

**USAID/DFID**

**Review of IMCI in the African Region**



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USAID, Bureau for Africa, Office of Sustainable Development  
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# **USAID/DFID Review of IMCI in the African Region August-September 2001**

## **Report**

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# Table of Contents

Background .....	1
Objectives .....	3
The mission .....	5
Findings and Conclusions.....	6
Progress in IMCI implementation.....	6
1. Global.....	6
2. Regional.....	9
3. Countries .....	12
Specific conclusions on implementation of IMCI.....	23
Monitoring and evaluation.....	28
Non-governmental organizations (NGOs).....	36
The private sector.....	37
Scaling up – conclusions based on the country findings .....	39
WHO and UNICEF regional support .....	43
Partnerships .....	44
Advocacy and fund raising.....	45
Recommendations .....	46
A. Recommendations to Funding Partners .....	46
B. Recommendations to WHO and UNICEF .....	47
C. Recommendations to Countries .....	49
Acknowledgements .....	50



## Background

Analysis of the state of children in Africa shows that, although progress in Africa has been slower than in other areas of the world, there have been improvements in both mortality and morbidity over the past forty years. In that time, infant and child mortality rates have fallen by a third. In many countries, over the past 20 years there has been a decline in some of the most important causes of mortality, particularly diarrhoeal disease and measles.

But these encouraging gains have been unevenly distributed among and within countries, and in the past 5 years the rate of decline has slowed, mainly as a result of an increase in the size of the population living in absolute poverty and the growing influence of the HIV/AIDS epidemic. The importance of poverty as an underlying cause is reflected in the prevalence of malnutrition in the under-fives, which is rising in many countries and overall for the region.

Child survival efforts during the 80s and 90s focused on specific causes of death, particularly diarrhoea, the immunisable childhood diseases and ARI. These programmes, particularly the first two, have been successful. In the early 1990s, WHO, UNICEF and their partners came to realise that sustaining and increasing the decline in mortality, particularly in Africa, would require an approach that took account of a wider range of causes of mortality and serious morbidity and increased the focus on children by national health authorities. The Integrated Management of Childhood Illness (IMCI) arose from this. As this report shows, IMCI has been introduced in the majority of countries in Africa, and considerable progress has been made.

IMCI, like any public health programme, will only achieve its potential impact when it covers its target population widely. Although progress is being made towards this, important obstacles have emerged and must be circumvented or overcome if IMCI is to fulfil its promise.

IMCI is an important weapon in the child health armoury in most countries in Africa. It is important that this weapon be developed and used as effectively as possible in the broad context of support to child health and development. This review was intended to provide information to enable countries and their partners to focus on the directions for the future for IMCI and other child health initiatives that will produce the best results in terms of reducing child mortality and serious morbidity.

Both USAID and DFID have invested significant resources during the past three years to contribute to achieving further reductions in infant and child mortality rates in Africa. USAID and DFID have provided

## **DFID/USAID Review of IMCI in the African Region**

funds to support the child health strategy adopted by UNICEF and WHO/AFRO in Africa at regional and country levels. Specifically, both donors have provided funds to WHO/AFRO to strengthen regional and country level planning, implementation, capacity building and the evaluation of child health programmes, including Roll Back Malaria (RBM).

In addition, USAID has provided UNICEF with funds to advance the global Household and Community Child Health agenda and the African regional child health initiatives, especially Community IMCI. Country level support has also been provided by USAID through UNICEF to six countries. DFID has supported child health country level activities in 9 countries. United Nations Foundation funds have been provided for community programmes in 4 countries.

In addition to reviewing Community IMCI, DFID had planned to conduct a general review of the progress in IMCI. It has been agreed that this review will satisfy both needs, i.e. conduct a general review of IMCI and have special focus on Community IMCI programmes.

The changes in child mortality rates - both falls and rises - and the development of new programmatic and systematic responses to child health development have turned a new light on IMCI. The recent expansion of the IMCI strategy into communities opens up new possibilities for sustainable health improvement and a way of bringing together health-related interventions from different programmes and sectors. It has become particularly important to be able to assess IMCI's potential contribution to the drive to improve care for children.

The review team was therefore asked to examine the available data on the outcome of IMCI implementation so far, to make an assessment of the procedures that are being put in place to monitor and evaluate activities from the community upwards and to recommend investment priorities, especially at country level and including government contributions, which will contribute to achieving reduction in infant and child mortality rates.

## Objectives

The objectives and tasks of the mission were as below.

**Objective 1:** *Assess progress made over the last 3 years in the development and implementation of IMCI, with particular emphasis on Community IMCI programmes at global, regional and country levels.*

### Tasks:

1. Review progress made at global level related to strategy development, description and articulation of the developed strategy, development and dissemination of clear guidelines and tools to help the implementation of the strategy.
2. Review the implementation of IMCI so far in the Region, giving special emphasis to the changes that have been brought about by the introduction of IMCI and the procedures that have been put in place to assess these changes.
3. Assess the adequacy of advocacy and fund raising efforts at global, regional and country levels.
4. Assess the level of coordination between community components for different child health programmes, e.g. IMCI, RBM, GAVI and nutrition, at global, regional and country levels.
5. Assess plans for monitoring and evaluating the impact of Community IMCI programmes and other IMCI activities.

**Objective 2:** *Undertake a "forward-looking" review and analysis of WHO/AFRO and UNICEF IMCI and HCCH programs supported by DFID and USAID, to examine partnerships that have been developed, e.g. IAWG and the Task Force Meeting. The role of NGOs will also be examined. Results of the review will guide WHO/AFRO, UNICEF, and countries, to strengthen partnerships and implementation of Community IMCI and other aspects of IMCI.*

### Tasks:

1. Assess the adequacy and effectiveness of established mechanisms to coordinate resources and efforts of different international partners at global, regional and country levels.
2. Assess the extent and effectiveness of including NGOs in Community IMCI and other IMCI activities.

## DFID/USAID Review of IMCI in the African Region

3. Assess mechanisms put in place to assure involvement of communities in Community IMCI at national and sub-national levels.

**Objective 3:** *In selected countries, review and analyse the process followed to introduce national and community child health strategies. Draw conclusions on common features that may make the process successful, assess the potential impact, identify opportunities for to scaling up of successful initiatives and suggest strategies for accelerating scaling up and mobilizing resources.*

### Tasks:

1. Review and assess the effectiveness of the process of engaging ministries of health, NGOs and community leaders at national and local levels in child health programs.
2. Draw conclusions on common features that make the introductory process if Community IMCI successful.
3. Assess the current strategies/plans for scaling up IMCI, including Community IMCI, beyond the initial implementation sites/districts and identify opportunities to accelerate the large-scale implementation.

**Objective 4:** *Recommend investment priorities, especially at country level and including government contributions, which will contribute to achieving reduction in infant and child mortality rates.*

### Tasks:

1. Based on the results of the above assessment suggest investment priorities for international donors and national governments to reduce under 5 mortality.
2. Recommend needed modifications to augment the impact of IMCI programmes
3. Recommend actions needed to strengthen the process of implementing IMCI, including Community IMCI, and strengthen collaboration between international partners
4. Recommend actions needed to accelerate scaling up of IMCI, including Community IMCI.

## The mission

### Mission members

Dr David Robinson, DFID consultant (team leader)  
Dr Dan Kaseje, UNICEF consultant  
Dr Suleiman Kimatta, UNICEF  
Dr Sylvia Meek, Malaria Consortium, DFID consultant  
Dr Tony Musinde, WHO  
Dr Clara Olaya, SARA/USAID consultant  
Dr Youssef Tawfik, SARA/USAID  
Dr Geoffrey Wandera, UNICEF/ESARO (joined the mission for the work in Uganda).

### Method of Work

The mission:

- Reviewed documents, including strategies, plans, records, reports and reviews from global, regional and country levels
- Visited the WHO African Regional Office (WHO/AFRO) and UNICEF East and Southern Africa Regional Office (UNICEF/ESARO), reviewed documents and held discussions with staff
- Visited three countries, Uganda, Malawi and Mali. In each country the mission:
  - Reviewed plans, reports and monitoring and evaluation data
  - Had discussions with staff of the health and other ministries
  - Visited two district health offices to discuss district plans and activities
  - Visited first level health facilities, observed and discussed the work of the staff
  - Visited villages and discussed community programmes
  - Had discussions with NGOs and other concerned bodies
  - Met representatives of DFID, USAID and other partners
  - Held a debriefing meeting for all those concerned.

### Timetable

August	
15/16	Team Leader visits UNICEF/ESARO
16/17	Team briefing and discussions on methodology for the review
18/24	Review of IMCI in Uganda
25	Mission divides – to Mali and Malawi

26/31	Reviews of Mali and Malawi Team reassembles in Harare
September 1/3	Compilation of data Meetings with WHO/AFRO staff
3	Debriefing of WHO and DFID, Harare

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## **FINDINGS AND CONCLUSIONS**

### **Progress in IMCI implementation**

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#### **1. GLOBAL**

##### ***Strategies***

WHO and UNICEF, with other partners, introduced IMCI in 1995. Originally, IMCI was a guideline and training course which was designed to improve the quality of care in the first level health facility. In its first two years it evolved into a broader strategy with three components: improving health worker skills, strengthening the health system and improving family and community health behaviour. This strategy was taken as the basis for support by partners for implementation by countries. The 1995 World Health Assembly adopted IMCI as a more cost-effective approach for child survival and development, and it was included in the WHO Ninth General Programme of Work (1996-2001).

The principles of the IMCI strategy have been widely accepted by countries and most of those that have adopted it have included IMCI in their health policies. The strategy has been the basis upon which global partnerships have been established, although there are some differences in approach among them, particularly as regards the community component.

Over the past two years the WHO Programme for Child and Adolescent Health and Development (CAH/WHO) has been working on a WHO strategy for child health. It is taking a broad life-cycle view of the child from birth to 19 years and invoking human rights as a basis for the strategy. IMCI is seen as an intervention to address specific

problems in the younger age groups, with potential benefits in terms of health and development at other ages.

The UNICEF strategy for IMCI is focused largely on the community component and takes the approach of rights-base programming. Although the emphasis is on the 16 selected focus behaviours, UNICEF sees IMCI against the background of Early Child Development, which should facilitate the inclusion of broader development issues in the planning with communities.

The mission found variations in views within WHO and UNICEF at regional and country level about the objectives and scope of Community IMCI. WHO seems to adhere more strongly than UNICEF to a definition which is based on the 16 focus behaviours and which is in reality an extension into the community of the other two IMCI components. UNICEF in practice appears to see Community IMCI more as an extension of Early Childhood Development, the links to the health facility being of lower priority. The same range of views is found among donors and partners in countries.

### ***Guidelines and tools***

Guidelines and tools for training have been developed and refined. Alternative approaches for in-service training have been explored, although almost all IMCI training outside Latin America (and all in Africa) currently uses a standard course lasting about 11 days. Pre-service training has been introduced for various cadres of health staff in a number of countries. Guidelines for case management at the first referral level facility are available.

Follow-up after training was introduced as an essential element of in-service training from the beginning. Standard tools for follow-up have been developed and modified to suit different country situations.

WHO/CAH recognises the crucial importance to the success of IMCI and other family health programmes of strengthening the health system. The Strategy aims to use the "needs" of IMCI in the health facility to stimulate the necessary changes in the health system. This information and advocacy role has been backed up by guidelines and tools for IMCI planning, improving the availability of the drugs essential for IMCI case management and strengthening the capacity of the district health system to manage severely ill children.

In principle, IMCI creates partnerships within the countries with programmes and institutions that have the capacity to make the necessary changes in the health system, using, *inter alia*, the tools that

## DFID/USAID Review of IMCI in the African Region

IMCI can provide. Experience suggests that these partners may often have more willingness than capacity, and that the major underlying weaknesses of the health system, including ineffective and incomplete decentralisation, human resource deficiencies, lack of management skills and inadequate logistics, may impede IMCI as much as they impede other programmes and strategies.

Since the introduction of IMCI there have been important changes in the environment in which it is implemented. In particular:

- there have been changes in planning and financing (such as the wider implementation of SWAPs);
- decentralisation has gathered pace;
- the private sector has grown in importance;
- NGOs have become more prominent as partners in implementation;
- Poverty Reduction Strategic Plans are being developed in many countries in Africa,
- there is a growing consideration of child rights as a basis for health care.

The basic tools for IMCI need to take account of these changes, and although WHO and UNICEF are working on some of the necessary tools, important gaps remain.

The family and community component has been developed at a slower pace than the other components. UNICEF has been the lead agency in its development, working with partners through the Interagency Working Group (IAWG) on Household and Community IMCI. The community IMCI strategy is based on enabling the community to address 16 “focus behaviours”, and a Participatory Rural Appraisal (PRA) tool for community dialogue has been developed. A stated central idea of the process is to build on the relevant community organisation and practices and to make full use of the health services available to the community. The principle has been followed of using experience from individual countries as the basis for the development of the generic tool. Uganda and Malawi are among the countries whose experience has been used.

The CORE group, with USAID support, has developed guidelines on “Reaching Communities for Child Health and Nutrition: NGO contribution to Community IMCI”. This has made a useful contribution to the search for valid methodology.

A Briefing Package for consultants is in late draft form. It is highly structured and gives detailed guidance on a series of steps for using the Community Dialogue approach to introduce the 16 Focus Behaviours (see below).

The early implementation of IMCI was monitored largely on process. At global level this was represented by “milestones” of the introduction process, a system which has the potential weakness that it depends on the universal acceptance of a standard approach to implementation of IMCI. In the past three years, WHO/CAH and its partners have developed tools for assessing the outcome of IMCI activities (the Multi-country Evaluation (MCE)) and for costing the introduction of IMCI. These have been tested and used in a small number of countries, including Uganda among those visited by the Mission. The results look encouraging and should eventually answer essential questions about the implementation of IMCI. The methodology is not yet adapted for use on the wider scale that would be needed to inform both national health authorities and their partners.

### ***Implementation***

A total of 86 states are now at some stage of implementation of IMCI. Of these, 16 are in the introductory phase, 49 are in early implementation and 21 are in the process of going to scale. Thirty-three countries have reported to WHO on the percentage of their districts in which there is some IMCI activity. Of these, 11 have IMCI activities in less than 10% of their districts, 8 have IMCI in at least part of 10% to 24% of districts, 7 in 25% to 49%, 4 in 50% to 74% and 3 (including Uganda) in 75% or more. This is not an indication of population coverage.

Other process data show that at least 60 countries have included IMCI as a part of their national health policy. About half that number have included IMCI in district planning, and about 35 countries have included the community component in their national IMCI strategies. Worldwide, more than 25,000 health workers at different levels have received training in IMCI case management. Follow-up has not been universal, but a number of countries have achieved high rates of follow-up, and the results from this follow-up show significant improvements in health worker performance.

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## **2. REGIONAL**

### ***Strategies***

The WHO African Regional Office has played an important part in shaping the global IMCI strategy. Its experience in supporting countries has been the basis for important developments in all three

## **DFID/USAID Review of IMCI in the African Region**

components. This has been facilitated by its programme of operations research related to IMCI. In 1995, the WHO/AFRO Policy Framework for Technical Cooperation with Member States confirmed IMCI as an appropriate for the Region. AFRO has formulated a Strategic Plan for 2000-2005, which emphasizes capacity building for sustainable development of IMCI at all levels of the health system and within the community. Partnerships with other programme areas such as Roll Back Malaria (RBM) are given priority.

UNICEF's East and Southern Africa Regional office has similarly been a focus for practical development of UNICEF's global strategies, particularly with regard to Community IMCI and Rights-based Programming.

### ***Guidelines and tools***

AFRO has adapted and/or developed training materials for in-service and pre-service training, including a six-day training course for senior health workers, which is currently under test. UNICEF has developed a tool for community baseline surveys and has developed and adapted PRA tools as the basis for implementation of Community IMCI. UNICEF/ESARO has prepared a "Resource Manual on Strategies and Implementation Steps for the Household and Community Component of IMCI". A briefing package for consultants on community IMCI is being developed jointly between WHO and UNICEF, based on African regional experience. Guidelines for the management of HIV/AIDS in IMCI are being developed, and AFRO is working on specific strategies for strengthening the health system for IMCI.

### ***Implementation***

IMCI has been introduced in Africa in 39 of the 46 countries of the WHO African Region plus Morocco, Egypt and Sudan. Of these countries, 12 are in the introductory phase, 21 (including Mali) are in the early implementation phase and 9 are in the process of expanding IMCI implementation to cover the whole country.

IMCI has been included as a part of national health policy in 28 countries, and it has been included into the district planning process in at least 15.

***Health worker skills.*** About 7000 workers of various types have been trained in IMCI case management, almost all with the 11-day course. Much of the training in the early phase has been dependent on external donor support, and in some countries this has continued.

Seventy percent of IMCI-trained health workers have been followed up at least once after training. Continuing reinforcement of IMCI through routine supervision is known to be problematical in many countries.

IMCI has been introduced into pre-service and undergraduate training for different levels of health workers in a number of countries in the region. At least 900 students have passed through such training. There are no data on the outcome of this, but it is assumed that even if pre-service training does not provide the intense focus on IMCI that the in-service training achieves, it should ensure that IMCI is absorbed as a basic skill. In most countries there is little or no extra cost involved in introducing IMCI into the curriculum and teaching. The severe constraints on recruitment of health workers that have been a part of structural adjustment in some countries threaten the effectiveness of this channel for IMCI skills development.

In some countries of Africa, as elsewhere, formal and informal private health care delivery is growing in significance. In Uganda, for example, 83% of first contacts for care-seeking outside the family have been shown to be with practitioners other than the government health facilities. Similar figures have been quoted for Nigeria. IMCI activities are largely focused on facilities that are within the public framework. The Regional strategy for involving the private sector depends mainly on "spillover" from in-service and pre-service training and the provision of materials. This may be neither sufficiently focused nor sufficiently controllable to achieve the IMCI goals of improved care (see section on "The private sector" below).

***Drug availability.*** Although drug availability is known to be difficult in some countries, 15 countries have adapted their essential drugs lists to include the drugs necessary for IMCI case management. A drug management assessment tool has been tried in two countries of the Region, Senegal and Uganda, and is available to be used in others. Revolving drugs funds, including the Bamako Initiative as used in Mali, are in use in several countries and appear to be useful in maintaining drugs supplies. There are worries about the effect on health service utilisation by the poorest families of introducing or maintaining cost recovery for drugs. For this and for more political reasons many countries are trying to sustain free services and drugs, at least for children.

The decisions on drugs supply do not rest with IMCI, but the drug needs for essential care for children must be given prominence in the debate to design or select the most appropriate mechanism for assuring drugs in different national circumstances. The development of Community IMCI can be an opportunity to stimulate decisions on drugs supplies in

the context of community participation in health service management (see comments below on Bamako Initiative).

**Referral care.** Ensuring referral care for children with severe illness is difficult in almost all countries of the Region. The WHO "Guidelines for care at the first-referral level" is available to the countries of the Region. Uganda is finalizing a referral care package that aims to improve care at the first referral level. Some countries are moving towards upgrading the skills of the first level health facility worker to manage these children, but difficulty with referral remains a serious constraint to the success of IMCI in reducing mortality.

Community IMCI is included in the IMCI plans of 16 countries in the Region. Active work is under way in 9. Six countries (Madagascar, Mali, Malawi, Nigeria, Tanzania and Zimbabwe) have received funds from the United Nations Foundation to implement Community IMCI. With technical support from UNICEF and WHO, baseline surveys have been conducted and PRA tools have been developed and adapted. Although the PRA principle remains constant, there seems to be a wide variation in the approaches taken in different countries, and the processes appear demanding on resources, considering the very large scale on which they must be used in the present strategy.

WHO and UNICEF have provided consultants to assist the planning and implementation of Community IMCI, and the two organisations are collaborating on the completion of a briefing package for consultants. The briefing package will need to maintain a flexible approach to take account of the many different community situations.

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### **3. COUNTRIES**

The three countries visited by the mission represent three stages in the implementation of IMCI, and there are important differences in their circumstances and the paths they have followed. This summary of findings will highlight important similarities and the lessons learned.

#### ***IMCI in national policy***

In all three countries IMCI has been adopted as a strategy within the national health plan. IMCI is also part of the minimum package of activities in each country. In both Malawi and Uganda IMCI has an important position in the national Poverty Reduction Strategic Plan, which will be partly funded from HIPC funds.

In Malawi and Mali, IMCI appears in national plans as a series of tasks rather than as a coherent programme of activities. The tasks are seen as being carried out by the health services in general or by existing programmes such as EPI, Child Health or Essential Drugs. This reflects IMCI's status as a strategy which in principle pervades the Ministry and informs and directs the actions of existing structures. It is to be implemented through the district health services as a function of the programmes at that level.

### ***Organisation and management of IMCI***

#### ***Uganda***

Uganda has designated IMCI as a programme within the Directorate of Child Health Services. The programme is staffed at the centre by two full-time officers, who are supported by staff funded by WHO and UNICEF. The programme has a government budget and has been successful in attracting bilateral funding for various projects. The assigned task of the MoH unit is to advocate for IMCI through the IMCI Task Force, to assist in policy formulation and to develop and adapt tools. In practice, the districts, which are responsible for implementation of IMCI, have limited human resources and capacity and the central IMCI unit carries a heavy load of supervision and support as well as organisation of training and follow-up. In addition the IMCI unit has responsibility for technical support to the recent introduction of Community IMCI, and the WHO-funded home-based fever treatment programme.

The IMCI Unit is highly effective and is the lynchpin of IMCI in Uganda. Its effectiveness means that rather than coordinating the relevant actions of partner programmes it tends to become responsible for them, thus increasing an already heavy load. With the present and foreseeable weakness of the District Health Management Teams, the unit can barely manage the present workload, let alone the increase inherent in scaling up. Zonal teams have been established to assist the central team and the districts but the sustainability of this arrangement is open to question.

#### ***Malawi***

In Malawi, at central level there is a small, part-time focal group consisting of two Ministry of Health staff and a WHO-funded National Programme Officer, which works under the Director of Child Health Services. Its task is to work with the national IMCI Task Force to

## **DFID/USAID Review of IMCI in the African Region**

promote the integrated strategy and to coordinate the work in different areas by the members of the Task Force. It also has responsibility for providing supervision and technical support to the district health teams in implementing IMCI activities, including training and follow up. Malawi has UNF funds for community IMCI, and the focal group and Task Force are responsible for coordinating this activity. The IMCI focal group has no budget line and must carry out all its functions from within the budget of related programmes.

### ***Mali***

The arrangement in Mali is very similar. IMCI is a strategy within the Reproductive Health Directorate. There is a single focal point who works part-time on IMCI, and a WHO-funded National Programme Officer. There is a national IMCI Working Group, which is not very active. However, there is consistency among the guidelines for IMCI, Nutrition and Malaria, and action is taken to avoid overlap in training activities.

There is no budget line for IMCI as such, but Government funds are channelled to IMCI activities carried out by existing child health programmes through the budget for the Minimum Package of Activities.

The responsibility for implementation rests with the district health teams, who are numerically adequate but lacking in the technical capacity for planning, monitoring and coordination.

The type of organisational structure that Malawi and Mali have evolved to deal with IMCI as a strategy has the potential advantage of promoting real collaboration with willing partners, but it seemed unlikely to the mission that the arrangement in either Malawi or Mali would be able to cope with scaling up much beyond the present number of districts, particularly as the managerial and financial capacity of the district health teams is low in both countries.

### ***Implementation of IMCI***

Almost all of the countries in the African region that are implementing IMCI, including all those visited by the mission, started with the first two components - improving the skills of health workers through training and strengthening the health system to enable the necessary drugs, supervision and referral. The third component, improving family and community health practices, was introduced later, after training was established. In most, but not all, instances community IMCI was

introduced into districts in which the other two components were already being implemented.

Community IMCI is being explicitly implemented in Uganda and Malawi. Both of these countries were sites for the development of the methodology that UNICEF and WHO are promoting for implementation throughout the region.

Although Mali has not yet started implementation of its Community IMCI plan, it has well-established community structures and procedures which are actively promoting community child health.

The principle of the methodology of introduction of Community IMCI is the use of "Community Dialogue". This is an adapted PRA process that, when used by UNICEF, focuses on specific health issues related to the 16 focus behaviours. The community and its supporting administrative and technical structures – the district administration, the health services and the local partners – are trained in the use of the methodology. The community then identifies its health problems and goes on to develop and implement a plan to address them. The plan should make full use of whatever health-related activities or organisations are already in place, so that Community IMCI assists in the coordination of community health activities rather than being a parallel community programme. The plan should include links with the local health facility to strengthen care seeking. The overall aim of the process is to increase the capacity of the community to address its own problems using its own resources or calling on those available in the district and elsewhere.

A baseline survey of the community's health status and needs enables changes to be determined by a simple monitoring process using a community-based information system. The community should be involved in, if not completely responsible for, monitoring the implementation of the plan.

The three countries visited present different perspectives on IMCI. The main findings from the three countries are summarised below:

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### ***Uganda***

Uganda was one of the first countries to introduce IMCI. It has become a highly innovative programme, developing approaches carefully tailored to the country's needs and circumstances as well materials and tools to address important issues and constraints.

## DFID/USAID Review of IMCI in the African Region

Uganda is in the expansion phase. Training and some elements of health service strengthening have been introduced into 43 of the 57 districts. Work on Community IMCI started in 1998 and it is being introduced on a limited scale so far. Eight districts have all three components under way.

So far about 50% of the necessary health workers have been trained, including staff from mission and other NGO health facilities. Training has taken place to some extent in more than 75% of the districts. The training programme was extended to take in 2000 Nursing Assistants who, despite their limited health training, are the *de facto* health providers in many first level health facilities. The programme has developed and is testing a six-day training course and packages for referral care and private practitioners. Reports from follow-up after training and the preliminary results of the MCE study in one district suggest that trained health workers have the skills to provide IMCI case management and that IMCI has improved the quality of care in their health facilities.

The training is the responsibility of the district health offices, but the districts are providing only 6% of the cost of the training and they have limited capacity to provide trainers or supervisors. Much of the training therefore involves central level staff and trainers.

The mission could not assess the training component in detail, but it noted that the health workers in the two health facilities in different districts visited were using IMCI case management selectively or not at all. The reasons given ranged from uncertainty about drugs supplies since the discontinuation of cost sharing (one health facility visited had effectively none of the IMCI drugs, which had resulted in a 90% decline in patient load) through lack of supervision from the sub-district to demotivation caused by unhappiness over allowances and pay. The MoH has now moved to ensure the payment of allowances.

Uganda has introduced IMCI into pre-service training for doctors and paramedical staff. The experiment has not yet been evaluated, but it is seen as a valuable way of increasing the profile of integrated care.

Until March 2001, Uganda was operating a cost-recovery scheme for drugs. This scheme had been an effective source of funds, and drugs supplies in health facilities had been reliable. Because of concerns that the cost might be a barrier to care for poor families, the scheme was discontinued. The effects of this are still being evaluated, with WHO support, but there are concerns that it may adversely affect the availability of IMCI drugs. The Ministry is taking steps to make funds available for drugs, which will be provided free of charge at all levels.

Uganda has recognised the difficulties of referral of severely ill children. As elsewhere the reasons for failure of referral range from socio-economic pressures through lack of transport to lack of confidence in the referral unit. The Programme has developed a referral package for the first referral level, and hopes to address some of the socio-economic causes through Community IMCI. More effective home care and early care seeking would reduce the need for referral, and the Home-based Treatment for Fever project may provide an answer to this for some areas. In the meanwhile, the majority of children requiring referral are not receiving it.

Uganda has stressed the importance of post-training follow up, and about 70% of trained health workers have received at least one follow-up visit. The long-term maintenance of these and other skills depends to a large extent on the continuous supervision and support that the health worker receives. This is the prime responsibility of the District and Subdistrict health offices. The mission was told, and observed, that these offices did not have the capacity to do this essential work, and that although efforts had been made to develop integrated checklists and procedures, supervision was carried out poorly and infrequently. The Programme is looking for ways of introducing internal supervision and problem solving, including the use of COPE, as a more feasible way of providing the necessary support for health workers.

**Community IMCI.** Uganda established a working group for community IMCI in 1998. The group agreed on principles and tailored available PRA guidelines to Ugandan needs. A communication strategy was developed with a focus on the 16 key behaviours. It included a users' manual of messages and actions, counselling cards and IEC materials.

An NGO steering committee was set up with support from BASICS to facilitate communication. Guidelines and tools were developed for baseline surveys and for planning at district level and in the community.

Activities have started in 8 districts, with different partners taking the lead, including UNICEF, a number of NGOs and the World Bank Early Child Development project.

The mission visited two districts. UNICEF was supporting the activities in one, while an NGO, Africare, was supporting the other. The main observations and conclusions follow:

- The UNICEF-supported district followed the UNICEF PRA guidelines. District level staff were trained in PRA techniques, followed by staff from each of the local council levels in a cascade. Finally, selected community volunteers (CORPS) were trained and they carried out a community assessment and were helped to prepare

## DFID/USAID Review of IMCI in the African Region

a community plan. The process, which is very effective, is demanding of time and human resources and may not be repeatable on a large scale, particularly if central programme staff must be involved in each district.

- The close link between the local councils and the community in carrying out their plan situates the health plan within the development programme for the district, which will be important for sustainability.
- The issues given priority in both districts - water supply, latrines and immunisation - required provision of materials and services rather than behaviour change. The results have been very good so far but a more measured approach may be needed for some of the 16 focus behaviours.
- The UNICEF process in Uganda is dependent on voluntary work, which, as elsewhere, raises questions of how to sustain the willingness of the volunteers.
- The process in the Africare project was more top down, with workers in each village paid by the project. Sustainability must be a concern.
- The Africare programme was built on an existing community water programme. The UNICEF programme seemed to take less account of existing community activities.
- In one district the community leaders expressed the desire to broaden the programme beyond the confines of health to include issues of education and agriculture.
- In both districts the local government health facilities had been left out of the process. In the Africare project, because the government health facilities are not easily accessible, care seeking was being channelled to private health care providers rather than the government health facility. In the other, the health facility was nearby, but had still not been involved. In effect, this community activity is separated from the other components of IMCI, which is a waste of opportunities both of taking advantage of improvements in the health facility that IMCI can produce and of strengthening the health facility's functions by closer linkage with the community. The health facilities have the unfulfilled potential to provide outreach care beyond routine immunisation, as well as follow up of cases and support to community education programmes.

## *Malawi*

Malawi started implementation of IMCI in 1997. After a prolonged adaptation process, training started in 4 of the 27 districts in 1999, with a target of training 60 to 80% of all health workers providing care for children. A pre-expansion review in 2000 led to plans for expansion to a further 7 districts. Work has started in five of these, no funds being available for the other two.

So far, 394 health workers have been trained in IMCI case management in 18 courses from the 9 districts. This includes some staff from mission health facilities. The total trained probably represents about 25% of the requirement, but the human resources data are not clear. The Government has provided no funds for the training, all the costs having been met by UNICEF and USAID. The average cost of training has been US\$12000 to \$14000 per course for 16 to 18 participants. Most trainees have received at least one post-training follow-up, but there has been little integration of IMCI supervision into the district supervision.

The mission's limited observation of trained health workers showed that they were using IMCI very selectively, sometimes reserving the full assessment for children who are thought to be particularly ill. There was a serious shortage of staff, which had resulted in the full or part-time closure of first level facilities in some districts. The main reasons for this were competition from mission facilities, which can pay better salaries, and losses from HIV/AIDS. There is limited formal or informal private care in the rural areas, and closure of a health facility is therefore a serious problem for the community it serves.

Drugs are provided free in the health facility in most parts of Malawi, and the supplies are in general reliable, although there are problems of "leakage". Revolving drug funds have been established with UNICEF support in some communities and are apparently working well. Other schemes are under way or planned for community-based care, including a free service provided in the name of the President and a UNICEF-supported project which will provide basic care through specially trained Health Surveillance Assistants (see below).

Referral has been a problem in Malawi. Attempts to solve this have included radio/telephone links with all first level health facilities. These are useful for many things. Each district has been provided with one or more ambulances, which are sent to pick up emergencies from health facilities. Many of the ambulances are now out of order, and the ambulance service has to give priority to the most dangerously ill people, who are often women with difficulties in labour. Referral for

the potential 7 to 10% of children who have pink IMCI classifications therefore remains problematical. The mission saw an example of practical, and effective, management of such cases using the resources of the first level health facility. In the absence of any other means of managing severely ill children this may be the best option for Malawi.

Supervision is universally weak because of the lack of transport. The radio links open up the possibility of providing health facility staff with regular contact and advice, but they are not often used in this way.

Malawi recognises the health service problems as a barrier to the development of specific care packages, including IMCI. There is a plan for decentralisation which aims to build the capacity of the districts over the next 10 years, by the end of which time they will be able to assume full responsibility for planning and implementing health care. It is difficult to see how the quality of operation of programmes, such as IMCI, which depend heavily on the health facilities, can be maintained in the meanwhile.

**Community IMCI.** The community component (ECSGD/IMCI) has been built on the base of the existing Early Child Survival, Growth and Development project (ECSGD). Malawi received US\$3.4 million for this component from UNF, and it is being given priority. Work on ECSGD/IMCI started in 2000. A national multi-sectoral task force on community IMCI was established with concerned ministries, including Health, Gender, Education, Agriculture and Community Development and NGOs.

Following the development and adaptation of the community dialogue tool by a consultant, the process started in 20 to 60 selected pilot villages in each of five districts with a baseline and community assessment. The mission visited villages in two districts. The same process had been used in both. The main observations and conclusions follow:

- Intersectoral coordination was commendably close and effective.
- Health Surveillance Assistants (HSAs) and extension workers from the other concerned Ministries were trained in Community Dialogue. The initial assessment and planning in villages was used as a part of that training, which is in future planned to last 15 days for each group. Trainers are from the district and the centre. This is a very heavy commitment and is unlikely to be sustainable even on a district-wide scale.

- Community-based organisations concerned with health issues in the villages were involved in the planning.
- The planning followed priorities set by the community, and included latrines, malaria (especially the need for bed nets) and the need for locally available treatment for fever and other common conditions. HIV was a major concern for which the communities sought guidance.
- The communities were obviously enthusiastic and involved at this early stage. It should be noted, however, that the topics being addressed were in the main straightforward and were more focused on provision – nets, drugs, and latrine buildings – than on behaviour change.
- The District Health Team had been very active in procuring and distributing bed nets at subsidised prices. They had been working with PSI in Blantyre and were exploring the possibility of importing nets directly from Tanzania.
- The early results of the community programme have been good. Latrines have been built and the use of bed nets has increased markedly.
- The 16 focus behaviours will be phased in through the community dialogue process as appropriate.
- The sustainable success of the HSAs and extension workers as facilitators of the community activities will be dependent on supervision and support. There are no funds for this, and their supervisors are already immobilized because their bicycles are broken. Attention to the health system infrastructure will be essential to the success of this programme.
- As in Uganda, the local government health facilities had not been involved at all in the planning or implementation of the community activities. This was particularly surprising because the HSA supervisors operate from the health centres and the HSAs themselves visit and work in the health centres from time to time.
- A joint communication strategy is being prepared under the aegis of the Task Force.

## *Mali*

Mali started implementing IMCI in 1996, but delays were caused by the lack of French-language guidelines and training did not start until 1998. The country is in the early implementation phase, with four districts partially covered with IMCI training. The mission was told by the focal point and the National IMCI Working Group that they had found the WHO approach to implementing IMCI heavy and demanding. It may be noted that this was at a time when a large number of countries were starting work with IMCI and WHO/AFRO was experiencing difficulties meeting the demands for technical support to countries.

A total of 81 workers have been trained, at an average cost of about US\$800 per trainee. The total includes some NGO health workers. A substantial proportion of the trainees have been followed up. There are no data on their performance, but the mission found that because of the shortage of staff and the heavy workload the health workers were only using their IMCI skills partially.

Although there are no hard data, the mission learned that a large proportion of sick children are taken first to care from the informal private sector. The national IMCI strategy does not take these practitioners into account.

Mali, with support from UNICEF, has developed well-organised drug revolving funds which not only provide funds for the purchase of essential drugs in the community and at first level health facilities but also fund in part the health facilities themselves, including salaries for staff. This system, the Bamako Initiative, creates a close working relationship between the community and its health facility. This can promote better utilisation and higher quality of care.

There were no data on referral care or supervision.

**Community IMCI.** Mali has a long tradition of community health activities, including the Bamako initiative, and there is a range of child survival programmes operating at village level. These include the UNICEF Village Approach, EPI outreach and a literacy programme which has been used to attract health workers.

Implementation of Community IMCI *per se* has not yet started. Mali has participated in the regional workshop in IMCI, and a plan has been prepared. The plan is heavy in equipment purchase and gives little consideration to the community level activities already being offered by different child health programmes. The plan does not

include any introduction of community IMCI to other child health programmes and partners, including NGOs.

From discussion with potential partners, it appears that the strategic and operational relationship of Community IMCI to the community activities included in other child health programs is not clear. From the strategic aspect, it is not clear whether the strategy aims to increase the communities' use of the local health facilities or to empower families to take care of their children's health at home. From the operational aspect, it is not clear how Community IMCI will be built on the community activities already in place.

At the central level, the Centre national pour l'information, l'éducation, et la communication de la santé has the technical capacity to prepare and use information materials and it is involved in the production of materials with Save the Children. At the district level, it seems that the district health teams know how to spread health messages but their capacity is limited when it comes to developing a cohesive communication strategy. The mass media are used but not according to a clear strategy.

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### ***Specific conclusions on implementation of IMCI***

- Because the three components have been introduced sequentially, the relationships between them have not been fully worked out, particularly with regard to the nature and requirements of the community component. Ideally, IMCI should be planned and implemented as a complete strategy within the framework of the existing child health system and taking advantage of whatever facilities and services, both public and private, there are available. It should strengthen what exists. The skills and capacity required at each level of the system, community, first level and referral level should be worked out in relation to the others, and the underlying infrastructural needs of all levels should be considered together.
- There is evidence from post-training follow-up that IMCI case management training leads to improvement in quality of clinical care. Follow-up has been assured to some extent by being linked to the training budget in some countries, but routine supervision remains weak, which may threaten the long-term maintenance of the health workers' skills.
- IMCI, as an overarching strategy, can play a useful role in highlighting health service issues relevant to its needs and lobbying for changes.

IMCI can also stimulate some technical changes. It has been successful in many countries in modifying essential drugs lists and in influencing the design of supervision tools. However, IMCI, like other specific health activities, cannot directly effect important changes in the operation of the health system. These include the day-to-day funding and management of supervision, the regular provision of drugs, and essential underlying issues such as filling the large gaps in human resources (particularly significant in Southern and Eastern Africa), and improving health worker motivation. Rather than being expected to solve these problems, IMCI needs to be planned in the context of vigorous health service development targeted on the needs identified for specific strategies and programmes, including IMCI.

- The mission's limited observations in three countries found that IMCI-trained health workers were using IMCI skills selectively or not at all. This may reflect the health system weaknesses found, including particularly shortage of manpower and deficiencies in drug supplies and supervision. This finding points up how vulnerable the efforts to improve health workers' skills are to the deficiencies of the health system, and calls into question the *de facto* priority often given to skills development over health service strengthening.
- IMCI training and health system strengthening in all countries in the Region is focused on the public sector, although in some countries a large and increasing proportion of first line care for women and children is provided by the private sector. Global, regional and national strategies and tools do not adequately address this issue or give guidance on how to take best advantage of this resource. The strategy adopted has relied mainly on "spillover" into the private sector from pre-service or in-service training, and most countries have so far made few systematic efforts to involve the private sector in IMCI.

### ***Community IMCI***

- Individual community projects visited by the mission show very encouraging success in terms of community involvement and outcome of the community's activities.
- Community IMCI offers a basis for addressing some of the important constraints facing IMCI and other child health programmes and strategies. Addressing the needs of the child at this level, rather than only at the health facility, can expose options for care, such as community based care which includes community drug supplies, action on care seeking for neonates, children and women, community action to facilitate referral, community support for families and children affected by HIV/AIDS, including community aspects of prevention of

MTCT and sustained support for children with malnutrition or chronic illness conditions (such as asthma).

These options must be seen within the context of the health system, making full use of the public health facilities and involving the private sector, not only for delivery of care but for supplies of drugs and bed nets and for social marketing in relation to the health objectives of IMCI. Community health action for IMCI will require institutional support for supervision, drug supply and continuing education. By approaching these from a community perspective district health managers may be able to identify ways of achieving them with community support which are less demanding on scarce district resources.

- A variety of community dialogue approaches are being used. The experience so far is very limited, and it may be too early to draw definitive conclusions on the most appropriate methodology. Those responsible for each approach, even within the same country, do not always seem to be aware of the situation and outcome in other sites. This must be addressed if full advantage is to be taken of the experience available. The eventual information exchange and guidelines must bring together the best of the experience from the different sites, including those undertaken by NGOs.
- The Community IMCI projects that the mission observed all used some variation of the Community Dialogue procedure. The depth and extent to which this procedure needs to be applied will vary among communities. In some, probably unusual, situations, where there is little pre-existing structure or experience in the community it may be necessary to use the whole process. In other communities – perhaps the majority - a lighter approach may be adequate. The emphasis should be on a minimum approach to the introductory process.
- The processes for introduction of Community IMCI that the mission saw in Uganda and Malawi require heavy inputs of time, human resources and money. They have been a good way of starting off, but they will be difficult to replicate on a large scale. Although it is too early to start scaling up, experiments and trials of methods should give priority to considerations of large-scale sustainability.
- WHO and UNICEF are preparing a briefing package for consultants on the support to the introduction of Community IMCI. It appears to be very complete but it may too prescriptive for the wide variety of circumstances that consultants will meet. It is important that the package gives guidance on how to build on health structures and activities that are already in place in the community. The consultants should focus particularly on building national and local capacity to carry out community dialogue. A pool of suitably trained and

## DFID/USAID Review of IMCI in the African Region

experienced consultants will be needed to take this process forward in the Region.

- It appears that the strategic and operational relationship of Community IMCI to the community activities included in other child health programmes is not always understood. From the strategic aspect, it is not clear whether the strategy aims to increase the communities' use of the local health facilities or to empower families to take care of their children's health at home. From the operational aspect, it is not clear how Community IMCI will be built on the community activities already in place.
- Although some Community IMCI experiments are dependent on paid community agents, their effectiveness and sustainability depend on the community being fully in control of the decisions on issues to be addressed, actions to be taken and the monitoring process. The PRA and community dialogue processes being introduced appear to achieve these ends
- Linkage of community health activities to the local government system and the community development structures is essential for maximum effectiveness and sustainability. It is particularly important to ensure this for projects, such as those run by some NGOs, where funding may not be sustained in the longer term.
- The communications elements of the Community IMCI activities that the mission saw were either poorly coordinated efforts at different levels within the health system or sharply focused but limited NGO activities. The introduction of Community IMCI is a good opportunity for countries to develop a coordinated communication strategy involving the full range of partners, including the Press and the mass media. The strategy should be centred on women and children and make full use of the most suitable media. Radio was seen to be an effective way of achieving wider scale and impact in all the countries visited.
- In Malawi and Uganda the process of introduction of Community IMCI has not directly involved the first level health facility. This is an important deficiency. To be fully effective, Community IMCI must strengthen the link between the community and its local health facility. From the community side this will enable care seeking and provide access to counselling and advice, as well as immunisation and other preventive services. The health facility will be stimulated to improve the quality of care and to make better use of outreach. The improved linkage will be particularly important in the long term care of children with malnutrition and people, including children, with symptomatic HIV infection.

- The Bamako cost recovery system not only generates money to provide essential drugs and to support the health facility, but also involves the community in the management of the facilities, thereby increasing quality and utilisation of services. Lessons may be learned from this that can be applied to Community IMCI in countries in which this process is not in place.
- If the first level health facility is to play an effective role in support of community IMCI the health workers must have the necessary skills. These may include community mobilisation, the supervision of community health workers and support to families at home. Plans for community IMCI should involve the health facility staff and should include ways of ensuring that health workers have the necessary skills, transport and supplies
- The mission heard about projects to ensure that treatment for malaria and other major causes of mortality is available within the community. Provided this is associated with health workers or volunteers with appropriate skills and support it promises to make a major difference. The effect of the availability of home-based care on the utilisation and work of the first level health facility must be considered. The facility and its staff must be enabled to carry out the new tasks that may be needed, which may include the care of more severely ill children.

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### ***Home based care for fever***

Malaria is the single greatest cause of child death in many countries in Africa, and a programme of home treatment of fever is being introduced experimentally in Uganda (supported by WHO/TDR). Antimalarials and, in some places, cotrimoxazole will be provided within communities to enable families to provide early treatment for children with fever. This programme has the potential to reduce infant and child mortality. Its management will require effective action in the community by trained health agents, and Community IMCI can provide a good foundation for it. As with other community based health activities, the effect of this programme on the role of the health facility must be defined so that the community can have the best possible support.

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## **Monitoring and evaluation**

### **Overall progress in Monitoring and Evaluation**

The early implementation of IMCI in countries was monitored very largely on process. In the past three years indicators and tools have been introduced for measurement of effectiveness and impact, including the Multi-Country Evaluation, community situation analysis, health facility surveys and the use of a new costing tool. Information on outcome and effectiveness is still only available from a few countries and areas, but the methods appear to be useful and the early results show encouraging evidence from some countries of changes in health worker skills, improved quality of care in health facilities and improvement in caretaker satisfaction. There is some evidence of cost savings resulting from rational use of drugs. There are as yet no data on the impact of IMCI on infant and child mortality. Given the limited coverage of IMCI in most countries this is to be expected. Demographic and Health Surveys may give an indication of this when IMCI coverage is more extensive.

Outcome indicators have been developed, and some countries have set outcome and impact targets, including case fatality rates for target conditions. Data are being collected in some countries. Data are not sufficiently used at the different levels of the health system for quality control and action.

Following a recommendation in 2000 to develop outcome targets for aspects of IMCI in addition to malaria, which has the Abuja Summit outcome targets for 2005 and the global impact target for 2010, new goals and targets have been developed, which were to be launched at the postponed UN Special Session for Children in September 2001. The new goals and targets are shown below:

<b>Condition</b>	<b>Goals and Targets</b>
General (International Development Targets)	Reduction in infant and under-five mortality rates by at least one third (2010) and by two thirds (2015) Reduction in maternal mortality ratio by at least one third (2010) and by three quarters (2015)
Malnutrition	Reduction in under five child malnutrition by one third and in low birth weight by at least one third
Water and sanitation	Reduction in proportion of households without access to hygienic sanitation facilities and safe drinking water by at least one third

## DFID/USAID Review of IMCI in the African Region

Condition	Goals and Targets
Immunisation	<ul style="list-style-type: none"> <li>• Achieve 90% immunisation coverage nationally with at least 80% in every district</li> <li>• Reduce deaths due to measles by 50% by 2005</li> <li>• Eliminate maternal and neonatal tetanus by 2005</li> <li>• Certify by 2005 the global eradication of poliomyelitis</li> </ul>
HIV/AIDS	<ul style="list-style-type: none"> <li>• By 2005 reduce HIV prevalence by 25% among youths (15-24 years)</li> <li>• By 2010 reduce global HIV prevalence by 25%</li> <li>• By 2005 reduce proportion of infants infected with HIV by 20%; and by 50% by 2010</li> </ul>
Malaria	<ul style="list-style-type: none"> <li>• Reduce by 50% the burden of disease associated with Malaria</li> <li>• Ensure that at least 60% of all people at risk of malaria, especially children and women, are protected by sleeping under insecticide-treated mosquito nets</li> </ul>

Uganda had also set targets for diarrhoea and pneumonia.

Data on health service strengthening, except from post-training follow-up, are scarce. Follow-up data from several countries show that the availability of drugs and equipment can be improved by the implementation of IMCI in the district, particularly when follow-up and supervision can be achieved.

The routine HMIS may provide valuable data on case management and utilisation of facilities, but offers little of value for monitoring health system quality issues. Data on drugs, immunisation and other aspects may be available from other sources but seem not to be used regularly for IMCI monitoring.

The baseline surveys undertaken as a part of the development of community activities will enable changes in practices to be evaluated. The methodology is demanding in terms of expertise and funds and may be difficult to replicate. A guideline is available from WHO/UNICEF to assist countries in the use of the tool.

The community-based information systems and the Multi-Country Evaluation (in Uganda and Tanzania in the African region) can in principle measure changes in mortality at the community level. HMIS is not a useful source of community information, but may detect changes in utilisation of health facilities arising from changes in care seeking.

### ***Procedures for monitoring and evaluation***

As IMCI is still a new approach there is great demand for evidence of its effectiveness. WHO, UNICEF and countries have made substantial efforts to collect data needed to monitor implementation and evaluate the approach. Some of the constraints to answering questions of effectiveness and cost-effectiveness are the difficulties of attributing changes in health worker and consumer behaviour and eventually health impact to IMCI alone when there are many influencing factors, such as access to drugs and staff motivation and availability which are specific to countries and time. The added value of the integrated approach is more difficult to measure than the impact of separate interventions.

Several approaches are being used to collect evidence, and are summarised below:

#### *Operational research*

- Simulations and modelling (estimating expected impact on mortality)
- Small-scale research to investigate implementation questions

#### *Evaluations*

- Health facility surveys in Tanzania, Uganda and South Africa
- Multi-country evaluation of IMCI, Tanzania and Uganda

#### *Documentation of experience*

- Results from follow-up visits to IMCI-trained health workers
- Collection and summary of data on facility utilisation
- Systematic tracking of activities and immediate outcomes

#### *Baseline surveys*

- Eritrea, Ghana, Malawi, Mozambique, Tanzania, Zambia, Zimbabwe

#### *First year and Annual reviews*

- First year reviews done in Botswana, Ethiopia, Madagascar, Malawi, Niger, South Africa, Tanzania, Uganda, Zambia

## Operational Research

AFRO has been supporting activities to develop an operational research agenda to meet countries needs and to develop local research capacity. In July 2000 the IMCI/AFRO Operational Research Committee held a two-week proposal development workshop in Midgard, Namibia, and in October 2000, IMCI/AFRO conducted a regional IMCI operations research conference in Lusaka, Zambia. Major recommendations and the Abstracts book are available.

An important initiative coordinated from WHO HQ is the IMCI Multicountry Evaluation (MCE). Two countries in Africa are involved with different components. Tanzania is undertaking a household survey, a health facility survey that includes costing data and mortality surveillance. Uganda has undertaken a baseline demographic and health survey of 14,000 households, and adaptation of costing instruments.

There is considerable scope for more institutions to become involved in operational research for IMCI, as there are many important unanswered questions.

## Results

### *Efficacy of interventions in the IMCI strategy*

Attempts have been made to collect evidence of the efficacy of the interventions within the IMCI strategy as summarised below:

<b>Intervention</b>	<b>Decline in Under 5 Mortality</b>	<b>Source</b>
ARI case management	35%	Sazawal & Black, 1992
ORT	4-14%	Oberle et al, 1990; Chen et al, 1983
Measles immunisation	20%	The Kasengo Project Team, 1981; Koenig, 1992
Weaning practices	2-12%	Ashworth & Feachem 1985

A range of different studies has been undertaken on the efficacy of case management for malaria, which depends very much on the delivery mechanism and the level of resistance to recommended antimalarials. The Multicountry Evaluation aims to evaluate the impact of the IMCI strategy on child health and mortality.

### ***Quality of care for children under five***

Health systems improvements have been documented as follows:

#### ***Policy changes***

By September 2001, according to AFRO data based on MOH reports:

- 37 countries have revised and updated their child health policies
- 17 countries have reviewed their essential drugs lists to include IMCI drugs
- 5 countries are prioritising purchase of IMCI drugs through cost-recovery, leading to enhanced availability

#### ***Organisation of facilities***

Some facility surveys noted that organisation of work in the health facility had improved with co-workers who had not had IMCI training being given responsibility for aspects of the process. However, this can only be done where sufficient staff are in-post, and the mission observed that staff shortages and heavy patient loads were major limiting factors.

#### ***Equipment and supplies***

In the South Africa Health Facility Survey (2001) 91% of all facilities had equipment and supplies to support full vaccination services. In Uganda (2000) 91% of facilities had weighing scales and vitamin A, and in Malawi (2000) all health facilities had a functioning ORT corner.

#### ***Drug availability***

In 2000, Zambia and Uganda used a DMCI assessment tool developed by Management Sciences for Health. In Zambia the tool was found useful in identifying problems related to drug availability. The tool has the potential to be used in obtaining baseline information which may be essential for planning. Observations during the current mission suggested that access to drugs was a major weakness limiting the benefits of IMCI.

#### ***Referral care***

- The results of a study on referral care conducted in Niger, Tanzania and Uganda have started to influence policy related to referral care.

- Uganda is in the process of finalising a Referral Care Package to improve conditions for children referred from first level health facilities.

### **Health worker skills**

Improvements in health worker skills have been documented with qualitative evidence of positive changes in health worker attitudes and skills. Striking quantitative data have been collected in the Multi-Country Evaluation in Tanzania, as shown in the following table:

*Comparison of IMCI and non-IMCI trained workers in Tanzania Health Facility Survey 2000*

<b>Activity</b>	<b>% IMCI-trained workers (N)</b>	<b>% non-IMCI trained workers (N)</b>	<b>P</b>
Child checked for 3 danger signs	96 (231)	6 (188)	Not def
Child checked for cough, diarrhoea, fever	95 (231)	36 (188)	<0.001
Weight checked against growth chart	77 (230)	5 (188)	<0.001
Child vaccination status checked	93 (229)	24 (188)	<0.001
Child <2y checked for feeding practice	86 (151)	0 (124)	Not def
Oral antibiotic/antimalarial prescribed correctly	73 (219)	35 (178)	<0.001
Child with pneumonia correctly treated	75 (59)	40 (52)	<0.01
Child with malaria correctly treated	88 (169)	25 (135)	<0.001
Child with anaemia correctly treated	44 (61)	4 (23)	<0.01

The following table shows that quality of care improves after training but that continued support is needed to maintain quality (Source: Uganda MOH follow-up data)

## DFID/USAID Review of IMCI in the African Region

IMCI task	End of IMCI course	Initial follow-up visit	Six months after initial follow-up visit
Correct assessment	86%	60%	59%
Correct classification	90%	81%	96%
Correct treatment	89%	83%	73%
Correct counselling	100%	91%	76%

### ***Improvements in careseeking behaviour***

The South African Health Facility Survey (2001) showed improvements in caretakers' knowledge on how to give ORS and oral antibiotics, and that a high percentage of caretakers knew at least two signs for seeking care. In Zimbabwe exclusive breastfeeding rates rose from 19% to 39% as a result of counselling, and in Madagascar the rate is 61%. This is promoted as the best feeding option for most infants irrespective of mothers' HIV status.

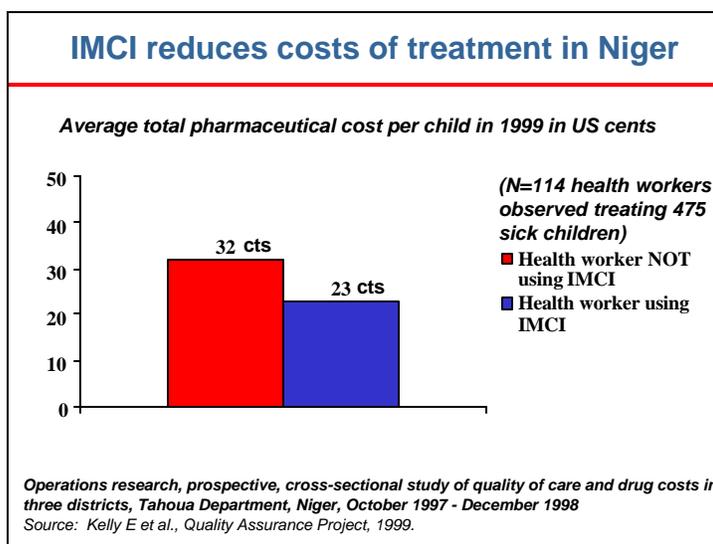
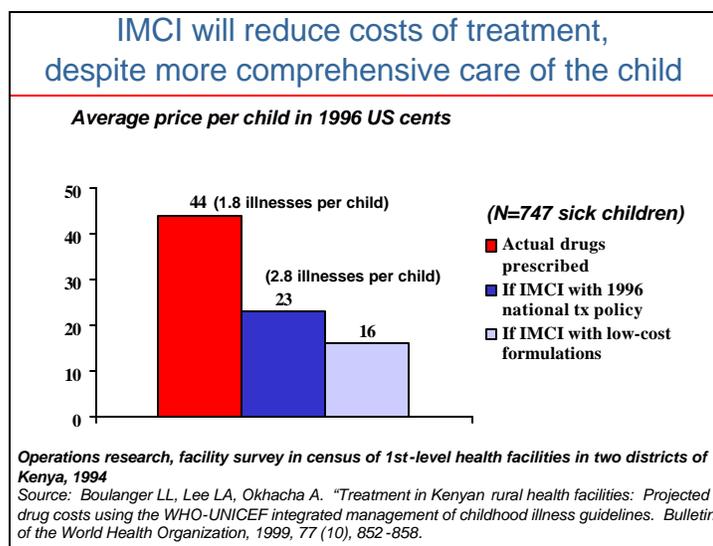
In Tanzania an increased attendance of under- fives was noted at facilities with IMCI (MOH documentation including HMIS data).

In Benin operational research in 2000 by the Centers for Disease Control, Atlanta, and the MOH showed that caretakers of ill children remembered 90% (n=23) of all messages immediately after an IMCI consultation and 82% (n=27) 24 hours later.

### ***Cost and cost-effectiveness***

There is much debate on the cost of the IMCI approach. The introduction process has been costly, although some of the initial costs are diminishing as international trainers can be replaced by national trainers and the process is institutionalised. The cost of the basic health worker course varies in different countries, depending on accommodation costs in locations providing access to a large enough range of conditions for practical work, but is significant ranging from US\$10,000 to US\$30,000 for courses of between 16 and 24 health workers. In several countries the ability to hold courses depends on *ad hoc* access to external funds. Some of the measures to improve efficiency, such as shortening courses and increased reliance on pre-service training should reduce costs further.

While IMCI is often quoted as being cost-effective in theory, since the separate interventions are themselves cost-effective, and savings are expected from integration, data are needed to determine this in areas where IMCI is used. Costing models have been developed, and are being used in Nigeria. The following two figures provide an indication of potential cost savings through more rational drug use in Kenya and some evidence of cost savings in Niger.



### ***Conclusions on Monitoring and evaluation***

- Most countries are limiting their targeting and monitoring to the process of implementation of IMCI rather than the outcome. Although the same can be said for most child health interventions, it is important for the future support of IMCI both within and outside countries that the outcome be measured.
- The tools that are currently available for monitoring the implementation process are in principle effective and have produced useful data when applied from the central level. It is essential that the tools be used fully at district level, which is where the information is most needed.
- Operations research and special studies such as MCE have shown the value of the new methods that are being developed for measuring outcome and effectiveness. Methods are needed that can feasibly be used by countries without large amounts of external financial and technical support, so that the information can be generated on a large scale and can guide the scaling up of IMCI.

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### **Non-governmental organizations (NGOs)**

International and larger national NGOs play an important part in development and implementation of IMCI in some countries, including the three visited by the mission. Individual NGOs or their coordinating bodies are members of the National IMCI Task Force in all the countries visited. Where NGO steering committees have been established, for example in Uganda with support from BASICS, they have proved to be a useful way of both improving coordination of NGOs and linking NGOs with policy makers at national level.

In many countries in the Region, not-for-profit private organisations, usually religious missions, provide a substantial proportion of the health care facilities. They usually work under the umbrella of the District or the MoH and participate in IMCI training. They are a potential resource for other aspects of IMCI but unlike other NGOs are rarely included as partners in IMCI planning and development. These organisations could provide ways to study different approaches to care and financing of care.

International and national NGOs also provide small-scale, often innovative, services. They have the advantage of having the resources to develop and test ideas which can be applied more widely. They often work close to communities. They are rarely able to sustain the services for long periods and it is important that they work in full coordination with district health authorities, do not raise expectations that cannot be fulfilled, and actively build the capacity of Community Based Organisations.

Some NGOs, particularly those, such as PSI, which are concerned with procurement and distribution, have strong links with the private sector. Collaboration with such NGOs at subnational/district level may open the way for the district management team to bring private sector resources to bear on the health care needs of their populations.

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## The private sector

The private health sector is becoming increasingly important in many countries in Africa. Data from Uganda, among other countries, show that a high proportion of families are seeking care for children from formal and informal workers in the private sector for common illness conditions, including those that are important causes of death. This probably occurs more in urban than rural areas and is less likely to be a major factor in very poor countries such as Malawi.

IMCI was conceived as a public sector intervention and has focused on this sector in all countries in Africa that are implementing it. Some countries have made attempts to influence practice in the formal private sector by inviting small numbers of such workers to participate in IMCI case management training courses. It is common for public sector workers to supplement their income with private practice, and it is hoped (but unfortunately by no means guaranteed) that they will use the same skills in private as they have been trained to do in public practice. In a few countries, including Uganda, there have been deliberate efforts to prepare and distribute information and training materials for private sector workers.

By introducing IMCI into the basic and undergraduate training of health workers some countries hope to provide a basis for good integrated practice for all workers, irrespective of whether they work in the public or private sectors. There are no data upon which to assess the success of this strategy.

## DFID/USAID Review of IMCI in the African Region

The non-formal sector, including particularly drug sellers, is of great significance, particularly where access to free public services is limited or where drugs are not available in the public facilities. The mission had no information on any attempts within the African region to address this part of the health sector. Previous attempts to involve these workers in the rational management of diarrhoea and ARI were not successful on a wide scale.

Effective action to improve the health care of children through IMCI or other strategies focusing on more than one condition will depend in the medium and long term on countries' success in engaging the private sector. Where national associations exist for physicians, nurses and pharmacists they may provide a valuable channel for education and accreditation in relation to child health practice. In their absence national health authorities must urgently seek other approaches.

Approaches to pharmacists and drug sellers may be most effectively made through wholesalers or other commercial linkages. Experience from some countries in Africa suggests that there may be widespread problems of counterfeit drugs and of inappropriate prescribing.

The private sector is also an essential partner in the provision of insecticide-treated bed nets. The mission found that NGOs could play an important role in fostering this partnership and acting as channels for distribution, particularly where there was an element of subsidy.

Linked to commercial supply of drugs and bed nets is the capacity of the private commercial sector for social marketing, which potentially has an important part to play in behaviour change for health in communities. Traditional district health management takes little account of the commercial sector, and the challenge will be to enable this linkage as a part of the essential strengthening of district capacity.

Effective planning for IMCI and its related actions on a wide scale will include engagement and coordination of the private sector in several areas, including quality control of drugs flowing through the private sector and of the prescribing by private sector health workers. The mission gained the impression that WHO, UNICEF and the national authorities were well aware of these issues but that there had been little progress towards defining effective ways of dealing with them.

Technical and funding partners should give emphasis to supporting countries in this area.

## Scaling up – conclusions based on the country findings

The overall conclusion of the review in relation to IMCI is that in the African region it has shown itself to have the potential to produce a large impact on child mortality, serious morbidity and development. It is most likely to achieve this effect if it is implemented as a part of a broad strategy for the health of women and children, benefiting from health service development and making full use of the resources of both the public and the private health sector. It is also clear that IMCI will only fulfil its promise if it can be implemented on a large scale.

The effectiveness of the first two components of the Strategy has been demonstrated on a smaller scale, in conditions where, particularly, it has been possible to achieve and sustain supervision and support to the health workers and the health facility.

The implementation processes so far used in all three countries have been expensive in terms of time, human resources and funds. In both Uganda and Malawi, maintenance of the present rate of expansion is absorbing almost all the available resources, particularly manpower, and some important issues pertaining to maintenance of quality remain unsolved. In particular, supervision is working well only where there are special inputs, and there are serious manpower shortages.

It should not be assumed that scaling up will consist of countries simply doing more of what they are doing now. Scaling up will be successful when the constraints which have become apparent during the early phases can be overcome. Some of the constraints may not be readily soluble, and countries and their partners may have to look for different ways of achieving the IMCI objectives.

Effective scaling up in the African situation calls for a strategic approach by countries and their technical and funding partners. The mission considered some issues in relation to this:

- Plans for scaling up revolve around the capacity of the implementing structures, usually the district, to undertake the necessary training, ensure the necessary strengthening of health systems and implement the community component. Decentralisation is proceeding in many countries, but the capacity of the districts often remains low. For example, in both Malawi and Uganda the districts are weak (particularly so in Malawi, where the decentralisation process is at early stage). Malawi's decentralisation plans extend over a decade and although they will eventually ensure the district capacity to undertake the necessary tasks, in the meanwhile there is a gap. Scaling up will

therefore put pressure on the central teams, which are also poorly equipped for the task. Uganda is forming Zonal Teams to strengthen the capacity of the central and district levels, but this must be seen as a short-term measure which cannot replace the districts eventually becoming capable of taking responsibility.

- The standard training in IMCI case management is effective. Some countries found it initially to be expensive (up to US\$800 per trained health worker), and demanding on the time of both trainees and trainers. Although the cost has fallen, these factors reduce the rate at which health workers can be trained. The targets set for training will make heavy demands when countries go to scale.

Some countries, including South Africa and Uganda, have experimented with alternative training courses, which might be more feasible on a large scale. Pre-service training is being introduced widely. While this should provide skills development at a lower cost and does help to define IMCI skills as basic, in some counties, such as Tanzania, many newly trained workers cannot be employed because of budgetary constraints.

Other options that might be considered include a more precise definition of the target for training and the skills required for workers to be effective, possibly including a focus on health facility in-charges, linking this with development of supervision skills so that the IMCI practices can be spread within the health facility.

- An important background to the weakness of many health programmes, including IMCI, is the overall deficiencies in human resources which are a major problem in many countries. Both numbers and motivation must be addressed.
- In many settings, IMCI will only achieve effective coverage if the planning for IMCI takes account of the private health sector. "Spillover" from public sector training and support is not likely to be an effective strategy in the long run. An active communication and quality improvement strategy, involving professional associations where they exist, will be required.

The private sector has an important part to play in the supply of drugs and insecticide treated bed nets as well as in provision of care. Planning at national and district level should include the private sector, and health authorities should explore ways of engaging drug providers and private sector health workers in planning for good quality care and for effective community health activities.

- Supervision and support of health workers and health facilities is essential if the required quality of care is to be achieved and maintained. Sustained, regular supervision has been achieved in few countries. Almost all countries face logistic problems in moving supervisory teams around. Partners, including NGOs, may be able to provide direct financial or logistic support to this. Alternatives to this type of direct supervision may also be sought. These might include the use of radio/telephone links (already available in Malawi but not used for supervision), training and support of facility in-charges as internal supervisors, or introduction of individual or group problem solving within the health facility – such as COPE. The countries and the bodies that support them should give at least as much priority to ensuring effective supervision as they do to training health workers.
- Community IMCI may change the way forward for IMCI by moving the focus from the health facility to the child in the family. Community action on disease prevention and early case management may change the load on the health facilities both quantitatively and qualitatively, particularly if medicines are made available in the community through drug revolving funds or other mechanisms. This must be reflected in the skills development and support for health workers at the first level health facility. At the same time, community IMCI may stimulate more effective action on a broad range of needs, including delivery and perinatal care, the management of symptomatic HIV, revival of routine immunizations and specific action to address psychosocial development of children, all of which require community participation.

For these reasons some countries may consider giving special emphasis to Community IMCI in planning to go to scale. This may be especially relevant in countries, like Mali, where community development strategies are already well established. The approach taken must explore the full range of channels – both public and private - open to the community to address its health problems.

The present procedures for introducing community IMCI are very demanding on resources and may be more complex and time-consuming than is needed for most communities. Considering the pivotal position of community IMCI it is essential that procedures be developed and supported that are simple, rapid and take account of the capacity and needs of different communities.

- A move towards the community for IMCI will not change the requirement for strong infrastructural support, usually from the districts. Community IMCI, as the mission saw it in two countries, will

require strong intersectoral capacity in the district for support to community planning and action. The health facilities must be able to supervise community health agents and strengthen the outreach facilities of the health centre. Community revolving drugs funds will require servicing and support. Districts will have to be able to implement communication strategies which bring together the community and the different levels of the district health and other sectors.

- Successful expansion will depend primarily on addressing the health care delivery and infrastructure needs, which hamper not only IMCI but also other essential care. The “needs” of IMCI relate also to other essential care. Essential drugs supply in the health facility affects every treatment programme; drugs supply in the community is especially relevant for community-based care of fever and pneumonia; referral is often most crucial for complications of delivery; effective supervision is a *sine qua non* of quality care in every field; close linkage between the trained health care deliverers, including the private sector, and the community will facilitate, *inter alia*, care seeking for the child who needs attention outside the home, routine immunisation and supplementation, nutrition support and the care of families affected by HIV.
- The priorities in supporting scaling up of IMCI should therefore be:
  - Strengthening essential components of the health system – particularly drugs supply, supervision and referral, targeting the changes on the operational needs of well defined strategies and programmes such as IMCI, RBM and Safe Motherhood
  - Acceleration of the building of the capacity of the district level to plan and manage health and development activities
  - Concomitant broad support to other programmes and strategies related to family health
  - Implementation of practical and affordable ways of introducing Community IMCI in a broad health development context, taking full advantage of all public and private channels
  - Exploring and implementing practical ways of utilizing the potential of the private health sector
  - Training of health workers at health facility and community level, using affordable training approaches

## WHO and UNICEF regional support

Both USAID and DFID have provided funds for building the capacity of WHO/AFRO and UNICEF/ESARO to support countries. AFRO now has a strong technical team in the Regional Office. In addition to providing technical support to all stages of implementation of IMCI, staff have been assigned to cover specific areas of work: documentation, advocacy, pre-service training, Community IMCI, infant feeding, research coordination and monitoring and evaluation. The AFRO team also supports 6 sub-regional officers (2 posts currently vacant) and 14 National Programme Officers who work within Ministries of Health. The AFRO team is well organised and capable of providing support across the full range of needs. The regional strategies and directions show evidence of increasing breadth, involving not only other WHO programmes but also becoming concerned with broader issues of health service development and private sector issues. An important gap in expertise is communications.

UNICEF has recently lost its regional IMCI officer. The replacement will be joined by a medical officer for IMCI whose focus will be Community IMCI in the context of rights-based programming. Community IMCI is becoming increasingly important and it needs to be broadly based. The UNICEF country offices have the expertise and capacity to provide the leadership for this in countries. WHO/AFRO is also playing an important support role for Community IMCI in countries. UNICEF regional offices do not have such a clearly defined role in support of country offices. They provide a certain amount of technical support, but they have limited capacity to guide country offices in terms of regional or global strategies. The support of the two regional offices for community IMCI could be further enhanced by planned close collaboration and support between them during this period when UNICEF is building its regional capacity.

Both Regional Offices have both played a part in shaping the global policies and strategies, and they have close working relationships with their Headquarters offices.

From discussions with the national IMCI staff and with UNICEF and WHO country offices in countries it is clear that both organisations are seen as providing effective support. WHO provided the initial technical support to introduction of IMCI in all three countries, and has continued to provide technical input in relation to the introduction and use of new materials and tools, such as the Multi-country evaluation and the pre-service training guidelines. UNICEF has provided essential financial and on-the-spot technical support to

training in all three countries and to the implementation of the Community Component. The two organisations complement each other well.

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## **Partnerships**

The major global partners for IMCI – WHO, UNICEF, World Bank, DFID, USAID and BASICS - along with some technical institutions, have developed a practical working relationship through formal or informal interagency working groups. These have been important in developing, *inter alia*, strategies for family and community care, the Multi-country Evaluation process and guidance on private/public collaboration in child health.

The most important operational partnership in the African Region is proving to be between IMCI and Roll Back Malaria (RBM). In the area of child health the objectives and approaches of the two strategies are very similar. Joint strategies for community action and for scaling up have been developed and the two Regional Task Forces were merged in 2000.

The combined Task Force has proved to be an effective way of bringing together a wide range of partners, including the major financial donors. It has proved useful for advocacy as well as coordination of planning between the major technical and funding partners.

Strong technical partnerships are developing between IMCI and other child-related programmes in AFRO, in particular with Vaccine Preventable Diseases (particularly surveillance, rejuvenation of routine immunisation) and with Nutrition (infant feeding and community nutrition programmes).

Coordination between the major partners at country level through IMCI Task Forces works well, but depends on the partners recognising mutual advantage. Where (as in Malawi) implementation of IMCI is the responsibility of various programmes rather than a central IMCI unit, the input of partners to the coordination process tends to be easier to sustain.

The detailed and well thought-out combined IMCI/RBM strategy at regional level for family and community activities is entirely appropriate. Evidence from the countries suggests that this can respond to a priority concern in the communities. In particular,

distribution of insecticide-treated bed nets was the first activity to be started in several of the communities, and the project for home-based treatment for fever will be managed through IMCI in Uganda.

The mission found some examples of good collaboration among different programmes and sectors in the development of IMCI in the countries visited, but IMCI is still seen by some programme managers as being a parallel child health programme rather than as an opportunity for coordination.

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## Advocacy and fund raising

WHO/AFRO has made a considerable effort in recent years to strengthen its advocacy for IMCI. It has produced good quality information materials which employ available hard data and has made effective use of the regional structures. The combined IMCI/RBM Regional Task Force has proved a valuable forum for advocacy. AFRO now has adequate capacity for advocacy, with one staff member specifically assigned to the task

There is a good understanding of IMCI among those programmes and organisations directly involved with IMCI, but the Strategy is not so clearly grasped by programmes and bodies not directly involved. The inclusion of the word "illness" in the title of the Strategy is seen by some as something of a stumbling block. The community component is less clearly understood, and it is important that advocacy activities and material clearly explain the three components and show how they operate as an inter-related whole. The use of documentary videos can be recommended.

Funds for IMCI in the Region obtained through WHO have grown substantially in the past two biennia. This is a reflection of effective information and contact with partners. It is also significant that an increasing number of countries (20 in the present biennium) have chosen to invest part of their WHO country budget in IMCI. However, external funds are provided by a small number of donors (3 in the present biennium). Both organizations need to expand the range of donors, including foundations and donors in the private sector. With the recognised importance of health sector development for the future expansion of IMCI, WHO/AFRO should be seeking partnership with donors with particular interests in health sector development.

## Recommendations

### A. Recommendations to Funding Partners

1. As a part of a broad approach to child health, IMCI has the potential to make a major contribution to the reduction in child mortality. The current IMCI activities in countries provide a good basis for the scaling up of implementation that is needed for this potential to be realised. Scaling up of IMCI will demand increased efficiency of implementation as well as intensified investment and broader involvement of implementing partners. Partners are encouraged to continue and increase their support to IMCI together with support to other family health interventions.
2. The major constraints to wide implementation of IMCI and other family health interventions relate to health service infrastructure and health service delivery elements, including the capacity of district management teams, human resources for health, drugs supplies, supervision and referral care. Action to address these constraints should be focused on the defined system requirements of IMCI and other specific family health interventions, and partners should support health authorities efforts to address these requirements through the most effective channels in individual countries.
3. An underlying constraint to effective health care delivery, including IMCI, is that national health systems are facing a critical shortage of human resources at all levels (caused mainly by retrenchment required by structural adjustment programmes, by HIV/AIDS losses or by losses to the private sector), and many staff are unmotivated due to a poor working environment. It is recommended that funding partners should support concerted national strategies for human resources strengthening across programmes, including and beyond IMCI. The strategies should include the use of private sector human resources.
4. Partners should support measures in the district to improve and sustain the quality of care in health facilities. This may include innovative approaches to support/supervision, such as radio communications, development and introduction of internal supervision and monitoring processes in health facilities and increasing the capacity of health worker to identify and solve problems in their own working environment (e.g. Client Oriented Provider Efficient, COPE).

5. A large proportion of childhood deaths occur at home, many of these children having had no contact with a health facility. Partners should give high priority to support for Community IMCI, including community-based treatment for fever and other conditions, which promises not only to improve family and community health and health behaviours but also to provide a stimulus to strengthening the first level health facility. The support to Community IMCI should promote the engagement of both private and public sector players in meeting the needs of the community, and should strengthen the capacity of the districts administrative systems to coordinate these inputs.
6. As a part of the support for Community IMCI, partners should invest in the development and implementation of comprehensive communications strategies in countries, which should focus on the mother/caretaker and use the full range of suitable, available channels. Resources will be needed to build the capacity of the appropriate Ministries and institutions in countries. Partners should also enable WHO/AFRO and UNICEF/ESARO to support countries and build local capacities in this field through the development of a pool of consultants.
7. Bilateral funding from donors needs to support both medium and long-term strategies for IMCI. In some cases national support may be through negotiation in sector wide planning. Partners should be aware that long-term investment will be required for sustained effect, and that this should dovetail with existing investments in community development.
8. Partners supporting IMCI through WHO and UNICEF are urged to continue their efforts to harmonise reporting requirements.

## **B. Recommendations to WHO and UNICEF**

WHO and UNICEF should support countries to achieve the recommendations to countries listed in the section below.

9. Drawing on the experience of those countries that are implementing it, WHO and UNICEF should develop a clear, practical description of what the community component of IMCI comprises, how it links with the other components, its relationship to other community health and development activities, and how it may be implemented in different situations, making full use of the full range of public and private sector resources available to the community.
10. IMCI will be able to make an impact on child mortality only if sustainable resources are made available for essential drugs and health systems support. WHO and UNICEF should assist countries to

- explore practical ways of ensuring drugs are accessible close to the community, such as cost sharing, drug revolving funds and community health funds with closer community involvement in the use and management of the health facilities. Suitable safeguards are essential for those who cannot contribute.
11. Health workers in facilities serving communities which are implementing Community IMCI may require new skills to enable them to support the community activities. These may include the use of outreach, community mobilisation on specific health issues and providing referral services and support for community health workers. WHO and UNICEF in collaboration with other partners such as NGOs may assist countries to develop and introduce the tools needed to provide the necessary skills.
  12. Continued investment is needed for improvement of health worker skills but successful expansion needs careful and urgent consideration of how to increase the efficiency of the process through cheaper and more sustainable methods, such as shorter courses, pre-service training and a greater emphasis on focused support/supervision. WHO and UNICEF should continue and accelerate work to develop alternative materials and tools for skills development and support countries in adapting them for their own use.
  13. The environment in which IMCI is implemented has changed significantly in the past five years with, in particular, the growing influence of the private health sector, increasing decentralisation, changes in planning and financing procedures (including SWAps), the development of poverty reduction strategic programmes, the growing awareness of child rights as a basis for health care development, and the increasing role of NGOs in health care. WHO and UNICEF should ensure that guidance is available to countries to enable them to plan and implement IMCI in the changing environment. This guidance, which should be drawn from country experience, may be through trained consultants, adaptation of existing guidelines or development of new ones if essential.
  14. The WHO and UNICEF regional offices should continue their efforts to advocate for IMCI among technical partners, national and international bodies. They should develop further “user-friendly” materials and use outcome data to focus on the effectiveness of the Strategy. Although there is wide recognition among partners and donors of the value of IMCI, few are providing support to WHO and UNICEF for its implementation. WHO and UNICEF should work to increase the number of supporting partners, including partners in the private sector.

**C. Recommendations to countries.**

15. The introduction and development of the IMCI Strategy in countries should take full account of existing programmes and activities for child health and, where appropriate, should strengthen or build on them. The structures needed to coordinate programmes to implement the IMCI strategy needs careful consideration at high government level.
16. Countries should plan IMCI activities at all levels, including the community, to achieve outcome and impact targets in addition to process targets. Information should be collected and used by the health system and community to monitor progress and to advocate to the population and to the technical and political systems for change.
17. Countries should move systematically to introduce Community IMCI. They should make use of well-tested tools for community dialogue from UNICEF and WHO and ensure that the process is sustainable from the start. Community IMCI should make use of and strengthen whatever community development structures, processes and channels for information and supply exist in the community. The introduction of Community IMCI should involve closely the first level health facility, and the function and capacity of the facility should be adapted to meet the changes in its work with the community.
18. The major constraints to scaling-up of IMCI and of the effective implementation of other family health interventions are in the health system. They must be addressed through deliberate action which focuses on the operational requirements of family health interventions, including IMCI. The constraints include shortages of staff, difficulties with drugs supplies, ineffective and irregular supervision and persistent problems with referral. These problems are often compounded by a weakness of district management. National health authorities must give priority to these issues as a prerequisites to success with IMCI and other health strategies and programmes
19. In most countries formal and informal private health care providers deliver a substantial proportion of first contact health care. National health authorities need to ensure the quality of this care and its complementarity with IMCI, so that it reinforces public sector efforts. Partners may support them in exploring and implementing suitable ways of doing this
20. NGOs are playing an important part in the development, implementation and scale-up of IMCI in countries, particularly the family and community activities. Countries, and partners who provide support to NGOs, should encourage their full involvement, but ensure that IMCI activities carried out by NGOs:

## **DFID/USAID Review of IMCI in the African Region**

- are consistent with national guidelines.
- are likely to be sustainable in the long term
- are fully coordinated under the leadership of the district technical and political system.
- use monitoring tools that are consistent with national procedures.
- increase the capacity of local structures and NGOs/CBOs

21. Given the role of non-profit organisations, such as religious institutions, which are responsible for a large proportion of health care in countries, countries should ensure that they are included in the development and capacity building for implementation of the IMCI strategy.

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