diseases and acute respiratory infections in countries and provinces that have not started IMCI implementation, in order to ensure at a later date an efficient and effective introduction of the approach.

5.1.4. Action by WHO:

- WHO should encourage countries to systematically implement IMCI within the framework of the Health sector Reforms.
- WHO should develop and make available to countries, specific guidelines on how IMCI could be implemented in the context of Health Sector Reforms.
- WHO should develop in the nearest future a guide for the training on facilitation techniques, including guidance on the course agenda.

- WHO to accelerate the process for the development of strategies for the introduction of IMCI in preservice medical and paramedical institutions.

5.2. Revision of the common approach for IMCI implementation

5.2.1. Action by countries, WHO and partners:

- Preliminary visit should be included as the first step for the introduction of IMCI in order to allow national authorities appreciate the implications of the implementation of this approach and take appropriate decisions.
- Consensus meeting should be as a necessary step after the adaptation of generic materials and before the commencement of training.

5.3. WHO 5-Year Plan of action to support IMCI Implementation in the Countries of the African Region

5.3.1. The 5-year plan of action as presented by WHO was well received and supported by countries and partners.

6. Conclusion

IMCI implementation in the African Region has experienced significant progress in the last 12 months. Countries have enjoyed support from WHO and various interested partners. Countries recognise the approach as a major tool for reducing childhood mortality. Consequently, they have demonstrated a significant degree of political commitment to the approach, although greater financial commitment will be required for country ownership of the process.

There has been a major effort at regional and national capacity building, but this will need to be strengthened in order to meet the increasing demand from countries.

Initial results of the performance of trained health workers are encouraging. Additional efforts and advocacy are required in order to improve facility support services which will help to further improve health worker performance.

As more experience is acquired, further guidance will be required from WHO in future to enhance implementation at country level.

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SECOND REGIONAL MEETING ON THE IMPLEMENTATION
OF THE INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI) IN AFRICA

DEUXIEME REUNION REGIONALE SUR LA MISE EN OEUVRE DE LA PRISE
EN CHARGE INTEGREE DES MALADIES DE L'ENFANT (PCIME) EN AFRIQUE

LISTE DES PARTICIPANTS/LIST OF PARTICIPANTS

NOMS & PRENOMS	PAYS	TITRE	ADRESSE	TEL.	FAX
Dr Sarmoye Cisse	Mali	MPN/OMS/Mali	Bureau de la Représentation B.P. 49	(223) 22-37-14	(223) 22-46-83
Dr S. M. Diakite-Diallo	Mali	Responsable LMD/IRA/Nutrition	Div. Santé familiale et communautaire B.P. 99	(223) 22-45-26	(223) 23 29 36
Madima Ba/Sangare	Mali	Médecin Chef de la Division Santé familiale et communautaire	B.P. E 1149	(223) 22 45 26	(223) 23 29 36
Dr Frank Matingu Mueke	Nigeria	Medical Officer, CDR	WHO Office P.O. Box 2152	861504	234 1 2694903
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Dr Garba Yaou Darey	Niger	Directeur de la Santé familiale	Ministère de la Santé publique B.P. 623 Niamey	227 72 36 00 Poste 3309	227 73 45 70 (227)72 24 24
Dr Elhadj Sani Zagui	Niger	Coordonnateur LMD	Ministère de la Santé publique B.P. 623 Niamey	72 36 00	(227) 72 24 24
Dr Colette Geslin	Niger	Country Adviser <i>BASICS</i>	B.P. 10577, Niamey	72 36 00 P.3576	(227) 72 24 24
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NOMS & PRENOMS	PAYS	TITRE	ADRESSE	TEL.	FAX
Dr Mary Peggy Shilalurey-Ngoma	Zambia	Medical Officer DPC IMCI Focal Point WHO	P.O. Box 32346 WHO Lusaka Zambia	260-1 221318 223251-3	(260-1) 223309 (260-1) 223210
Dr Elwyn Mwika Chomba	Zambia	Chairperson IMCI Advisory Committee	P.O. Box 31210, Lusaka Zambia	260-1 291607	

**DEUXIEME REUNION REGIONALE SUR LA MISE EN OEUVRE DE LA PRISE
EN CHARGE INTEGREE DES MALADIES DE L'ENFANT (PCIME) EN AFRIQUE**

SECRETARIAT

NOMS & PRENOMS	PAYS	TITRE	ADRESSE	TEL.	FAX
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Dr Manlan	OMS/AFRO	HRH, Regional Adviser	B.P. 6 Brazzaville	(242) 83 93 23	(222) 83 94 00
Ms A. Konde	OMS/AFRO	HRN, Regional Adviser	B.P. 6 Brazzaville	(242) 83 93 22	(242) 83 94 00
Dr M. Mathey-Boo	OMS/AFRO	IRM, Regional Adviser	B.P. 6 Brazzaville	(242) 83 93 13	(242) 83 94 00
Dr L. Sanwogou	OMS/AFRO	HED, Regional Adviser	B.P. 6 Brazzaville	(242) 83 93 36	(242) 83 94 00
Dr A. B. Ntabona	OMS/AFRO	FHP a.i., Regional Adviser	B.P. 6 Brazzaville	(242) 83 91 12	(242) 83 94 00
Dr M. Chisale	OMS/AFRO	EDP, Regional Adviser	B.P. 6 Brazzaville	(242) 83 93 40	(242) 83 94 00
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**SECOND REGIONAL MEETING ON THE IMPLEMENTATION OF INTEGRATED MANAGEMENT
OF CHILDHOOD ILLNESS (IMCI) IN AFRICA**

LIST OF PARTNERS

NOMS & PRENOMS	PAYS	TITRE	ADRESSE	TEL.	FAX
Mr Dennis Carol	Washington	USAID			
Dr Paultre P. Desrosiers	Washington	Technical Officer	BASICS 1600 Wilson BLVD	(703) 312 6856	(703) 312 6900
Dr Mutombo wa Mutombo	Sénégal	Child Survival Regional Advisor	BASICS Project BLD EST X 2, Rue Pointe, Dakar	(221) 25 3047 (221) 24 46 04	(221) 24 24 78
Dr Vincent Orinda	New York	Senior Adviser, Child Health	UNICEF 3, United Nations Plaza New York, NY 10017 USA	(1) 212 326 7336	(1) 212 326 7059
Dr Suzanne Prysor-Jones	U.S.A.	SARA Project Director	AED. 1255 23rd St NW Washington DC 20037	(1) 202 884 8812	(1) 202 884 8701 Sprysor AED Org.
Dr A. Robb	England	Overseas Development Administration	O.D.A. Victoria Street London		
Dr Bob Pond	U.S.A.	Technical Officer	BASICS Project U.S.A.	(703) 312 6800	(703) 312 6900

APPENDIX C

UPDATE OF THE WHO/AFRO AND BASICS WORKPLAN

IMCI IN WEST AFRICA

REGIONAL OBJECTIVE

To build regional capacity for IMCI implementation and to improve the quality of child care services

OVERALL ANTICIPATED RESULTS

- 1 Countries will have been assessed for IMCI feasibility and will have begun implementation
- 2 IMCI tools adapted to countries in the region
- 3 Cadre of regional consultants trained in IMCI in Niger
- 4 Quality of care assessed

STAGES OF PROCESS

- | | |
|--|---|
| <ol style="list-style-type: none"> 1 Initial visit to the country 2 Orientation Workshop 3 Development of a training plan 4 Adaptation of training materials 5 Reproduction of adapted materials 6 Selection and procurement of essential drugs 7 Baseline Study 8 Master Training 11 days | <ol style="list-style-type: none"> 9 Training of Trainers (5 days) 10 Training of First line health workers (11days) 11 Follow-up and evaluation 12 Replanification |
|--|---|

OPERATIONAL TARGETS FY 97

STAGES	REGIONAL	BUKINA FASO	COTE D'IVOIRE	MALI	NIGER	SENEGAL	TOGO	CONGO/BRAZZA	COMMENTS
1	Completed	N/A	BASICS 25 - 31 Jan 97	WHO Completed	WHO Completed	N/A	BASICS 4 - 7 March		
2	Q1	N/A	12 - 16 May 97	12 - 14 March	completed	27 - 29 Jan 97	10 - 12 April 97	Q1 (TBD) Regional	WHO/AFRO
3	BASICS Q2	N/A	BASICS TBD	BASICS 10 - 14 March	BASICS Q 2 (TBD)	BASICS TBD	BASICS June - July 97	Q2 TBD	
4	N/A	N/A	TBD	7 - 25 May	TBD	TBD	TBD	TBD	
5	Q2	N/A	TBD	November	TBD	TBD	TBD	N/A	
6	BASICS Q2	N/A	BASICS 12 - 16 May 97	BASICS	BASICS 10 - 14 Mar 97	BASICS 27 - 29 Jan 97	BASICS 19 - 23 May 97	BASICS Regional TBD	
7	Q2	N/A	TBD	TBD	TBD	TBD	TBD	TBD	

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IMCI IN WEST AFRICA

OPERATIONAL TARGETS FY 97									
STAGES	REGIONAL	BUKINA FASO	COTE D'IVOIRE	MALI	NIGER	SENEGAL	TOGO	CONGO/BRAZZA	COMMENTS
8	N/A	N/A	BASICS TBD	BASICS Jan/Feb 98	BASICS TBD	Completed	TBD	N/A	
9	N/A	N/A	BASICS 3 - 7 Feb. 97	BASICS Feb 98	BASICS Completed *	Completed	BASICS TBD	N/A	
10	Q2 (TBD)	BASICS/WHO 3 participants	BASICS 3 participants	WHO 3 participants	WHO 3 participants	BASICS 3 participants	BASICS 3 participants	N/A	
11	Q2 (TBD)	BASICS/WHO 2 participants	BASICS 2 participants	WHO 2 participants	WHO 2 participants	BASICS 2 participants	BASICS 2 participants	N/A	
12	N/A	N/A	TBD	TBD	TBD	TBD	TBD	N/A	
13	N/A	N/A	TBD	TBD	TBD	TBD	TBD	N/A	
14	N/A	N/A	TBD (98)	TBD (98)	TBD (98)	TBD (98)	TBD (98)	N/A	
CDD/ARI Assess	N/A	TBD	Completed	Completed	Completed	TBD	TBD	N/A	
Planning/ review of CDD/ARI	N/A	10 - 15 Feb. 97	Completed	Completed	Completed	Completed	TBD	N/A	
CDD/ARI TOT	N/A	TBD	TBD	TBD	TBD	N/A	TBD	WHO	
S-regional Orientation meeting	Q1 TBD	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
IMCI Adaptation training	Q2 TBD	N/A	Participants	Participants	Participants	Participants	Participants	N/A	

AFRO - MEMORANDUM

From : ^{Ko} Dr A. Kaboré
Conseiller régional chargé de la lutte
Our Ref.: contre les maladies diarrhéiques
pour le Directeur régional

To: Dr Adama Koné Date: 11 mars 1997
BASICS Dakar
s/c WR/Sénégal

Our Ref.: D3/48/1
A4/48/1

Originator Subject: COMMENTAIRE SUR VOTRE
RAPPORT DE LA REUNION
CONJOINTE DU MOIS DE
DECEMBRE 1996

Nous vous remercions pour votre mémorandum du 3 janvier 1997 par lequel vous transmettez le rapport sur la réunion de planification tenue en décembre 1996.

Nous nous excusons pour le temps mis pour vous répondre.

Nous souhaiterions faire quelques observations sur le contenu du document.

1. **Au chapitre Nutrition (page 4)**

Le cours régional de formation des nutritionnistes est effectivement prévu pour mai 1997. Il s'agit cependant d'une activité régionale BASICS. L'OMS étudiera la possibilité d'y contribuer ou participer et non prendre le rôle prépondérant en organisant le cours.

Par ailleurs, il était convenu que BASICS transmette le module "Food Box adaptation" à tous les partenaires pour information et commentaires.

Nous pensons qu'il y a une certaine confusion quant à l'organisation de cours de formation de nutritionnistes en adaptation. Pour AFRO, la formation en adaptation n'est pas conçue pour la nutrition uniquement, mais pour l'adaptation du matériel générique OMS/UNICEF aux conditions du pays. Par conséquent, nous ne voyons pas comment l'OMS pourra être responsable de l'activité que vous suggérez.

cc: Représentant de l'OMS, Sénégal

2. **Chapitre Information Education et Communication**

Nous nous réservons quant à l'organisation d'atelier en IEC sur la Prise en Charge Intégrée des Maladies de l'Enfant (PCIME). Nous sommes d'avis que pour le moment la PCIME s'occupe de la communication interpersonnelle. L'IEC est plus large que la communication interpersonnelle et nous ne croyons pas que pour le moment à l'étape actuelle de la mise en oeuvre de la PCIME, il est temps de mettre l'accent sur la l'IEC.

Nous sommes par ailleurs inquiet que des programmes radio IEC sur la PCIME soient planifiés quand nous savons que peu de pays ont mis en oeuvre cette approche. Nous pensons qu'on risque de créer des besoins sans pouvoir répondre.

3. **Chapitre SMCI and CDD/ARI (page 5)**

Pour ce qui est du "Régional Interagency Coordinating Committee" (RICC) nous voudrions avoir plus d'informations sur ses objectifs et ses cibles avant de pouvoir nous prononcer sur cette structure.

4. **Chapitre "Pre-service training"**

A la page 7 au quatrième tiret, nous pensons qu'il s'agit d'une évidence et nous ne voyons pas la nécessité de le mentionner dans ce document.

PCIME et LMD/IRA

En plus du résumé fait en page 6 et 7 du projet de rapport, nous suggérons que le rôle de chaque partenaire soit bien spécifié pour chaque pays comme convenu lors de la réunion:

Burkina Faso

- Une planification conjointe BASICS/OMS est prévue pour le premier trimestre 1997.
- BASICS supportera les activités CDD/ARI en fonction des résultats de la mission conjointe de planification du premier trimestre, en relation probablement avec les activités du POA 1997 de CDR/AFRO.

Togo

- Sur financement du fonds régional REDSO, BASICS supportera les activités de mise en oeuvre de la Prise en Charge Intégrée des Maladies de l'Enfant (PCIME).
- Des fonds complémentaires sont à rechercher par BASICS afin d'être en mesure de supporter également des activités CDD/ARI.



Côte d'Ivoire

- BASICS souhaiterait conduire son "Rapid Health Facility Assessment" (RHFA) en même temps que le "CDD Health Facility Survey" (HFS) programmé par la Côte d'Ivoire avec l'appui technique de CDR/AFRO pour le premier trimestre 1997. Il s'agira de voir comment introduire certaines questions du RHFA dans le protocole du CDD/HFS de l'OMS.
- BASICS (Dr Adama Koné) participera à l'atelier national MeDed du 20 au 27 janvier 1997.
- BASICS n'est pas sûr de son implication dans la mise en oeuvre des activités CDD/ARI.

Mali

- BASICS envisage apporter son appui technique uniquement aux activités de mise en oeuvre de la PCIME et LMD/IRA telles que programmées par CDR/AFRO.

Niger

- BASICS envisage apporter son appui technique uniquement aux activités de mise en oeuvre de la PCIME et LMD/IRA telles que programmées par CDR/AFRO.

APPENDIX D

**LIST OF THE PARTICIPANTS IN THE
SECOND IMCI ORIENTATION WORKSHOP IN BAMAKO, MALI**

List of the Participant in the Second IMCI Orientation Workshop in, Bamako, Mali

Groupe I (Politiques et directives)

Prof. Toumani Sidibé, Hopital Gabriel Touré
Dr. Mahamadou Thera, Mopti
Dr. Djankiné Kayantao, Hopital Point G.
Dr. Sékou Koita, Mopti
Dr. Sibiri Camara, EIPC
Dr. Kagnassy Dado Sy, SFC Dvision

Groupe II (Médicaments et Financement)

Dr. T.S. Musinde, WHO/AFRO
Dr. Safiatou Coulibaly, Hopital Gabriel Touré
Dr. Marie Claire Dao, Bamako Commune V
Dr. Sidy Diallo, CNI (PEV)
Dr. Anne Ringuede, Pop/Council
Mme. Fanta Coulibaly, SFC Division
Dr. S. Diakité Boré, DRS/Koulikoro

Groupe III (Gestion/Coordination)

Dr. Sarmoye Cisse, MPN/WHO
Dr. Sira Mama Diakité, SFC Division
Dr. Hadizatou Traoré, Hopital Gabriel Touré
Dr. Oumar Maïga, DRS/Mopti
Dr. Seydou Diarra, CSR/Djenné
Dr. Ouologueme
Ms. Fatima Maïga, CNIEC

Groupe IV (Formation et supervision)

Dr. Paultre P. Desrosiers, BASICS Technical Officer
Prof. Alhousséini Ag Mohamed, CHU Gabriel Touré
Dr. Georges Dakono, CS/Koulikoro
Dr. Fanta Diallo Touré, Groupe PIVOT
Dr. Issaka Niambelle, CPS
Dr. Aïssata Ba Sidibé, UNICEF
Ms. Karen Hawkins Reed, USAID TAACS Officer

**DEUXIEME SEMINAIRE D'ORIENTATION
" PCIME " AU MALI**

Bamako, 12 au 14 Mars 1997

1. Introduction

Le Mali a organisé le séminaire d'orientation sur la PCIME. en juillet 1996. A la fin de ce séminaire le Gouvernement et ses partenaires au développement sanitaire ont confirmé leur volonté de mettre en oeuvre cette stratégie. Un groupe de travail a ensuite été créé.

Il a la responsabilité de mener l'étape suivante : l'adaptation du matériel générique de formation. En vue de démarrer cette étape, la Division de la Santé Familiale a décidé d'organiser ce second séminaire d'orientation qui se veut plus technique que politique.

2. Objectifs

Informers les participants sur :

- les bases du développement de la PCIME
- la procédure, les étapes et
- les implications de la mise en oeuvre.

* Proposer les solutions aux problèmes : qui peuvent avoir une incidence sur la mise en oeuvre de la PCIME.

* Faire le point de la mise en oeuvre de la PCIME au Mali

* Planifier la première année de la mise en oeuvre de la PCIME.

3. Résultats attendus

1. Les participants et les membres du groupe de travail auront été informés sur :

- les bases du développement de la PCIME
- la procédure, les étapes
- les implications de la mise en oeuvre.

2. Des solutions seront proposées aux problèmes identifiés.

3. Un plan d'action de la première année sera préparé avec détail sur l'adaptation.

4. Méthode de travail

La méthode de travail est constituée des présentations en plénière suivies de clarification et des travaux de groupe et discussions des résultats.

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5. Calendrier d'activités

<u>Jour et heure</u>	<u>Activités</u>	<u>Intervenant</u>	<u>Président(1) Rapporteurs(2)</u>
Jour 1 (12/03/97)			
9: 00	Cérémonie d'ouverture		Professeur Toum SIDIBE.
9: 30	Présentation des objectifs et méthode de travail.	DSFC	Madame COULIB
9: 45	PCIME : bases et procédure.	Dr. MUTSINDE	Madame KAGNA
10: 15	Clarifications et discussions		
10: 45	Pause-café		
11 00	PCIME : Implications , étapes de mise en oeuvre.	Dr. MUTSINDE	
11 :45	Clarification et discussions		
12: 30	Pause-déjeuner		
13: 30	Etat de mise en oeuvre de la PCIME au Mali : I. Réalisations à ce jour II. Leçons apprises des autres pays. Facteurs favorisants. III. Relation PMA et PCIME.	Dr. CISSE Dr. DIAKITE Dr. MUTSINDE	Dr. NIAMBELE, Président. Madame TOUR Dr. SIDIBE
14. 45	Introduction aux travaux de groupe sur les problèmes pouvant avoir de l'incidence sur la mise en oeuvre de la PCIME.	Dr. DESROSSER	
16: 00	Fin de la première journée.		

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Jour 2 (13/03/97)			
9: 00	Présentation des travaux de groupe. Identification des problèmes.		CPS
11 00	Pause-café		
11 :30	Travaux de groupe : choix des solutions et des recommandations aux besoins.		
12: 30	Pause (libre)		
13: 30	Travaux de groupe (suite)		
14. 00	Présentation des résultats		
16: 00	Fin de la deuxième journée.		

<u>Jour et heure</u>	<u>Activités</u>	<u>Intervenant</u>	<u>Président (1) Rapporteurs (2)</u>
Jour 3 14/03/97			
9:00	La planification de la première année : activités et ressources nécessaires.	Dr. MUTSINDE	Dr. Sidi DIALLO Dr. DIAKITE Sira Dr. OUOLOGUE
10:00	Clarifications et discussions		
10:15	Pause		
10:30	Travaux de groupe : inventaire des ressources disponibles.		
11:30	Présentation des travaux de groupe.		
12:30	Pause		
13:30	Elaboration du plan de la première année et recommandations pour assurer le succès de la mise en oeuvre.		
15:00	Adoption du plan et des recommandations		
15:30	Pause Cérémonie de Clôture.		
16:00	Présentation du plan d'action et des recommandations.	1 Représentant des Régions.	
	Clôture.-		

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