

IMCI

information

INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS (IMCI)

DEPARTMENT
OF CHILD AND
ADOLESCENT
HEALTH AND
DEVELOPMENT
(CAH)

HEALTH SYSTEMS
AND COMMUNITY
HEALTH (CHS)

Integrated Management of Childhood Illness: Global status of implementation

June 1999

Overview

Integrated Management of Childhood Illness (IMCI) is a broad strategy, encompassing interventions at home and in the health system. It aims to reduce childhood death, illness and disability and to contribute to improved growth and development.

Implementation of IMCI involves three phases, discussed in more detail below: introduction, early implementation, and expansion. By June 1999, 63 countries were at different stages of implementation (see map) and at least 12 others had expressed interest but had not yet started activities:

- **The introduction phase** – 20 countries were in the process of introducing IMCI (Belarus, Benin, Bhutan, China, Colombia, Georgia, Ghana, India, Iran, Kenya, Kyrgyzstan, Laos, Myanmar, Namibia, Syria, Tajikistan, Turkey, Turkmenistan, Uzbekistan, Yemen)
- **The early implementation phase** – 31 countries had successfully introduced IMCI and had moved on to preparation for and implementation of initial activities in selected districts (Argentina, Armenia, Azerbaijan, Bangladesh, Botswana, Cambodia, Côte d'Ivoire, El Salvador, Egypt, Eritrea, Ethiopia, Haiti, Honduras, Kazakhstan, Paraguay, Madagascar, Malawi, Mali, Moldova, Morocco, Mozambique, Nicaragua, Niger, Nigeria, Pakistan, Senegal, South Africa, Sudan, Togo, Venezuela, Zimbabwe)
- **The expansion phase** – 12 countries had moved from early implementation to expansion of activities and geographic coverage countries (Bolivia, Brazil, Dominican Republic, Ecuador, Indonesia, Nepal, Peru, Philippines, United Republic of Tanzania, Uganda, Viet Nam, Zambia)

Some countries are also implementing complementary IMCI activities to improve the health system and family and community practices. UNICEF, in collaboration with the WHO Department of Child and Adolescent Health and Development (CAH), is supporting and documenting family and com-



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munity level experience in a limited number of countries, in order to help guide activities elsewhere.

The introductory phase

The purpose of the introductory phase is to ensure that key Ministry of Health (MoH) officials understand the IMCI strategy and its implications. Activities in this phase include:

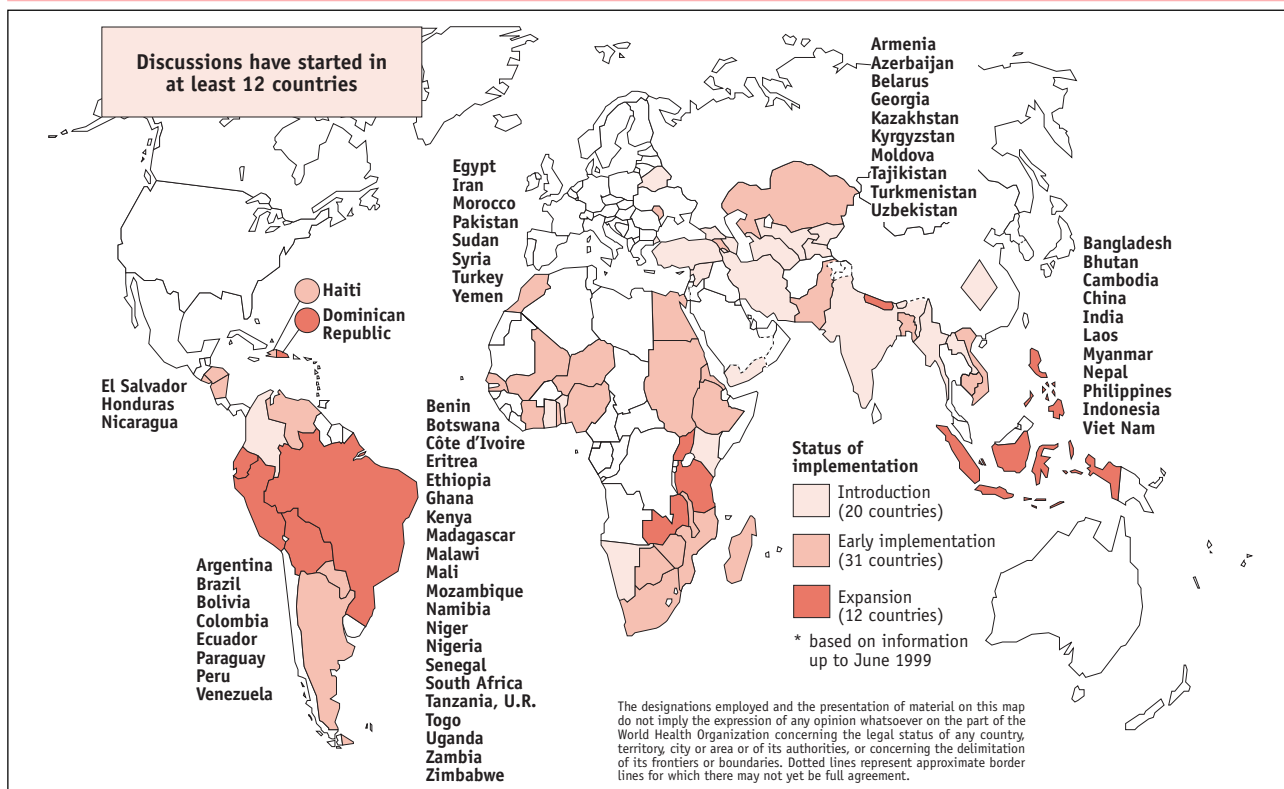
- initiation of contact to provide information,
- holding orientation meetings, and
- building of national capacity in IMCI.

These initial activities are essential for the MoH to be able to establish an IMCI management structure and to move forward with IMCI preparation and planning. Experience to date shows that orientation must be comprehensive and thorough. The involvement of senior MoH officials, above the level of individual programmes, facilitates decision making and consensus building. Coordination of interested partners is critical, and needs to be considered early in the planning process.

The early implementation phase

During this phase, Ministry of Health staff plan and prepare for IMCI implementation, carry out and monitor IMCI activities in a limited number of districts, to provide the basis for future planning. Activities in this phase include:

COUNTRIES IMPLEMENTING IMCI*



- adaptation of the generic IMCI clinical guidelines to reflect the epidemiological and cultural characteristics of the country,
- selection of a limited number of districts for initial implementation,
- planning for IMCI activities at both national and district levels,
- building national and district capacity to implement IMCI activities, and
- monitoring the implementation of the strategy.

Other issues that need to be considered early in the planning process include: the relationship of IMCI with ongoing health sector reforms, drug availability and policy, supervision, links with health information systems and existing community interventions. Experience in the countries that have completed this phase shows that achieving consensus on the adapted clinical guidelines takes time, but that achieving this consensus is critical. It has also demonstrated that follow-up visits to trained health workers are important for reinforcing new skills.

The expansion phase

The third phase includes efforts both to increase access to interventions initiated during the early implementation phase and to broaden the range of IMCI interventions. Problems identified during the early implementation phase are addressed, priorities agreed, and strategies for expanding access while maintaining quality are developed. Other activities in this phase include further strengthening of district-level capacity, improved drug availability and management, monitoring, and measurement of outcome indicators. WHO/CAH and UNICEF are working to broaden the range of IMCI interventions. Tools for interventions at referral-level health facilities and in the community will be made available soon.

Progress in selected countries

CAH and collaborating agencies provide technical assistance to countries in preparation for and early implementation of IMCI. The principle adopted in the first countries to introduce IMCI has been to implement activities in a small number of districts initially. Careful monitoring and documentation of experience has provided useful lessons about the process of adaptation to meet national requirements, as well as information to guide plans for expansion.

The following briefly summarizes progress in a selection of countries:

After orientation of high-level decision-makers, programme managers, professional associations and representatives from major donor agencies in 1995, **Indonesia** successfully completed adaptation and translation of all IMCI training materials in 1997. The adaptation process was coordinated by a national IMCI task force and involved all the relevant technical programmes and the Indonesian Paediatric Society. The first 11-day training course in English was conducted in June 1997, followed by five courses in Indonesian. Implementation, including follow-up after training, has started in two WHO-supported pilot districts. Special planning meetings have been organized for many other provinces in preparation for the implementation of

IMCI. The Asian Development Bank, UNICEF and the World Bank have included IMCI in projects they support in Indonesia. In addition to the in-service training of health workers from first-level health facilities, Indonesia plans to include IMCI in the curricula of at least 12 of the country's medical schools, from September 1998. The national IMCI task force is developing innovative methods of training health workers from first-level health facilities in IMCI, and is preparing local IMCI planning and adaptation guides for use in different parts of the country. Work has been also begun on developing IMCI training materials for more peripheral health workers.

Nepal established a "Working Group for IMCI" in 1997. The guidelines and training materials have been adapted and translated into Nepali. IMCI training courses at national and district levels, including one facilitator training course, have been conducted successfully and follow-up visits to trained health workers have started. IMCI is implemented in one district. A district planning workshop and a national review and re-planning meeting was held in September 1998, to provide the basis for the expansion phase.

The Ministry of Health and Population in **Egypt** adopted the IMCI strategy in 1997 in the context of its efforts to integrate vertical programme activities and move towards health sector reforms. After an orientation meeting for staff from relevant programmes, academic institutions and interested partners, a focal person was appointed and an IMCI working group established. Preparatory work was assigned to two subgroups: one for adaptation of the clinical guidelines and another for planning IMCI implementation. In March 1998, the IMCI working group developed a detailed national plan of activities addressing all components of the IMCI strategy. IMCI has been included in the basic package of services to be delivered in primary health care facilities, an initiative supported by WHO, UNICEF, USAID and the World Bank. The basic package of services is a component of health sector reform and inclusion of IMCI will ensure sustainability and continued support for the strategy in the future.

Peru, the first country to have adapted and used the Spanish translation of the IMCI clinical guidelines and training materials, conducted an international adaptation workshop in July 1996. This provided an opportunity to introduce health authorities from other countries in the Region to the adaptation process. Similarly, in October and November 1996, two international courses were held to train national trainers, and senior paediatricians from neighbouring countries planning to introduce IMCI. The Peruvian Ministry of Health has developed a shortened version of the generic training materials which still includes the content of the clinical guidelines and the most important elements of clinical practice during training. IMCI is part of the national health strategy, and training activities related to IMCI receive financial support from the Ministry of Health. Follow-up visits to health workers recently trained, supervision and monitoring are conducted regularly and show encouraging results, including increased user satisfaction. At the beginning of 1998, almost 500 physicians and nurses working in first-level health facilities in 12 sub-regions had received training in IMCI.

In the **Philippines**, a national IMCI orientation and planning workshop

was held in 1995. In February 1996 a national IMCI Task Force was established, bringing together staff from the Department of Child Health and other concerned programme areas under the leadership of the Director of Child Health. The Task Force took charge of the planning and adaptation process. Two adaptation groups, consisting of Department of Health staff, paediatricians and technical experts, undertook the technical review and adaptation, which was completed in early 1997. The first training – for core trainers and other senior staff – took place in July 1997 in Davao, followed by facilitator training for this same group. Subsequently additional facilitators were trained and this was followed by the training and follow-up of first-level health workers in one district in each of two provinces. The two districts were supported in planning for training, follow-up and the provision of essential drugs. The results from the follow-up have been very encouraging, with almost all health workers enthusiastically adopting IMCI. The experience to date of training and follow-up is currently being reviewed to provide the basis for planning for the future. IMCI has been included as an important component of the Early Child Development Project funded by the World Bank and the Asian Development Bank in three regions of the country, and UNICEF will support activities in some other regions. Steps to introduce pre-service training in IMCI in medical and nursing schools are now being taken.

In mid-1995, **Uganda** established a broadly based Task Force to steer IMCI implementation. Adaptation of the clinical guidelines and training materials was completed in July 1996. Training for national trainers began in August 1996, immediately followed by the training of district trainers who, in turn, have conducted training of first-level health workers. The training process includes one follow-up visit to health workers four to six weeks after the training to help them start IMCI and reinforce their skills. After one year of implementation, Uganda reviewed the experience gained in the two initial districts and began the expansion phase. By May 1998, 24 districts had started to introduce IMCI and six of them already had more than 50% of their first-level health staff trained in IMCI. To make IMCI more effective in the new districts, the Ministry of Health adapted the feeding recommendations and local terms used in the clinical guidelines for several regions. IMCI is now included in national health policy and in district development plans. The Ministry of Health plans to introduce IMCI community interventions in selected districts during 1998 and pre-service training for first-level health workers in 1999. Major partners, including UNICEF and the World Bank, are supporting the Ministry of Health in its efforts.

Good progress has also been made by the **United Republic of Tanzania**. The IMCI course had already been partially adapted for the field test of the generic course in Arusha in early 1995, and the adaptation was completed by August 1996. The first course for national trainers, which included training in facilitation skills, took place in Morogoro in September 1996, followed by a workshop to develop follow-up procedures. With financial support from WHO, UNICEF, GTZ, DFID and IDRC, the first round of training for district-level trainers started in October the same year, and for first-level health workers in November. This course, like most of the subsequent train-

ing, was in Kiswahili, a translation having been completed in late 1996. Two thirds of health workers were followed up four to six weeks after their training and the findings showed that almost all were successfully practising their new skills. Training, including follow-up, and implementation has now been conducted in seven selected districts. Tanzania recognises the importance of including IMCI skills and knowledge in the basic training of paramedical staff, and is now using the training materials in two training schools, one for Assistant Medical Officers and one for Clinical Officers. In May 1998, the experience with IMCI was evaluated to guide future plans for implementation. The review showed that most of the objectives of the initial phase had been reached, but that further progress will require strengthening the district health system, particularly with regard to essential drugs, referral care, supervision and monitoring, and to improving family and community child care practices. The future strategy and plans link IMCI to the health sector reform which is under way at all levels in Tanzania.

In **Kazakhstan**, a national IMCI orientation meeting was held in November 1997. After the Government of Kazakhstan had adopted the IMCI strategy for implementation, a national IMCI secretariat was formed and preparation for the adaptation of the IMCI clinical guidelines was initiated. The national adaptation and planning workshop followed in March 1998. With support from the USAID-funded BASICS project and the WHO Regional Office, the Committee of Health of Kazakhstan conducted qualitative research in collaboration with the Manoff Group, to identify feeding practices and main feeding problems in the country. In July, key staff from the IMCI secretariat were trained in an 11-day IMCI training course in Indonesia. By the end of September, the final draft of the national IMCI training materials was completed. It was used for an inter-country IMCI training course for participants from 7 countries of the region, which was conducted in October. The first national IMCI training course was held in November. Kazakhstan has a key role for the entire WHO European Region, because it was selected as the "early use country" for the regional strategic approach to IMCI. Because of similarities in disease patterns and socio-economic conditions other countries in the Region will be able to take maximum advantage from the experiences gained in Kazakhstan.

Regional strategies

The WHO **African Region** has prepared a strategy in conjunction with UNICEF, the World Bank and other major donors committed to health development in Africa, to support countries to introduce IMCI. The strategy includes strengthening the capacity of the Regional Office to provide consultant and technical support, and encouraging countries to take greater financial responsibility for the initiative.

In the **Region of the Americas**, a document has been developed outlining objectives, strategies and implementation phases. In addition, the Regional Office for the Americas, in collaboration with USAID and the BASICS project, has designed a five year Regional Plan that includes IMCI implementation in eight Latin American countries between 1997 and 2001. ■

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