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

Brazzaville, Congo

25-28 février 1997

Dr. Mutombo wa Mutombo

BASICS Technical Directive: 000-FA- 01- 014
USAID Contract Number: HRN-6006-C-00-3031-00

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ACRONYMES

AFRO	Bureau Regional de l'OMS pour l'Afrique
BASICS/HQ	Basic Support for Institutionalizing Child Survival/Headquarters
BASICS	Basic Support for Institutionalizing Child Survival
CHD/HQ	Child Health Division/Head Quarters
DDC/AFRO	Director of Disease control
IRA	Infections Respiratoires Aigue
LMD	Lutte contre les Maladies Diarrhéiques
ODA	Overseas Development Administration (Grande Bretagne)
OMS	Organisation Mondiale de la Santé
PCIME	Prise en Charge Intégrée des Maladies de l'Enfant
PEV	Programme Elargi de Vaccination
SARA	Support for Analysis and Research in Africa
TEHIP	Tanzania Essential Health Intervention
UNICEF	United Nations Children's Fund
USAID	Agence des Etats-Unis pour le Dévelopment International

RESUME

Six pays (l'Uganda, la Tanzanie, la Zambie, le Mali, le Niger, et le Togo) et six agences et organisations (l'OMS, l'UNICEF, l'ODA, le TEHIP, SARA et BASICS) ont pris part à la deuxième réunion régionale sur la mise en oeuvre de la Prise en Charge Intégrée des Maladies de l'Enfant en Afrique (PCIME). Cette réunion a été organisée par AFRO du mardi 25 au vendredi 28 février 1997 au Bureau Régional de l'OMS pour l'Afrique.

La première, qui s'était tenue du 31 janvier au 02 février 1996 avait regroupé l'OMS, l'UNICEF, la Banque Mondiale, la GTZ, SARA, et BASICS. Elle avait pour objet de partager le concept et le rationnel de la PCIME, d'obtenir le consensus sur les stratégies et les mécanismes de coordination et de développer un plan de mise en oeuvre pour la région.

La présente réunion a pour principale objet de faire le point et de partager les leçons tirées sur un an de mise en oeuvre. Les éléments saillants issus des présentations et des discussions sont résumés dans les 12 points ci-dessous:

1 La décision par le pays de s'engager dans le processus de la PCIME doit être consécutive à une information claire et adéquate de la part des agences techniques qui l'appuient.

2 L'appropriation de l'approche par les pays est un facteur important de durabilité; elle doit se matérialiser par un engagement politique et financier ferme. En outre, elle passe par l'utilisation des structures de soutien existants (centre de formation, système de distribution des médicaments, services de suivi/évaluation ...).

3 Il est essentiel d'obtenir par la négociation le consensus de tous les programmes impliqués dans la PCIME ainsi que celui des partenaires clés; l'obtention de ce consensus reste un processus de longue haleine; elle constitue toutefois un élément incontournable pour le succès et la durabilité de l'approche.

4 Un autre élément de la durabilité de la PCIME consiste dans la prise en compte du mouvement des réformes en cours dans le secteur de la santé. Elle doit en effet être intégrée dans ces reformes; pour éviter d'oeuvrer en marge de celles-ci, les services ou les responsables des reformes du secteur de la santé doivent être conviés aux ateliers d'orientation sur la PCIME.

5 L'introduction de l'approche dans les écoles de formation de base en vue de renforcer la formation est une nécessité qui doit être prise en compte par les pays qui sont avancés dans le processus de mise en oeuvre de la PCIME.

6 Le renforcement de la collaboration avec l'université par notamment par l'implication des pédiatres, et la disponibilité constante des nationaux et des consultants compétents ont été

des facteurs qui ont catalysé et favorisé la mise oeuvre de la PCIME dans les pays représentés à la réunion.

7 Sur la base de l'expérience acquise pendant cette première année de mise en oeuvre, une étape additionnelle a été ajoutée au processus; il s'agit de la pré-visite; son objectif est d'identifier les besoins du pays et de déterminer s'il est prêt à entamer le processus d'introduction de la PCIME.

8 Les difficultés rencontrées par la région pendant cette première année de mise en oeuvre sont relatives à l'insuffisance d'experts compétents et d'expérience, vue la jeunesse de l'approche, à la pression croissante des pays et des partenaires pour accélérer la mise en oeuvre de la PCIME, à la complexité et la longueur du processus d'introduction de l'approche, et à la difficulté d'obtenir le consensus de tous les programmes impliqués.

9 La nécessité de renforcer les capacités de facilitation des facilitateurs retenus pour la PCIME a été suffisamment soulignée; plusieurs scénarios ont été proposés; le draft de formation des facilitateurs préparé par la Zambie avec l'appui de BASICS a été présenté à l'assistance en vue de solliciter le feed-back.

10 L'importance de former les superviseurs dans la PCIME a été soulignée; c'est la garantie pour un suivi de qualité des personnes formées. Les visite de suivi devront être planifiées, budgétisées et effectuées dans les quatre à six semaines qui suivent la formation; elles devront, de préférence, être effectuées par les formateurs, au moyen d'un outil de suivi simple.

11 Les aspects relatifs à la législation en vigueur dans le pays ne doivent pas être occultés; l'exemple frappant qui en a été donné concerne le personnel habilité à poser l'acte médical et le type de médicaments disponibles par niveau.

12 En dehors de la mise en oeuvre de la PCIME, les programmes LMD et IRA doivent continuer à bénéficier de l'appui des partenaires.

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I. CONTEXTE

La première réunion consultative sur la mise en oeuvre de la Prise en Charge Intégrée des Maladies de l'Enfant (PCIME) dans la Région Africaine a eu lieu du 31 janvier au 02 février 1996 au Bureau de l'OMS à Brazzaville. Etaient présentes outre l'OMS, les organisations et agences suivantes: l'UNICEF, la Banque Mondiale, la GTZ, SARA et BASICS.

L'objet de la réunion était *(i)* de partager avec les partenaires le concept et le rationnel de la PCIME, *(ii)* d'obtenir le consensus sur les stratégies et les mécanismes de coordination et (iii) de développer un plan pour la mise en oeuvre de l'approche dans la région.

Au cours de la réunion, le concept et le rationnel de la PCIME avait été discutés; il en est de même du processus de mise en oeuvre et des étapes. Celles-ci étaient au nombre de huit, à savoir: le plaidoyer, l'atelier d'orientation, la planification des activités de la première année, l'adaptation des matériels de formation et l'examen des problèmes liés à la gestion (approvisionnement en médicaments, surveillance, supervision), le lancement de la formation, la surveillance, l'évaluation et la replanification.

Quinze pays (le Madagascar, l'Ethiopie, le Mali, le Niger, l'Uganda, la Tanzanie, la Zambie, le Botswana, le Congo, l'Erythrée, le Ghana, le Sénégal, le Sierra Leone, la Côte d'Ivoire et le Togo) avait été identifiés comme "premiers utilisateurs." Huit d'entre eux avaient déjà démarré les activités; il s'agit du Madagascar, de l'Ethiopie, du Mali, du Niger, de l'Uganda, de la Tanzanie, de la Zambie, et du Togo.

La présente réunion se situe dans la droite ligne de celle de février 1996; elle a pour principale objet de faire le point et de partager les leçons tirées sur un an de mise en oeuvre de la PCIME dans la région africaine.

Six pays y ont été conviés: l'Uganda, la Tanzanie, la Zambie, le Mali, le Niger, et le Togo. Les trois premiers sont suffisamment avancés dans le processus de mise en oeuvre; ils ont en effet déjà procédé à la formation des formateurs et des agents de santé de première ligne ainsi qu'au suivi de ceux-ci. Les trois derniers pays ont tout au plus atteint l'étape de l'atelier d'orientation.

Les Agence et organisation suivantes y étaient représentées: l'UNICEF, l'ODA, le TEHIP, SARA, et BASICS

II. OBJET DE LA REUNION

La rencontre avait pour objectif général de renforcer la mise en oeuvre de la PCIME dans le région africaine.

Les objectifs spécifiques étaient au nombre de trois

1. Adopter, sur la base des différents rapports sur l'état d'avancement de la mise en oeuvre de la PCIME, des recommandations pour l'avenir de l'approche dans la région.

2. Réviser l'approche commune de la mise en oeuvre de la PCIME adoptée lors de la première réunion de coordination.

3. Adopter le projet de plan d'action quinquennal pour l'appui à la mise en oeuvre de la PCIME dans les pays de la région.

Les résultats attendus de la rencontre découlent des objectifs spécifiques

- Des recommandations pertinentes adoptées pour améliorer la mise en ouvre de PCIME dans la région.

  L'approche commune de la mise en oeuvre de la PCIME adoptée lors de la première réunion de coordination révisée.

- Le projet de plan d'action quinquennal pour l'appui à la mise en oeuvre de la PCIME dans les pays de la région adopté par les partenaires.

III. DEROULEMENT ET RESULTATS DE LA REUNION

Il s'est tenu du mardi 25 au vendredi 28 février 1997 au Bureau Régional de l'OMS pour l'Afrique la deuxième réunion régionale sur la mise en oeuvre de la prise en charge des maladies de l'enfant en Afrique; six pays y ont pris part (l'Uganda, la Tanzanie, la Zambie, le Mali, le Niger, et le Togo) et les agences et organisations ci- après y étaient représentées : l'UNICEF, l'ODA, le TEHIP, SARA, et BASICS.

Les programmes de travail de l'atelier est en annexe 1, et la liste des participants et en annexe B.

Les programmes de travail était organisé en cinq sessions:

1. La Session 1, présidée par l'auteur, a eu à traiter, à travers deux présentations, de la situation de la mise en oeuvre de la PCIME au niveau régional et global.

Dans la région africaine, huit pays sont dans le processus de mise: l'Ethiopie, l'Erythrée, le Mali et le Niger ont déjà bénéficié d'un atelier d'orientation; le Madagascar a entamé le processus d'adaptation des manuels génériques; l'Uganda, la Tanzanie et la Zambie sont en train de préparer l'évaluation de la première année de mise en oeuvre.

2. La Session 2, présidée par le Dr D. Barakamfitiye, directeur du contrôle de la maladie auprès d'AFRO (DDC/AFRO), a permis de partager et de discuter des expériences de trois pays dans la mise en oeuvre de la PCIME: l'Uganda, la Tanzanie et la Zambie.

L'Uganda a mis en exergue l'importance d'obtenir tôt, à la phase initiale de planification et lors de l'atelier d'orientation, le consensus des programmes clés impliqués dans la PCIME (LMD, IRA, nutrition, paludisme), des pédiatres, des écoles de formation, du programme des médicaments essentiels et les partenaires.

La Tanzanie avait servi en mars-avril 1995 de terrain de pré-test du matériel de la PCIME développé par l'OMS; par la suite, elle a pu traduire le matériel adapté en swahili, langue d'enseignement dans les écoles de formation des infirmiers; elle a en outre organisé à l'intention des facilitateurs un cours sur les techniques de facilitation; ce cours de cinq jours a utilisé comme matériel de base le guide des facilitateurs de l'OMS. Elle est en train d'introduire le concept de PCIME dans l'enseignement de base.

Alors que la Tanzanie et l'Uganda avaient mis un point d'honneur à parcourir pas à pas les différentes étapes de mise en oeuvre telles que recommandées par l'OMS, la Zambie quant à elle, a été beaucoup plus inovative et pragmatique. Son expérience est forte en enseignement: particulièrement la nécessité d'impliquer les experts nationaux dès la phase initiale du processus; cette implication a été obtenue à la suite d'innombrables négociations menées avec les nationaux au niveau central et régional.

La Zambie est en pleine réforme du secteur de la santé et la PCIME doit, en vue de la pérennisation, être prise en compte dans ces reformes.

3. La Session 3, présidée par Dr J. Tulloch CHD/HQ, a donné aux partenaires l'occasion de partager leur expérience dans l'appui à la mise en oeuvre de la PCIME. chacune des organisations ou agences évoquées plus haut a donné un exposé de ses interventions.

4. La Session 4, qui a eu le même président que la Session 3 a eu à traiter, avec la présentation et la discussion du plan quinquennal 1997-2001, des perspectives de la PCIME dans la région.

Selon le plan quinquennal, la mise en oeuvre de la PCIME se fera de façon progressive: 20 pour cent des pays en 1997, 60 pour cent en l'an 2001. Les stratégies de mise en oeuvre s'articulent autour de: *(i)* la promotion des activités durables, *(ii)* le développement et l'utilisation judicieuse des capacités régionales

et sous-régionales, *(iii)* l'amélioration de la collaboration avec les partenaires et *(iv)* la promotion des activités de recherche

5. La Session 5, présidée par le Dr D Barakamfitiye, avait pour objet l'examen et l'adoption du rapport et des recommandations de la réunion; le document y relatif peut être consulté en annexe C.

En marge de ces sessions, les rencontres ont été organisées entre les six pays présents pris individuellement et l'ensemble des partenaires. L'objet de ces rencontres était de discuter plus en profondeur avec les représentants des pays concernés en vue d'identifier les besoins spécifiques en appui par rapport non seulement à la PCIME mais aussi au programme LMD et IRA; et d'en ébaucher le calendrier.

Les éléments saillants issus des présentations et des discussions de la réunion sont résumés dans les points ci-dessous:

- La décision par le pays de s'engager dans le processus de la PCIME doit être consécutive à une information claire et adéquate de la part des agences techniques qui l' appuient.

- L'appropriation de l'approche par les pays est un facteur important de durabilité; elle doit se matérialiser par un engagement politique et financier ferme. En outre, elle passe par l'utilisation des structures de soutien existants (centre de formation, système de distribution des médicaments, services de suivi/évaluation...).

- Il est essentiel d'obtenir par la négociation le consensus de tous les programmes impliqués dans la PCIME ainsi que celui des partenaires clés; l'obtention de ce consensus reste un processus de longue haleine; elle constitue toutefois un élément incontournable pour le succès et la durabilité de l'approche.

- Un autre élément de la durabilité de la PCIME consiste dans la prise en compte du mouvement des réformes en cours dans le secteur de la santé. Elle doit en effet être intégrée dans ces reformes; pour éviter d'oeuvrer en marge de celles-ci, les services ou les responsables des reformes du secteur de la santé doivent être conviés aux ateliers d'orientation sur la PCIME.

- L'introduction de l'approche dans les écoles de formation de base en vue de renforcer la formation est une nécessité qui doit être prise en compte par les pays qui sont avancés dans le processus de mise en oeuvre de la PCIME.

- Le renforcement de la collaboration avec l'université par notamment par l'implication des pédiatres, et la disponibilité constante des nationaux et des consultants compétants ont été des facteurs qui ont catalysé et favorisé la mise oeuvre de la PCIME dans les pays repésentés à la réunion.

- Sur la base de l'expérience acquise pendant cette première année de mise en oeuvre, une étape additionnelle a été ajoutée au processus; il s'agit de la prévisite; son objectif est d'identifier les besoins du pays et de déterminer s'il est prêt à entamer le processus d'introduction de la PCIME.

- Les difficultés rencontrées par la région pendant cette première année de mise en oeuvre sont relatives à l'insuffisance d'experts compétants et d'expérience, vue la jeunesse de l'approche, à la pression croissante des pays et des partenaires pour accélérer la mise en oeuvre de la PCIME, à la complexité et la longueur du processus d'introduction de l'approche, et à la difficulté d'obtenir le concensus de tous les programmes impliqués.

- La nécessité de renforcer les capacités de facilitation des facilitateurs retenus pour la PCIME a été suffisamment soulignée; plusieurs scénarios ont été proposés; le draft de formation des facilitateurs préparé par la Zambie avec l'appui de BASICS a été présenté à l'assistance en vue de solliciter le feed-back.

- L'importance de former les superviseurs dans la PCIME a été soulignée; c'est la garantie pour un suivi de qualité des personnes formées. Les visite de suivi devront être planifiées, budgétisées et effectuées dans les quatre à six semaines qui suivent la formation; elles devront, de préférence, être effectuées par les formateurs, au moyen d'un outil de suivi simple.

- Les aspects relatifs à la législation en vigueur dans le pays ne doivent pas être occultés; l'exemple frappant qui en a été donné concerne le personnel habilité à poser l'acte médical et le type de médicaments disponibles par niveau.

- En dehors de la mise en oeuvre de la PCIME, les programmes LMD et IRA doivent continuer à bénéficier de l'appui des partenaires.

IV. CONCLUSIONS

La deuxième réunion régionale sur la mise en oeuvre de la PCIME dans la région africaine a été riche en enseignement. L'analyse des 12 premiers mois de mise en oeuvre a démontré les progrès réalisés sur le terrain, mais elle a surtout mis en exergue la complexité de l'approche.

Les performances du personnel ayant bénéficié de la formation en PCIME sont encourageantes; toutefois, l'amélioration des structures de soutien existants (système de distribution des médicaments, système de supervision, services de suivi/évaluation...) mérite toute l'attention des décideurs; elle va en effet contribuer au renforcement des performances.

Les pays participant ont adhéré à la PCIME et reconnaissent qu'elle constitue un outil efficace pour réduire la mortalité chez les enfants de moins de 5 ans. Cependant les ressources financières y afférentes sont encore et surtout extérieures. Pour l'appropriation de l'approche par les pays et pour la durabilité de celle-ci, un engagement financier conséquent de la part des gouvernements doit être de mise.

Les reformes du secteur de la santé en cours dans les pays de la région constituent une opportunité pour intégrer la PCIME. Celle-ci devra en effet être repensée et planifiée dans le contexte de ces reformes et non en de celles-ci; il y va de sa durabilité.

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ANNEXES

ANNEXE A

PROGRAMME DE TRAVAIL

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	

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

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 h00 - 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

SESSION 7: Adoption of the report and closure

Chairman: Dr D. Barakamfitiyé, DDC

11 h 00 - 12 h 00	Consideration and adoption of the report of the meeting	
12 h 00 - 12 h 30	Closing :	
	- Recommendations	
	- General remarks	DDC
	- Closure	RD

27 February 1997

ANNEXE B

LISTE DES 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

LISTE DES PARTICIPANTS/LIST OF PARTICIPANTS

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Madima Ba/Sangare	Mali	Médecin Chef de la Division Santé familiale et communautaire	B.P. E 1149	(223) 22 45 26	(223) 23 29 36
Dr Frank Matingu Mueke	Nigeria	Medical Officer, CDR	WHO Office P.O. Box 2152	861504	234 1 2694903
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Dr P. S. Mongi	Tanzania	CDR/IMCI	WHO Country Office P.O. Box 9292	251 51 113005 251 51 116412	255 51 116412
Dr Saidi M. Egwaga	Tanzania	Programme Manager CDD/ARI/ IMCI MOH	P.O. Box 9083 Dar es Salaam	255 51 20261 7 251 51 112883	255 51 39951
Dr Leslie Mgalula	Tanzania	TEHIP District Support Officer	P.O. 9292 WHO Country Office	251 51 116412	255 51 116412
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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

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ANNEXE C

RAPPORT DE LA REUNION

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

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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.

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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 peadiatricians, 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

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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.

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4.2.2.3. **Adaptation of generic materials**

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

4.2.2.4. **Preparation for training**

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

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

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

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

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

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

4.2.2.6. **Facilitating Factors:**

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

4.2.2.7. **Constraints:**

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

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4.2.2.8. **Lessons learned:**

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

4.2.2.9. **Key Issues discussed**

The following were discussed in plenary:

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

4.2.2.10. **Recommendations**

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

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

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

4.2.3.1. The following steps were followed:

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

* workshop on planning of training and follow-up strategies

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

4.2.3.2. **Difficulties**

Zambia mentioned similar difficulties on implementation as those of Tanzania:

* transport difficulties (for patients and participants)

* pressure from National Board of Health to reduce Infant Mortality

4.2.3.3. **Lessons learned:**

* training courses have been conducted centrally and therefore there are not enough facilitators

* since supervisors were not trained in IMCI, it has been difficult to conduct quality supervision

4.2.3.4. **Critical Analysis of Tanzania and Zambia Experiences:**

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

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

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

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

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

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

4.3.3.5. **Key Issues:**

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

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

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

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

4.2.3.6. **Recommendations:**

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

4.3. Experiences of partners

4.3.1. Support for IMCI Implementation: BASICS

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

It is a USAID-funded project.

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

BASICS Project's support to IMCI in African countries:

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

- Zambia
- Madagascar
- Eritrea

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

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

4.3.1.3. Potential countries for future IMCI support:

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

4.3.1.4. **BASICS Regional Support in IMCI**

Regional office in Dakar (Senegal).

- There are 2 IMCI trained consultants.

BASICS HQ in Washington

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

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

4.3.1.5. **BASICS Global support**

BASICS has developed several materials for IMCI training:

- The complementary course - targeted to health workers with little literacy and capability to read.

- Course for training IMCI facilitators (still in draft).

- The preparatory guide - guide to help managers prepare introduction of implementation in the country.

- Drugs supply management course.

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

4.3.1.6. **Support for NGOs**

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

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

4.3.1.7. **Discussion**

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

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

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

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

4.3.2.1. Introduction

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

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

4.3.2.2. The broad objectives of TEHIP are :

To:

- increase and strengthen the capacity of district health management teams (DHMTs) and authorities in the two participating districts to effectively plan and deliver essential health interventions based on burden of diseases and cost effectiveness analysis and;

- measure, assess and document the overall impact and lessons learned in delivering selected health interventions at the district level

Currently TEHIP is operating in two districts Rufiji and Morogoro.

4.3.2.3. Characteristics of TEHIP

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

4.3.2.4. TEHIP Support for IMCI implementation in Tanzania:

- TEHIP has identified IMCI as one of the most cost-effective interventions in provision of health services.

- TEHIP is supporting the 2 districts in IMCI implementation in the following areas:

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

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

4.3.2.5. **Discussions**

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

4.3.2.6. **Recommendation**

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

4.4. Prospects

The presentations can be grouped under two themes:

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

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

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

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

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

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

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

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

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

4.4.2 Prospects

Several presentations were made on prospects.

4.4.2.1. WHO/AFRO

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

4.4.2.2. Partners

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

4.4.3. Plenary Discussions

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

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

4.4.3.2. The Training of Trainers and Facilitators

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

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

5. Recommendations

5.1. Improvement of IMCI Implementation

5.1.1. Actions by countries:

- Countries should take ownership of IMCI through the provision of a budget line by the government as well as the WHO country office.

- Health Sector Reforms process going on in many countries should be seen as an opportunity to introduce IMCI in the Minimum Package to be implemented at the district-level

5.1.2. Action by countries, WHO and Partners:

- Ensure the strengthening of facility support services in order to obtain optimal IMCI implementation (organization of patient flow at health facilities, improvement of referral services, supervision, provision and distribution of drugs including the pre-referral drugs for IMCI, and improvement of IEC in IMCI).

- National managers of programmes related to IMCI implementation should be invited to various national, intercountry and regional IMCI meetings, subject to the availability of funds.

5.1.3. Action by countries and partners:

- Partners should continue to support activities for the control of diarrhoeal diseases and acute respiratory infections in countries and provinces that have not started IMCI inplementation, 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 avaialable to countries, specific guidelines on how IMCI could be implemented in the context of Health Sector Reforms.

- WHO should develop in the nearest future a guide for the training on facilitation techniques, including guidance on the course agenda.

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

5.2. Revision of the common approach for IMCI implementation

5.2.1. Action by countries, WHO and partners:

- Preliminary visit should be included as the first step for the introduction of IMCI in order to allow national authorities appreciate the implications of the implementation of this approach and take appropriate decisions.

- Consensus meeting should be as a necessary step after the adaptation of generic materials and before the commencement of training.

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

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

6. Conclusion

IMCI implementation in the African Region has experienced significant progress in the last 12 months. Countries have enjoyed support from WHO and various interested partners. Countries recognise the approach as a major tool for reducing childhood mortality. Consequently, they have demonstrated a significant degree of political commitment to the approach, although greater finanacial 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 form WHO in future to enhance implementation at country level.