

**SECOND REGIONAL MEETING ON
THE IMPLEMENTATION OF IMCI,
BRAZZAVILLE**

February 25-28, 1997

Dr. Bob Pond

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ACRONYMS

AFRO	WHO African Regional Office
ARI	Acute Respiratory Infection
BASICS	Basic Support for Institutionalizing Child Survival
CDD	Control of Diarrheal Diseases
CHD	Child Health and Development
DD	Diarrheal Disease
DHMT	District Health Management Team
HIS	Health Information System(s)
IEC	Information, Education and Communication
IMCI	Integrated Management Childhood Illness
IRA	Infection Respiratoire Aigüe
M&E	Monitoring and Evaluation
MOH	Ministry of Health
ODA	Overseas Development Agency (England)
R&D	Research and Development
SARA	Support for Analysis and Research in Africa
STD	Sexually Transmitted Disease
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

The Second Regional Meeting on the Implementation of the Integrated Management of Childhood Illness (IMCI) was convened by WHO/AFRO in Brazzaville from 25-28 February, 1997. The meeting was attended by over 50 representatives of various organizations, including WHO/AFRO, WHO/CHD/Geneva, and ministries of health or government academic institutions in Mali, Niger, Togo, Uganda, Tanzania, and Zambia. Other partner organizations represented included UNICEF/Health/NY, ODA, USAID, SARA, BASICS, and the Tanzania Essential Health Interventions Project. A list of participants is included as an appendix, along with the program of the meeting and the WHO/AFRO report on the meeting.

The objectives of the meeting were as follows:

- I. To provide an update on the current status of the implementation of IMCI in the region, especially in the three early-use countries: Tanzania, Uganda and Zambia.
- II. To share experiences between partners and donors in the implementation of IMCI.
- III. To discuss the WHO/AFRO 5-year plan for implementation of IMCI.

Dr. Antoine Kabore, WHO/AFRO's regional advisor for CDD and IMCI, opened the main part of the meeting by noting the following lessons learned during the first year of IMCI implementation:

- 1) WHO/AFRO had found that it was invaluable to conduct, as a first step in preparing a country for IMCI, a "preliminary-visit" to assess the health care delivery system and to determine the feasibility of the existing health system supporting the introduction of IMCI.
- 2) Ownership of the IMCI approach by national authorities is essential.
- 3) National authorities must better understand the implications of IMCI.
- 4) IMCI must build on existing systems.
- 5) IMCI should build on health sector reform.
- 6) Early incorporation of IMCI training into pre-service training is highly desirable.
- 7) Universities and the general pediatric community should be engaged in the initiative.
- 8) Frequent visits by external consultants were required.

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9) There is strong pressure for nationwide implementation.

WHO/AFRO insisted that IMCI was not a program, but advocated for creation of a Ministry of Health budget line for IMCI in countries implementing the approach.

Dr. Jim Tulloch, director of WHO/CHD/Geneva, noted that at a recent retreat of his division the decision had been reached that the IMCI initiative should be global in scope and not limited to demonstration activities in a few countries. However, given that resources and capacity are limited a longer-term perspective is necessary. Tulloch reported that his division was working on the development of other materials to complement the existing IMCI course for first-level health facilities: a guide to adaptation of the course, guidelines for initial follow-up visits four to six weeks after training, a drug supply management course for first-level facilities, guidelines for referral care, and guidelines for planning and program management, including M&E. With respect to interventions to improve drug management, the director of WHO/CHD/Geneva remarked that the first step for his division was to better understand the activities and strategies of WHO/DAP.

UNICEF/New York's senior advisor for Child Health noted that there is not yet an official UNICEF statement on IMCI. However, during the meeting the UNICEF senior advisor met with the director of WHO/CHD/Geneva to draft a joint statement on IMCI that will now go for review and hopefully, eventually be approved by the two organizations.

The highlight of the meeting was the presentation by representatives from Tanzania, Uganda, and Zambia of early experiences with implementation of IMCI activities. Lessons learned are summarized in a separate section of this report.

Following the conclusion of the Second Regional Meeting on IMCI, staff of WHO/AFRO met on April 1, 3, and 4 with representatives of various partner organizations (WHO/CHD/Geneva, UNICEF, ODA, USAID/SARA, and BASICS) to present and discuss the WHO/AFRO 5-year plan of action entitled Implementation of the IMCI, CDD and ARI in the African Region: Plan of Action, 1997-2001. Dr. Barakamfitye, WHO/AFRO's director of DDC, opened the discussions by noting the following:

- * This document is definitely a WHO document.
- * Having said this, any partner should find its place in supporting the plan.
- * IMCI is a piece of a larger solution, it cannot do everything. IMCI cannot be responsible for drug supply, health sector development and health reforms; IMCI focuses on the quality of care. Be careful not to embrace everything, otherwise we lose quality. We must have a limit, otherwise IMCI will just explode. Alone, IMCI cannot improve the quality of care, but its place must be clear.

WHO/AFRO's draft 5-year plan is included as Appendix F. The objective of the plan is "to improve the quality of care provided to children under-5-years of age at the first-level health facility." A logical framework is included as the last two pages of the draft plan of action. In brief, the plan calls for WHO/AFRO to support the implementation of IMCI activities in 28 of the region's 46 countries by the year 2001. WHO/AFRO is to provide intensive support to 11 of these countries during this period, meaning that they will be aiming for nationwide training coverage by the year 2001. During this same time period, WHO/AFRO hopes to sustain CDD activities in 43 countries and to support implementation of ARI activities in 31 countries where these programs already exist. After reviewing the plan on April 3, representatives of several partner organizations offered their comments. A selection of these comments is summarized in Appendix G. Included as Appendix H are the written comments on the plan which the BASICS representative presented to WHO/AFRO on April 3 after discussions with the USAID/SARA representative. Appendix I summarizes key responses provided by staff of WHO/AFRO to some of these comments.

Representatives from UNICEF and BASICS departed on April 3. Discussions continued on April 4 between WHO/AFRO and the representative of USAID/SARA. These final discussions are summarized in a separate report by the representative of USAID/SARA.

LESSONS LEARNED DURING THE FIRST YEAR OF IMCI IMPLEMENTATION

The highlight of the Second Regional Meeting on Implementation of IMCI was the presentation by representatives from Tanzania, Uganda, and Zambia of the first year of experiences with implementation of IMCI activities. **While it is too early to draw firm conclusions from all of these early experiences, it is nevertheless worthwhile to make note of and follow up on some of the findings:**

- a) Uganda and Zambia both had found it useful to continue course **adaptation** discussions and to further develop the IMCI algorithm even after training had begun.
- b) Tanzania and Zambia had found it useful to provide facilitators with an additional four or five of **instruction in facilitation methods** after they had participated in the 11-day course and before they first facilitated the 11-day course. Uganda was also interested in introducing such a practice. In a plenary discussion lead by Dr. Hirschall of WHO/CHD/Geneva, meeting participants concurred that this should become the standard approach advocated in other countries yet to start IMCI training.
- c) Data from Uganda and Zambia show that thus far it has cost roughly \$1,000 for each health worker trained in the 11-day course. This is for courses conducted without any international consultants.

- d) In each of the three countries, it has thus far been found best to **train at central or regional sites**. Program coordinators from each of the three countries felt that it would not be practical to establish IMCI training sites in the majority of the districts in their countries because of a lack of suitable facilitators, patients, transport, accommodation, and facilities. This issue deserves further examination because decentralization of training might reduce the costs of training and help promote district ownership and control of IMCI.
- e) In one of the first two districts where training was conducted in Uganda, one-fourth of the participants had great difficulty or were unable to read the 400+ pages assigned during the 11-day course. In this district, the facilitators decided to omit the module *Assess and Classify the Young Infant*. In spite of this early experience, subsequent trainings in Uganda have suggested that with improved logistics it may still be practical for participants to complete all the modules in 11 days. Data presented from Tanzania, where the training materials have been translated into Kiswahili, showed that 2 of 6 assistant medical officers, 4 of 19 clinical officers, and 1 of 4 nurses had **problems understanding the modules**. While the so called “complementary IMCI course” that is now under development will presumably help address this difficulty, more data is needed on how health workers with various levels of literacy and other learning skills perform with the existing course.
- f) The representatives from Uganda and Tanzania noted that in the existing 11-day course, the last two modules are rushed. “Many health workers find that the counseling module is particularly difficult. During follow up, it was found that there were lots of omissions with assessment of feeding.” A representative from Tanzania remarked that follow-up visits had shown that “assessment of feeding is often forgotten” by health workers training in IMCI. Surveys conducted in Zambia demonstrated that the aspects of sick child management that had changed the least as a result of IMCI training were **nutritional/feeding assessment and counseling**.
- g) In each country, **preparations carried out at the district level seemed essential to the long-term success of IMCI**:
- I. Efforts to sensitize and develop the commitment of non-clinical, as well as clinical officials of the DHMT and the in-charges of health facilities.
 - II. Efforts to improve the supplementary (non-kit) drug supply.
 - III. Assistance with identification and development of training sites.
 - IV. Guidance with selection of course participants.
 - V. Strengthening of supervisory systems.

VI. Advocacy to include IMCI in district workplans.

- h) In each country, efforts were underway to **revise routine reporting forms** as part of health reforms. Efforts to include in the new forms the IMCI categories had met with only partial success. HIS designers do not yet understand the syndromic classifications taught in the IMCI course. For example, they would prefer to collect statistics on meningitis and cerebral malaria rather than on the broad category of *Very Severe Febrile Disease* which is taught in the IMCI course. Early experience has shown, however, that persistent consultation and lobbying by IMCI advocates can help to introduce some of the IMCI classifications into the HIS.
- i) In each of the three early-use countries, **essential drug kits supplied most of the oral drugs needed for IMCI** (cotrim, chloroquine, ORS, +/- vitamin A), **but not the injectables** (quinine, chloramphenicol, gentamycin) **needed for pre-referral treatment**. Presently it appears that in these three early-use countries, government pharmaceutical units and their donors either do not understand or do not support the need for such injectable drugs to be supplied to front-line health facilities for urgent pre-referral treatment. The shortage of these injectable drugs at front-line health facilities and weaknesses in referral systems may seriously limit the impact of IMCI on severely ill children in general, and sick young infants in particular.
- j) Of equal concern for tropical Africa is the impact of chloroquine-resistance on the effectiveness of the IMCI approach to management of malaria. Chloroquine-resistance is a major and growing problem in all three of the African early-use countries. Yet, in all three cases, the IMCI algorithm as currently adapted essentially trains the health worker to initially treat all fevers with chloroquine. Following a series of research studies documenting that roughly 40 percent of malaria in Zambia is highly (RII or RIII) chloroquine-resistant, authorities in that country have now officially conceded that a child should instead be treated with sulfa-pyrimethamine (SP) if the mother gives a history of prior treatment during this episode of fever with chloroquine. Formative research is now underway in Zambia to develop questions which health workers can use to determine whether the child has been treated with chloroquine. As part of the preparations for IMCI, this research and research documenting the extent of chloroquine-resistance should be conducted elsewhere in Eastern and Central Africa. Given trends in the further development of chloroquine resistance in Africa, it will likely be appropriate in the next several years for more countries on the continent to go the way of Malawi and switch to use of SP as a first-line anti-malarial. As the Malawi example illustrates, such a policy change requires years of support and preparations.
- k) The representatives from Uganda noted that **follow up** [as specified in the WHO document on initial IMCI follow-up] may not be sustainable. "There is no way, given the available funds from donors, that we can have quarterly visits....In terms of personnel, this will consume too much of the time of central personnel...Follow up must be district-

based in the long term.” The representative of the Tanzania Essential Health Interventions Project noted that, “Districts are concerned about supervising only one component of the health services.” In Zambia, efforts are underway to integrate supervision of IMCI into district-based supervision of child health, reproductive health, STDs, tuberculosis, and water/sanitation services. The BASICS representative working in Niger briefly recounted over two years of experience in that country with collaboration between the local health services, BASICS, and the Quality Assurance Project on approaches to sustaining the quality of integrated case management of sick children. These approaches combined a structured method of problem identification (e.g., use of a supervisory checklist) with a participatory method of problem resolution.

- 1) In none of the three early-use countries has work begun on IEC activities in support of IMCI.

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS: TAKING STOCK OF THE INITIATIVE

A. Progress with IMCI Adaptation and Training

After about a year of intensive implementation of IMCI activities in three early-use” countries in Africa, it is appropriate to review the lessons learned and the current status of the initiative. IMCI has proven to be remarkably popular among African Ministries of Health. Government officials in a growing list of African countries have expressed a strong interest in IMCI and have begun preparatory discussions: Eritrea, Ethiopia, Ghana, Madagascar, Mali, Niger, Nigeria, South Africa, and Togo. Official interest in the initiative has also mounted within the early-use countries themselves, and there is now strong pressure to expand IMCI activities much faster than was originally planned.

The IMCI adaptation process has proven to be a remarkably effective mechanism for further development and the updating of national health policies and practices ranging from immunization schedules to the design of forms for routine reporting of health events. Integration of a wide range of health issues makes the initiative remarkably robust; makes it attractive to numerous policy advisors and decisionmakers; and gives IMCI a good deal of leverage during discussions about the reform of health management systems, such human resource development, M&E, and drug supply. IMCI has been especially effective at engaging nutrition policymakers in national child survival program implementation.

As demonstrated by studies such as those conducted in Lusaka (see the table on the next page which was presented at the Brazzaville meeting), the IMCI course has proven itself, with some notable exceptions, to be an effective intervention for training front-line health workers in the fundamentals of quality management of sick children. It still appears likely that a significant minority of health professionals now managing sick children will do better with a training

approach that requires less than the 400 pages of reading in the existing course. Fortunately, such an alternative training approach, the so-called "complementary course," is now under development and should be ready for field testing later this year.

Early experience in each of the three early-use countries suggests that the existing course is least effective at changing health workers' nutrition counseling practices. This warrants further evaluation and perhaps modification of this component of the course or modification of the placement of the nutrition counseling component within the 11-day course schedule.

Health Facility Survey Findings Before and After IMCI Training in Lusaka

	Frequency action taken	
	3 months before (n=186)	2 months after (n=230)
If child had a cough or difficulty breathing		
* Counted respiratory rate	2%	70%
* Looked at chest	43%	87%
* Prescribed antibiotics	50%	37%
If child had diarrhoea		
* Checked skin pinch	33%	54%
* Prescribed ORS	68%	100%
Mother told how to give medications	42%	98%
Asked mother to repeat how to give medications	10%	44%
Mother encouraged to increase feeding	14%	45%

B. Further Development of IMCI: Is it time to broaden the scope of the initiative?

The popularity and robustness of IMCI is testimony to the excellent job done by WHO in developing the approach. In the course of the first year of intensive implementation, WHO has also done an excellent job maintaining and defending the quality of course adaptation and training. Recognizing the necessity of going beyond training, WHO has developed and introduced guidelines for initial follow up of IMCI-trained health workers. Organizations outside of WHO which are interested in adopting or supporting the initiative have a good deal to learn about the many details that must be attended to if they want to propose alternative approaches to IMCI adaptation or training.

In some other important respects, however, the initiative would benefit from a broadening and an opening up of discussions. Part of the final afternoon of the Brazzaville meeting was set aside to discuss two key technical issues: training of facilitators and initial follow-up visits. These sessions were quite productive. There appeared to be, however, at the Brazzaville meeting, a certain reluctance to reach beyond the boundaries of a defined "IMCI program" to address with due consideration the related issues of IEC, drugs, supervision, and building of decentralized capacity for management of IMCI. It is ironic that even as it was pointed out that "IMCI is not a program," there were a number of examples of vertical program thinking:

- * Reluctance to confront systems issues
- Vertical approach to initial follow up (visits carried out by central staff and IMCI facilitators)
- * Emphasis on revision of drug kits rather than building district capacity to manage drugs
- * Advocacy for a line item for IMCI in ministry budgets

This sometimes vertical perspective is, no doubt, a reflection of the youth of IMCI. A year from now systems issues will hopefully address at the Third Regional Meeting on the Implementation of IMCI. There should be structured discussions on topics such as routine follow up. Appropriate experts, including some who come from outside of "IMCI programs," but who are well oriented to IMCI issues, should be invited to present succinct, relevant technical updates on topics such as drug management, IEC, and district capacity building.

In light of the eventual need to broaden the scope of IMCI, and considering the significant investment required to implement the initiative (thus far training alone has cost roughly \$1,000 per health worker), partners outside of WHO have a key role to play in the provision of technical and financial resources. Partner organizations could play a leading role in further development work as well as helping to support expanded implementation of IMCI. Concerning the current coordination of partners in support of IMCI, three facts stand out:

1. The draft 5-year plan of action for IMCI/CDD/ARI presented by WHO/AFRO is, as Barakamfitye noted, "definitely a WHO document." It is a work plan for WHO's regional office. It would be appropriate to go further and develop a **Strategy for Regional Implementation of IMCI**. Such a work plan would help to mobilize support for IMCI from other partners. The most striking example of the difference between a work plan for the regional office and a strategy for regional implementation is in the approach to IEC. During discussions of the 5-year plan of action, the staff of WHO/AFRO emphasized their own reluctance to take responsibility for IEC activities other than the interpersonal communication provided in health facilities during the sick child consultation. Representatives of WHO/CHD/Geneva, UNICEF, BASICS, and SARA each suggested that communications activities have been an important component of CDD and other child survival programs to date and other partners should, if necessary, take responsibility for the development and implementation of IEC in support of IMCI. Hopefully future drafts of the 5-year plan of action will reflect this and other potential contributions of the partners.
2. One of the most encouraging developments to emerge from the Brazzaville meeting was the drafting of a **WHO/UNICEF joint statement on IMCI**. As noted by the UNICEF representative, to date UNICEF/NY has not had an official policy position on IMCI. This should soon change and UNICEF should emerge to play its own role in leading the development and implementation of appropriate aspects of the initiative. In particular, UNICEF may be the logical agency to lead the coordination of efforts to develop an approach to IEC in support of IMCI. This could make an enormous difference to the success of the initiative.
3. There has been no **IMCI partner coordination meeting** for well over a year. Such a meeting should be convened soon. The IMCI initiative is entering a new stage where the scale of implementation is growing geometrically and the developmental needs have expanded considerably beyond the initial focus on the generic algorithm and training approach. In this setting, improved partner coordination is essential.

At the Brazzaville meeting, Tulloch and Hirnschall of WHO/CHD/Geneva noted that one opportunity to pursue partner coordination would be the meeting on R&D in support of IMCI that is to take place in Geneva in mid-1997. WHO/CHD/Geneva invites partners to work with them to develop the agenda for such a meeting. Various issues of concern to the partners could be included on such an agenda. At the R&D meeting, participants could decide how best to pursue R&D related to each of these issues. Working groups with representatives from various partners could be formed to meet subsequently and follow up on these issues.

APPENDIXES

APPENDIX A

INVITATION TO THE MEETING SPECIFYING OBJECTIVES

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Ref: D3/48/1 Subject: SECOND REGIONAL MEETING ON THE IMPLEMENTATION OF
R4/48/1 INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI) IN
AFRICA, BRAZZAVILLE, CONGO, 25 - 28 FEBRUARY 1997

In 1996, the WHO Regional Office for Africa began implementing the Integrated Management of Childhood Illness (IMCI) approach. By the end of 1996, seven countries (Eritrea, Ethiopia, Mali, Niger, Tanzania, Uganda and Zambia) were at different stages of implementation of this approach.

This has been made possible through a series of activities in collaboration with African countries and our partners from multi and bilateral organizations. Orientation workshops were held in several countries to inform the Ministers of Health, WHO country technical support teams, national programme managers for the control of diarrhoeal diseases and acute respiratory infections along with other managers of relevant programmes and interested partners on the implementation of IMCI.

On its part, WHO/AFRO organized the first Regional IMCI coordination meeting of interested partners in Brazzaville from 21 January - 2 February 1996. At that meeting a consensus was obtained on issues related to IMCI implementation in the Region.

In order to provide appropriate and coordinated support to countries, and to effectively implement the approach, the WHO Regional Office for Africa is organizing the Second Regional Meeting on the Implementation of Integrated Management of Childhood Illness (IMCI) in Africa from 25 - 28 February 1997 in Brazzaville. This meeting is intended to bring together all partners interested in the successful implementation of IMCI in countries of the African Region.

The objectives of the meeting are to:

- i) provide an update on the current status of the implementation of IMCI approach at country and regional levels;
- ii) share experiences between partners and donors in the implementation of this approach;
- iii) discuss the 5 year (1997 - 2001) plan of implementation of IMCI in the region.

Copy to:
Dr Tulloch Director CHD/HQ, Geneva

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The expected outcomes of the meeting are as follows:

- i) Pertinent recommendations formulated for the improvement of the implementation of IMCI in the Region.
- ii) A common process adopted for the implementation of IMCI in the countries of the Region.
- iii) Common orientation adopted by partners and donors for implementing IMCI during the next 5 years.

The method of work will include presentations and discussions in plenary. The working languages are English and French, with simultaneous interpretation. A provisional agenda will be sent to you as soon as finalized under a separate cover.

We are suggesting that BASICS/USAID make a 20 minute presentation on Supporting Implementation of IMCI: Process and Collaboration with Partners on Day 2 (26 February) of the meeting.

We would appreciate the representation, participation and contribution of your organization at this important meeting at your own cost.

We look forward to your response and participation in the meeting, and subsequent reinforcement of our collaboration.

Thank you.

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APPENDIX B
LIST OF PARTICIPANTS

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

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

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

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

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

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

LIST OF PARTNERS

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APPENDIX C

PROVISIONAL PROGRAMME OF THE MEETING

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

Brazzaville, 25 - 28 February 1997

PROVISIONAL PROGRAMME OF THE MEETING

REV.1

Day 1: Tuesday 25 February 1997

08 h 30 - 8 h 55	Administrative arrangements	CTO
09 h 00 - 09 h 15	Opening remarks	RD
09 h 15 - 09 h 30	Objectives and expected outcomes of the meeting	DDC
09 h 30 - 09 h 35	Election of the bureau and adoption of the programme of the meeting.	

OBJECTIVES :

- i) to adopt, based on reports to the meeting, relevant recommendations for improvement of IMCI implementation in the Region.
- ii) to revise common approach adopted in February 1996 for IMCI implementation.

SESSION 1: Regional and global status of implementation

Chairman: Dr. Mutombo Wa Mutombo, BASICS

09 h 35 - 10 h 05	Status of the implementation of IMCI in the Region and lessons learned.	CDD/AFRO
10 h 05 - 10 h 30	Discussions	

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- 10 h 30 - 11 h 00 Tea Break
- 11 h 00 - 11 h 30 The place of IMCI in relation to other programmes
- 11 h 30 - 12 h 00 - Discussions
 - Wrap up of the session
- 12 h 00 - 13 h 30 Lunch break

SESSION 2: Country experiences

Chairman: Dr D. Barakamfitiyé, DDC

- 13 h 30 - 14 h 00 Experience of Uganda in IMCI implementation
- 14 h 00 - 14 h 30 Experience of Uganda in following up the health
workers trained in IMCI
- 14 h 30 - 15 h 30 Discussions
- 15 h 30 End of first day

Day 2: Wednesday 26 February 1997

SESSION 3: Country experiences (Continued...)

Chairman: Dr D. Barakamfitiyé, DDC

- 08 h 30 - 09 h 00 Experience of Tanzania in IMCI implementation
- 09 h 00 - 09 h 30 Experience of Tanzania in following up the health
workers trained in IMCI

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- 09 h 30 - 10 h 30 Discussions
- 10 h 30 - 11 h 00 Tea break
- 11 h 00 - 11 h 30 Experience of Zambia in IMCI implementation
- 11 h 30 - 12 h 00 Experience of Zambia in following up the health workers trained in IMCI
- 12 h 00 - 12 h 30 Discussions
- 12 h 30 - 14 h 00 Lunch break
- 14 h 00 - 14 h 30 - Discussions (Continued)
- Wrap up on country experiences

SESSION 4: Experiences of partners

Chairman: Dr J. Tulloch, CHD/HQ

- 14 h 30 - 14 h 50 Support for IMCI implementation BASICS
- 14 h 50 - 15 h 10 Discussions
- 15 h 10 End of second day

Day 3: Thursday 27 February 1997

SESSION 5: Experiences of partners (Continued...)

Chairman: Dr J. Tulloch. CHD/HQ

08 h 30 - 08 h 50 Support for IMCI implementation. TEHIP

08 h 50 - 09 h 10 Discussions and wrap up on experiences of partners.

SESSION 6: Prospects

Chairman: Dr J. Tulloch. CHD/HQ

OBJECTIVE :

- iii) to adopt the provisional five-year plan of action (1997-2001) for support to countries on IMCI implementation in the Region.

09 h 10 - 09 h 40 Provisional five-year plan of action for IMCI implementation in the Region (1997 - 2001)
CDD/AFRO

09 h 40 - 10 h 30 Discussions and wrap up

10 h 30 - 11 h 00 Tea break

11 h 00 - 11 h 20 Statement of UNICEF

11 h 20 - 11 h 40 Statement of SARA

11 h 40 - 12 h 00 Statement of USAID
12 h 00 - 12 h 20 Statement of ODA
12 h 20 - 12 h 40 Wrap up on prospects
12 h 40 - 14 h 00 Lunch break
14 h 00 - 16 h 00 Plenary discussions
16 h 00 - 17 h 00 Meeting with Uganda
17 h 00 - 19 h 00 Reception Club/WHO.

Day 4: Friday 28 February 1997

07 h 30 - 08 h 15 Meeting with Zambia
08 h 15 - 09 h 00 Meeting with Mali
09 h 00 - 09 h 45 Meeting with Niger
09 h 45 - 10 h 30 Meeting with Togo
10 h 30 - 11 h 00 Tea break

APPENDIX D

**PRESENTATION ON USAID/BASICS SUPPORT FOR
IMPLEMENTATION OF IMCI IN AFRICA**

BASICS Project Support to IMCI in Africa

I. Country-level support

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

- Zambia
- Madagascar
- Eritrea

B. BASICS' projects in several countries can support IMCI operations research and demo activities

- Niger
- South Africa
- Nigeria (in the private sector)

C. Potential sites for future IMCI support

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

BASICS Project Support to IMCI in Africa

II. Regional support

BASICS regional office in Dakar

- ◆ 2 IMCI trained consultants

BASICS HQ office in Washington

- ◆ 8 IMCI trained consultants
- ◆ 2 IMCI adaptation consultants
- ◆ contract with the Manoff Group that developed the IMCI feeding adaptation protocol and has several nutrition adaptation consultants

BASICS plans to expand the pool of consultants for clinical adaptation, strengthening of supervision, and nutrition adaptation (Note: upcoming conference to train franco phone W. Africa nutrition consultants)

USAID-funded consultants will also be available to support drug management, malaria, IE&C and M&E aspects of IMCI

These consultants will be available to support country-specific and regional IMCI efforts

BASICS Project
Support to IMCI in Africa

III. Global support

- A. The complementary course
- B. French and Spanish translations
- C. Course for training IMCI facilitators
- D. The preparatory guide
- E. Drug Supply Management course

IV. Support for NGO's

Conference in May at BASICS HQ to orient
Care, Hope, World Vision, Save the Children,
Africare, ADRA, Project Concern,

APPENDIX E
MEETING REPORT

WHO AFRICAN REGIONAL OFFICE

DIVISION OF INTEGRATED DISEASE CONTROL

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

MEETING REPORT

1. Introduction

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

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

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

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

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

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

2. Objectives and Expected Outcomes

2.1 General Objective

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

2.2 Specific Objectives

To:

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

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

2.3 Expected Outcomes

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

3. Method of Work

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

4. Meeting Proceedings

4.1. *IMCI: Regional and Global situation*

This session had two presentations:

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

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

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

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

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

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

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

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

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

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

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

4.1.1.2. Lessons learned at Regional level

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

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

4.1.1.3. Constraints

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

4.1.1.4. Prospects

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

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

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

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

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

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

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

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

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

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

4.2. COUNTRY EXPERIENCES

4.2.1. UGANDA

4.2.1.1. Introduction

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

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

4.2.1.2. Objectives

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

4.2.1.3. Key Issues Discussed

a) Introduction of IMCI

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

partners.

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

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

b) Training

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

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

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

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

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

c) Difficulties encountered:

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

d) Follow-up after training

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

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

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

4.2.1.4. Recommendations

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

4.2.1.5. Conclusion

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

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

4.2.2. TANZANIA

IMCI implementation in Tanzania followed different steps namely:

4.2.2.1. Initial Preparation

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

4.2.2.2. Development of a plan of action

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

4.2.2.3. **Adaptation of generic materials**

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

4.2.2.4. **Preparation for training**

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

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

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

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

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

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

4.2.2.6. **Facilitating Factors:**

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

4.2.2.7. **Constraints:**

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

4.2.2.8. Lessons learned:

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

4.2.2.9. Key Issues discussed

The following were discussed in plenary:

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

4.2.2.10. Recommendations

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

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

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

4.2.3.1. The following steps were followed:

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

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

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

4.2.3.2. Difficulties

Zambia mentioned similar difficulties on implementation as those of Tanzania:

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

4.2.3.3. Lessons learned:

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

4.2.3.4. Critical Analysis of Tanzania and Zambia Experiences:

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

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

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

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

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

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

4.3.3.5. Key Issues:

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

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

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

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

4.2.3.6. Recommendations:

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

4.3. Experiences of partners

4.3.1. Support for IMCI Implementation: BASICS

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

It is a USAID-funded project.

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

BASICS Project's support to IMCI in African countries:

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

- Zambia
- Madagascar
- Eritrea

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

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

4.3.1.3. Potential countries for future IMCI support:

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

4.3.1.4. **BASICS Regional Support in IMCI**

Regional office in Dakar (Senegal).

- There are 2 IMCI trained consultants.

BASICS HQ in Washington

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

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

4.3.1.5. BASICS Global support

BASICS has developed several materials for IMCI training:

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

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

4.3.1.6. Support for NGOs

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

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

4.3.1.7. Discussion

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

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

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

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

4.3.2.1. Introduction

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

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

4.3.2.2. The broad objectives of TEHIP are :

To:

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

Currently TEHIP is operating in two districts Rufiji and Morogoro.

4.3.2.3. Characteristics of TEHIP

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

4.3.2.4. TEHIP Support for IMCI implementation in Tanzania:

- TEHIP has identified IMCI as one of the most cost-effective interventions in provision of health services.
- TEHIP is supporting the 2 districts in IMCI implementation in the following areas:

- * In the development of annual health plans according to district health profiles (HMIS).

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

4.3.2.5. Discussions

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

4.3.2.6. Recommendation

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

4.4. Prospects

The presentations can be grouped under two themes:

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

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

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

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

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

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

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

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

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

4.4.2 Prospects

Several presentations were made on prospects.

4.4.2.1. WHO/AFRO

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

4.4.2.2. Partners

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

4.4.3. Plenary Discussions

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

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

4.4.3.2. The Training of Trainers and Facilitators

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

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

5. Recommendations

5.1. Improvement of IMCI Implementation

5.1.1. Actions by countries:

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

5.1.2. Action by countries, WHO and Partners:

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

5.1.3. Action by countries and partners:

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

5.1.4. Action by WHO:

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

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

5.2. Revision of the common approach for IMCI implementation

5.2.1. Action by countries, WHO and partners:

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

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

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

6. Conclusion

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

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

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

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

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APPENDIX F

WHO/AFRO'S DRAFT 5-YEAR PLAN OF ACTION

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR AFRICA

DIVISION OF INTEGRATED DISEASE
PREVENTION AND CONTROL

IMPLEMENTATION OF THE INTEGRATED MANAGEMENT
OF CHILDHOOD ILLNESS, CONTROL OF DIARRHOEAL
DISEASES, AND ACUTE RESPIRATORY INFECTIONS
IN THE AFRICAN REGION: PLAN OF ACTION
1997 - 2001

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1. Background

Diarrhoeal diseases and acute respiratory infections (ARI) are still the leading causes of childhood morbidity and mortality in the African Region. It is common for children under five years of age to experience 3 to 4 episodes of diarrhoea yearly. In some areas young children spend 15 to 20% of their life with diarrhoea illness. Every year around 800 000 children under five years die of diarrhoea and 1 200 000 of ARI mainly pneumonia.

In order to adequately deal with these problems 42 of the 46 countries in the African Region are implementing with WHO technical support diarrhoeal diseases control programme and 28 countries ARI programme. These countries are conducting both in service and pre service training courses, especially for diarrhoeal diseases control. As a more sustainable method, training courses for strengthening the teaching of diarrhoeal diseases in medical schools (MedEd) and in nursing and paramedical schools (BasEd) are now conducted in many countries of the Region.

Although these programmes do not yet have a nation-wide coverage, some encouraging results have been observed (e.g. severe cases of diarrhoea are seen less often in hospitals). This is an indication of the need for continued support from WHO and other partners.

In addition, it is known that diarrhoeal diseases, ARI, malaria, measles and malnutrition are the main reasons for outpatient consultations in children under five years of age in the African Region. These diseases are also responsible for most childhood deaths.

Most of these diseases and deaths can be prevented by the use of simple and affordable techniques and medications. The recently developed WHO/UNICEF package on the Integrated Management of Childhood Illness (IMCI) is based on this principle. It addresses the management of pneumonia, diarrhoea, malaria, measles and malnutrition which account for 70% of childhood deaths. It integrates curative, preventive and promotional services to provide a comprehensive and more effective delivery of child health services.

Many countries in Africa regard IMCI as a response to the needs of the masses and expect its implementation to improve equity and child survival. World Health Organization's Regional Office for Africa has therefore decided to support its Member States to implement IMCI, without neglecting the programmes for the control of diarrhoeal diseases and acute respiratory infections which are already well established in many countries.

Consequently, a regional strategy for the implementation of IMCI was developed in 1996. The strategy adopted by the African Region is a phased approach which takes cognisance of the complexity and duration of IMCI implementation. Thus, in the initial phase, only a few countries are selected for implementation. Even in those countries, implementation is limited to a few districts in order to provide the much needed experience in planning and implementation. Thereafter, there will be regional, intra-country and intra-district expansion.

Since 1995, WHO/AFRO has collaborated with interested multi and bilateral agencies as well as countries interested in the IMCI approach to ensure qualitative implementation in the Region.

The preliminary experience, results and lessons learned from the countries advanced in implementation using the Regional strategy, especially Uganda, Tanzania and Zambia, are encouraging and provide a good basis for future plans for expansion and collaboration.

Due to the phased implementation approach, it is understood that there will be countries, and regions/districts within countries which will not be implementing IMCI for the first few years. In such regions/districts, activities for the control of diarrhoeal diseases and acute respiratory infections will continue in order to further improve child survival.

The purpose of this document is to present the regional plan of activities for the control of diarrhoeal diseases and acute respiratory infections as well as the implementation of IMCI approach in Africa for the next five years. This result-oriented five year plan will provide great opportunities for collaboration with all partners with a similar vision and objective.

2. Context

It is common knowledge that health service coverage as well as the quality of care are unacceptably low in the African Region. Consequently there is low health facility use rate. The WHO/UNICEF IMCI package is therefore targeted at reinforcing the skills of the first-level health workers in order to improve the quality of care and therefore health service use rate. The role of the community-based health worker cannot be under-estimated in the management of childhood illness, but appropriate materials are yet to be developed for this cadre.

The WHO/UNICEF IMCI generic modules are, for the moment the best available materials on integration of child health services. Countries understand that these materials have to be adapted to the epidemiological and cultural situation at national or provincial level.

The plan will be implemented in four blocs :

- The Western African bloc, for the West African countries.
- The Southern African bloc for Southern African countries.
- The Horn of African bloc, for countries from the Horn of Africa.
- The Central African Bloc, for countries from Central Africa.

In order to ensure correct implementation process in each country, it is proposed to have a "national officer" for IMCI based in Country Offices.

Currently, WHO/AFRO has the following as human resource: Three medical officers and one technical officer at the Regional level, one medical officer at the Southern African bloc, one medical officer at the West African bloc and one based in Nigeria.

3. Goal

To contribute to the reduction in childhood mortality in the African region.

4. Objectives of the plan

4.1 GENERAL OBJECTIVE

To improve the quality of care provided to children under 5 years of age at the first level health facility

4.2 SPECIFIC OBJECTIVES

Diarrhoeal Diseases:

to implement diarrhoeal disease control activities in 43 countries of the Region where diarrhoea represents a public health problem.

Acute respiratory infections:

to implement ARI control activities in 31 countries where the programme already exists.

Integrated Management of Childhood Illness (IMCI):

to implement IMCI activities in 28 countries, eleven of which are "countries for intensive support". these countries account for more than 80% of childhood deaths in the Region.

5. Targets

5.1 REGIONAL TARGETS FOR IMCI 1997-2001.

For 1997: At least 20% of countries in the Region will be implementing IMCI (10 countries, 6 of which are countries for intensive support).

For 1998: At least 30% of countries in the Region will be implementing IMCI (14 countries, 8 of which are countries for intensive support).

For 1999: At least 40% of countries in the Region will be implementing IMCI (18 countries, 11 of which are countries for intensive support).

For Year 2000: At least 50% of countries in the Region will be implementing IMCI (23 countries, 6 of which are countries for intensive support with country-wide implementation of IMCI).

For Year 2001. At least 60% of countries in the Region will have planned and implemented IMCI activities (28 countries, 11 of which are countries for intensive support with country-wide implementation of IMCI).

5.2 COUNTRY - LEVEL TARGETS FOR IMCI:

District Coverage

Due to the limited global and regional experience in IMCI implementation, countries are advised to limit implementation to 2 districts in the first year. At the end of the first year, an evaluation is conducted, the results of which will be used for determining the expansion process and rate. At this time, it is envisaged that countries will have both intra-country and intra-district expansion thereby progressively increasing the number of regions/provinces as well as districts implementing the approach. This method of expansion is preferred in order to maintain quality of implementation and hence achieve improved quality of care.

The countries of the Region will therefore have different levels of coverage depending on the degree of success of implementation, the available resources as well as the number of years for which implementation has been on-going.

Assuming a significant degree of success in the first year, by the second year of implementation, a country that commenced implementation in 2 districts will have at least 6 districts in 2 regions (2 initial, 2 additional from same district, and 2 new ones from the second region).

With each passing year and an increasing number of trained and experienced nationals to support country-level implementation, expansion is expected to be more rapid. By the year 2001, it is expected that the 11 countries for intensive support will have nationwide implementation.

Training Coverage:

15% of the health facilities in selected districts should have 100% of the health workers managing children under 5 years of age trained by the end of the first year of implementation.

By the second year of implementation, 40% of health facilities in selected districts should have 100% of health workers managing children under 5 years of age trained.

By the third year of implementation, 60% of health facilities in selected districts should have 100% of health workers managing children under 5 years of age trained.

By the fourth year of implementation, 80% of health facilities in selected districts should have 100% of health workers managing children under 5 years of age trained.

By the fifth year of implementation, 100% of health facilities in selected facilities should have 100% of health workers managing children under 5 years of age trained.

By implication, these health facilities are expected to be capable of providing standard case management of childhood illnesses.

5.3 REGIONAL TARGETS FOR CDD/ARI 1997 - 2001.

5.3.1 For 1997:

- * 100% of countries in the African Region will have operational diarrhoeal control activities, and 60% will have operational ARI control activities.
- * 40% of health facilities in countries with operational control activities will be capable of providing standard diarrhoeal case management and 20% ARI standard case management
- * 25% of children with diarrhoea and 10% of children with ARI presenting at health facilities with capability for providing standard case management will be correctly managed.
- * ORS access rate will be increased from 62% (1994) to 82%
- * ORS/RHF use rate will be increased from 56% (1994) to 70%
- * 75% of countries in the Region will have integrated epidemic control of cholera and dysentery into diarrhoeal control activities
- * 60% of children under 5 years of age presenting with dysentery at health facilities capable of providing correct case management will be correctly managed

5.3.2 For Year 2001:

- * 100% of countries in the African Region will have operational diarrhoeal diseases control activities, and 80% will have operational ARI control activities
- * 80% of facilities in countries with operational control activities will be capable of providing correct standard case management, and 40% ARI standard case management
- * 50% of children with diarrhoea and 20% of the children with ARI presenting at health facilities with capability for providing standard case management, will be correctly managed
- * ORS access rate will be increased from 80% (1997) to 100%
- * ORS/RHF use rate will be increased from 70% to 90%

6. STRATEGIES

In order to obtain meaningful results with the available resources, WHO/AFRO will adopt a strategic orientation which enables it give priority to countries of the Region that contribute most to the burden of disease and deaths in children under 5 years (childhood mortality of 100,000 deaths per year or more), where there is evident government political and financial commitment, and those which require minimum contribution for success. The following strategies will be implemented :

6.1 STRENGTHENING NATIONAL CAPACITY

In its technical cooperation with Member States, WHO/AFRO is committed to building and strengthening national capacity in order to promote sustainable development. To this end, competent nationals will be identified and given the necessary support to take responsibility for country-level activities as well as support other countries of the region in the implementation of activities. This will include the recruitment and support of:

- a) National IMCI/CDD/ARI officers: The countries where IMCI is implemented and particularly the eleven for intensive support will have national officers.
- b) Regional consultants will be trained to support countries in IMCI implementation:

To enable AFRO satisfy the increasing demand for technical support as cost-efficiently as possible, a pool of skilled expertise will be developed within countries of the Region. They will be used as intercountry consultants for planning, training, adaptation, monitoring and evaluation. As much as possible, they will be polyvalent consultants with training in:

- i) IMCI case management and
Facilitation techniques
- ii) Adaptation
- iii) Planning and evaluation

6.1.1 CONDUCT PLANNING MEETINGS WITH SELECTED COUNTRIES

Rational and efficient planning process will be encouraged in all countries of the region for various aspects of implementation such as:

- a) Introduction of IMCI - preliminary visit. The objective of this visit is to introduce IMCI to the key persons in the Ministry of Health of the country in question, and to assess the feasibility of IMCI implementation in that country.

It is the first step taken when a country expresses interest in IMCI implementation. The results of this visit should help the Ministry of Health to

take decision whether it will implement IMCI immediately or postpone it until it fulfills the implementation requirements while continuing to reinforce CDD and ARI programmes.

b) Orientation Meeting - this is a meeting that brings together decision makers, key programme managers, paediatricians and interested partners at country-level in order to have a common understanding of IMCI and its implementation, as well as the implications of its implementation for the health care delivery system. It also enables the countries and partners make a written commitment for IMCI implementation including the establishment of an IMCI Working Group.

c) Development of training strategy

The objectives of this planning exercise are to:

- i) develop in countries a training strategy for the implementation of IMCI;
- ii) define roles and responsibilities of key implementing national institutions;
- iii) develop a national workplan for training in IMCI; and
- iv) develop a plan for monitoring and evaluation.

d) Development of strategy for follow-up and monitoring of trained health workers.

The objectives include, to:

- i) identify the needs for following up health workers after they have been trained in IMCI;
- ii) decide on what information is needed about the quality of training and health workers' performance after training, and how it will be collected, summarized and used;
- iii) match the needs for follow-up with the opportunities that exist in countries for providing follow-up; and
- iv) develop a workplan to implement follow-up after training.

6.1.2 SUPPORT COUNTRIES FOR ADAPTATION OF GENERIC MATERIALS.

As produced, the IMCI training materials are generic, and therefore require adaptation based on the epidemiological and local situation in each implementing country or even in the regions within a particular country. The process of adaptation is critical to the quality of training of health workers and their subsequent performance in their local setting. During the

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adaptation process a consensus among participating programmes and partners should be built. The steps of adaptation include the following :

- a) Conduct adaptation workshop
- b) Conduct food and fluid studies
- c) Conduct local terminology studies
- d) Conduct consensus meetings
- e) Produce adapted materials
- f) Provide consultant support at every stage of adaptation

6.1.3 SUPPORT COUNTRIES IN TRAINING ON IMCI (IN COUNTRIES):

Adopting a cascade pattern requires quality training of national and district core facilitators who would support district-level activities including training, monitoring and supervision of the trained health workers.

Core national facilitators: receive training in both

- a) Case Management Training and
- b) Facilitation Technique

District IMCI trainers: receive training in both

- a) Case Management Training and
- b) Facilitation Technique.

Training of Frontline Health Workers:

- a) Case Management Training.

Training of supervisors and follow-up:

- a) "Supervisory skills" training .

Training in Drugs Management

This is a training course for pharmacists and pharmacy technicians to improve support services in IMCI implementation.

1.4 Promote operational research.

To improve implementation of IMCI in countries, operational research will be promoted. Special emphasis will be put on collaboration with the Universities of the Region in this area.

2 PROMOTION OF SUSTAINABLE ACTIVITIES IN COUNTRIES

Concerted efforts will be made by WHO/AFRO and her partners to improve facility-support services in order to empower trained health workers to provide quality care to children presenting at health facilities and to sustain activities.

2.1 Drugs availability

Acceptable level of drugs supply is one of the criteria for selecting countries to implement IMCI, because drugs availability is crucial to the improvement of the quality of care and reduction in childhood mortality. Supplies could be assured in one of three ways namely:

- * collaboration with existing Bamako Initiative projects with community ownership
- * improvement of drugs procurement, storage and distribution mechanisms in countries, in collaboration with national pharmacists and pharmaceutical boards
- * mobilization of resources to procure and supply seed-stock of drugs for implementation

2.2 Support supervision will be improved to ensure the reinforcement of the knowledge and skills of health workers after returning to their facilities.

2.3 Strengthening preservice training

WHO, AFRO and partners will encourage the development of pre-service training courses, for sustainable development. Preservice training remains the most sustainable method of training of health workers and achieving reasonable change in behaviour in developing countries, and therefore requires emphasis.

Preservice training in paramedical institutions:

- a) Training of tutors from paramedical institutions in both
 1. Case Management Training and Facilitation Techniques.

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- b) Training of nursing/paramedical students:
 - i. Case management - to be included in the school curriculum.
 - ii. Follow-up of institutions implementing IMCI.
 - iii. Increase number of countries and institutions implementing IMCI.

9 Preservice training on IMCI in medical institutions :

- i. Introduce IMCI in medical institutions.
 - ii. Follow-up medical institutions implementing IMCI.
 - iii. Increase the number of countries and institutions implementing IMCI.
- d) Evaluate IMCI implementation in preservice institutions.

6.2.4 Improve data processing in countries and communication mechanism between countries and partners

- a) Procure and supply computers and accessories for national programmes; and
- b) Improve communication with the subregional offices (e mail, fax, telephone).

6.3 STRENGTHENING MONITORING AND EVALUATION ACTIVITIES IN COUNTRIES

Emphasis will be put on improving the implementation of IMCI/CDD/ARI through a continuous process of monitoring the quality of training and performance of health workers, and periodic evaluation.

6.3.1 Monitor and evaluate IMCI activities in participating countries

- a) End of first year evaluation - the results are used for review and replanning as well as for expansion.
- b) Periodic review - this could be a mid-term or end of project evaluation. A 2-yearly evaluation by external consultants will assist in replanning and refocussing of activities.
- c) Quarterly publication of a bulletin on IMCI in the Region.
- d) Annual regional meeting on the implementation of the IMCI approach in Africa.

For the purposes of monitoring and evaluating the targets set, feasible mechanism and appropriate tools have been identified or proposed, and will be applied accordingly.

Data will be obtained from :

- a) quarterly reports from country offices using forms which will be developed ;
- b) annual country profiles;
- c) periodic reports from other partners;
- d) consultants' reports.

Standard WHO tools will be applied for health facility and house hold surveys.

CDD, ARI and IMCI indicators are in the annexes.

6.4 STRENGTHENING CAPACITY OF AFRO SUB-REGIONAL TEAM

In order to provide technical support close to the countries, WHO/AFRO operates a decentralised system of intercountry and country level positions. This system reinforces the Regional Office capacity for rapid response to country needs. The following intervention would further strengthen this level of support:

- a) Medical Officer to reinforce the West African Sub-region - to be based in Abidjan (Côte d'Ivoire).
- b) Medical Officer responsible for the Central African countries - To be based in Yaoundé (Cameroun).

6.5 STRENGTHENING CAPACITY OF AFRO REGIONAL TEAM

With increasing demands from Member states for technical support from AFRO, there are clear advantages in strengthening the capacity of the Regional office to respond promptly and appropriately to these demands. This would be done through the recruitment of the following staff members:

- a) One programme assistant at WHO/AFRO to coordinate all administrative matters between AFRO and the member states.
- b) One medical officer at WHO/AFRO responsible for strengthening implementation activities.
- c) One medical officer at WHO/AFRO responsible for BasEd and MedEd.

6.6 IMPROVEMENT OF COLLABORATION WITH PARTNERS

In order to maximise the contributions of multi and bilateral agencies as well as non-governmental organizations, efforts will be made to promote their collaboration and commitment at every stage of implementation.

This will be done using the comparative advantage of partners in specific areas as research, drugs management and procurement, and by encouraging joint activities in some countries.

INTERVENTIONS/ACTIVITIES/BUDGET - see Annex

WHO AFRICAN REGIONAL IMCI APPROACH

COUNTRY LEVEL

GOAL

To contribute to the reduction in childhood mortality in the African Region

OBJECTIVE

To improve the quality of care provided to children under 5 years of age at the first level health facility

EXPECTED RESULTS

Ownership of IMCI taken by country	National capacity developed for IMCI implementation	Quality inservice training courses conducted using adapted IMCI mat.	Facility support services improved	IMCI incorporated into preservice paramedical and medical institutions	IMCI implementatn. improved and expanded using evaluation results
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INDICATORS

- Availability of written decision on implementation of IMCI by country

- Availability of budget line for IMCI activities by government.

- Availability of budget line for IMCI implementation by WHO country office

- % National experts trained in :
 * case management and facilitation techniques
 * adaptation,
 * planning and evaluation

- % Training courses conducted using adapted materials.

- % Training courses conducted using adapted materials and meeting quality criteria.

- % districts implementing IMCI that received drugs for initiating or strengthening Bamako Initiative

- % Health facilities that have at least one h/w trained and supervised quarterly.

- % Health facilities implementing IMCI that have OPD adequately organized.

- % Training institutions that have nursing/paramedical students trained.

- % Training institutions that have medical students trained.

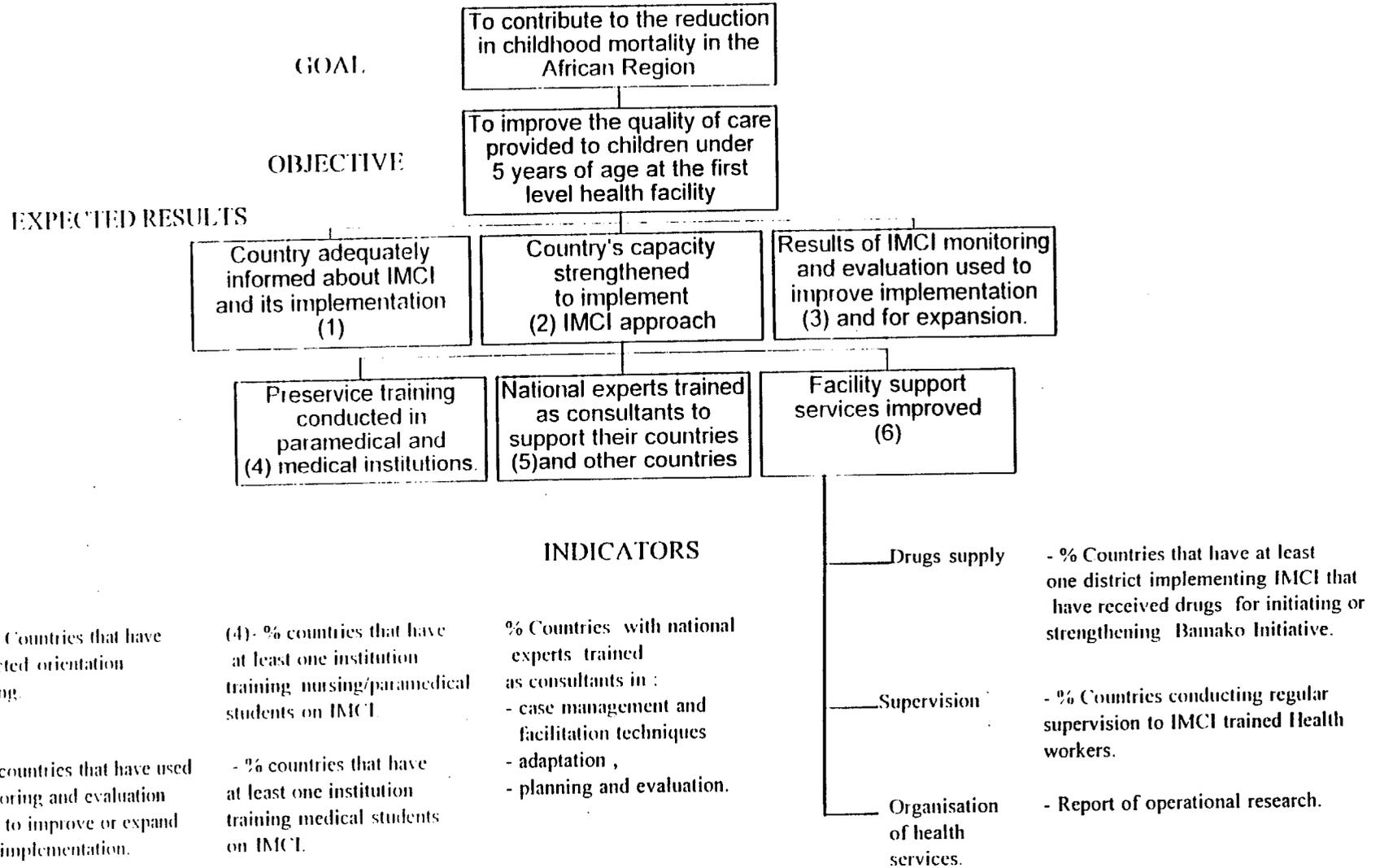
- Number of new districts implementing IMCI.

- % Health facilities having 100% of health workers managing children <5 years trained on IMCI.

- % sick children < 5 years attending HF's with IMCI trained H/W's correctly managed.

WHO AFRICAN REGIONAL IMCI APPROACH

REGIONAL LEVEL



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(1) - % Countries that have conducted orientation meeting.

(3) % countries that have used monitoring and evaluation results to improve or expand IMCI implementation.

(4) - % countries that have at least one institution training nursing/paramedical students on IMCI.

- % countries that have at least one institution training medical students on IMCI.

% Countries with national experts trained as consultants in :

- case management and facilitation techniques
- adaptation ,
- planning and evaluation.

APPENDIX G

**SELECT COMMENTS OF PARTNER ORGANIZATIONS ON
WHO/AFRO'S DRAFT 5-YEAR PLAN FOR IMCI/CDD/ARI**

**Select comments of partner organizations on
WHO/AFRO's 5 year plan for IMCI/CDD/ARI**

1. Dr. Vincent Orinda, the UNICEF Senior Advisor for Child Health, noted that IMCI had been developed as a technical approach but that prior to this meeting a strategy for implementation had yet to be defined. "This document takes us forward towards defining such a strategy for implementation."
2. Dr. Gottfried Hirschall of WHO/CHD/Geneva suggested that WHO/AFRO might consider including improved care at the community-level in the objective of their plan. He suggested that UNICEF in particular would be interested in extending IMCI beyond the facility. The UNICEF representative indeed noted that IEC had been an important and successful component of CDD programs and that it would be a "step backwards" to confine IMCI to the facility. Staff of WHO/AFRO felt however, that "the tools don't exist" to promote IMCI in the home and community and "implementation at the facility will improve care in the home" because of improved facility-based counseling practices. One representative of WHO/AFRO suggested that to do justice to home-based care, interventions should be developed to improve the quality of care provided by CHWs.
3. The UNICEF representative suggested that WHO/AFRO may want to focus on coverage as well as the quality of services¹. The strategy should emphasize demand for and access to services as well as supply of services.

¹For example, it might be appropriate to look at indicators such as the training coverage rate or the pneumonia treatment coverage rate.

APPENDIX H

**COMMENTS OF THE BASICS' REPRESENTATIVE ON WHO/AFRO'S
DRAFT 5-YEAR PLAN**

**Implementation of IMCI, CDD and ARI in the African Region:
Plan of Action, 1997--2001**

Comments of Bob Pond
BASICS Project

General Comments:

WHO/AFRO is to be congratulated and thanked for developing a visionary five year Plan of Action for support of IMCI, CDD and ARI activities in the region. The frame work they have laid out is not only a plan for their own activities, but an instrument for mobilizing and coordinating the efforts of other development assistance agencies. Given the widespread interest in the region in the newly emerging IMCI initiative and the heightened concern about the future of CDD and ARI activities, the Plan of Action is timely. Based upon early experience with implementation of IMCI activities in Tanzania, Uganda and Zambia, it is now possible to think strategically. WHO/AFRO's Plan of Action is a major step towards defining the work to be done in the next five years.

I want to thank WHO/AFRO for the chance to learn from the experiences of the early-use countries during the 2nd Regional Meeting on IMCI as well as the opportunity to offer the following comments.

1. **Expected Results--** The Country Level and Regional Level frameworks provided on the last two pages of the Plan of Action identify important "Expected Results" of the Regional IMCI Approach. The relationship between the narrative and these frameworks might be clearer if these "Expected Results" were included in the narrative. Perhaps the "Expected Results" at regional and country levels could be included at the end of section 4.2 following the specific objective pertaining to implementation of IMCI. This might make the specific objective pertaining to IMCI more compelling.
2. **Improved Care in the Home and Community--** The following points were made at the meeting at AFRO on March 1:
 - a) significant reductions in child mortality will depend upon improved care in the home and community;
 - b) the impact of the IMCI initiative depends upon improvements in the demand for (i.e. care seeking behavior) as well as improvements in the quality of services at the first-level facility;
 - c) CDD programmes have made considerable progress with IEC activities that extend beyond the counseling provided at health facilities;
 - d) If we are talking about a 5 year vision, we should allow for further developments. Allow for setting of targets even where we do not have all the necessary tools at the moment;
 - e) Other partners, particularly UNICEF, are keen to help develop and support the use of such tools.

In light of these considerations, I offer the following comments:

- a) Concerning the third line of the "Context" section on page 3: the "IMCI package" (once further developed to include appropriate communications approaches) could also target and improve child health practices in the home and community;
- b) Concerning the "GENERAL OBJECTIVE" on page 4 and in the two frameworks: As discussed on March 1, the words "at the first level facility" could be omitted. This would also be consistent with AFRO's eventual support for IMCI MedEd and other activities to improve referral level care;
- c) Consider adding a new strategy such as "Support IEC for improved care in the home and community". You may or may not wish to acknowledge in the narrative that this strategy would be pursued in collaboration with UNICEF and other partners. This could come after strategy 6.2 and before strategy 6.3. The sub-components of such a strategy might include:
 - 6.X.1-- Support development of national IEC strategy for IMCI;
 - 6.X.2-- Support development of model IEC tools and approaches;
 - 6.X.3-- Support countries in implementation of IEC strategy.
- d) Consider adding to the Country Level framework an expected result related to improved care in the home and community.

3. Introduction of IMCI (Preliminary visits) -- This is discussed on the bottom of page 7 and the top of page 8 of the Regional Plan of Action. The objectives, scope and number of visits/consultations required to pursue this preliminary process might need to be expanded upon, especially for countries interested in IMCI, but for whom the Orientation Meeting, Planning of Training, Adaptation Process and Implementation of Training will be delayed for more than one year.

To express this in the form of a question, what should WHO/AFRO and its partners do in the interim to prepare for IMCI in that sizeable number of the 28 IMCI targeted countries where a formal launching of IMCI activities will be delayed for 1 to 4 years?

For some countries, WHO/AFRO might participate in key national policy reviews (e.g. to reform the essential drugs list, the HMIS, or antimalarial drug policy), assessments (e.g. surveys of existing drug supply or the quality of existing services) or demonstration activities (e.g. such as those undertaken with integrated training and supervision in select districts in Niger, Kenya and South Africa) that help a country and/or help initial focus districts to prepare for IMCI. In some countries, efforts to improve facility support services or integrated IEC might proceed in advance of formal introduction of IMCI. WHO/AFRO could seek opportunities to advise and support such complementary efforts.

4. Strengthening District/Provincial Capacity for Management of IMCI--A lesson learned from early experiences with IMCI in Tanzania, Uganda and Zambia is that district health officials play key roles in the planning and implementation of IMCI training and supervision and in the strengthening of other facility support services (drug supply and facility organisation). It is worth noting that strategies 6.2.1 (improve drugs availability) and 6.2.2 (improve supportive supervision) in the WHO/AFRO Plan largely depend upon the strengthening of decentralized management capacity.

As a result of health sector reforms in many countries in the Region, many of the management functions once reserved for national program coordinators are being transferred to district and provincial authorities. This has important implications for WHO/AFRO and other agencies seeking to build or sustain capacity for child health activities including CDD, ARI and IMCI.

As a sub-strategy for those countries undergoing decentralization of the health services, WHO/AFRO, its National CDD/ARI/IMCI counterparts and its international partners could be engaged in the broad process of district capacity building. It might be appropriate, for example to include as 6.1.5 a section such as "Support for building district/provincial capacity for management of IMCI".

User-friendly technical guidelines may be needed as well as workshops and other fora for supporting districts and provinces in the use of such guidelines. WHO/AFRO could play a leading role in developing such guidelines based upon experience in early-use countries as well as in sharing between countries model guidelines and other approaches to building decentralised capacity for management of IMCI.

5. Development of HIS to Support IMCI-- The routine reporting system can be a key tool for monitoring of IMCI and for reinforcing use of the diagnostic approach taught in the IMCI course. Put another way, when the health worker is obliged to report on disease classifications that are different from those taught in the IMCI course, they are given mixed signals about the best way to classify sick children and they must spend extra time compiling health statistics.

Ideally, a country's routine reporting forms could be adjusted to include many of the same classifications as taught in the IMCI course. Experience from each of the 3 early-use countries has shown that HIS designers do not yet understand the syndromic classifications taught in the IMCI course. For example, they would prefer to collect statistics on meningitis and cerebral malaria rather than on the broad category of Very Severe Febrile Disease which is taught in the IMCI course. Early experience has shown, however, that persistent consultation and lobbying by IMCI advocates can help to introduce some of the IMCI classifications into the HIS.

WHO/AFRO could work with national counterparts before and after the formal launching of IMCI to encourage development of reporting systems that are more consistent with this somewhat novel approach to classification of sick children. This might be included in the Plan, for example as a new section after 6.2.2 and before 6.2.3.

6. Identification of Priorities for Research and Development in Support of IMCI--

The need to build capacity for operational research is noted as strategy 6.1.4. Perhaps as another strategy (e.g. after 6.2 and before 6.3) WHO/AFRO may want to convene a working group whose task it is to identify priorities for such research and development. This could be a separate strategy coming after 6.2 and before 6.3.

Many of the items for the R&D agenda might best be identified by front-line implementers of IMCI activities at national and district levels. These public health practitioners could be asked to identify the key developmental priorities required for more effective implementation of IMCI activities. In some instances, the most appropriate response to R&D issues identified from the field might be to locate and share with the field staff a well documented and effective solution to the problem. In other instances, further primary research and developmental effort may be required and the R&D working group could seek appropriate partners to undertake and to sponsor the work.

7. Other assorted comments--

- a) Page 3, last paragraph: other WHO human resources in the region include the APO's for CDD/ARI/IMCI
- b) Page 4, Regional targets: it is helpful to indicate that the "intensive support" is to come from WHO/AFRO
- c) Page 6, Regional targets for CDD/ARI: to be consistent with the targets specified on page 4 (43 countries to have CDD programmes and 31 countries to have ARI programmes) the targets should be 94% for CDD and 67% for ARI
- d) Page 7, Strengthening National Capacity: it may be helpful to elaborate on the types of expertise that are required in "Planning and Evaluation" and the mechanisms that might be used to develop this expertise.
- e) Page 9, Training in Drugs Management: does WHO have a course for pharmacists and pharmacy technicians? The Drug Supply Management course developed in collaboration with BASICS targets front-line health workers. WHO/AFRO may wish to collaborate with WHO-DAP and partners to develop training for district-level drug management staff.
- f) Page 10, Drugs availability: The second bullet might be elaborated upon. For example: "improvement of drug **selection, forecasting, storage and distribution mechanisms in countries in collaboration with national pharmacists and pharmaceutical boards and district and facility level staff with responsibility for drug management**"
- g) Page 10, 6.2.2 (Support supervision): Again, note that this depends upon efforts to develop district capacity for management of IMCI. It may also be worth noting that efforts to improve support supervision might be undertaken in collaboration with national Quality Assurance efforts that have been launched in several countries in the Region (including Uganda and Zambia) as part of health sector reforms.

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APPENDIX I

**KEY RESPONSES OF STAFF OF WHO/AFRO TO THE WRITTEN
COMMENTS OF THE BASICS REPRESENTATIVE**

**Key Responses of Staff of WHO/AFRO
to the Written Comments of the BASICS Representative**

1. Concerning the preliminary visits (item #3), WHO/AFRO acknowledged that in countries where IMCI implementation might be delayed for one or more years then it might be appropriate to consider more than one visit. However, they felt that specific objectives needed to be specified for each supplemental visit. They noted that the regional office was already engaged in many of the preparatory activities suggested in the comments (e.g. participation in key national policy reviews). It was then suggested that this was not well reflected in the draft Plan of Action and the regional office may wish to take credit for IMCI preparatory activities which they were already supporting.

2. Concerning mechanisms to develop national capacity for management of IMCI (item #7d), WHO/AFRO noted that they planned to engage and develop regional and country consultants who had "polyvalent" expertise in IMCI planning and evaluation. WHO/AFRO had no specific tools or mechanisms for training these consultants, although WHO/CHD/Geneva was reported to be considering the development of formal guidelines for planning and evaluation. BASICS and SARA representatives pointed out that it might be productive to organize regional seminars at which these consultants could update their expertise and share experiences in such areas as drug management, IEC, quality improvement and other aspects of district capacity building. WHO/AFRO noted that they did hold such seminars. Again, it was suggested that this might be reflected in the Plan of Action. WHO/AFRO expressed particular interest in learning more about the approaches which MSH has developed for assessing national drug management and for building district capacity in drug management.

3. At the close of the meeting on April 3, the WHO/AFRO CDD/IMCI Regional Advisor extended an invitation to BASICS to propose specific plans for AFRO/BASICS collaboration.