



SOUTIEN POUR
L'ANALYSE ET LA RECHERCHE
EN AFRIQUE

WHO/AFRO IMCI Task Force Meeting

Harare, Zimbabwe

June 22-25, 1999

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Period Covered

June 22 - 25, 1999

City and Country Visited

Harare, Zimbabwe

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Submitted to

AFR/SD

Date Prepared

19 October 1999

Date Submitted

30 October 1999

Summary Report

Drs Suzanne Prysor-Jones and Marc Debay attended the 1999 IMCI Task Force organized by WHO/AFRO in Harare. After 4 years of implementation support from WHO/AFRO, 28 countries are now at some stage of IMCI implementation (13 in introduction phase, 12 in early implementation phase, and 3 in expansion phase). The IMCI strategy has been included in national policies in 13 countries, as part of an official minimum package of activities and/or within health reform. Two countries (Uganda and Tanzania) are in the introductory phase of the household and community component of IMCI. IMCI has been included in 5 training schools in two countries (Tanzania and Ethiopia) and tutors have been trained in Uganda.

Results

Immunization services have improved and missed opportunities reduced. Studies have shown improvements in the quality of care: weighing of children increased from 5% to 80%, administration of first dose of drugs in the health facility rose from zero to 75%, appropriate counseling increased from 2% to 55%. Antibiotic use for cough or cold dropped from 45% to 10%, and appropriate case management rose from 5-7% to 80% immediately after training, dropping to 65% one year after training. Drug kits in some countries are lasting longer due to more rational use of drugs. Clearer records on childhood illness are being kept, and improved client satisfaction has been registered in response to health providers now undressing children for examinations, talking to caretakers and giving first doses of treatment. In Tanzania, very low health facility utilization rates increased by 20-40%.

The SARA Project is funded by the
U.S. Agency for International
Development (AFR / SD / HRD) and
operated by the
Academy for Educational Development
in collaboration with
Tulane University
JHPIEGO
Macro International
Morehouse School of Medicine
Porter/Novelli
Population Reference Bureau



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Pryor-Jones participated in a round-table discussion with various donor agencies and also in a separate meeting with AFR/SD and WHO/AFRO. Issues raised included only three countries have reached the expansion phase of IMCI, weak management capacity at decentralized levels is a problem, insufficient staff at AFRO and BASICS have caused some delays in country implementation, the need to document implementation issues and engage in advocacy for scaling up, need to present IMCI as an investment cost to donors such as the World Bank, need for a tool for IMCI planning/implementation at District level, need for IMCI to be part of discussions on health sector reform, need (for advocacy with the Bank) to show how IMCI affects "trigger" indicators, need to mobilize WHO and UNICEF Representatives as advocates for IMCI.

Indicators were suggested for monitoring IMCI implementation, and some next steps were laid out. For AFR/SD and SARA, these included following up with advocacy at the World Bank - including an advocacy brochure and possibly meeting with Task Managers in D C, following up with COPE and the linkage with AFRO, possibly reviewing experiences to date with supervision of IMCI, looking into dissemination mechanisms and how to facilitate the exchange of documents, tools, etc between countries, and assisting with developing a briefing package for component 3 consultants.

IMCI Task Force Meeting, Harare
June 22 - 25 1999
Suzanne Prysor-Jones Meeting Notes

4 Years of Implementation

Adopted strategy four years ago by WHO AFRO 17 countries in 98 now 28 countries in the region are implementing More now in the implementation phase
13 in introduction phase, 12 in early implementation phase, and 3 in expansion phase
The IMCI strategy has been included in 13 countries These have adopted IMCI as strategy by making it part of either the minimum package of activities or of health reform

Policies

Review and development of national policies on Essential Drugs Lists (EDL) nutrition, malaria, EPI, HMIS
Zambia and Uganda are changing laws about nurses and nurse aides (previously were non prescribers) Now legally able to prescribe

Consultants

in 1996-7 only 36 regional consultants (not including national experts and facilitators), in 1997 58, and 1999 85 being used across countries

Training

3000 health workers have been trained Trained workers are sharing knowledge and skills with untrained staff (peer training) Want to capitalize on this
150 students trained in 5 schools 72 tutors trained

Results

Immunization services have improved missed opportunities reduced
Quality of care weighing 80% as opposed to 5% first dose of drugs in facility now 75% before not at all, counseling 2% and now 55%, antibiotic use was 45% for cough or cold, now less than 10%, and correct case management 5 or 7% and now 80% able to manage cases appropriately (drops to 65% after one year and therefore refresher courses important)

Kits now last longer as more rational use of drugs

Clearer records are being kept

Improved client satisfaction health providers are undressing children, talking to caretakers and giving first doses of treatment

Health systems improvements in starting tasks among staff, revival or opening of ORT corners

Increased utilization rate from 20 to 40% recorded TEHIP

Innovative methods of improving referral

- Community component 2 countries in introductory phase Uganda has a strategy document and PRA Tanzania has done a KAP survey tool and study
- Zambia using CHWs to follow up cases that do not return

- Village Health days being used for IMCI outreach
- IMCI is promoting nets in TEHIP

Last years recommendations

- 1 On reducing the adaptation period exchange of materials between countries in same epidemiological blocks, inter sectoral collaboration for information gathering about food, fluids, etc
- 2 Document the cost of IMCI and see how to reduce costs spreadsheet developed to document costs and results shared in Arusha scale up meeting Guidelines developed to capture needs and costs of expansion (Arusha)
 - Introduction of IMCI in service training systems
 - Introduction into basic training institutions
 - Plans to include IMCI in District Health Team capacity building training course at WHO AFRO??
 - Peer training spontaneous training may reduce costs
- 3 Train consultants to support countries Niger training course and 5 in Tanzania Course Directors and Clinical Instructors trained by apprentice-ship
- 4 Basic training recommendation 73 tutors trained, 5 schools in 2 countries (Tanzania and Ethiopia)
- 5 Definition and development of community component Several meetings held, draft guidelines, strategy documents
- 6 Support priority operational research African Experts met in June Jan 99 generic protocols Referral system research started in Niger Tanzania and Uganda Compliance issues Organization of services (not started yet?)
 - Hopkins impact study on IMCI in Tanzania and Uganda AFRO priorities are part of the 10 identified at global level Gil Burnham and Stan Becker
- 7 Review and improve drug systems and rational drug use Meeting June 98 and in Geneva in October 98 and May 99 for global WG National EDP staff are members of IMCI WGs Reviews conducted in Tanzania, Zambia, Uganda
- 8 Evidence based district health plan support for Brochure Indicators
- 9 Improvement of severely ill and where referral not possible Using the annex on where referral is not possible using cost sharing funds to purchase 2nd line drugs (Tanzania and Uganda), Patients followed by CHWs in Tanzania and Zambia

Loco Costing too includes the adaptation process, training follow up, then inclusion in pre service training Groups went further in discussion needs and unit costs for implementation at District level

WHO / Geneva (Gottfried)

Research in case management Management of severe illness where referral is difficult meningitis, non severe pneumonia, dehydration, severe malnourished Reducing use of IV antibiotic cs for pneum Guidelines for serious infection or severe malnutrition at the referral level are being tested and finalized

- Impact of IMCI nutrition counseling (Brazil and Pakistan)
- Community based nutrition in India and Peru

- Zinc and breastfeeding to prevent diarrhoea and pneumonia
- Care seeking and compliance in Ghana Kenya Sudan Sri Lanka and Ecuador and Mexico
- Module on care for psycho social development being tested in Brazil
- Manual on community support systems and their use
- Training course for health workers on HIV and infant feeding,,field tested in Harare (good where already familiar with breastfeeding counseling)
- IMCI Planning guide now in working draft

Pre service Planning for paramedical 5 medical and 8 Paramedical in 7 countries in Africa (as well as Tanzania and Ethiopia?)

- Bolivia showed before and after less than 5 % checked for danger signs and more than 40% after training
- IMCI included in World Bank supported health project in 29 countries Gambia, Madagascar Mauritania, Uganda, and Tanzania
- Nepal data on some systems improvements, scales, ORT units, vaccines source of drinking water, sterilizer, mothers counseling cards

Country team proposals (7)

CHW materials in PAHO, Asea has basic health worker materials

New ways of training being explored by regional offices

As indicators,? for scaling up ? use at least 3 IMCI in service training courses conducted for first level health workers Included in at least 3 District development plans

Challenges include expanding range of conditions to be covered by IMCI e.g for neonatal period, dealing with areas of HIV high prevalence links with RBM resource mobilization, expanding coverage and scale without loss of quality

IMPACT Integrated Management of pregnancy and childhood ? new package of materials being developed

TEHIP

Graphs on reallocation of resource through District health Plans, based on burden of disease and plotting budget accordingly More for Malaria, IMCI less for Immunization and TB Malaria has 45% of deaths, 10% nutrition, 7% diarrhoea, and 7% ARI of children dying at home (83%), about 46% never came to health facilities

Burkina (Prof Tall) Dr Germain Traore at the DSF is responsible for follow up and maternal health program A meeting was held in Burkina following the Dakar conference, and have a plan for regional ateliers (3) Ouaga, Bobo, Ouayagiyia Problems of funding UNFPA program did not have anything as already have plan and budget, and not in there As want to disseminate the study first Issue of balkanization of country by donors

Zambia after first year, saw that District capacity a problem cost of training, need to have 50% of health workers in each facility trained Need more government commitment and support Now 17 Districts components 2 and 3 initiated but not developed fully yet Plan of action for expansion

Dr Lucille Imboua Le plaidoyer en Cote d Ivoire UNICEF and GTZ are helping with finances IMCI integrated into PMA 5 sub working groups with Professors of Pediatrics Pediatricians were important in the advocacy effort and getting the right people involved Pilot districts volunteered/requested to be the pilot areas 40k government (72%) and 16k (26%) from partners in first phase of adaptation, etc

Togo pediatricians are involved but this has not had the same effect they haven't been a very positive interest (?)

Tanzania Pre service training in blocks Medical school planned Research on % of children needing urgent referral, as part of what to do when referral not possible Initial data show that this is 8%? Need for a strong central team (working group, full time Coordinator) District ownership , plans, budgets, implementation capacity (problematic)

Uganda 18 months off early implementation (3 District to 20 Districts) District ownership a real issue as well as capacity

Nigeria on advocacy Done at all levels through orientation meetings, preliminary District visits Pediatric and Nursing Associations as well as NGOs were targeted for involvement

Pre Service Training (Dr Lulu)

Addresses the needs of the *private sector*, since many trainees go into this sector Low cost, sustainable

Uganda formed a pre service sub committee with MOH Training Division, Paediatrics, etc Sensitization workshop for tutors, previsits to schools and clinical sites and then training of some tutors and facilitation skills course

Options block, staggered or combined (staggered with synthesis bloc)
No materials for the synthesis block or for the staggered approach

Tanzania prioritized audience e.g pediatric nurses Clinical Officers, etc i.e people who will be prescribing Tanzania students will be very dispersed, so have to decentralize follow up visits In Gondar, visits were done during internship training If graduates don't know where are going, or going in areas where no IMCI This is a problem

(Al Abassi, Tony Musinde **Mali** Community component 1996 plus Djenne, Kolokani, Kolondieba and Bla have some experience with community outreach strategy IMCI component 1 and 2 is starting in Djenne, Bamako District, and Koulikoro WHO planning retreat in October or November Adama suggested that should take last day to do joint planning with UNICEF and BASICS Also idea of 3 day meeting to share experiences on community component)

Uganda has some data on reduction of costs of antibiotics post IMCI Influence of IMCI on drug system vit A, harmonization of donor achats, local depots established local buying of 2nd line drugs, revision of kit contents, etc

Prof Mukasa Makerere Operations Research AFRO Research Committee and steering

Committee (Gamatie, Timate, Wafula)

Criteria for AFRO priorities (common problem serious, amenable to remedy)

- Pre service training
- drug supply management
- referral system / care Protocol developed % needing referral, contribution of referral classifications (ARI or Diarrhea,, etc () % conforming to referral guidelines and obstacles Uganda Tanzania
- caretaker compliance Protocol developed Study factors influencing compliance to drug admin, feeding return to facility immediately, return for follow up
- organization of work at health facility Protocols Describe service delivery sequence Determine organizational factors which influence efficiency Tanzania Zambia Uganda
- Coordination with Geneva (same themes are common) Need to identify research teams now??
- Tanzania Health Users Trust Fund for District research needs

Gottfried 10 priority areas identified for Operations Research

(numbers refer to votes on priorities)

- 1 Health services utilization 30 use of traditional healers and drug seller , public private mix issues
- 2 Availability of drugs (29) what interventions for increasing availability at first level what cost, how far can IMCI improve availability
- 3 Alternative models of training (23) need more acceptable alternatives for other providers, etc pre service mechanisms
- 4 New adaptations of guidelines (22) other diseases or symptoms e g dengue, peri natal care, HIV AIDS
- 5 Referral pathways and services (22) to improve referral and increase rx options at first level where referral not possible
- 6 Linking community and health services (21) e g CHWs
- 7 Cost effectiveness of IMCI (21)
- 8 Feasibility of integrated supervision (20)
- 9 Impact of IMCI on care seeking behaviour(18) part of the multi country evaluation
- 10 Reinforcing and sustaining skills (16) through refresher courses supervision, etc

Process of protocol selection each region will now develop proposals and submit to a committee for selection of proposals and groups workshop in September in Alexandria for refinement of proposals

Multi country evaluation of IMCI impact on child health, nutrition and mortality, costs of implementation, etc 4 to 5 studies using different but compatible designs Look at coverage, outcomes and impact in phased way depending on phase of programs Prospective study 45 years Complementary studies may be needed on specific aspects Criteria for country selection will IMCI be implemented, high mortality levels, population size, political stability, regional distribution, diversity of epidemiology ad programs Tanzania Ifakara Health Research and Development Centre Uganda JHU USAID Bangladesh One site in Americas

Have indicators progress on the cost components Evaluation instruments partly developed
Resume Doyin

Recommendations

- Schools should be included in national task forces
- Components 2 and 3 should also have pre service interventions
- Local manufacturing to reduce costs and inter-country purchase
- IMCI should be present at drug issues discussion
- Use evidence based arguments (continue to do this) to influence drug availability at country level

OR

committee should involve implementing agents at sub national level to make sure that program needs are addressed

- IMCI Malaria collaboration
- The Bank Julie McLaughlin

Why is Bank interested in IMCI? Policy now

- improve HNP outcomes for the poor
- enhance performance of HNP services, secure sustainable financing
- Task Managers believe that IMCI is efficient and cost effective (see Dalys)
- Emphasis on quality and performance of health services

Evidence that IMCI prioritizes health outcomes for the poorest services target poorest 20%
table on priority diseases program benefits that accrue to that 20%

Part of essential package of health services

Allocative efficiency right proportionate distribution for greatest effect greater coverage of
IMCI does that

Explicit IMCI Gambia, Uganda, Zambia, Mali Tanzania, Madagascar Mauritania

SWAPs or SIPs in Africa is the trend and imply

- 1 Process of setting National priorities with participation of range of stakeholders and input from technical agencies (instead of donor defined priorities through tied financing)
- 2 Financiers assessment program (technical validity, efficiency, objectives capacity to implement, participation, etc)
- 3 Public budget, bilateral grants and Bank Credits disbursed against government defined program / budget

Audiences for advocacy

- SWAP Chief health Planer Financial Controller MOH Decision Makers
- Donor financed Projects bilaterals, WHO, UNICEF
- Decentralized budgeting District Decision Makers
- DCA Development Credit Agreement where one sees the whole picture lots of flexibility and government officials can affect allocations

Arguments Divide between investment and recurrent costs
IMCI has mostly investment costs don't load things with the essential health services costs
investments adaptation, materials, TOT training
recurrent refresher courses
Essential health services investment preservice Recurrent essential drugs supervision staff
Don't include this in the IMCI box
Roll BM is an objective and IMCI can market itself as a way to achieve IMCI
both demand systems strengthening
the bank looking at how to incorporate priority programs into Sector Programs and Health
reforms (Bank is interested in this)
Potential synergies similar demands to strengthen health system and critical technical linkages
in malaria affected countries in Africa
TEHIP importance of District planning budgeting, etc
EU and Scandinavians are only focusing on the Health Care System, HRD Drugs, planning and
budgeting

Recommendations where SARA contribution may be needed
WHO strategies to facilitate advocacy with decision makers (1 to institutionalize within
government priorities, 2 to have adequate resources)
Components 2 and 3 in pre-service

Special Meeting with Partners
Staff in central office
Documentation and pre-service
family and community
planning
evaluation plus technical Officer (Gene)

In countries have APOs and DROC Angola (need a technical person) Ethiopia and Nigeria
have person
Sub regional blocks W Africa Musinde, Horn with Onango, Southern, Liz Mason, Central
Africa Block does not have anyone and very slow implementation Probably need someone
1998 Achievements
Ghana (9) and CI (12 F and 1 Lusophone) orientation meetings Strong support from BASICS
and UNICEF
Annual meeting on review and planning of IMCI activities with regional and sub regional staff
Produced an annual plan of action for 1999
Adaptation guidelines revised for francophone countries Used for consultant training in Geneva
Documentation
IMCI Newsletters (quarterly) Editorial committee with AFRO and WHO country staff
Discussions begun on Advocacy materials
Prelim visits to 7 Gambia Kenya Angola Benin and those below
Orientation meetings in 4 (CI Kenya Malawi, Mozambique plus Zanzibar
9 country adaptation workshops

8 food and fluid studies
5 countries held consensus meetings
2000 health workers trained in 116 courses
Pre-service in 3 countries
Breastfeeding counseling course in 2 countries
Tanzania and Uganda national IMCI evaluation and monitoring
OR 10 experts from 10 countries are part of the IMCI Research Committee Referral
Caretaker compliance and Organization of work at health facilities Sites have been identified,
and activities started
28 out of 46 have started implementation, but still only 3 going to scale

Issues

Only 3 in expansion phase Internal constraints in countries human financial resources
1 Weak District capacity to take on IMCI training and supervision Over dependence on the
central level Small pool at central level is bottle neck 2 Uganda model of zonal training
teams collaborating with Malaria to have zonal teams (clinicians from regional hospitals) as
trainers plus a couple of supporting staff who work with Districts Is it sustainable as in
addition to own work and no special remuneration for it One recommendation is to
institutionalize this level of management but government has phased out the Provincial level
Need a vehicle etc

In Tanzania want to reviving Provincial role?? Going out from the hospitals?
Adama insufficient staff at AFRO and BASICS e.g we have delayed Mali Sub regional staff
are needed at AFRO and careful planning with AFRO and UNICEF Liz where health reforms
often regional level abolished and central level reduced Where there is a provincial level,
countries are moving quicker Malawi has just abolished this level and will be a real problem
Need to put this on higher level agendas document some of these issues?? Involve other
District staff at the beginning? Gottfried where imbedded into other projects, has done better,
e.g IBD project in Indonesia, So Donor support mobilized more easily

IMCI is not providing technical support for budgeting (investment vs recurrent) and
management issues Tanzania, have worked through the technical officer and she has helped
to plan roll out Ethiopia and Uganda would like such officers also and that would help
Alabassi SIPs and SWAPs are also taking a lot of energy (like NIDs) Need to infiltrate these
processes and use them rather than being blocked by them RBM will be same issue IMCI
should get in there and take some lead Sub regional level is key, e.g Mali and implementation
of BI, etc

Musinde Need tool for IMCI implementation at District level also do one year planning at
District level and this is not enough for mobilizing and advocacy How to plan IMCI as part of
district planning cf EPI, that has APOs and planning tools
Antoine supervision capacity problem and health sector reform linkage is problematic, we are
not involved

Julie Bank is looking for 12 trigger core indicators that will be linked with disbursement Get

into one of those and you will become important

? SARA could help document the management bottlenecks at central regional district levels
? Work with the W BANK for Mali and Senegal scaling up (Flavia)
Common plan of action with BASICS to be evaluated UNICEF wants joint assessment visits to strategise and plan
Flavia Help technical people to do advocacy within government Perhaps need a tool for that ?_SARA Also WRs and UNICEF bosses should do advocacy How can we get them to be advocates

2 Also NIDs have taken over energies and activities postponed Ethiopia, Madagascar, Niger and Mali were expected NIDs in all of these micro and macro planning (3 in a year)

3 Also financial aspects Districts have not always made provision missed planning cycles sometimes Need advocacy a year in advance for both national and other levels

Need to include denominators and monitor coverage, e.g. 2000 trained

Need management indicators

Need to Involve more partners A map of needs would be useful for talking to other partners

AFRO Plans for future 2000 2005

Speeding up implementation

Sept in Namibia 2000 Ministers meeting and want to present 5 year plan

Objectives capacity, sustainable implementation, partnerships, and OR

Priority Interventions consolidate and sustain capacity building, sustainable activities(pre service drugs), resource mobilization, building partnerships, promotion of research m and e, networking for information sharing

% countries implementing IMCI

% where is fully implemented in all selected districts

% where is implemented in at least one medical school

% where implemented in at least one paramedical training school

% children needing oral antibiotic and who are prescribed correctly

% children who need oral antimalarial and who are prescribed correctly

% children who need referral and who are effectively referred

No or operational research results used for improving the implementation of IMCI

Budget for 2000 2001

Capacity materials and training 1 7k (APOs NPOs

Improved health systems 354 (drugs, supervision, OR)

Strengthening Regional and sub regional capacity 4 754 (consultants, AFRO staff

Communities empowered to prevent an manate 264 (consultants, introduction in country, early implementation and expansion phase

Evidence 1 08k (meetings, docs)

Total 9 025k for the 2 years

Sources in the past 2 years Geneva 31% AFROPOC 22% USAID 22% DIFID 16% regular AFRO budget 7% Luxemb 6% Total 6 474k

12

DIFID have some funds for regional What is impact, what is value to money she needs that to argue for resources

Want an NPO in each of the 11 target countries DIFID supporting Nigeria one

Issue of motivation of community health workers review paper??

Advocacy tools for technical people within their governments

document management blockages

Printing of exercise module for pre service for sustainability of training materials

S Africa University of Natal about to introduce IMCI Nursing Association interested probably in staggered fashion in several schools (?)

NEXT STEPS

- RPM to work with AFRO to have a meeting with country drug management people and EDP/AFRO (?on the assessment tool, TA needs, etc) , which would give rise to a plan of action with RPM
 - Follow up needed with the Bank (Hope) ? SARA advocacy brochure might help possible meeting with task managers in D C about essential drugs etc They need to have the essential drug lists, etc
 - Follow up with COPE Suzanne to contact Julie Becker about budget and keeping in the loop re COPE exchanges with AFRO Ask Julie B to share evaluation protocols with AFRO
 - Supervision issues ? Possible need to review supervision experiences and issues to date
 - OR - look into mechanisms for dissemination
 - planning meeting with UNICEF
 - research mobilization Getting it into SWAPS (* consult with Kraushaar, Waters)
 - consultation on trends
 - exchanges of documents and how to organize that
 - briefing of consultants
- * Work with Remi to get together briefing materials for consultant orientation on PRA, planning, assessment tools, IMCI, communications, etc