

Trip Report

The Second Regional Meeting on the Implementation of Integrated Management of Childhood Illness (IMCI) in Africa

Brazzaville, Congo: February 24–March 4, 1997

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Objectives

The objectives of Suzanne Prysor-Jones' visit to Brazzaville February 24-March 4, 1997 were:

1. To attend the second regional meeting held by the World Health Organization Africa Regional Office (WHO/AFRO) on implementation of Integrated Management of Childhood Illness (IMCI).
2. To assist WHO/AFRO in planning specific activities in the context of the USAID Africa Bureau's grant to this organization.
3. To follow up with WHO/AFRO on the status of the Health Systems Research Project expansion into Francophone Africa.

Regional Meeting on the Implementation of IMCI in Africa

This was an extremely interesting and important meeting attended by country teams from WHO "early use" countries: Zambia, Uganda, and Tanzania (already implementing IMCI) and Mali and Niger (at the "orientation" stage, according to WHO), as well as by WHO/Geneva, Vincent Orinda, senior advisor for Health at UNICEF/New York, and Alistair Robb, a British Overseas Development Administration (ODA)-funded officer who will be based at WHO/AFRO as of April 1997.

The meeting centered around the presentations of the Zambia, Uganda, and Tanzania experiences so far with IMCI implementation, and on the WHO/AFRO strategy and plan of action for the IMCI in Africa.

The WHO/AFRO strategy is presented in Appendix A, along with comments on it written up by Bob Pond of BASICS/Washington after discussions with Prysor-Jones (Appendix B). Notes from the country presentations are included in Appendix C. The WHO/AFRO report of the whole meeting is attached in Appendix D.

Prysor-Jones made a presentation on the USAID Africa Bureau's perspective on a strategy for Africa and on SARA activities that are germane to IMCI. The overheads used are attached in Appendix E.

Some notable positive points of the meeting were:

- ◆ The country presentations were extremely detailed and interesting. The country teams working on IMCI are obviously very committed and enthusiastic about the benefits and potential of the approach. The lessons from the first year of implementation were very much those that might be expected, in the light of 10 years experience with CDD and ARI, confirming the need to pay attention to:

Regional Meeting on the Implementation of IMCI in Africa

- ♦ issues of drug supply, supervision, and the organization of work at the health facility;
 - ♦ human and other resources required to implement IMCI at the central, regional, and district levels. IMCI is often being implemented by CDD/ARI program managers, who are becoming quickly overwhelmed as IMCI becomes more than a pilot experience;
 - ♦ pre-service training;
 - ♦ sensitization and commitment of decision makers and early inclusion of the pediatric community;
 - ♦ the organization of training courses. It is difficult to have sufficient, available, and capable facilitators, and to organize hands-on case management during the courses;
 - ♦ the average time required to attend correctly to each case (around 17 minutes);
 - ♦ and the need for several in-depth supervision visits to ensure that IMCI norms are internalized and respected.
- ◆ Some interviews with caretakers in Tanzania indicate that the beneficiaries are pleased with the increased attention that their children are receiving when IMCI is being implemented.
 - ◆ The WHO/AFRO strategy does now include drugs, supervision, organization of work, under a result entitled “improving health facility support services.” After some discussions in the small group planning session (see #2 below), this also is reflected in the Plan of Action for WHO/AFRO.
 - ◆ With the support of WHO/Geneva, the goal of the WHO/AFRO strategy is now “to improve the management of childhood illnesses.” The addition “in health facilities” was dropped, and thus leaves room for improvement of the quality of care in the home as well as the health facility.
 - ◆ UNICEF expressed interest in collaborating closely on the IMCI initiative, particularly in the areas of community and home care.

Some issues

- ◆ WHO/AFRO regards IMCI as an “approach” and not an initiative or program. This decision stems from wanting to avoid the idea that there must be a separate, “vertical” structure that deals with IMCI in ministries of health. Although this concern may be a valid one, experience from the

Planning Specific Activities in the Context of the AFR/SD Grant to WHO/AFRO

field suggests that the committee or structure that is responsible for promoting IMCI implementation in decentralized systems must have a clear status and, also some authority in order to be able to fulfil its quite complex role of improving the quality of care through IMCI implementation.

- ◆ WHO is, in general, cautious and often, in fact, reticent to work with USAID projects on the development of tools and materials for IMCI. WHO/Geneva found it appropriate to state several times during the meeting that the *SARA Guide for the Introduction of IMCI* is not recommended by WHO.
- ◆ WHO/AFRO would like to have a “catalyst” in each country implementing IMCI. This is a sound principle that we have supported. However, the WHO intention to contract 28 new national experts for IMCI (one in each country) seems to overlook the existing resources that should be tapped first, e.g., BASICS country representatives, WHO existing country teams, etc.
- ◆ IEC is only addressed in the WHO strategy/work plan insofar as improved counseling at the facility may lead to improved practices in the home. The AFRO team was adamant in not including any other IEC activities (even coordination with other actors) at this stage of implementation. The team prefers to include in their plans only activities for which they feel they can be directly responsible.
- ◆ WHO did not consider orientation of catalysts on how to facilitate assessment and problem solving on systems issues for IMCI to be a necessary activity.

Planning Specific Activities in the Context of the AFR/SD Grant to WHO/AFRO

An all day meeting was held with Drs. Kabore, Loco, Oluwole, Musinde, and Mueke. Working from the Regional IMCI Plan of Action and Budget 1997–2001, attached in Appendix F, Prysor-Jones discussed with the WHO team the items that they would like to cover under the AFR/SD Grant to WHO/AFRO (see Appendix G).

Prysor-Jones encouraged the team to identify the bottlenecks to implementation, with a view to speeding up the process, especially in Francophone Africa, while maintaining good quality work. One of the main bottlenecks was felt to be the limited human resources available in the AFRO team. The following additional posts were therefore suggested:

***Planning Specific Activities in the Context
of the AFR/SD Grant to WHO/AFRO***

- ◆ A program assistant to help with the operations aspects of IMCI implementation in Brazzaville;
- ◆ A medical officer to be based in Brazzaville, responsible for introducing IMCI into pre-service training settings;
- ◆ A medical officer to be based in West Africa, making a two-person team for that sub-region; and
- ◆ A medical officer to be based in the Horn of Africa.

To support the strengthening of national capacity to implement IMCI, the Team feels that a full-time national expert should be contracted by WHO and serve as a "catalyst." Suggestions that BASICS staff and/or WHO country team staff may be able to play this role were not considered practical. The Team would like USAID funds to cover a national expert for:

- ◆ Tanzania (one year only);
- ◆ Uganda (two years);
- ◆ Niger (two years); and
- ◆ Mali (two years).

As far as training inter-country consultants are concerned, the Team would like USAID funds to cover:

- ◆ One training in 1998 on IMCI for consultants;
- ◆ A facilitators training following this;
- ◆ A training in 1998 on adaptation of the algorithm; and
- ◆ Some travel for consultants to team up with experienced evaluation experts.

The team did not feel that any training or orientation was necessary on planning and systems issues/implications of IMCI for the health system for catalysts or consultants.

To improve facility support services, the Team agreed, after much discussion, that funds may be needed and should be budgeted for local assessment of some of the systems issues, and also for some technical assistance. Ninety-six thousand dollars

***Follow Up on the Status of the Health Systems Research
Project (HSR) Expansion into Francophone Africa***

per annum is thus being requested for do assessments in four countries each in the areas of drugs, supervision, and organization of health services, as required. Consultant trips are budgeted for five countries in each of these same areas.

The Team was unwilling to put any funds aside for IEC assessment or technical assistance. They feel that IEC will be adequately covered by the improvements in counseling at the health facility that will result from IMCI training and follow-up. They feel that it is not in their manageable interest to do more to improve case management in the home.

For pre-service training, the Team budgeted \$111,000 for the first year for visits to schools, consultants to train tutors, training materials, training and follow up, mostly of nursing schools in three countries. They also budgeted a consultation for Zambia to work with the Medical School. Four additional countries are to be covered in the second year, for a second year total of \$188,000. The seven countries targeted are Niger, Mali, Uganda, Ethiopia, Zambia, Tanzania, Togo.

The total budgeted for USAID support over a two-year period is \$1,635,000.

**Follow up on the status of the Health Systems Research Project
(HSR) expansion into Francophone Africa**

Pryor-Jones met with Dr. Luis Sambo and Prof. Manlan on plans for HSR in Francophone Africa. Dr. Sambo has charged Prof. Manlan with following this project. CESAG is indeed being considered as a possible seat for HSR/ Francophone, and, in principle, Prof. Manlan is to visit the institution with Prof. Mwaluko from HSR/Harare. Since Mwaluko's travel schedule is so tight, Prof. Manlan may try to make an initial visit before mid-year, following a trip that is planned to The Gambia.

Funding for HSR activities in Francophone Africa is not yet secured. It was agreed that a strategy for fund raising should probably be developed with the institution that is selected to house the initiative. SARA services were offered to assist in priority setting and proposal development, if required.

Appendix A: The WHO/AFRO Strategy

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.

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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.

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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

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.

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6.1.4 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.

6.2 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.

6.2.1 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

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

6.2.3 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.

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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.

CDE, 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.

7. INTERVENTIONS/ACTIVITIES/BUDGET - see Annex

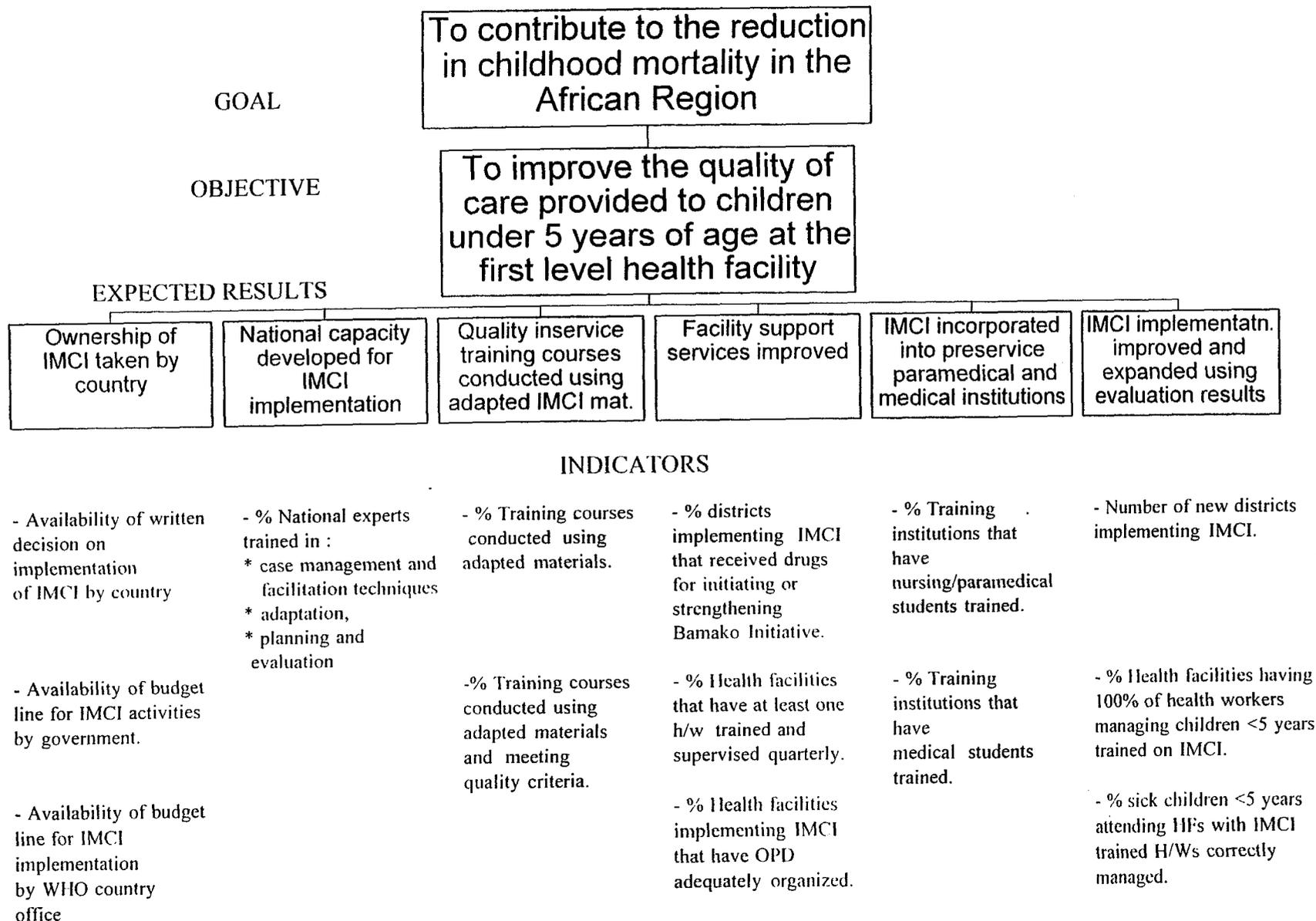
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WHO AFRICAN REGIONAL IMCI APPROACH

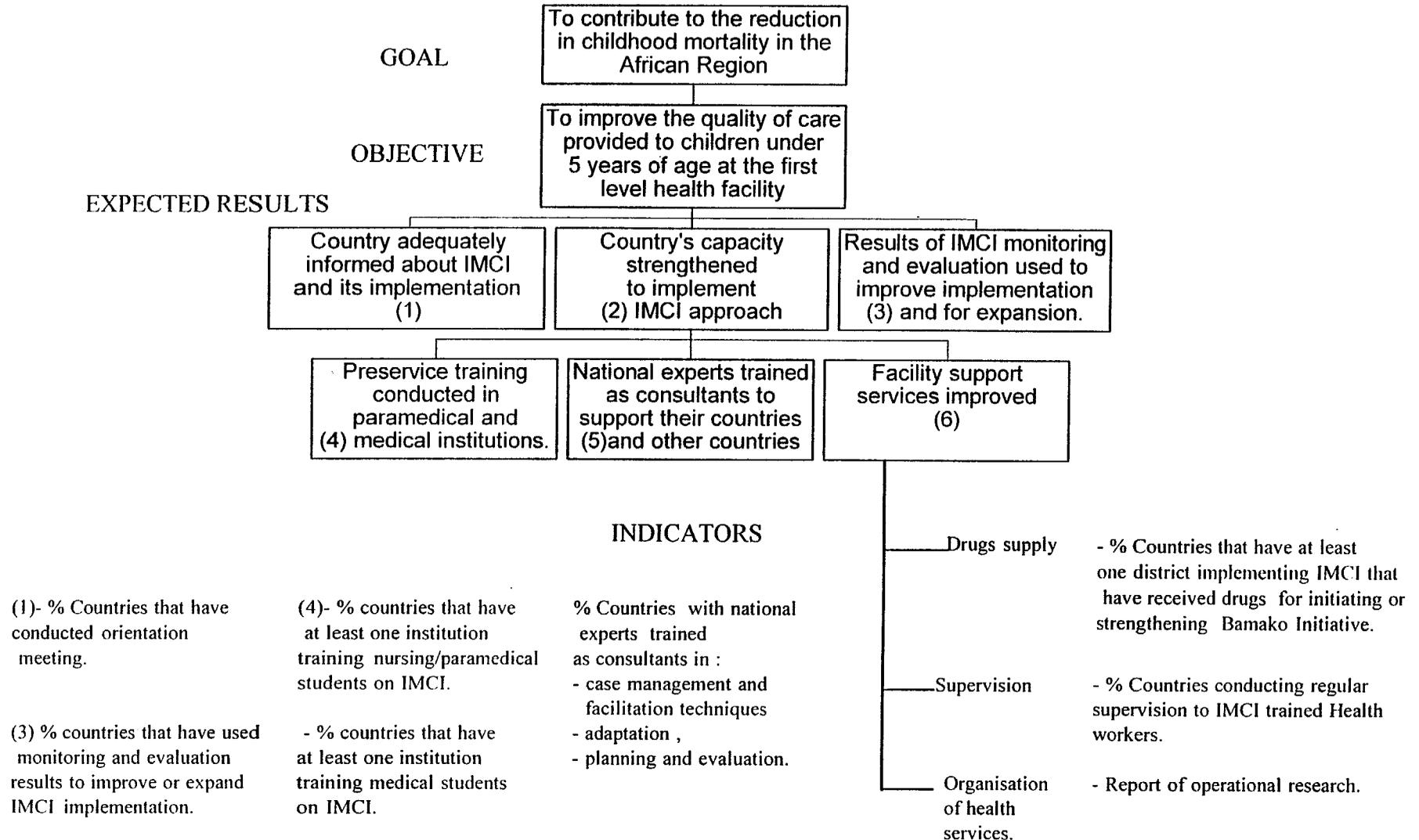
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COUNTRY LEVEL



WHO AFRICAN REGIONAL IMCI APPROACH

REGIONAL LEVEL



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Appendix B: Comments by Bob Pond

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 subcomponents 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.

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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 manage**
- 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.

Appendix C: WHO/AFRO and Country Presentations

WHO/AFRO and Country Presentations

The following points were brought up by Dr. Kabore in his initial presentation of IMCI in the Africa region, following one year of implementation experience, mainly in the three WHO "early use" countries: Tanzania, Uganda, and Zambia.

Presentation by AFRO

Lessons Learned

- ◆ Countries must take ownership of IMCI;
- ◆ Countries must be well-informed about IMCI and its implications before deciding to adopt it;
- ◆ Sustainability of IMCI is enhanced by using existing structures;
- ◆ Early incorporation into pre-service training enhances sustainability;
- ◆ Early involvement of pediatricians helps acceptability, and linkage building between universities and ministries of health; and
- ◆ Skilled consultants making frequent visits are needed to assist with IMCI.

Problems Encountered

- ◆ There is inadequate experience with implementation of IMCI.
- ◆ The number of experts and consultants is insufficient.
- ◆ There is undue pressure from "partners" for rapid expansion of IMCI, thus endangering the quality of the endeavor.
- ◆ The complexity and long duration of the IMCI introduction process is a problem.
- ◆ It is difficult to obtain quick consensus of program managers at country level.

Prospects

- ◆ A preliminary visit to countries (before the orientation meeting) is an important part of the introduction process.

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- ◆ There is need for continued support of countries and national capacity building.
- ◆ There is a need to encourage country ownership.
- ◆ The inclusion of IMCI in pre-service training will be encouraged.
- ◆ CDD and ARI programs should be reinforced in countries and regions that are not yet implementing IMCI.
- ◆ A five-year regional plan is needed for the development and implementation of IMCI.

The British Overseas Development Administration (ODA) is providing a grant to WHO/AFRO of approximately 1.1 million dollars both for malaria and for IMCI over a two-year period. Incidentally, the ODA representative volunteered that the SARA Guide for the Introduction of IMCI had been useful in the development of the grant agreement with AFRO.

The Uganda Experience

- ◆ Working on the introduction of IMCI forced the definition of guidelines for malaria and for the treatment of malnutrition to be defined by the programs and units responsible for these issues. There was apparently some discordance of advice given by WHO/Geneva and WHO/AFRO on malaria policies, which confused issues at the country level.
- ◆ The need for external support at the beginning of IMCI introduction was clearly felt by the Ugandan MOH, especially in the domain of nutrition.
- ◆ A vigorous approach is needed to follow up with other programs and directors during IMCI introduction, even if it seems like every one is in agreement during the orientation meeting.

Problems Encountered in Uganda

Central Level

- ◆ Consensus building and acceptance of IMCI was not always easy.
 - ◆ Some programs did not have policies, making IMCI implementation difficult, but also useful in that it created pressure for policy formulation.
 - ◆ Not all the IMCI drugs were on the essential drug list or in drug kits, which are made up in Europe and take approximately two years to
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change. Vitamin A is now in the kit, but the pre-referral drugs (chloramphenicol, gentamicin, and quinine) have to be specially provided by the districts, using their own funds.

- ◆ The Health Management Information System (HMIS) is being revised. Many discussions were possible and necessary to influence its content in order to include data useful for IMCI.
- ◆ The only logistics support available is through the CDD program, which had to be stretched out to cover ARI and IMCI activities. Three vehicles are needed to implement IMCI courses in the districts, owing to the practical work required during the course. Also three sets of VCR/TV equipment are necessary. These resources are not available as yet.
- ◆ Planning the IMCI activities has been hampered by the uncertainty of the availability of funds from the different donors involved.

District Level

- ◆ At facility level, there have been issues of inadequate space, lack of equipment, drugs and supplies.
- ◆ The organization of work at the facility level also has been problematic, e.g., the practice of doing health education in large groups.
- ◆ Nurses are not officially authorized to prescribe drugs or to examine patients in Uganda, although many in fact do, in rural health centers.
- ◆ Drugs are given out by "dispensers," not physicians, clinical officers, nurses, etc., and these dispensers have not attended the 11-day courses.
- ◆ The referral system is poor in Uganda, often requiring long waits for buses, etc.
- ◆ Record-keeping often is done poorly. A system has been found whereby a summary of the IMCI case is recorded, since it is not possible to record everything (assessment, classification, and treatment) in detail for each patient. A laminated IMCI chart is used for reference only.

Facilitating Factors (Uganda)

- ◆ Commitment of CDD program staff, who are spearheading the initiative.
 - ◆ Technical strength of the facilitators doing the training (members of the Dept. of Pediatrics).
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- ◆ The cooperation and quality of the training units and district services.
- ◆ Donor support and interest, especially the WHO and UNICEF country offices.
- ◆ The high demand from the districts.

Difficulties (Uganda)

- ◆ Demand for IMCI in the districts is now in excess of the implementation capacity of the central Ministry; there are no regions/provinces at intermediate level in Uganda.
- ◆ The “wrong” participants are sometimes sent to IMCI training courses, despite instructions, making the preparation of district facilitators difficult.
- ◆ Facilitators from outside the Ministry of Health, e.g., from the university, sometimes demand consultants fees.
- ◆ The duration of the course has been an issue. It was initially planned to have 13 days, but 11 days is quite enough, and facilitators skills cannot be transferred during that time.
- ◆ There have been problems finding enough cases for hands-on clinical practice.
- ◆ There have been some drug supply problems.
- ◆ Transportation to clinical sites has been difficult.
- ◆ There have been transfers out among trained staff, e.g., in the child survival training unit.

Lessons Learned (Uganda)

- ◆ The absence of policies has some advantages (e.g., IMCI can have an influence in formulating new policies) and some disadvantages (e.g., formulating consensus policies is time-consuming).
 - ◆ It is helpful to start “from the bottom up,” i.e., to have some field experience before policies are formulated.
 - ◆ It is important to build on existing systems, and not to create parallel, new, and unsustainable efforts.
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- ◆ There is need for continued efforts at different levels to ensure the acceptability of IMCI.
- ◆ There is need for close working relationships between the central and district levels (no regions/provinces in Uganda).
- ◆ Local studies are needed to back up the IMCI guidelines (for local acceptability).
- ◆ Follow-up and monitoring as planned may not be feasible or sustainable. Eight districts are implementing IMCI and the central level is having difficulty doing adequate follow-up.

Plans/Hopes/Suggestions/Comments from Uganda

- ◆ Uganda wishes to include IMCI in pre-service training for medical assistants, nurses, and physicians. They feel that a child health and development unit is required, since the load of IMCI is too much for the CDD/ARI program to implement. At least one extra person is required to help with IMCI.
 - ◆ IMCI should be included in district plans—district authorities must be sensitized for this to happen.
 - ◆ District planning capacity needs to be increased, and supervision is necessary.
 - ◆ A focal person for IMCI is necessary in each district.
 - ◆ The child survival training facilities need upgrading.
 - ◆ There is too much reading for participants to do in the “assess” module.
 - ◆ The counseling module is seen by participants as difficult.
 - ◆ IMCI has highlighted the need to advocate for better services at referral services.
 - ◆ A separate five-day facilitators course is needed, as well as a two-day orientation for course directors.
 - ◆ Nursing aids run 40 percent of the health units in the country, and require a simplified course.
 - ◆ The 11-day course costs around \$15,000 for 20 participants.
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- ◆ The problem of having no regions/provinces may be addressed by identifying strong districts and using them as training sites and, perhaps, even to supervise other districts.
- ◆ Two hours are needed for follow-up supervision after training.
- ◆ Immediate problem solving is important during follow-up.

The Tanzania Experience

The IMCI training modules were field tested in Tanzania in early 1995. This gave rise to some modifications of the course and the strategy for implementation. The course was translated into Swahili in order to improve its suitability for mid-level health workers.

Criteria

Criteria for the choice of districts to implement IMCI include:

- ◆ The presence of an active CDD/ARI zonal coordinator.
- ◆ A good district medical officer.
- ◆ Donor support in the District.
- ◆ Limited distance from the trainer/supervisors.

Training

Training was done in regional or district hospitals, since the child survival training unit receives only referral patients. Training took place at three levels:

- ◆ training of master trainers, who are senior pediatricians from universities and regional and zonal CDD/ARI coordinators.
- ◆ training of trainers for three regions (11 days of case management and 4 days of facilitators skills).
- ◆ training of front line workers in four districts (two from each health facility).

Two training schools are incorporating three or four-week blocks of training on IMCI. Tutors have been trained and IMCI will be subject to examination. It will later be formally included in the curricula.

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Enabling Factors

- ◆ MOH interest.
- ◆ donor support.
- ◆ Technical assistance available.
- ◆ The TEHIP (Tanzania Essential Health Interventions Project) will implement and evaluate the impact of IMCI.
- ◆ The Training and MIS departments are both ready to incorporate IMCI into curricula and the information system, respectively.

Difficulties

- ◆ Poor communications with the districts.
- ◆ IMCI training is expensive to implement (long course, requiring transport to training sites, etc.) and requires much logistics support.
- ◆ The training requires long absences from the working place, this is especially difficult for the facilitators/pediatricians.
- ◆ Close supervision is needed and follow-up was not adequately funded at the start.
- ◆ The central staff is too small, and no new staff are to be recruited.
- ◆ One follow-up visit after training is not enough to change practices; two or three more are necessary.
- ◆ Clinical supervisors are needed at district level (the only clinical member of the District Health Management Team is the director).
- ◆ Of the 27 trainers trained, only 19 were adequate, and 13 readily available to do training in the districts.
- ◆ Follow-up visits showed an average of 17 minutes spent with each patient.
- ◆ Problems during follow-up included poor feeding assessment, danger signs forgotten, and some major symptoms not asked about. Over two thirds were satisfactory, however.

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- ◆ Several facility constraints were encountered during follow up, including lack of referral possibilities in two thirds of cases, cold chain problems in one third, lack of timing devices, shortage of trained staff, inadequate registers, etc.

Some Results

- ◆ Chart books and mothers cards are being used.
- ◆ Some participants have trained/informed others in their workplaces, e.g., about counseling on breastfeeding and using drugs at home.
- ◆ An improved division of tasks can be seen in some facilities with IMCI implementation.
- ◆ There is more rational use of drugs, especially antibiotics, according to the registers.
- ◆ The majority for facilities have re-opened ORT corners.
- ◆ Mothers seem to appreciate the time given to them, the counseling, the giving of the first dose of drugs at the facility, and the follow-up care.

Lessons

- ◆ IMCI needs more preparation than CDD and ARI training.
- ◆ Government (inter-sectoral) support is needed for implementation
- ◆ Capable tutors are essential.
- ◆ IMCI training needs considerable human capital and funds.
- ◆ It is important to integrate IMCI into pre-service training.

Challenges

- ◆ It is unclear how sufficient coverage of IMCI training can be obtained.
 - ◆ Integration of IMCI into health sector reform is an important issue.
 - ◆ Pressure is coming from donors for increased coverage as well as quality of training.
 - ◆ A good plan is required for expansion.
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- ◆ The inclusion into pre-service training is not easy.
- ◆ The availability of pre-referral drugs is a problem.

Future Plans

- ◆ Evaluation of activities in late 1997.
- ◆ Introduction into pre-service training in 1997.
- ◆ Expansion to other districts in 1998.
- ◆ Pre-referral drugs to be included in drug kits.
- ◆ More donors will be encouraged to participate (USAID, ODA, World Bank).
- ◆ Management must be strengthened, especially at central level where human resources are inadequate.

General Issues

- ◆ There is need to advocate for clear inclusion of IMCI and other technical areas in health reform, in order to improve the performance of the system.
- ◆ Jim Tulloch promised that WHO will come out with a statement on what IMCI can do for other programs, and what IMCI requires from other programs.
- ◆ The Tanzania group stressed the need to look at all the systems that affect health provider performance when doing follow up and supervision.
- ◆ Tanzania has five years of experience with medical schools, introducing CDD education. They feel that it is easier to work with the schools of clinical officers, and intend to start to introduce IMCI there first.

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The Zambia Experience

Some Results from Initial Implementation

With practice, health workers spend from 7 to 15 minutes with each child. Initially, this time span was from 10 to 60 minutes.

After training:

- ◆ The use of antibiotics was rationalized.
- ◆ Greatly increased advice on how to give medicines, increasing of fluids and feeding, and counting of respiratory rates.
- ◆ Areas of difficulty included advising mothers when to return, poor assessment of nutritional status, feeding, palmar pallor, oedema, and poor counseling.

The Impact of Health Reforms on IMCI

In general, reform has been helpful for IMCI, since there is an emphasis on integration. On the other hand, there is much change to manage, with simultaneous health reform and IMCI.

Some Implementation Issues / Difficulties

- ◆ Training 20–22 people costs around \$25,000, including the drugs used and hiring of transport.
- ◆ Problems of expanding training to the whole country while maintaining quality control, since there are limited resources, facilities for training, facilitators, and supervisors.
- ◆ IMCI was introduced before the materials were fully adapted. Adaptation was done as the process evolved, especially since several languages have been used for some parts of it.
- ◆ The Technical Committee for IMCI is difficult to mobilize, since everyone is being coopted for the Central Health Board, and has little time to meet.
- ◆ Some confusion of materials between BASICS and AFRO.

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Positive Points	Negative Points
<ul style="list-style-type: none"> * The general climate of change leads to opportunities for innovations. * New cooperation between health systems reform (HSR), WHO, and IMCI. * Systems are being improved, e.g., logistics, drugs, malaria, nutrition. * There is a sense of enthusiasm and hope for making things better. * Increased awareness of the health situation has been fostered. * There is more control and ownership of districts and communities. * Integrated service delivery provides an opportunities for clinical integration. * The reforms have encouraged polyvalent workers. * Arguments for IMCI (cost-effective, rationalizes drug use, reduces mortality, improves quality of care) gibe with health reform approach. * The delays in setting up the HMIS allow time to integrate IMCI. * There is improved collaboration with partners. * Pediatric association and university people are working better with MOH. 	<ul style="list-style-type: none"> * The process of decentralization has been too slow, and there has been a lull in program activities while “capacity building” for decentralization takes place. * There has been little thought on how to give technical support to districts, do advocacy, address policy issues, for the main thrusts of the health system (reproductive health, child health, HIV/AIDS, sanitation, TB). * There has been considerable movement of personnel under the Health Boards, so constant advocacy is required to encourage stability to consolidate technical gains. * There is much shifting of policies. * There is much political pressure to do training, and inadequate time to strategize. * There is inadequate leadership for some of the technical innovations. * Central Health Board is unhappy with the cost of the IMCI workshops. This is in opposition to concerns to preserve the quality of the training. * Child health does not have a prominent place in the main health “thrusts”. * The role of the region is unclear, and little capacity building at regional level has been done.

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- ◆ Screening is, in fact, done by environmental health assistants, with limited reading skills, so need a course with reduced reading, more based on practical work.
- ◆ No document exists of integrated policies and guidelines.
- ◆ There is a need for integrated guidelines for planning and implementation also.
- ◆ Problem of drugs needed for referral not being in the drug kit system. The IMCI group is negotiating with the national drug program to review the essential drugs policy.
- ◆ A new MIS system is being introduced in Zambia, and IMCI is making a contribution to its design.

Recommendations

- ◆ There is a need to integrate IMCI into pre-service training.
- ◆ There is a need to train more facilitators, course instructors, and clinical instructors.
- ◆ It is very important to identify and solve problems in their settings, especially for the systems issues that arise during IMCI implementation.
- ◆ Frequent supervision from the district teams after the first follow-up visit will be critical to successful changes in health worker behavior.
- ◆ Supportive services need to be strengthened.

Appendix D: The WHO/AFRO Report

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

Brazzaville 25-28 Février 1997

RAPPORT DE LA REUNION

Introduction

En Afrique, les principales causes de mortalité des enfants de moins de 5 ans, telle que la pneumonie, les maladies diarrhéiques, malaria, rougeole et malnutrition peuvent être traités ou prévenues par l'utilisation des techniques simple financièrement accessible et efficaces. La majorité des enfants se présentent souvent une ou plus de ces maladies en consultation dans laes formations sanitaires dont les soins restent encore sub-optimaux.

En d'améliorer la qualité des soins offerts aux enfants de mois de 5 ans au niveau des formations sanitaires de premier recours, en utilisant les techniques simples et des médicaments financièrement accessible, l'OMS et l'UNICEF ont développé un paquet pour la Prise en charge Intégrée des Maladies l'enfant (PCIME). Ce packet intègre les soins curatifs, préventifs promotionnels à offrir dans une approche globale et plus efficace pour la survie de l'enfant.

Plusieurs pays africains considèrent la PCIME comme une réponse aux besoins de la population et espèrent que son application contribuera à une réduction drastique de la mortalité de l'enfant. En conséquence, le Bureau régional de l'OMS a adopté cette approche comme un moyen d'appuyer les pays membres dans leur lutte pour l'amélioration de la survie de l'enfant.

En 1995, le Bureau régional a commencé a mise en oeuvre de la PCIM. Les pricipales étapes parcourues en 1996 en vue de la mise en oeuvre comprend une série de séminaires d'orientation au sein de la DDC et avec les autres unités à Afro; Les unité de l'OMS/AFRO et les partenaires intéressés à la PCIME; les responsables nationaux des programmes de lutte contre les maladies diarrhéiques et les infactions respiratoires aigües.

A ce jour, sept pays dont l'Eritrée, l'Ethiopie, le Mali, le Niger , a Tanzanie, l'Uganda et la Zambie ont commencé la mise en oeuvre de la PCIME. Plusieurs autres pays ont manifesté leur intérêt.

Un des résultats des séminaires d'orientation a été la résolution prise pour conduire des revues et évaluation périodiques de la mise en oeuvre dans la Région africaine de l'OMS. En guise de la mise en oeuvre de cette résolution, la « Deuxième Réunion Régionale sur la mise en oeuvre de la PCIME en Afrique » a été organisée à Brazzaville du 25 au 28 février 1997.

1.1. Objectif général

Renforcer la mise en oeuvre de la Prise en Charge Intégrée des Maladies de l'Enfant dans la Région africaine.

1.2. Objectifs spécifiques

- i) Adopter, sur la base des différents rapports sur l'état d'avancement, des recommandations pertinentes pour améliorer la mise en oeuvre de la PCIME dans la Région.
- ii) Reviser l'approche commune pour la mise en oeuvre de la PCIME adoptée lors de la réunion de Février 1996.
- iii) 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.

2. RESULTATS ATTENDUS

- 2.1. Des recommandations pertinentes adoptées pour améliorer la mise en oeuvre de la PCIME dans la Région.
- 2.2. L'approche commune pour la mise en oeuvre de la PCIME adoptée en Février 1996 révisée.
- 2.3. Le projet de plan d'action quinquennal pour l'appui à la mise en oeuvre de la PCIME dans la Région adopté par les partenaires.

3. METHODE DE TRAVAIL

Les travaux se dérouleront en plénière.

Les activités à mener pour atteindre les objectifs ci-dessus et obtenir les résultats attendus sont les suivantes:

- 3.1. Examiner les rapports sur l'état d'avancement de la mise en oeuvre de la PCIME au niveau régional et au niveau des pays.
- 3.2. Echanger les expériences entre Pays et Partenaires sur la mise en oeuvre de cette approche.
- 3.3. Examiner un projet de plan d'action quinquennal (1997-2001) d'appui à la mise en oeuvre de la PCIME dans la Région.

**RAPPORT DE LA SESSION 1:
SITUATION REGIONALE ET MONDIALE.**

Cette session comprenait deux exposés:

Le premier, présenté par le Dr Antoine Kabore, est intitulé "*Situation de la mise en oeuvre de la PCIME dans la région et les leçons apprises*".

Le présentateur a fait un bref rappel de la situation sanitaire en Afrique, mettant en exergue les difficultés rencontrées dans la prise en charge des cas, la rareté des ressources, le coût élevé des médicaments, la perte de confiance envers les services de santé, tous autant d'éléments qui justifient la nécessité d'intégrer la prise en charge des maladies de l'enfant.

L'approche se différencie des projets et contribue à donner une réponse adéquate à la prise en charge des cas. Elle ne nécessite pas la mise en place d'une structure spéciale.

La définition d'une stratégie régionale de mise en oeuvre a été mise au point; le document de référence avait pour objectifs:

- l'amélioration de la qualité de la prise en charge des enfants de moins de 5 ans
- l'introduction progressive de l'approche dans les pays de la région (10% des pays à la fin de 1996, 20% à la fin de 1997, et 50% à la fin de 2001).

Le présentateur a également rappelé les étapes essentielles retenues dans l'introduction de l'approche: le plaidoyer, le séminaire d'orientation, la planification des activités de la première année, l'adaptation du matériel générique, la formation, le suivi/évaluation et la replanification.

Actuellement, 8 pays de la région sont en train de mettre en oeuvre cette approche: l'Ethiopie, l'Erythrée, le Mali et le Niger ont déjà organisé leur séminaire d'orientation; le Madagascar va bientôt organiser le processus d'adaptation du matériel générique; l'Ouganda, la Tanzanie et la Zambie préparent l'évaluation de la première année de mise en oeuvre.

Une étape supplémentaire a été jugée nécessaire: il s'agit de la prévisite dont l'objectif est d'identifier les besoins du pays et de déterminer s'il est prêt à entamer le processus d'introduction de la PCIME. L'Afrique du Sud, le Botswana et le Zimbabwe ont bénéficié de la visite préliminaire.

Pour favoriser la pérennisation de l'approche au niveau des pays, trois éléments ont été identifiés: la prévisite, l'organisation des réunions pour obtenir le consensus national, la création d'une ligne budgétaire pour l'introduction de l'approche.

Les leçons apprises:

- La décision par le pays de s'engager dans le processus doit être consécutive à une information claire et adéquate.
- L'appropriation de l'approche par les pays, par un engagement politique et financier ferme, est un facteur de durabilité important. Celle-ci passe en outre par l'utilisation des structures de soutien existants dans le pays (centre de formation, système de distribution des médicaments, services de suivi/évaluation ...).
- L'introduction de l'approche dans les écoles de formation en vue de renforcer la formation de base.
- Le renforcement de la collaboration avec l'université par l'implication des pédiatres
- L'importance de la disponibilité constante des nationaux et des consultants compétants.

Les difficultés:

Les difficultés rencontrées dans la mise en oeuvre au niveau de la région sont l'insuffisance d'experts compétants et d'expérience (vue la jeunesse de l'approche), la pression croissante des pays et des partenaires pour accélérer la mise en oeuvre, la complexité et la longueur du processus d'introduction de la PCIME, la difficulté d'obtenir le consensus de tous les programmes.

Les perspectives

- La prévisite est une partie intégrante du processus.
- Le renforcement de l'expertise nationale et l'appropriation de l'approche par les pays sont une nécessité; il en est de même de l'intégration de l'approche dans le cursus des écoles de formation de base.
- Le renforcement des programmes LMD/IRA doit continuer.
- Un plan quinquennal de mise en oeuvre doit être adopté par le bureau régional.

Le deuxième exposé, présenté par le Dr Jim Tulloch, portait sur "*la place de la PCIME par rapport aux autres programmes*".

Le présentateur, après avoir rappelé le focus de la PCIME à savoir les 5 pathologies responsables de la majorité des décès des enfants (la diarrhée, la pneumonie, le paludisme, la malnutrition et la rougeole), a souligné la nécessité de collaboration entre l'ensemble des programmes: la LMD, les IRA, le Palu, le Nutrition, le PEV ...).

Au niveau du siège de l'OMS, une dizaine de divisions ont été impliquées dans la conceptualisation de l'approche.

Le présentateur a ensuite tracé l'historique de la mise au point de l'approche et le matériel qui a été produit en plus des modules génériques de formation: guide d'adaptation, gestion des médicaments, matériel pour renforcer la qualité de la référence, guide pour le suivi de la formation, guide pour la planification, le monitoring et l'évaluation.

La PCIME apparaît comme faisant partie des réformes du système de santé en cours dans les pays; d'où la nécessité d'une coordination des interventions de tous les partenaires: OMS, UNICEF, BASICS, GTZ, SARA, Banque Mondiale, Banque Africaine de Développement ...

Les discussions ont essentiellement porté sur les points suivants:

- la différentiation entre prévisite et paidoyer.
- la clarification sur la dénomination de l'approche.
- la place des autres programmes de santé dans la PCIME: Nutrition, paludisme ...
- l'impact de la PCIME sur les reformes du système de santé
- les limites de l'approche.
- la nécessité de renforcer le volet communication

Des clarifications y ont été apportées.

Les recommandations issues des discussions:

- l'appropriation de l'approche par les pays est un élément de durabilité.
- la disponibilité des cadres nationaux et des experts compétents sont des facteurs de succès dans la mise en oeuvre.
- l'implication des écoles de formation dans la mise en oeuvre de l'approche catalyse son acceptation et le consensus national.
- l'introduction de l'approche dans les écoles de formation est incontournable; elle constitue, en effet, la stratégie de renforcement de la formation de base.
- Le renforcement des programmes LMD/IRA doit continuer.

EXPERIENCE PAYS :

UGANDA

Resumé session 2

Président: : Dr D. Barakamfitiye
 Rapporteur : Dr M. Sani Zagui, Dr M.P. Shilalukey Ngoma

1. Introduction

Les étapes de la mise en oeuvre de la PCIME en Ouganda et les leçons apprises ont été largement présentées par le Dr Kenya Mugisha, responsable national et le Dr D.J. Nsungna, personne focale pour la PCIME en Ouganda.

Le processus de la planification initiale, l'orientation et l'acceptation de la PCIME, l'adaptation, les progrès réalisés, les leçons tirées et les perspectives ont été présentés.

2. Objectif de la session

L'objectif de la session est de partager les expériences vécues par l'Ouganda en matière de mise en oeuvre, la formation, le suivi de la PCIME. Les autres pays pourront devenir capables de mieux planifier l'introduction de la PCIME.

3. Les points principaux discutés

3.1 Introduction de la PCIME

Lors de la planification initiale et l'orientation, il est extrêmement important d'obtenir un consensus parmi tous les programmes impliqués dans la PCIME (PLMD/IRA, nutrition, médicaments essentiels, les institutions de formation etc..) pédiatres et les principaux partenaires.

L'engagement de tous les programmes est nécessaire pour appuyer le processus d'adaptation des modules en cohérence avec les politiques du pays, sur les sujet comme l'allaitement maternel vitamine A vaccination etc.. avant la formation.

3.2 Formation

L'objectif principal de la formation en Ouganda était d'accroître la capacité de district à travers un système de décentralisation.

Des critères ont été utilisés pour sélectionner les sites de formation. La proximité du district au centre, expérience de la formation à la prise en charge des cas de diarrhée/IRA, une formation sanitaire adéquate, possibilité d'hébergement et la disponibilité des médicaments etc..

L'Ouganda a "un cas control" de la situation de la formation avec un district répondant aux critères de sélection et un autre qui n'y répond pas.

Les performances des personnes formées n'ont pas été trop différentes. Dans tous les 159 agents de santé inclus les 22 instructeurs cliniques ont été formés pendant 8 cours.

Quelques difficultés ont été notées en ce qui concerne la formation. Il s'agit de la sélection des participants appropriés, l'insuffisance des cas au niveau du district, le manque de transport, de médicaments et les déplacements fréquents des agents de santé.

3.3 Suivi de la formation

L'objectif du suivi est de renforcer les aptitudes des agents de santé formés, enregistrer les performances du personnel et résoudre les problèmes en vue de maintenir la qualité de la formation.

Le suivi a montré que la disponibilité des médicaments et fournitures était inadéquate, mais les agents de santé ont réalisé des performances acceptables dans la résolution immédiate des problèmes et l'utilisation de la brochure des tableaux.

La visite de suivi a aussi montré que la référence était difficile à cause du manque de transport.

Recommandations

1. A la planification initiale et à chaque étape du processus de mise en œuvre de la PCIME, l'obtention du consensus avec tous les programmes et partenaires principaux est essentielle.
2. Il y a lieu d'envisager la possibilité de modifier la loi relative à la prescription des médicaments par les infirmiers afin de permettre ces derniers à prescrire les médicaments recommandés.
3. Les directives politiques doivent être clarifiées pour assurer une meilleure prise en compte des programmes spécifiques dans la PCIME.
4. Il est recommandé à partir de l'expérience Ougandaise, que les directeurs de cours bénéficient de deux jours d'orientation.
5. Le suivi devrait être mené à travers les systèmes existants.

Conclusion

Le but principal de l'introduction de la PCIME est de réduire la mortalité infantile à travers des soins de meilleure qualité.

La complexibilité du processus de l'introduction de la PCIME a été démontrée à travers l'expérience Ougandaise.

FILE : SESSION 3.Fr

EXPERIENCE EN TANZANIE

La mise en oeuvre de la PCIMC en Tanzanie a suivi différentes étapes :

1. Préparation initiale :

- réunion d'explication du processus
- testing du matériel OMS
- formation des facilitateurs cliniciens et agents SMI.

2. Développement d'un plan d'action

Identification des districts tests selon des critères : existence de ressources, performances en LMD/IRA, distance raisonnable.

3. Adaptation du matériel

En collaboration avec les programmes PEV, Paludisme et l'Université, le module a été élaboré Swahili.

4. Préparatif de la formation

Identification des sites de formation et des participants : nationaux, régionaux et locaux.

5. Formation du personnel et suivi

- Formation des pédiatres principaux, des coordinateurs de zone, des agents dans 4 districts au total 91 agents formés.
- Développement d'un plan de suivi des agents formés
- Introduction de la PCIME dans les écoles de formation de base (plan d'action). Deux groupes de superviseurs ont été formés en 2 jours.

L'équipe de mise en oeuvre de la PCIME a identifié des facteurs facilitant des contraintes et tirés des leçons :

Facteurs facilitants

- Intérêt du gouvernement pour la PCIME
- Disponibilité des ressources humaines, financières
- Présence de partenaires (TEHIP, HMUS) qui veulent appuyer l'introduction de PCIME..

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Contraintes

- Difficultés de communication
- Coût élevé de l'approche (déplacement des participants)
- Absence longue des facilitateurs qui sont peu nombreux
- Nouveauté de l'approche nécessitant plusieurs replanifications
- Matériel audio-visuel coûte très cher
- Supervision nécessite des moyens de transport.

Leçons apprises

- Nécessité d'une bonne préparation
- Appui intersectoriel et sectoriel
- Engagement du gouvernement
- Nécessité de former tous les agents
- Introduction de la PCIME dans les écoles de formation
- Veiller à la qualité de la formation
- Rigueur dans des critères de sélection

Les points suivants ont été discutés en plénière :

- Approvisionnement en médicaments essentiels
- Les compétences des formateurs en nutrition
- L'aspect planification de la PCIME dans le cadre de réforme du secteur de santé.

Recommandations

- Incorporer la PCIME dans le processus de réforme du secteur de la santé pour l'institutionnaliser
- Mettre à contribution les chargés des réformes sanitaires dans les ateliers de la PCIME

EXPERIENCE DE LA ZAMBIE (Financement BASICS, OMS, UNICEF)

La Zambie a organisé une série de réunions pour obtenir le consensus de la PCIME. Ensuite, un atelier a procédé à l'adaptation des directives.

Les étapes suivantes ont été suivies :

- planification de la mise en oeuvre
- adaptation du matériel
- replanification des activités
- atelier de planification stratégique.

Un certain nombre de documents ont été élaborés pour le SIS et sont en cours de testing.

La Zambie a mentionné les mêmes contraintes de la mise en oeuvre que la Tanzanie :

- difficultés de transport (malades et participants)
- pression du conseil national de la santé pour la baisse du TMI.

Leçons apprises

- Non disponibilité des facilitateurs
- Manque de formation des superviseurs.

Recommandations

- La PCIME nécessite l'obtention d'un consensus
- L'OMS doit appuyer les pays à mettre les programmes en oeuvre. Le processus prendra du temps car les soins de santé constituent un tout.

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EXPERIENCE DES PARTENAIRES

Président : Dr J. Tulloch CHD/HQ

Thème : Appui à la PCIME

EXPERIENCE DE BASICS

BASICS est un projet financé par l'USAID et crée à partir des anciens projets REACH, HEALTHCOME, PRITECH.

BASICS a été retenu pour 5 ans à partir de 1993 comme une agence technique principale dans les programmes de survie de l'enfant dans différents pays.

BASICS a des projets au niveau des pays où ils appuient la mise en oeuvre de la PCIME. Il s'agit de Zambia, Madagascar et Eritrea.

Dans d'autres pays, BASICS APPUI la recherche opérationnelle en matière de PCIME. Ainsi, le Niger, l'Afrique du Sud, le Nigéria (secteur privé) et Kenya (sous supervision de CDC) les pays potentiels à l'appui de BASICS sont Ethiopie, Afrique du Sud, Mali, Togo, Bénin, Kenya et Sénégal.

APPUI REGIONAL A LA PCIME

Au niveau régional, BASICS a un bureau au Sénégal. Deux de ces membres ont déjà été formés comme consultants.

Au niveau du Siège, à Washington, BASICS dispose de 8 cadres formés comme consultants au PCIME. Avec le groupe MANOFF, plusieurs autres consultants seront formés.

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BASICS planifie d'accroître le nombre de ses consultants pour l'adaptation clinique des modules y compris la nutrition, le renforcement de la supervision. Ces consultants seront disponibles pour appuyer les autres domaines comme la gestion des médicaments, le paludisme, l'IEC, Monitoring et l'évaluation en relation avec la PCIME. Ils seront disponibles pour appuyer les efforts de mise en oeuvre de la PCIME tant au niveau pays que régional.

APPUI DE BASICS AU NIVEAU GLOBAL

BASICS a développé plusieurs manuels de formation à la PCIME :

- . Le cours complémentaire destiné à enseigner la PCIME aux agents de santé ayant une faible capacité de lecture,

- . Cours pour la formation des facilitateurs en PCIME (en cours)

- . Le guide à préparation - Guide pour aider les managers à l'introduction de la PCIME dans le pays

- . Gestion des médicaments.

BASICS appuiera les ONG dans la mise en oeuvre de la PCIME. Ainsi, il collaborera avec CARE, HOPE, WORLD VISION, Save the Children, Africare, ADRA concernés par cet appui.

Pour compléter la présentation du Dr B. Pond, deux autres cadres de BASICS, Dr P. Desrosiers et Dr Mutombo ont donné des informations spécifiques aux pays en Afrique de l'Ouest (5 pays : Côte d'Ivoire, Mali, Niger, Sénégal et Togo), futurs bénéficiaires de l'appui de BASICS.

Discussions

Dr Tulloch a fait remarquer que parmi les matériels de formation énumérés, certains ont été développés en collaboration avec l'OMS (Cours complémentaire et gestion des médicaments). L'OMS revoit encore le cours pour la formation des formateurs à la PCIME.

Elle ne recommande pas l'utilisation par les pays du guide à la préparation de la mise en oeuvre de la PCIME auquel BASICS fait allusion.

Les conseillers OMS au Nigéria et en Afrique de l'Ouest ont exprimé leur appréciation de la collaboration entre l'OMS et BASICS. Ils ont recommandé qu'elle continue dans une meilleure approche pour une mise en oeuvre efficace de la PCIME en Afrique.

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COLLABORATION WITH PARTNERS IN THE IMPLEMENTATION
OF IMCI IN TANZANIA

TANZANIA ESSENTIAL HEALTH INTERVENTION

Project - TEHIP
Chairman : Dr J. Tulloch (CHD/HQ)
Rapporteurs : Dr Kenya Mungisha (Uganda)
Dr Eli A. Agbobl (Togo)

INTRODUCTION

The 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) - Tanzania is implementating TEHIP in collaboration with IDRC (International Development Research Center) and WHO.

The broad objectives of TEHIP are :

- To ncrease and strengthen the capacity of district health management teams 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 asses and document the overall impact and lessons learned in delivering selected health interventions at the district local.

Currently TEHIP is operating in two districts Rufifi and Morogoro.

Characteristics of TEHIP

- TEHIP is a from 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.

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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 :

1. In development of annual health plan according to district health profiles (HMIS).

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

Discussions

TEHIP was congratulated for the support provided to IMCI implementation.

Recommendation

It was recommended that TEHIP should work in collaboration with the local team in charge of IMCI implementation in Tanzania.

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**RAPPORT DES TRAVAUX DE LA 6EME SESSION
DU PROGRAMME : LES PERSPECTIVES**

Les exposés développés pendant cette session peuvent être regroupés en deux grands thèmes.

- Le plan quinquennal pour l'appui de l'OMS dans la mise en oeuvre de la PCIME dans la Région africaine.
- Les perspectives des partenaires (UNICEF, USAID/SARA, ODA, etc.).

1. Resumé des exposés

1.1 Plan quinquennal de l'OMS pour la mise en oeuvre de la PCIME dans la Région Afrique. L'élaboration d'un plan quinquennal pour la Région africaine s'est avérée nécessaire en raison d'un contexte caractérisé par une compréhension mauvaise et insuffisante du concept de la PCIME, d'une mauvaise qualité des soins dans les formations sanitaires de premier niveau.

L'objectif principal visé par ce plan quinquennal est d'améliorer la qualité des soins aux enfants de moins de 5 ans dans les formations sanitaires de premier niveau.

L'implantation de la mise en oeuvre de la PCIME dans les pays augmentera de manière progressive de 20 % des pays en 1997, elle atteindra 60 % des pays en l'an 2001. Au niveau des districts sélectionnés dans les pays où l'implantation de la PCIME est adoptée, la formation du personnel sanitaire augmentera de manière progressive de 15 % des districts en 1997 pour atteindre 100 % des districts en l'an 2001.

Les stratégies à déployer seront axées sur les éléments suivants : la promotion de la durabilité des activités dans le pays par le respect des étapes de la mise en oeuvre, le développement des compétences nationales, sous-régionales et leur exploitation judicieuse. Le renforcement des capacités régionales au niveau de l'équipe OMS Afrique, l'amélioration des relations avec les partenaires, la promotion de la recherche.

L'implantation de la mise en oeuvre de la PCIME exige des pays un certain nombre de mesures et de dispositions à prendre dont les principales sont : l'appropriation de la PCIME, l'adaptation du matériel générique, la

promotion des compétences nationales, le développement des services d'appui comme le service de médicaments essentiels, l'inscription d'une ligne budgétaire pour la PCIME dans le budget de santé du pays, l'introduction de la PCIME dans le cursus des écoles de médecine et paramédicales

1.2 Les discussions très riches qui ont suivi l'exposé abordent les points suivants :

- les domaines de recherche à privilégier dans la PCIME;
- le niveau d'introduction de la PCIME dans le cursus des Ecoles de formation;
- la nécessité d'une prévisite prenant en compte tous les aspects importants de l'implantation et de la mise en oeuvre de la PCIME.

1.3 Les perspectives

Plusieurs exposés ont été développés sur les perspectives.

1.3.1 Les perspectives régionale de l'OMS

Pour l'OMS, les activités des programmes LMD/IRA doivent être maintenues et poursuivies jusqu'à l'implantation complète de la mise en oeuvre de la PCIME dans les pays, ceci pour ne pas faire augmenter le taux de la mortalité infantile.

1.3.2 Les perspectives des partenaires

Il ressort des interventions des partenaires (UNICEF, USAID/SARA, ODA) qu'ils apportent leur appui et leur solidarité à la mise en oeuvre de la PCIME chacun ayant défini ses objectifs clairs et ses cibles d'appui tant au niveau régional qu'au niveau des pays.

2. Discussion en plénière

Une discussion en plénière a été consacrée à deux préoccupations des participants : la qualité de la formation et du suivi, et la qualité de la formation des formateurs et des facilitateurs.

2.1 La visite de suivi des agents après leur formation s'est avérée capitale pour l'amélioration de la qualité de la formation. Cette visite

renforce la qualité de la formation, elle sert de lien entre la formation et la supervision habituelle. Elle devrait être planifiée, budgétisée et exécutée 4 à 6 semaines après la formation de préférence par les formateurs avec un outil simple et pertinent.

2.2 La formation des formateurs et des facilitateurs

Plusieurs modèles de schéma de formation de formateurs et de facilitateurs sont tirés de l'expérience des pays comme la Zambie, la Tanzanie, ont été présentés et discutés longuement au cours de cette session.

Des recommandations pertinentes, pratiques ont été dégagées à la lumière des discussions et des propositions concrètes de durée de formation ont été formulées.

Appendix E: Overheads

USAID AFRICA BUREAU

■ Supports : • IMCI to improve Quality of Care
• WHO/AFRO leadership for regional strategy

■ Hopes regional strategy will:

1. Show how systems issues will be addressed to improve q.o.c.
2. Show how bottlenecks to expansion (while maintaining quality) can be systematically addressed
3. Show how capacity building can be accelerated

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Systems issues : opportunities in IMEI context

1. Through systematic discussions at preparatory stage (drugs, supervision, IEC, et
2. Following demonstration experiences with training - follow up - evaluation cycle
3. Through problem-solving activities during implementation / expansion esp. at facility and District levels
4. Through mobilization of internal + external

HUMAN RESOURCES bottlenecks

■ Country implementers

- course directors + facilitators
- clinical instructors
- nutrition researchers
- supervisor/ problem-solvers

■ country catalysts for whole process preparation → evaluation

■ Regional technical staff + consultants for

- preparation + planning (systems issues, training, etc.)
- adaptation
- nutrition research → messages
- training
- monitoring + evaluation

USAID AFRICA BUREAU FUNCTIONS

- Supports WHO/APRO regional strategies
- Sensitizes USAID bilateral mission
- Supports BASICS activities in Africa
 - * West Africa Regional Office
 - * Nutrition activities
 - * Country program development
- Promotes coordination with other donors
- develops complementary tasks/activities through SARA

SANA PROJECT ACTIVITIES '97-'99

- Assist Africa Bureau in its functions
- Identifying gaps - needs - solutions
- Promote capacity building for nutrition aspect with SONANET and ORANA/BANES; Designing by dialogues
- Promote capacity building for advocacy with CAFS and CESAG; Advocacy Training Guide
- Support other cap. building efforts e.g. country catalysts, cadre development
- Make Repertory Guide available (Eng. French) (guide for systematic discussion of key I/MCI preparation issues)

Appendix F: Regional IMCI Plan of Action and Budget 1997-2001

- Can only do health facility IPC.
- Waiting for tools.
- When tools will try to do something.
- When CDD or ARI activities, can continue help countries to implement IEC.
- Malawi also have IEC (bednets) not IMCI (DRAFT)

• Nuhori educ.

AFRICAN REGIONAL IMCI PLAN OF ACTION AND BUDGET 1997-2001

EXPECTED RESULTS	INTERVENTIONS/ACTIVITIES	INDICATORS	PROPOSED BUDGET					
			1997	1998	1999	2000	2001	Total
1.1 Administrative matters between AFRO and countries coordinated	1. Strengthen & support AFRO Team							
	1.1 Recruit Programme Assistant for African Regional Office (P2)	1.1 Programme Assistant in place.	80.000 10.000	80.000 10.000				
1.2 Implementation of IMCI activities in countries coordinated	1.2 Recruit Medical Officer to coordinate implementation of IMCI activities (P4)	1.2 Medical Officer in place.						
1.3 Introduction of IMCI CDD and ARI activities medical school and paramedical institutions followed specifically.	1.3 Recruit Medical Officer to support MedEd and BasEd activities (P4)	1.3 Medical Officer in place	110.000 18.000	110.000 18.000				
	2. Strengthen & support sub-regional capacity							
2.1 Close and effective support given to central African countries implementing IMCI	2.1 Recruit medical officer to support central African countries to implement IMCI (P4)	2.1 Medical Officer in place						
2.2 Close and efficient support given to western African countries implementing IMCI	2.2 Recruit medical officer to strengthen the support given to western african countries for IMCI implementation (P4)	2.2 Medical Officer in place	110.000 18.000	110.000 18.000				
SUBTOTAL								

2.3. to Horn of Africa

USAID

110.000
18.000

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AFRICAN REGIONAL IMCI PLAN OF ACTION AND BUDGET 1997-2001

(DRAFT)

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EXPECTED RESULTS	INTERVENTIONS/ACTIVITIES	INDICATORS	PROPOSED BUDGET					
			1997	1998	1999	2000	2001	Total
	3.1. Strengthen & support national capacity							
3.1 Close and efficient support to IMCI activities in countries by WHO national IMCI CDR Officer	3.1 Recruit 28 WHO national IMCI/CD Officer (Contractual Service Agreement SSA - Sp. Serv. Agreement)	3.1 Proportion of WHO national IMCI, CDD and ARI Officers recruited	Tanz. OK USAID Ug. 28 Nig. 28 Mal. 28	Tanz 28 ^(18.5) Ug. 28 Ug. 28 Nig 28 Mal. 28				
3.2 National skilled expertise developed within countries of the Region in:	3.2 Train national expert to support their countries and other countries as consultants in:							
- Case management on IMCI; - Facilitation techniques; - Adaptation - Planning and evaluation	- IMCI case management ^{68 E. Afr.} (80 consults) - facilitation techniques (80 consults) - adaptation (44 consultants) - Planning & evaluation 20 consults <u>2 Za</u> <u>2 Tang</u> <u>2 Mal</u> <u>2 E. Afr.</u> <u>2 Nig</u> <u>2 Mal</u>	3.2 Proportion of country experts trained in case management, facilitation techniques, adaptation, planning and evaluation.	16 covered Case an facil. - 10 adapt 0 prepar	16 people Nig. (16) 53.5 13.2 26.5 18 (6 pers)				
4.1. 39 countries took clear decision on IMCI implementation	4.1 Conduct IMCI preliminary visit in 39 countries of the Region.	4.1 Proportion of countries visited - proportion of countries that took decision on IMCI implementation among those visited						
4.2 Countries adequately informed about IMCI and its implications	4.2 Conduct orientation meeting in 39 countries	4.2 Proportion of countries that conducted orientation meeting						
4.3. 28 countries conducted planning and training strategy on IMCI which includes workplan for training, evaluation and monitoring	4.3 Conduct planning of training strategy in 28 countries of the Region.	4.3 Proportion of countries that conducted planning of training strategy.						
SUBTOTAL								

11/25
F. phone 97
Adapt - 8/25/97
Orient. - 1/2/97

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EXPECTED RESULTS	INTERVENTIONS/ACTIVITIES	INDICATORS	PROPOSED BUDGET					
			1997	1998	1999	2000	2001	Total
<p>4.4 Planning for follow up and monitoring of trained health workers developed for each of the 28 countries</p> <p>5.1 Adaptation process of IMCI supported by skilled consultants in 28 countries</p> <p>5.2 IMCI material adapted for each of the 28 countries</p>	<p>4.4 Conduct planning for follow-up and monitoring strategy of trained health workers for 28 countries</p> <p>5. Support countries for adaptation of generic materials.</p> <p>5.1 Recruit 3 skilled consultants to support every stage of the adaptation process in each of 28 countries</p> <p>5.2 Conduct adaptation workshop in 28 countries</p>	<p>4.4 Proportion of countries that had planning workshop for follow-up and monitoring</p> <p>5.1 Proportion of countries recruited in 28 countries.</p> <p>5.2 Proportion of consultants with adapted materials using skilled consultants -Proportion of countries that have conducted adaptation workshop</p>						
<p>5.3 Results from fluid and food studies available in 28 countries.</p> <p>5.4 Results from local terminology studies available in 28 countries</p>	<p>5.3 Conduct food and fluid studies in 28 countries <i>consultant</i></p> <p>5.4 Conduct local terminology studies in 28 countries <i>consultant</i></p>	<p>5.3 Proportion of countries that conducted food and fluid studies</p> <p>5.4 Proportion of countries that conducted local terminology studies</p>						
<p>5.5 Consensus on the implementation of IMCI in 28 countries built.</p> <p>5.6 Adapted IMCI materials printed and available in 28 countries</p>	<p>5.5 Conduct consensus meeting in 28 countries</p> <p>5.6 Produce adapted IMCI materials in 28 countries</p>	<p>5.5 Proportion of countries that conducted consensus meeting</p> <p>5.6 Proportion of countries that have produced adapted IMCI materials</p>						
SUBTOTAL								

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AFRICAN REGIONAL IMCI PLAN OF ACTION AND BUDGET 1997-2001

(DRAFT)

EXPECTED RESULTS	INTERVENTIONS/ACTIVITIES	INDICATORS	PROPOSED BUDGET					
			1997	1998	1999	2000	2001	Total
7. Facility support-services improved <i>After pre-visit: - assessment - consultations</i>	7. Drugs							
	7.1 Introduce IMCI in districts with existing Bamakp initiative <i>system of medic.</i>	7.1 Proportion of districts with BI effectively implementing IMCI activities						
	7.1.1 Procure drugs to initiate or strengthen BI in districts implementing IMCI	7.1.1 Proportion of districts implementing IMCI that received drugs for initiating or strengthening BI						
	7.1.2 Recruit consultants to improve drugs procurement, storage and distribution mechanism in 28 countries in collaboration with other partners	7.1.2 Proportion of countries benefiting from consultant support to improve drugs procurement, storage and distribution mechanisms	3.000×4 12.000	4.000×5 20.000				
	7.1.3 Train 2688 health workers on drugs management	7.1.3 Proportion of health workers trained on drugs management	3.000×4 12.000	4.000×5 20.000				
	Supervision							
	7.2 Conduct regular support supervision of IMCI-trained health workers <i>Assist countries to improve supervision of IMCI trained health workers</i>	7.2 Proportion of IMCI-trained health workers that are regularly supervised	3.000×4 12.000	3.000×4 12.000				
Organization of Health Services								
7.3 Conduct operational research on the physical organizational structure of health facilities implementing IMCI	7.3 Report of operations research available.	3.000×4 12.000	3.000×4 12.000					
SUBTOTAL								

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EXPECTED RESULTS	INTERVENTIONS/ACTIVITIES	INDICATORS	PROPOSED BUDGET					
			1997	1998	1999	2000	2001	Total
	9. Improve communication system and data processing							
9.1 Regional, subregional and country level have computers and accessories necessary for conducting activities	9.1 Supply regional (3), sub-regional (4), and country level (11 countries) with computers and accessories	Proportion of recipients supplied with computers and accessories						
9.2 Communication activities between countries, the Region and partners supported	9.2 Improve communication (e-mail, fax, telephone) in 4 subregional offices	Proportion of recipients supplied with improved communication services						
	10. Monitor and evaluate IMCI activities							
10.1 First year IMCI implementation in 28 countries evaluated	10.1 Evaluate the first year IMCI implementation in 28 countries	10.1 Proportion of countries that have the first year IMCI implementation evaluated						
10.2 IMCI implementation in 28 countries evaluated 2 yearly.	10.2 Evaluate IMCI implementation every 2-years in 28 countries	10.2 Proportion of countries that have 2 yearly IMCI evaluation						
10.3 Countries and partners informed quarterly on the implementation of IMCI	10.3 Publish quarterly regional IMCI bulletin.	10.3 Quarterly IMCI Bulletin published						
10.4 Countries and partners informed annually on the implementation of IMCI in the Region	10.4 Organize annual regional meeting on IMCI implementation in Africa							
SUBTOTAL								
GRAND TOTAL								

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Appendix G: AFRO/SD Grant to WHO/AFRO

**PLAN FOR USAID SUPPORT OF THE IMCI
REGIONAL PLAN OF ACTION 1997 AND 1998**

Expected results	Activities	Indicators	1997 Budget	1998 Budget
1.	1. Strengthen and support ARFO reg.team			
	1.1 Recruit Progr.Assist. for the Region		80.000 10.000 (trav)	80.000 10.000 (trav)
	1.3 Recruit Med.Off. for pre-service		110.000 18.000 (trav)	110.000 18.000 (trav)
	2. Strengthen & support intercountry capacity			
	2.2. Recruit Med.Off. for W. Africa		110.000 18.000 (trav)	110.000 18.000 (trav)
	2.3 Support Med.Off. for Horn of Africa			110.000 18.000 (trav)
			346.000	474.000

Results	Activities	Indicators	1997 Budget	1998 Budget
	3. Strengthen and support national capacity			
	3.1 Recruit National Officers (catalysts)			
	- Tanzania			28.000 trav.incl
	- Uganda		28.000 trav.incl	28.000 trav.incl
	- Niger		28.000 trav.incl	28.000 trav.incl
	- Mali		28.000 trav.incl	28.000 trav.incl
	3.2 Train national /inter-country consultants			
	- IMCI (Fr)		Niger (covered)	53.500
	- Facilitation(Fr)			13.200
	- Adaptation			26.500
	- Evaluation		18.000 (6)	18.000 (6)
			102.000	223.000

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Results	Activities	Indicators	1997 budget	1998
	<p>7. Improve facility support services</p> <p>Drugs 7.1.2 Assist countries to address drug system problems.</p> <p>Supervision 7.2 Assist countries to improve supervision of IMCI-trained health workers</p> <p>Organisation of Health Services 7.3 Assist countries to improve health facilities organisation for IMCI implementation.</p>		<p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p> <p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p> <p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p>	<p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p> <p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p> <p>12.000 (4 assessments local cost)</p> <p>20.000 (5 consultant trips)</p>
			96.000	96.000

Results	Activities	Indicators	1997 budget	1998 budget
	8. Pre-service training			
	8.1 Preliminary visits to para-medical schools		15.000 (3 countries, consult.& counterparts)	20.000 (4 countries)
	8.2 Recruit consultants to train tutors		15.000	20.000
	8.2.1 Train tutors (paramed)		45.000 (3 countries)	60.000 (4 countries)
	8.3 Provide training materials		21.000 (3 countries)	28.000 (4 countries)
	8.4 Follow up of schools and trainees		10.000 (2cs)	25.000 (5cs)
	8.5 Consultants for med. Schools			
	8.5.1 Training of tutors (medical)	Zambia	5.000	15.000
	8.6 Follow-up of schools and trainees			15.000
				5.000
			111.000	188.000

Total 1997: \$654.000

Total 1998: \$981.000

Grand total : \$1.635.000

Appendix H: 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

LISTE DES PARTICIPANTS/LIST OF PARTICIPANTS

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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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